Evergreen Home Health

GROWING STRONGER EVERY DAY, WITH EVERGREEN HOME HEALTH.

Patient Admission Documents

Evergreen HC Group, Inc

403 W Main St Suite A1
Gaylord, MI 49735
(989) 214-1114

This packet contains important information regarding your care and services with Evergreen Home Health. Please read through carefully and keep it for future reference. If you have any questions, feel free to contact our office.

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EVERGREEN HOME HEALTH

403 W Main St Suite A1
Gaylord, MI 49735
Office: (989) 214-1114
Fax: (866) 410-7843

Dear Patient,

Welcome to Evergreen Home Health! We are honored that you have chosen us to provide your home health care needs. As an ACHC-accredited and CMS-certified skilled home health provider, we are committed to delivering the highest standards of care with professionalism, compassion, and expertise.

Our mission is to enhance your quality of life by offering comprehensive healthcare services in the comfort of your home. Our dedicated team of licensed nurses, therapists, and home health aides is here to support your recovery, independence, and overall well-being.

Our Services Include:

- **Skilled Nursing: Expert medical care including wound care, medication management, post-surgical care, and disease education.**
- **Therapy Services: Personalized physical and occupational therapy to help you regain strength, mobility, and independence.**
- **Home Health Aide Services: Assistance with daily activities such as personal care, bathing, dressing, light housekeeping, meal preparation, and companionship.**

We understand that each patient is unique, and we tailor our services to meet your specific needs. Our team will work closely with you, your family, and your healthcare providers to develop a personalized plan of care aimed at achieving your health goals.

Communication is key to effective care, and we encourage you to reach out with any questions or concerns. Our staff is available 24/7 to provide support and ensure your comfort and peace of mind. For operational concerns, please contact our Clinical Director at (989) 214-1114.

Thank you for entrusting Evergreen Home Health with your care. We look forward to being a valuable partner in your journey toward improved health and independence.

Warm regards,

The Evergreen Home Health Team

Admission Service Agreement

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CONSENT FOR CARE / SERVICE

I hereby consent to and authorize Evergreen HC Group Inc., DBA Evergreen Home Health (hereinafter referred to as the "Organization" and the "Agency"), along with its agents and associates, to provide care and treatment to me in my home as prescribed by my attending physician and in accordance with the Organization's policies and procedures. I understand that I am required to have an attending physician throughout the duration of my care, unless otherwise determined by the Organization. I acknowledge that I have received an explanation of the services to be provided, including the disciplines involved, the medication schedules and treatments, the proposed frequency of visits, and the anticipated outcomes. I have also participated in the development and have been informed of my role in the development and modification of my plan of care, as well as the process of making changes if necessary. Furthermore, I understand that in the absence of the Organization's staff, I and/or my designated family member(s) or caregiver(s) will be responsible for my care.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby consent to and authorize the organization to release and receive information for the purposes of treatment, payment and health care operations. The exchange of information may occur between, but is not limited to, physicians, third party payers, other health care providers, and regulatory and/or accrediting reviewers.

☐ I have a **legal** representative _____(name/title if applicable); they received a written copy of the patient's Rights and Responsibilities, the Transfer and Discharge policy, the agency's Administrator's contact information for complaints, and the OASIS privacy notice BEFORE home health services were provided.

☐ My **selected** representative is _____(name/relationship to patient); I want them to receive the following written documents (by checking a box below you are indicating which documents you want them to receive)

☐ the patient's Rights and Responsibilities ☐ the agency's Transfer and Discharge policy

I understand they will receive a copy **within 4 business days from the initial evaluation date**.

LIABILITY FOR PAYMENT

I certify that all the information given by me to the organization is correct for requesting and applying for payment under Title XVIII (Medicare), Title XIX (Medicaid) of the Social Security Act and/or from any third-party payer. I understand and agree to pay deductibles, co-payments, spend downs and any amount due after payment of benefits on my behalf by any and all third-party payers.

I verify that◯I am ◯am not a participating member of an HMO (Health Maintenance Organization). If I enroll in one, I will immediately notify the organization.

I understand that the services provided to me by this organization will be billed as follows:

◯ Medicare fee for service (Project 100% covered).

◯ Medicaid (Project 100% covered after meeting spend down and/or other requirements).

◯ Insurance (Coverage varies with individual policy). The patient's anticipated payment amounts per visit will be provided in writing when the insurance company informs the organization of the patient's financial liability. See organization's separate Visit Rate information. When known at time of Admission: Project _____ % of charges to be covered after deductible met. (Specify amounts if known _____).

◯ Private Pay (See separate Private Pay Rate Sheet. Patient is responsible for the timely payment of all charges.)

ASSIGNMENT OF BENEFITS

I request that payment of authorized benefits detailed on the attached Assignment of Benefits Form (if applicable) be made on my behalf directly to the organization. In the event Medicare does not cover certain services, the patient will receive an Advanced Beneficiary Notice of Non-Coverage (ABN) explaining financial responsibility. Clinicians are required to provide the ABN before services are rendered.

CONSOLIDATED BILLING - SUPPLIES

I understand that I will be informed which supplies are covered by Medicare while I am under a physician's home health plan of care. I understand that when the organization provides these types of supplies, I have no financial liability, but if I choose to obtain them or not to use the organization's vendor and/or brands, I will be responsible for the payment of that bill. I also understand when I am no longer an active patient under a Medicare home health plan of care that I am responsible for obtaining supplies and arranging for payment under Medicare Part B.

ACKNOWLEDGEMENT OF INFORMATION

I have received and understand the verbal and written information provided to me on the following:

- **Agency Cost of Services** list and my responsibility for that cost.
- **The nature, frequency, and visit schedule of home visits I will receive**; the medication schedules and treatments, and I have participated in the planning of my care.
- **Advance Directives**. I understand that the Organization will respect individual choice and will not discriminate whether I have an Advance Directive or a Do Not Resuscitate (DNR) directive.
- **Patients Rights and Responsibilities**.
- **Statement of Patient Privacy Rights and Privacy Act Statement-Health Care Records**.
- **Basic Home Safety.**
- **Emergency planning related to a disruption in service and emergency instructions related to changes in my medical condition.**
- **Infection control.**
- **Agency's Transfer/Discharge Policy.**
- **Agency's Complaint/Grievance Procedure,** including the name and contact information of the Clinical Director and Administrator.

ACKNOWLEDGEMENT SIGNATURES

This Admission Agreement is applicable to this admission to the organization. I understand what I have read and what was explained to me and agree with the terms and conditions above. I understand that any party may terminate this agreement at any time for any reason.

_____ _____ _____ _____

Agency Representative Signature *Date* *Patient or Authorized Representative* *Date*

_____ _____

Financial Guarantor (if different than above) *Date*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ _____

Patient Signature *Date*

Patient Unable to Sign Because: _____

_____ _____

Legal Representative (If Applicable) *Date*

_____ _____

Agency Representative Signature *Date*

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Home Health Tentative Visit Plan (by Discipline)

Patient Name: _____ **Patient ID**: _____

Services & Frequency (Check all that apply)

Disclaimer: This schedule is **tentative** and may change following the comprehensive evaluation and with ongoing treatment needs. The admitting clinician will review any changes with the patient/caregiver and the ordering provider.

☐ **Skilled Nursing (SN)** **Freq:** _____

☐ **Home Health Aide (HHA)** **Freq:** _____

☐ **Physical Therapy (PT)** **Freq:** _____

☐ **Occupational Therapy (OT)** **Freq:** _____

☐ **Medical Social Work (MSW)** **Freq:** _____

☐ **Speech Pathology (SLP)** **Freq:** _____

Acknowledgment

I understand this schedule is **tentative** and may be adjusted after the initial evaluation and as my condition or goals change. I will be informed of any changes.

Patient Signature: _____ Date: _____

Agency Representative: _____ Date: _____

Assignment of Benefits (AOB)

I, or my Authorize Representative (hereafter "I"), authorize and request (payor) _____ to pay Evergreen HC Group Inc DBA Evergreen Home Health (Agency) all applicable health care and insurance benefits that would otherwise be payable to me.

Primary Payor	
Program Name	
Policy Number	
Claim Number	
Group Number	
Primary Insured	
DOB:	

Secondary Payor	
Program Name	
Policy Number	
Claim Number	
Group Number	
Primary Insured	
DOB:	

Release of Health Information: I authorize the release of any health information necessary to determine benefits payable by the Payor. I have received a copy of Agency's Notice of Privacy Practices as required by HIPAA. Such releases may occur via unsecured electronic networks. I will notify Agency of any changes in my health care or insurance coverage.

Financial Responsibility: This AOB is an addendum to the Admission Services Agreement, assigning to Agency all applicable health care or insurance benefits payable to me. If the Payor issues payments to me instead of directly to Agency, I must immediately forward those payments to Agency. Except where prohibited by law, government program requirements, or contractual agreements, if a Payor refuses to pay for any services, equipment, deductibles, co-payments, or charges not covered by insurance or social agencies, I am personally responsible for these costs. The individual signing as "Authorized Representative" or "Financial Guarantor" will jointly assume all financial responsibilities, except where such liability is restricted by applicable law, government program guidelines, or contractual terms.

Authorized Representative Acknowledgment and Signature: An authorized representative, legal guardian, conservator, family member, power of attorney, or interested third party must sign if applicable. I agree to make payments on the patient's behalf or take responsibility if the patient or Payor cannot. I accept responsibility for all damages and liability if payment is not made to Agency. I agree with all statements herein.

_____ _____ _____ _____

Agency Representative *Date* *Patient or Authorized Representative* *Date*

_____ _____

Financial Guarantor (if different than above) *Date*

Authorization for Direct Payment via ACH (ACH Debit)

Patient Name: _____ **Patient ID:** _____

Direct Payment via ACH is the transfer of funds from a consumer account for the purpose of making a payment.

I (we) authorize Evergreen HC Group Inc ("COMPANY") to electronically debit my (our) account (and, if necessary, electronically credit my (our) account to correct erroneous debit) as follows:

Select One:

◯ Checking Account

◯ Savings Account

at the depository financial institution named below ("DEPOSITORY"). I (we) agree that ACH transactions I (we) authorize comply with all applicable law.

Depository Name _____

Account Holder Name _____

Routing Number _____

Account Number _____

Amount of debit(s) or method of determining amount of debit(s) [or specify range of acceptable dollar amounts authorized]: **Applicable bi-weekly service charge**.

Frequency of debit(s): **Bi-weekly as outlined in the COMPANY's current year billing schedule.**

I (we) understand that this authorization will remain in full force and effect until I (we) notify COMPANY, in writing, that I (we) wish to revoke this authorization. I (we) understand that COMPANY requires at least 2 weeks prior notice in order to cancel this authorization.

Account Holder Name(s) _____

Account Holder Signature(s) _____

Date _____

Credit Card Authorization Form

Patient Name: _____ **Patient ID:** _____

Credit Card Information				
Card Type:	☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX
	☐ Other _____			
Cardholder Name (as shown on card):				
Card Number:				
Expiration Date (mm/yy):				
Cardholder ZIP Code (from credit card billing address):				

***NOTE: CREDIT CARD PAYMENTS INCUR A 3.0 % SERVICE CHARGE**

INITIAL SERVICE DEPOSIT:
◯ N/A ◯ I authorize Agency to charge my credit card: $_____

MEDICAL SUPPLIES:
◯ N/A ◯ I authorize Agency to charge my credit card: $_____ ◯ One-time ◯ Recurring, every: _____

PAYMENT FOR SERVICES PROVIDED:
◯ N/A ◯ I authorize the Agency to automatically charge this account for future invoices. I grant permission to the Agency to make recurring charges to my credit card based on my standard service schedule, bi-weekly as specified on the current year Agency billing schedule. If necessary, the Agency may adjust any transactions that have been credited or debited in error. This authorization will remain effective until I provide written notice to the Agency to cancel it, allowing sufficient time for the Agency and the credit card processing company to process the request.

PAST DUE INVOICES - AUTHORIZATION:
I authorize Agency to charge my account if my bill is not paid in full within 10 days following the invoice due date.

GENERAL AUTHORIZATION:
I authorize Agency to charge my credit card on file or with my verbal authorization. I agree to pay for services and supplies provided, and indemnify Agency against any liability from this authorization. My signature on this form serves as the authorized signature on the credit card charge slip.

Cardholder Signature: _____ **Date:** _____

SENSORY-IMPAIRED AND LIMITED ENGLISH PROFICIENCY (LEP) PATIENT SUPPORT FORM

This form helps us understand your communication needs so we can provide the best support possible. All services listed are available to you **free of charge** as required under **Title VI of the Civil Rights Act of 1964** and other federal regulations. We are committed to ensuring meaningful access to our services for individuals with disabilities and Limited English Proficiency (LEP).

You are not required to rely on a caregiver, family member, or friend for interpretation. Our agency provides **interpreters and sign language services** to assist you in understanding service agreements and other documents. If you prefer to use someone you know, we will respect your choice.

Communication Abilities and Preferences:

Before proceeding, please check below if any of the following apply to you. If none apply, you may skip the remaining questions.

☐ **I have difficulty speaking, hearing, or understanding spoken language.**

☐ **I require assistance with written communication or reading materials.**

☐ **I need translation or interpretation services.**

If you checked any of the above, please complete the questions below:

1. **Are you able to speak?**
   ◯ Yes ◯ No
2. **Can you understand others by lip reading?**
   ◯ Yes ◯ No ◯ N/A (I do not have any sensory impairment that would require lip reading)
3. **Can you communicate through writing (paper and pencil)?**
   ◯ Yes ◯ No ◯ N/A (I do not have any verbal communication difficulties)
4. **Would picture or word cards help you communicate with nurses and caregivers?**
   ◯ Yes ◯ No
5. **Would you benefit from a telephone amplifier to increase sound clarity?**
   ◯ Yes ◯ No
6. **Do you require Braille materials or equipment?**
   ◯ Yes ◯ No
7. **Would you like assistance from a translator or interpreter (spoken or sign language)?**
   ◯ Yes ◯ No
8. **Can you communicate with our office using a TTY/TDD device?**
   ◯ Yes ◯ No

Available Auxiliary Aids and Services:

- Professional interpreters (spoken and sign language)
- Google Translate or other translation app-based software
- Flash cards
- Braille materials
- Telephone amplifier
- Writing materials (e.g., marker and dry erase board)
- Video Relay Services (VRS)
- **United Way of America Directory:** (703) 836-7100
- **The Alliance of Information and Referral Services (AIRS):** (815) 744-6922

Patient Information and Acknowledgement of Receipt:

By signing this form, I acknowledge that I have received information about the communication assistance services available to me, as required under Title VI of the Civil Rights Act of 1964 and other federal regulations, including interpreter services, auxiliary aids, and translation options. I understand that these services are available to me at no cost and can be requested at any time.

Name: _____ **Date:** _____

Signature: _____

For assistance, please contact our office at **989-214-1114** to request interpreter services or auxiliary aids at any time.

Advance Directives

Evergreen Home Health
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Patient Name: _____ Patient ID: _____

Patient Advance Directive Rights

At Evergreen HC Group, you have the legal right to decide about your medical treatment, including accepting or refusing care.

Understanding Advance Directives

Advance Directives are legal documents that outline your medical care preferences if you cannot decide for yourself. They ensure your healthcare wishes are known and respected. Types include:

- **Living Will:** Details the medical treatments you want or don't want.
- **Durable Power of Attorney (POA) for Health Care:** Names someone to make healthcare decisions for you.
- **Do Not Resuscitate (DNR) Order:** Tells providers not to perform CPR if your heart stops or you stop breathing.

Agency Policy on Advance Directives

Our agency does not discriminate based on whether an individual has an Advance Directive. To ensure your preferences are followed:

- Inform your physician and our agency if you have an Advance Directive.
- Notify us immediately if you create, change, or revoke an Advance Directive.
- Without a physician-signed DNR order, you will be considered Full Code, meaning resuscitation efforts will be made in a medical emergency.

Patient Advance Directives Information

Your Advance Directive information will be kept confidential in your clinical record. When relevant, your physician will be informed, necessary orders will be obtained, and our staff will be notified to ensure that your wishes are respected.

Please indicate your current Advance Directive status:

☐ I do not have an Advance Directive. ☐ I have a Living Will.

☐ I have a Durable Power of Attorney (POA) for Health Care.

- Named POA: _____ Phone: _____

☐ I have a Do Not Resuscitate (DNR) order.

☐ I have another type of Advance Directive: _____

Acknowledgment

I hereby acknowledge receipt of written information regarding my right to create Advance Directives. This includes my right to accept or refuse medical or surgical treatment, and my right to formulate Advance Directives in accordance with the law. I will furnish a copy of any documented Advance Directive to the agency if and when I prepare such a document.

Patient Signature: _____ Date: _____

Agency Representative: _____ Date: _____

Understanding Advance Directives

What are advance directives?

"Advance directives" are legal documents that allow you to plan and make your own end-of-life wishes known in the event that you are unable to communicate. Advance directives consist of (1) a living will and (2) a medical (healthcare) power of attorney. A living will describes your wishes regarding medical care. With a medical power of attorney you can appoint a person to make healthcare decisions for you in case you are unable to speak for yourself.

What is a living will?

A living will is an advance directive that guides your family and healthcare team through the medical treatment you wish to receive if you are unable to communicate your wishes. According to your state's living will law, this document is considered legal as soon as you sign it and a witness signs it, if that's required. A living will goes into effect when you are no longer able to make your own decisions.

What is a medical power of attorney?

A medical power of attorney is the advance directive that allows you to select a person you trust to make decisions about your medical care if you are temporarily or permanently unable to communicate and make decisions for yourself. This includes not only decisions at the end of your life, but also in other medical situations. This document is also known as a "healthcare proxy," "appointment of healthcare agent" or "durable power of attorney for healthcare." This document goes into effect when your physician declares that you are unable to make your own medical decisions. The person you select can also be known as a healthcare agent, surrogate, attorney-in-fact or healthcare proxy.

Who should I select to be my medical power of attorney?

You should select someone you trust, such as a close family member or good friend who understands your wishes and feels comfortable making healthcare decisions for you. You should have ongoing conversations with this person to talk about your wishes at the end of life. Make sure your medical power of attorney feels comfortable and confident about the type of medical care you want to receive.

Most state laws prevent your doctor or any professional caregiver from being assigned as your healthcare agent. You can also select a second agent as an alternate in case your first healthcare agent is unwilling or unable to serve.

National Hospice and Palliative Care Organization
CaringInfo

Understanding Advance Directives

What do I need to know about end-of-life decisions to prepare my advance directive?

Learn about life-sustaining treatments

Life-sustaining treatments are specific medical procedures that support the body and keep a person alive when the body is not able to function on its own. Making the decision about whether or not to have life-sustaining treatments can be a difficult decision depending on your situation.

You might want to accept life-sustaining treatments if they will help to restore normal functions and improve your condition. However, if you are faced with a serious life-limiting condition, you may not want to prolong your life with life-sustaining treatment. The most common end-of-life medical decisions that you, family members or an appointed healthcare agent must make involve:

- Cardiopulmonary Resuscitation (CPR)
- Do Not Resuscitate Order (DNR)
- Do Not Intubate Order (DNI)
- Artificial Nutrition and Hydration

What is cardiopulmonary resuscitation (CPR)?

Cardiopulmonary resuscitation (CPR) is a group of procedures used when your heart stops (cardiac arrest) or breathing stops (respiratory arrest). For cardiac arrest the treatment may include chest compressions, electrical stimulation or use of medication to support or restore the heart's ability to function. For respiratory arrest treatment may include insertion of a tube through your mouth or nose into the trachea (wind pipe that connects the throat to the lungs) to artificially support or restore your breathing function. The tube placed in your body is connected to a mechanical ventilator.

What are advance directives?

A Do Not Resuscitate (DNR) order is a written physician's order that prevents the healthcare team from initiating CPR. The physician writes and signs a DNR at your request or at the request of your family or appointed healthcare agent if you do not want to receive CPR in the event of cardiac or respiratory arrest. The DNR order must be signed by a doctor otherwise, it cannot be honored. DNR orders:

- Can be cancelled at any time by letting the doctor who signed the DNR know that you have changed your decision.

- Remain in effect if you transfer from one healthcare facility to another. However, consult the arrival facility's policy to make sure. Also, the DNR may not be honored if you are discharged from the facility to your home if your state does not have an out-of-hospital DNR policy.
- May not be honored during surgery but this is something very important to discuss with your surgeon and anesthesiologist before surgery so your wishes are honored.
- Should be posted in the home if that is where you are being cared for.

If there is no DNR order, the healthcare team will respond to the emergency and perform CPR. The team will not have time to consult a living will, the family, the patient's healthcare agent or the paient's doctors if they are not present.

What is a Do Not Intubate (DNI) order?

When you request a DNR order, your physician may ask if you also wish to have a "do-not-intubate" order. Intubation is the placement of a tube into the nose or mouth in order to have it enter your windpipe (trachea) to help you breathe when you cannot breathe adequately yourself. Intubation might prevent a heart attack or respiratory arrest.

Refusal of intubation does not mean refusal of other techniques of resuscitation. If you do not want mechanical ventilation (breathing), you must discuss intubation because it may be included as part of a DNR order. Even if you have completed a DNR order that does not mean that you have refused to be intubated. If you do not want life mechanically sustained, you must discuss your decision about intubation with your doctor.

What is artificial nutrition and hydration?

Artificial nutrition and hydration are treatments that allow a person to receive nutrition (food) and hydration (fluid) when they are no longer able to take them by mouth. This treatment can be given to a person who cannot eat or drink enough to sustain life. When someone with a serious or life-limiting illness is no longer able to eat or drink, it usually means that the body is beginning to stop functioning as a result of the illness.

How can I prepare my advance directive?

You can fill out a living will and medical power of attorney form without a lawyer. The National Hospice and Palliative Care Organization, your state hospice organization, local hospitals, public health departments, state bar associations or state aging offices provide state-specific forms and instructions. It is very important that you use advance directive forms specifically created for your state so that they are legal. Read the forms carefully and make sure you follow legal requirements determined by your state. You may need to have a witness signature and get the forms notarized (signed by a notary public.)

Keep your completed advance directive in an easily accessible place and give photocopies to your primary medical power of attorney and your secondary, alternate agent. This document stays in effect unless you cancel it or decide to complete a new one with changes.

Understanding Advance Directives

Can healthcare professionals refuse to honor my advance directive?

Some healthcare professionals may choose to ignore what is written in your living will if they believe that what is written is against your best interest or for moral or religious reasons. In some cases there may be a misunderstanding of the law, medical ethics or professional responsibilities. It is important for you to know if your doctor will honor your request. Bring your completed living will to your next healthcare appointment and ask your doctor if he or she has questions or concerns.

Who would decide about my medical care if I did not complete an advance directive?

If you are unable to make decisions, healthcare professionals must consult your family members. Some states have decision-making laws to identify individuals who may make decisions on your behalf when you do not have an advance directive, such as your spouse, parents or adult children.

Does my advance directive include my wishes about organ donation, cremation or burial?

Some states may include your wishes about whether you want to be an organ donor as part of the advance directive. If it is not included, you can still write down your decision about organ donation. However, you should fill out a specific form for that purpose.

You should also let your loved ones know if you wish to be buried or cremated.

National Hospice and Palliative Care Organization

CaringInfo

www.CaringInfo.org

CaringInfo@nhpco.org

Consumer InfoLine: 800-658-8898

Multilingual InfoLine: 877-658-8896

Patient Rights and Responsibilities

As a home health care provider, we must inform you of your rights in a comprehensible manner before treatment begins, during the initial evaluation visit, and as needed thereafter. If you are unable to exercise these rights yourself, your family or guardian may do so on your behalf.

YOU HAVE THE RIGHT TO:

- Receive a copy of these rights and responsibilities in a format you understand before receiving care.
- Exercise your rights at any time.
- Access auxiliary aids and language services for free.
- Receive services without discrimination based on various personal attributes.
- Have your property and person treated respectfully.
- Identify visiting personnel through photo ID.
- Be free from mistreatment, abuse, neglect, and property misappropriation.
- Participate in and consent to or refuse care with respect to:
    - Completing assessments;
    - Care based on assessment;
    - Plan of Care;
    - Care disciplines;
    - Visit frequency;
    - Expected outcomes and risks;
    - Treatment effectiveness factors;
    - Changes in care.
- Receive information about the agency's service scope and limitations.
- Receive all services outlined in your Plan of Care as per physician orders.
- Choose your healthcare provider.
- Refuse care after understanding the consequences.
- Be informed of your right to create an Advanced Directive under state law.

CONFIDENTIALITY - YOU HAVE THE RIGHT TO:

Patients are entitled to maintain a confidential clinical record and the privacy of all information contained therein, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) law and regulations (45 CFR parts 160 and 164) concerning the collection and transmission of Protected Health Information (PHI) data (OASIS). Access to or release of patient information and clinical records is authorized only in compliance with these regulations (45 CFR parts 160 and 164).

Additionally, patients will be informed of the Agency's policies and procedures regarding the disclosure of patient records.

FINANCIAL - YOU HAVE THE RIGHT TO:

- Be informed, both orally and in writing, about charges before care/service is provided. This includes:
    - Payment expected from third parties and charges you will be responsible for.
    - Potential payments from Medicare, Medicaid, or other federal programs known to the Agency.
    - Charges not covered by these programs.
    - Charges you must pay before starting care.
- Any changes in payment and charges, communicated promptly and before the next home health visit, as per 42 CFR §411.408(d)(2) and 42 CFR §411.408(f).
- Receive written notice in advance if a service may not be covered, or if ongoing care is to be reduced or terminated. Be informed of any financial benefits when referred to an Agency.

COMPLAINTS OR GRIEVANCES - YOU HAVE THE RIGHT TO:

- Be informed of how to contact the Agency if dissatisfied.
- Voice grievances or complaints regarding treatment, care, service delivery, respect for property or person, or violation of any rights, and recommend policy or personnel changes without fear of restraint, interference, coercion, discrimination, or reprisal.
- Have grievances or complaints about treatment, care, service delivery, or lack of respect for property investigated.

You may call our office **24 hours a day, seven days a week**, or submit your complaint in writing to:

Agency:	Evergreen Home Health		
Attn Administrator	Christopher Churches		
Address:	403 W Main Street Suite A1		
City:	Gaylord	**State / Zip**:	Michigan, 49735
Phone:	(989) 214-1114	**After Hours #:**	(989) 214-1114
Office Business Hours	Monday through Friday 8:30am-5:00pm (closed on major holidays)		
On-Call Hours	24/7 on call		
Hours of Operation:	Office Hours: Mon-Fri 08:30AM-05:00PM (closed on major holidays), 24/7 On-Call		

- Be informed about the state toll-free Home Health telephone hotline, its contact details, operating hours, and primary purpose. The hotline is available to receive complaints or questions regarding local Home Health agencies.

  State Toll-Free Home Health Hotline Number: 1-800-882-6006
  Hours of Operation: Available from 8 AM to 5 PM Monday through Friday, except state Holidays or online by going to: https://www.michigan.gov/lara/bureau-list/bsc (click on “file a complaint” link)

- Complaints or concerns can also be directed our accreditation body, the **Accreditation Commission for Health Care (ACHC) Complaint Hotline: 1-855-937-2242**

Here are the contacts for federally-funded and state-funded entities in your area:

Agency on Aging – Region 9	Agency on Aging – Region 10	Center for Independent Living
Name: Northwest Michigan Community Service Agency (NEMCSA)	**Name:** Area Agency on Aging of Northwest Michigan (AAANM)	**Name:** Michigan Statewide Independent Living Council
Phone #: (989) 358-4600	**Phone #:** (231) 947-8920	**Phone #:** (800) 808-7452
Address: 2569 US-23 Alpena, MI 49707	**Address:** 1609 Park Dr Traverse City, MI 49696	**Address:** Website: https://www.misilc.org/

Aging and Disability Resource Center	Quality Improvement Organization	Protection and Advocacy Agency
Name: Northwest Michigan Community Service Agency (NEMCSA)	**Name:** Livanta, LLC	**Name:** Area Agency on Aging of Northwest Michigan (AAANM)
Phone #: (989) 358-4600	**Phone #:** (888) 524-9900	**Phone #:** (231) 947-8920
Address: 2569 US-23 Alpena, MI 49707	**Website:** https://www.livantaqio.cms.gov/en/states/michigan	**Address:** 1609 Park Dr Traverse City, MI 49696

TRANSFER/DISCHARGE - YOU HAVE THE RIGHT TO:

Be informed of the Agency's transfer and discharge policies. The Agency may transfer or discharge you if:

- Your welfare requires it and the Agency and physician agree they can no longer meet your needs.
- You or the payer stop paying for services.
- Your goals in the Plan of Care are achieved, as agreed by the physician and Agency.
- You refuse services or choose to be transferred or discharged.
- Disruptive, abusive, or uncooperative behavior in your home impairs care delivery or Agency operations.

AS A PATIENT YOU HAVE THE RESPONSIBILITY TO:

- Assist in maintaining a safe, non-abusive environment and identify safety concerns to Agency staff.
- Notify the Agency of any of the following:
    - When scheduled visits cannot be kept or when the schedule needs to be changed.
    - Any problems or dissatisfaction with the services provided. You and your representative, if any, are responsible for understanding and exercising your rights to optimize response to and satisfaction with home care services.
    - The existence of, or changes to advance directives.
    - If family members are unavailable to assist with your care.
    - Any perceived risks or unexpected changes in your condition (e.g., hospitalization, changes in the plan of care, symptoms to be reported, pain, homebound status or change of physician).
    - If you do not understand any instructions or find them difficult to follow.
- Provide accurate and complete information about your present and past medical history, hospitalizations, medications, pain management, and any other relevant information so the Agency can supply appropriate materials to make informed decisions about treatment, the cost of treatment, and assist in establishing an effective care plan.
- Take responsibility for actions if you choose not to follow the Plan of Care.
- Show respect and consideration for Agency personnel and property.
- Accept qualified Agency personnel without discrimination based on race, religion, political belief, sex, social status, sexual orientation, marital status, age, or handicap.
- Meet financial commitments agreed to with the Agency.
- Establish a contingency plan with the Agency in case the Agency is unable to provide services. The Agency will make every effort to visit or contact you if there is an emergency that disrupts service. If you have a medical emergency and are unable to contact the Agency, you should access emergency assistance by calling 9-1-1.
- You or your representative are responsible for immediately reporting if property, money, and/or valuables are missing or damaged during the time home care services are provided.

IF THE PATIENT LACKS THE CAPACITY TO EXERCISE THESE RIGHTS, THE RIGHTS SHALL BE EXERCISED BY AN INDIVIDUAL, GUARDIAN, OR ENTITY LEGALLY AUTHORIZED TO REPRESENT THE PATIENT.

ACKNOWLEDGEMENT:

I have read and received a copy of the rights and responsibilities. A representative of the Agency discussed these with me before the start of care. My signature confirms my understanding of these rights and responsibilities.

Agency Representative	*Date*	*Patient or Authorized Representative*	*Date*

HIPAA Authorization Form

Patient Name	
Patient Date of Birth	

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the disclosure, exchange, and transmission of my health information as outlined below.

AUTHORIZED PERSONS/ORGANIZATIONS TO DISCLOSE INFORMATION:

- Evergreen HC Group Inc (DBA Evergreen Home Health)
- Any physician, medical practitioner, or health care provider
- Any hospital, clinic, pharmacy, or other medical or medically related facility or association
- Any insurance company or insurance support organization
- Any employer or plan administrator
- Any government agency
- Any organization or entity administering a benefit program
- Any rehabilitation organization or program

INFORMATION TO BE DISCLOSED: I authorize the release, sharing, exchange, and transmission of the following information, which may occur via unsecured electronic networks:

- Chart notes, photographs, x-rays, operative reports, laboratory and medication records
- All other medical information, including but not limited to:
    - Medical history, diagnoses, examinations, testing, and test results
    - Prescriptions, prognosis, and treatment plans for any physical or mental condition
    - Information related to disorders of the immune system, including HIV, AIDS, or related conditions
    - Information regarding communicable diseases or disorders
    - Psychiatric or psychological conditions, including test results, treatments, or therapies
    - Substance abuse information, including alcohol and drug-related conditions, treatments, or therapies
    - Non-medical information such as eligibility for benefits, earnings, or financial data

PURPOSE OF DISCLOSURE: This information will be used to assist Evergreen HC Group Inc and the authorized organizations in determining and implementing an appropriate plan of care tailored to my needs.

ACKNOWLEDGEMENT AND UNDERSTANDING: By signing this authorization, I acknowledge the following:

- This authorization remains valid for the duration of my care unless revoked earlier in writing.
- I may revoke this authorization at any time by submitting a written request to Evergreen HC Group Inc. I understand that any revocation will not affect disclosures made in reliance on this authorization before the revocation date.
- My care with Evergreen HC Group Inc is not conditioned upon signing this authorization.
- A photocopy or electronic version of this authorization is as valid as the original.
- I understand that information disclosed under this authorization may no longer be protected by federal privacy laws if re-disclosed by the recipient, though it may still be protected under other state or federal laws.

PATIENT SIGNATURE:	**IF SIGNED BY A LEGAL REPRESENTATIVE:**
Printed Name: _____	**Name & Relationship** _____
	Authority to Act: ☐ **POA** ☐ **Legal Guardian**
Signature: _____	**Signature:** _____
Date: _____	**Date:** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PROTECTED INFORMATION

While receiving care from our organization, information regarding your medical history, treatment, and payment for your health care may be originated and/or received by us. Information which can be used to identify you and which relates to your past, present or future medical condition, receipt of health care or payment for health care ("Protected Information").

OUR RESPONSIBILITIES:

Under federal law, we are required to:

- Provide you with notice of our legal duties and our policies regarding the use and disclosure of your Protected Information.
- Maintain the confidentiality of your Protected Information in accordance with state and federal law.
- Honor your requested restrictions regarding the use and disclosure of your Protected Information unless legally authorized to release your information without your authorization, in which case you will be notified within a reasonable period of time.
- Allow you to inspect and copy your Protected Information during regular business hours.
- Act on your request to amend your Protected Information within sixty (60) days and notify you of any delay requiring an extension of up to thirty (30) additional days.
- Provide you with an **accounting of disclosures** upon request, which lists times your Protected Information has been shared without your direct authorization.
- Accommodate reasonable requests to communicate Protected Information by alternative means or methods.
- Abide by the terms of this notice.
- Notify you in the event of a **breach** of your Protected Information.

HOW YOUR PROTECTED INFORMATION MAY BE USED AND DISCLOSED:

1. Treatment, Payment, and Health Care Operations

- **Treatment Purposes:** We may use or disclose your Protected Information to provide you with medical treatment or services. This includes communication among healthcare professionals regarding your care and treatment options.
- **Payment Purposes:** Your Protected Information may be used or disclosed for billing and payment processing, including claims to insurance providers and prior authorization requests.
- **Health Care Operations:** We may use your Protected Information for administrative, training, and quality assurance activities.

2. Other Permitted Uses and Disclosures

We may disclose your Protected Information **without** your authorization in the following situations:

- As required by law (e.g., public health reporting, law enforcement requests, national security, etc.).

- To avert a serious threat to health or safety.
- To comply with health oversight activities, such as audits and investigations.
- For organ and tissue donation purposes.
- For workers' compensation or other similar programs.

YOUR RIGHTS REGARDING YOUR PROTECTED INFORMATION:

You have the right to:

- **Inspect and Copy:** You may request to view or obtain a copy of your health records, subject to legal limitations.
- **Request an Amendment:** If you believe your Protected Information is incorrect or incomplete, you may request an amendment.
- **Receive an Accounting of Disclosures:** You may request a list of disclosures of your Protected Information made by our organization that were not for treatment, payment, or healthcare operations.
- **Request Confidential Communications:** You may request that we communicate with you using alternative means or locations.
- **Request Restrictions:** You may ask us to restrict certain uses or disclosures of your Protected Information; however, we are not always required to agree to your request.
- **Obtain a Copy of This Notice:** You have the right to receive a paper or electronic copy of this notice upon request.
- **File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or the **U.S. Department of Health & Human Services (HHS)** without fear of retaliation.

FILING A COMPLAINT:

If you believe your privacy rights have been violated, you may contact:

Christopher Churches
Evergreen HC Group Inc
403 W Main Street Suite A1 Gaylord, MI 49735
Phone: 989-214-1114

Or, you may file a complaint with the **U.S. Department of Health & Human Services Office for Civil Rights**:

Website: https://www.hhs.gov/hipaa/filing-a-complaint/
Phone: 1-800-368-1019

We will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE:

We reserve the right to revise our practices with respect to Protected Information and to amend this notice. Should our information practices change, we will provide you with an updated copy either electronically or by print. In addition, a current notice of our privacy practices may be obtained from Evergreen's office located at 403 W Main Street Suite A1, Gaylord, MI 49735.

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS
This statement gives you notice required by law (the Privacy Act of 1974).
This statement is not a consent form. It will not be used to release or to use your health care information.

I. Authority for collection of your information, including your social security number, and whether or not you are required to provide information for this assessment. Sections 1102(a), 1154, 1861(z), 1864, 1865, 1866, 1871, 1886(j) of the Social Security Act.

Medicare participating inpatient rehabilitation facilities must do a complete assessment that accurately reflects your current clinical status and includes information that can be used to show your progress toward your rehabilitation goals. The inpatient rehabilitation facility must use the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IFR-PAI) as part of that assessment, when evaluating your clinical status. The IRF-PAI must be used to assess every Medicare Part A fee-for-service inpatient, and it may be used to assess other types of inpatients. This information will be used by the Centers for Medicare & Medicaid Services (CMS) to be sure that the inpatient rehabilitation facility is paid appropriately for the services that they furnish you, and to help evaluate that the inpatient rehabilitation facility meets quality standards and gives appropriate health care to its patients. You have the right to refuse to provide information to the inpatient rehabilitation facility for the assessment. Information provided to the federal government for this assessment is protected under the Federal Privacy Act of 1974 and the IRF-PAI System of Records. You have the right to see, copy, review, and request correction of inaccurate or missing personal health information in the IRF-PAI System of Records.

II. PRINCIPAL PURPOSES FOR WHICH YOUR INFORMATION IS INTENDED TO BE USED

The information collected will be entered into the IRF-PAI System No. 09-70-1518. Your health care information in the IRF-PAI System of Records will be used for the following purposes:

- support the IRF prospective payment system (PPS) for payment of the IRF Medicare Part A fee-for-services furnished by the IRF to Medicare beneficiaries;
- help validate and refine the Medicare IRF-PPS
- study and help ensure the quality of care provided by IRFs;
- enable CMS and its agents to provide IRFs with data for their quality assurance and ultimately quality improvement activities;
- support agencies of the State government , deeming organizations or accrediting agencies to determine, evaluate and assess overall effectiveness and quality of IRF services provided in the State;
- provide information to consumers to allow them to make better informed selections of providers;
- support regulatory and policy functions performed within the IRF or by a contractor or consultant;

- support constituent requests made to a Congressional representative;
- support litigation involving the facility;
- support research on the utilization and quality of inpatient rehabilitation services; as well as, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health for understanding and improving payment systems.

III. ROUTINE USES

These "routine uses" specify the circumstances when the Centers for Medicare & Medicaid Services may release your information from the IRF-PAI System of Records without your consent. Each prospective recipient must agree in writing to ensure the continuing confidentiality and security of your information. Disclosures of protected health information authorized by these routine uses may be made only if, and as, permitted or required by the 'Standards for Privacy of Individually Identifiable Health Information.' (45 CFR Parts 160 and 164). Disclosures of the information may be to:

1. To agency contractors or consultants who have been contracted by the agency to assist in the performance of a service related to this system of records and who need to have access to the records in order to perform the activity;
2. To a Peer Review Organization (PRO) in order to assist the PRO to perform Title XI and Title XVIII functions relating to assessing and improving IRF quality of care. PROs will work with IRFs to implement quality improvement programs, provide consultation to CMS, its contractors, and to State agencies;
3. To another Federal or State agency:
    a. To contribute to the accuracy of CMS's proper payment of Medicare benefits,
    b. To enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds, or
    c. To improve the state survey process for investigation of complains related to health and safety or quality of care and to implement a more outcome oriented survey and certification program.
4. To an individual or organization for a research, evaluation, or epidemiological projects related to the prevention of disease or disability, the restoration or maintenance of health epidemiological or for understanding and improving payment projects.
5. To a member of Congress or to a congressional staff member in response to a inquiry of the Congressional Office made at the written request of the constituent about whom the record is maintained.
6. To the Department of Justice (DOJ), court or adjudicatory body when:
    a. The agency or any component thereof; or
    b. Any employee of the agency in his or her official capacity; or
    c. Any employee of the agency in his or her individual capacity where the employee; or

d. The United States Government; is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation and the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.

7. To a CMS contractor (including, but not necessarily limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such program.
8. To another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud or abuse in whole or part by Federal funds, when disclosure is deemed reasonable necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat frauds or abuse in such programs;
9. To a national accrediting organization that has been approved for deeming authority for Medicare requirements for inpatient rehabilitation services (i.e., the Joint Commission for the Accreditation of Healthcare Organizations, the American Osteopathic Association and the Commission of Accreditation of Rehabilitation Facilities). Data will be released to these organizations only for those facilities that participate in Medicare by virtue of their accreditation status.
10. To insurance companies, third party administrators (TPA), employers, self-insurers, manage care organizations, other supplemental insurers, non-coordinating insurers, multiple employer trusts, group health plans (i.e., health maintenance organizations (HMO) or a competitive medical plan (CMP)) with a Medicare contract, or a Medicare-approved health care prepayment plan (HCPP), directly or through a contractor, and other groups providing protection for their enrollees. Information to be disclosed shall be limited to Medicare entitlement data. In order to receive the information, they must agree to:
    a. Certify that the individual about whom the information is being provided is one of its insured or employees, or is insured and/or employed by another entity for whom they serve as a third party administrator;
    b. Utilize the information solely for the purpose of processing the individual's insurance claims; and
    c. Safeguard the confidentiality of the data and prevent unauthorized access.

IV. EFFECT ON YOU IF YOU DO NOT PROVIDE INFORMATION

The inpatient rehabilitation facility needs the information contained in the IRF-PAI in order to comply with the Medicare regulations. Your inpatient rehabilitation facility will also use the IRF-PAI to assist in providing you with quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect

information also could make it difficult to evaluate if the facility is giving you quality services. If you choose not to provide information, there is no federal requirement for the inpatient rehabilitation facility to refuse you services.

CONTACT INFORMATION

If you want to ask the Centers for Medicare & Medicaid Services to see, review, copy or request correction of inaccurate or missing personal health information which that Federal agency maintains in its IRF-PAI System of Records:

Call 1-800-MEDICARE, toll free, for assistance in contacting the IRF-PAI System of Records Manager.

TTY for the hearing and speech impaired: 1-800-820-1202

This is a Medicare & Medicaid Approved Notice.

Home Health Agency (HHA)
Outcome and Assessment Information Set (OASIS)

Statement of Patient Privacy Rights

As a home health patient, you have these privacy rights:

- **You have the right to know why we need to ask you questions.**

  We're required by law to collect health information to make sure you get quality health care, and that payment for Medicare and Medicaid patients is correct.

- **You have the right to have your personal health care information kept confidential.**

  We may ask you to tell us information about yourself so that we'll know which home health services will be best for you. We keep anything we learn about you confidential.

  This means only those legally authorized or with a medical need to know will see your personal health information.

- **You have the right to refuse to answer questions.**

  We may need your help to collect your health information.

  If you choose not to answer, we'll fill in the information as best we can. You don't have to answer every question to get services.

- **You have the right to look at your personal health information.**

  It's important that the information we collect about you is correct. If you think we made a mistake, ask us to correct it.

  If you're not satisfied with our response, you can ask the Centers for Medicare & Medicaid Services (the federal Medicare and Medicaid agency) to see, review, copy or correct your personal health information.

  See the Privacy Act Statement for more details about your privacy rights.

Need to correct your personal information?

To see, review, copy, or correct your personal health information in federal records call **1-800-MEDICARE (1-800-633-4227)** for help contacting the HHA OASIS System Manager. TTY users call 1-877-486-2048.

This is a Medicare & Medicaid Approved Notice.

Evergreen Home Health

GROWING STRONGER EVERY DAY, WITH EVERGREEN HOME HEALTH.

Emergency Preparedness Plan

In case of a disaster, bad weather, or emergency, the Agency has a plan to continue essential Patient services. Home care visits will be maintained if possible, but staff safety is a priority. If travel is unsafe, we will call you to inform you that your caregiver cannot make it.

Patients have priority codes that are updated as needed, determining response priority during emergencies. These codes and helpful information for Emergency Management Services are kept at the Agency office.

LEVEL I - Patients in this priority level need uninterrupted services. The patient must have care. In case of a disaster or emergency, every possible effort must be made to see this patient. The patient's condition is highly unstable, and deterioration or inpatient admission is highly probable if the patient is not seen. Examples include patients requiring life-sustaining equipment or medication, those needing highly skilled wound care, and unstable patients with no caregiver or informal support to provide care.

LEVEL II - Services for patients at this priority level may be postponed with telephone contact. A caregiver can provide basic care until the emergency situation improves. The patient's condition is somewhat unstable and requires care that should be provided that day but could be postponed without harm to the patient.

LEVEL III - The patient may be stable and has access to informal resources to help them. The patient can safely miss a scheduled visit with basic care provided safely by family or other informal support or by the patient personally. Visits may be postponed 72 hours or more with little or no adverse effects. A willing and able caregiver is available, or the patient is independent in most activities of daily living.

If bad weather or other issues prevent Agency staff from reaching you, check local radio, TV, or news websites for official information. Follow emergency personnel instructions. You might need to take shelter, go to a specific place, or evacuate. Notify the Agency if you evacuate.

EMERGENCY SITUATION GUIDELINES:

POWER OUTAGE: In the event of a power outage and the Agency's phone lines are unavailable, contact 911 or visit the emergency room if it is an emergency. If it is not urgent, reach out to your nearest relative or neighbor for assistance.

LIGHTNING:

- Indoors: Avoid using tubs, faucets, and sinks as metal pipes can conduct electricity. Stay away from windows and refrain from using corded phones except in emergencies.
- Outdoors: Steer clear of natural lightning rods like tall trees in open areas and distance yourself from any metal objects.

FLOOD: Be vigilant of flood hazards, especially if residing in low-lying areas, near water bodies, or downstream from dams. Flooding may take days to develop, but flash floods can cause raging waters within minutes. Six inches of moving water can be hazardous. Avoid walking through moving water; use a stick to test the ground firmness if necessary.

LANDSLIDE: If you live in a low-lying area or near streams/channels, monitor any sudden changes in water flow or clarity. Move away from the landslide path or debris flow quickly. Mudflows can move faster than running speed. Before crossing bridges, look upstream and do not proceed if a mudflow is approaching.

TORNADO: Upon tornado sighting, move to the lowest floor and find an interior room. Suitable shelters include basements, rooms without outside walls, bathtubs, and spaces under stairs. Public buildings typically have designated shelter areas. Stay away from windows and doors, protect your head under sturdy furniture, and remain sheltered until the danger passes.

For bed-bound individuals: Move the bed away from windows and use heavy blankets or pillows to protect the head and face. If in a vehicle, trailer, or mobile home: Exit immediately and seek a sturdy structure or lie flat in the nearest ditch, covering your head. Do not attempt to outdrive a tornado due to their unpredictable paths.

WINTER STORM: Heavy snowfall and extreme cold can isolate regions, causing blocked roads and downed power lines. Wear layers of loose, lightweight clothing rather than one heavy layer. Opt for hats and tightly woven, water-repellent outer layers. Mittens are preferable over gloves for warmth.

HURRICANE: Preparation is crucial for hurricane survival. Stay informed about the storm's path and expected arrival. Prepare for floods, high winds, and property damage. Secure outdoor items in waterproof places, cover windows with wood, shutters, or masking tape, and fill clean bathtubs with water. Evacuate to a shelter if needed.

EARTHQUAKE: Protect yourself from falls and falling objects. Remain where you are and stay away from building exteriors, power lines, trees, street lights, and signs.

- Indoors: Take cover under sturdy tables and protect your head. If using a wheelchair, move to a doorway, lock the wheels, and cover your head. In bed, protect your head with a pillow.
- Outdoors: Stay there and avoid buildings. In a car, park away from dangers and stay inside until shaking stops.

After the earthquake: Wait before moving, make noises or shine a flashlight if trapped, and prepare for aftershocks.

WILDFIRE: Wildfires spread rapidly and often begin unnoticed. If a wildfire threatens your area, evacuate immediately when instructed by authorities. Wear cotton or wool clothing, including long pants, long sleeves, jackets, and boots. Carry gloves, a face-covering handkerchief, water, goggles, a flashlight, mobile phone, and portable radio. Bring essential documents and designate a safe meeting place. Close all interior doors, remove flammable curtains, turn off pilot lights, and move overstuffed furniture to the room center. Park vehicles in garages with keys in the ignition facing outwards.

BIOLOGICAL THREAT: Follow official news and information for disease symptoms, danger areas, medication/vaccination distribution, and medical attention locations. If encountering suspicious substances, leave the area promptly. Cover your mouth and nose with layered fabric, consider wearing a face mask to prevent germ spread, and follow public health directives during quarantine. Remove contaminated clothing, wash thoroughly, and seek medical care if exposed.

CHEMICAL EXPOSURE: Seek immediate medical screening and treatment. Drink only stored water.

- If Outdoors: Move upwind and uphill from contaminants.
- If Indoors: Seal doors, windows, vents, and electrical outlets with plastic and duct tape. Maintain water in sink and toilet traps.

If contaminated: Remove clothing carefully, wash skin, rinse eyes if irritated, decontaminate eyeglasses, and follow local emergency instructions post-sheltering.

EXPLOSION: Take cover under sturdy furniture if debris is falling. Once safe, exit cautiously, avoiding smoke, fire hazards, damaged floors, and stairs. Do not retrieve possessions or use elevators. Move away from windows, glass doors, sidewalks, and streets used by emergency responders. Make noise or use a flashlight if trapped, limit shouting to avoid dust inhalation, and reduce unnecessary movement.

EMERGENCY KIT FOR THE HOME: Prepare for bad weather or emergencies with a kit containing a battery-powered radio, flashlights, extra batteries, non-perishable food, manual can opener, utensils, cups, plates, medications, extra blankets, bottled water, extra fuel, and a portable battery pack for cell phones.

SHELTER SUPPLIES: When evacuating to a shelter, bring a two-week supply of medications, medical supplies (e.g., oxygen, wheelchair), special dietary foods, air mattress/cot, bedding, lightweight folding chair, extra clothing, hygiene items, eyeglasses, important documents, and photo ID. Most shelters will have generator-powered electricity.

EMERGENCY PREPAREDNESS AND PETS: Ensure pet safety by planning ahead. ID pets with secure collars and attach identification to cages. Assemble a pet disaster kit with a five-day supply of food, water, bowls, medications, leashes, harnesses, waste disposal supplies, photos of you with your pets, and feeding/behavior information. Plan evacuation logistics for pets, noting that public shelters typically exclude them. Identify pet-friendly hotels, boarding facilities, and vet services, and prepare a contact list.

PATIENT SPECIFIC EMERGENCY PREPAREDNESS PLAN

Patient Name: _____ Patient ID: _____

Address: _____

Emergency Contact Name: _____ **Phone:** _____

YOUR ASSIGNED PATIENT CLASSIFICATION CODE IS:

◯ **LEVEL I** ◯ **LEVEL II** ◯ **LEVEL III**

EVACUATION PLANS:	
If you need to leave your home:	Self-evacuate, if able, out of nearest exit. Call emergency services if unable to self-evacuate. Notify the Agency if you evacuate to another location or emergency shelter.
If you need to leave your city:	Arrange self-transport, transport via EMS, or contact family. Notify the Agency if you evacuate to another location or emergency shelter
Critical medication & DME to accompany you:	
Additional Life Sustaining Treatments needed:	

◯ **Family to provide transport** ◯ **Transport via Emergency Services** ◯ **No Transport Assistance Needed**

PATIENT SPECIFIC EMERGENCY PLANS	
Fire Plan:	Patient or caregiver to call 911, notify emergency contact, evacuate if necessary, agency to resume care as soon as safely possible.
Tornado Plan:	Patient to seek shelter in basement or other safe area immediately, notify emergency contact, agency to resume care as soon as safely possible.
Flood Plan:	Evacuate to highest level in home as soon as reasonably possible. Notify emergency contact and/or 911, Patient to evacuate area as soon as reasonably possible, agency to resume care as soon as safely possible.
Winter Weather Plan:	Notify emergency contact and/or evacuate if necessary, agency to resume care as soon as safely possible.
Power Outage Plan:	Notify emergency contact, call 911 if needed (for DME requiring power), evacuate if necessary, agency to resume care as soon as safely possible.
Other:	

ACKNOWLEDGEMENT: I acknowledge that I have received a copy of my Emergency Preparedness Plan. I acknowledge that I have participated in developing my Patient specific Emergency Plan. I understand that I must contact the Agency if I relocate during an emergency. I agree to notify the Agency immediately if any of my emergency contact information or evacuation plans change.

_____ _____

(Patient/Representative Signature) (Date)

_____ _____

(Agency Representative Signature) (Date)

When to Contact: Agency, Doctor, or 911

Situation	Call the Agency (Routine Issues)	Call the Doctor (Urgent, but not life-threatening)	Call 911 (Emergency)
Uncontrolled Bleeding	N/A	If minor and persistent despite first aid	If severe, heavy, or spurting blood, or if patient becomes dizzy/unresponsive
Diabetic Episode	N/A	If blood sugar is persistently high/low despite corrective action	If unconscious, confused, or having seizures due to blood sugar levels
Breathing Problems	N/A	If mild shortness of breath worsens or oxygen levels are declining	If severe difficulty breathing, gasping, or lips/fingers turning blue
Chest Pain	N/A	If mild and intermittent, but new or worsening	If crushing chest pain, pain radiating to jaw/arm, or accompanied by sweating, nausea, or dizziness
Falls/Injury	Notify agency if a minor fall occurs	If pain/swelling is present and persistent but no obvious deformity	If unconscious, bleeding heavily, or suspected broken bone (e.g., limb looks deformed)
High Fever (≥ 101°F)	Notify agency if persistent but no other symptoms	If fever persists despite medication, or is accompanied by chills, confusion, or dehydration	If fever is very high (>104°F), causing seizures, or patient is unresponsive
Infection Signs	Notify agency if new redness/swelling at wound or IV site	If fever, pus, or spreading redness is present	If patient becomes unresponsive, has sepsis signs (confusion, extreme weakness)
Severe Pain	N/A	If new or worsening pain that doesn't improve with medication	If pain is sudden, severe, or causing inability to function

Situation	Call the Agency (Routine Issues)	Call the Doctor (Urgent, but not life-threatening)	Call 911 (Emergency)
Seizures	N/A	If known seizure disorder and episode is typical	If first-time seizure, seizure lasting >5 minutes, or repeated seizures without regaining consciousness
Stroke Symptoms (FAST: Face drooping, Arm weakness, Speech difficulty)	N/A	N/A	**Call 911 immediately** for any stroke signs
Sudden Weakness or Paralysis	N/A	If mild but persistent weakness	If sudden loss of movement, coordination, or vision
Severe Allergic Reaction (swelling of face/lips, difficulty breathing)	N/A	N/A	**Call 911 immediately** for anaphylaxis
Mental Health Crisis (Severe anxiety, suicidal thoughts)	Notify agency if increased anxiety affecting care	Call doctor if worsening depression, suicidal ideation without immediate intent	**Call 911 if patient has suicidal intent, self-harm, or is a danger to others**
Medication Reaction	Notify agency if mild side effects occur (e.g., nausea)	Call doctor if new rash, swelling, or worsening symptoms	Call 911 if patient has difficulty breathing, throat swelling, or severe dizziness
Power Outage (for life-support devices)	Notify agency immediately	Call doctor if backup oxygen supply is running low	Call 911 if life-sustaining equipment fails (e.g., ventilator stops working)
Other:			
Other:			
Other:			
Other:			

Patient Discharge / Transfer Policy

Policy

EVERGREEN HOME HEALTH will define the circumstances when a patient would be transferred to another organization or discharged. The patient and patient representative, if any, has a right to and will be informed in writing of the Home Health Agency's (HHA's) policies and procedures on transfers and discharges. The patient/caregiver will participate in discharge planning activities beginning with the initial visit. A patient will be transferred to an acute care facility for symptom management, medical treatment, and changes in the patient's condition that cannot be safely managed in the home setting.

Procedures

The patient and patient representative, if any, have the right to be informed of the HHA's policies and procedures on transfers and discharges. This written information will be provided to the patient within four business days of admission. The HHA may only discharge or transfer a patient from the agency if:

- The transfer or discharge is necessary for the patient's welfare because the HHA and the physician or allowed practitioner who is responsible for the home health plan of care agree that the agency can no longer meet the patient's needs, based on the patient's acuity. The HHA will arrange for a safe and appropriate transfer to another care entity when the needs of the patient exceed the HHA's capabilities.
- The patient or payor will no longer pay for the care/services provided by the HHA.
- The transfer or discharge is appropriate because the physician or allowed practitioner who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care have been achieved. The HHA and the physician or allowed practitioner who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services.
- The patient refuses services or elects to be transferred or discharged.
- The HHA determines, under a policy set by the HHA for the purpose of addressing discharge for cause that meets the requirements of 42 CFR 484.50(d)(5)(i) through (d)(5)(iii), that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the home health clinician to operate effectively is seriously impaired. The HHA must do the following before it discharges a patient for cause:
    - Advise the patient, representative, if any, the physician or allowed practitioner(s) issuing orders for the home health plan of care, and the patient's primary care practitioner or other healthcare professional who will be responsible for providing care and services to the patient after discharge from the HHA, if any, that a discharge for cause is being considered.
    - Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or the situation.
    - Provide the patient and representative, if any, with contact information for other agencies or providers who may be able to provide care.
    - Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into the patient's clinical records.
- The patient dies.
- The HHA ceases to operate.

The HHA will develop and implement an effective transfer and discharge planning process for patients who are transferred to another HHA, or who are discharged to a Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), or Long-Term Care Hospital (LTCH). **EVERGREEN HOME HEALTH** will assist patients and their

caregivers in selecting a post-acute care provider by using and sharing data that includes but is not limited to HHA, SNF, IRF, or LTCH's data on quality measures and data on resource use measures. The HHA will ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. The Clinical Manager will assign this activity to an appropriate clinician who is familiar with the patient's healthcare needs, goals of care, and treatment preferences.

EVERGREEN HOME HEALTH will forward all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences to the receiving facility or healthcare practitioner to ensure the safe and effective transition of care. The HHA will comply with any requests made by the receiving facility or healthcare practitioner for additional clinical information that may be necessary for treatment of the patient.

A transfer summary will be completed, a copy maintained in the patient record, and a copy forwarded to the receiving healthcare service provider. The transfer summary will include but not be limited to:

- Date of transfer.
- Patient-identifying information.
- Emergency contact.
- The destination of the patient being transferred.
- The date and name of the person receiving the transfer summary.
- The patient's physician or allowed practitioner's name and phone number.
- Diagnosis related to the transfer.
- Significant health history.
- Transfer orders and instructions.
- A brief description of care/services provided and ongoing needs that cannot be met.
- Status of patient at the time of transfer.

A completed transfer summary will be forwarded to the receiving healthcare provider within two business days of a planned transfer if the patient's care will be immediately continued in such healthcare facility. If the patient is still receiving care in the healthcare facility at the time when the HHA becomes aware of the transfer, a completed transfer summary will be forwarded to the receiving healthcare provider within two business days of becoming aware of an unplanned transfer.

EVERGREEN HOME HEALTH will maintain a copy of the transfer summary in the clinical record and document the date the transfer summary was sent/forwarded to the receiving healthcare provider and any additional clinical information/documents that were sent with the transfer summary.

Patients will be notified in a timely manner of the need to plan for discharge. Planning for discharge will involve the patient and other caregivers involved in the patient's care and treatment in the home. Patient needs for continuing care, to meet their physical and psychosocial needs, will be identified prior to discharge.

Communication of an anticipated discharge will be provided to the physician or allowed practitioner, and other community agencies, as indicated and authorized by a signed release of information documents. This may include but not be limited to community agencies that provide case management services for consumers receiving multiple services from multiple providers when the Case Manager's knowledge of this change in service receipt enables their ability to coordinate/case manage the consumer's overall service plan.

The discharging clinician will provide the patient/caregiver with all applicable discharge instructions regarding any other follow-up care needed, when discharged to self-care, including any community services available. Appropriate referrals will be made to meet any continuing patient needs. Discharge instructions provided, and

referrals made, will be documented in the patient's record along with the patient's response to the discharge planning activities and coordination with other providers.

A discharge summary will be completed, which includes but is not limited to:

- Date of discharge.
- Patient-identifying information.
- The patient's physician or allowed practitioner's name and phone number.
- Diagnosis.
- Reason for discharge.
- A brief description of care/service provided.
- Patient's medical and health status at the time of discharge.
- Any instructions given to the patient or responsible party at discharge.

The last remaining discipline to provide care/services will complete a discharge from the agency summary, which will minimally reference all of the disciplines/services provided throughout the services episode, in addition to the details of their specific discipline.

A completed discharge summary will be forwarded to the primary care practitioner or other healthcare professional who will be responsible for providing care and services to the patient after discharge from the HHA, if any, within five business days of the patient's discharge.

EVERGREEN HOME HEALTH will maintain a copy of the discharge summary in the clinical record and document the date the discharge summary was sent/forwarded to the primary care practitioner or other healthcare professional provider, and any additional clinical information/documents that were sent with the discharge summary.

Medicare and Medicare HMO patients will be issued a Notice of Medicare Non-Coverage (NOMNC) at least 48 hours prior to the termination of home health services, which explains the patient's right to an immediate independent review of the proposed discontinuation of services. If the patient chooses such independent review, the HHA will immediately contact the state's Quality Improvement Organization (QIO) office to facilitate the process. The HHA will comply with the requirements of 42 CFR 405.1200 through 405.1204.

A transfer and discharge comprehensive assessment will be completed within 48 hours of each of these events for applicable patients.

Patient Discharge & Transfer Acknowledgment Form

Purpose of This Notice: This document provides information on the reasons for patient discharge or transfer from Evergreen Home Health services and what to expect during the process.

Reasons for Discharge or Transfer:

Evergreen Home Health may discharge or transfer a patient under the following circumstances:

1. **Completion of Care** – The patient has achieved the goals outlined in their plan of care and no longer requires home health services.
2. **Transfer to Another Facility** – The patient requires a higher level of care or specialized treatment that can be best provided at a hospital, skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), or long-term care hospital (LTCH).
3. **Patient Choice** – The patient or their legal representative elects to discontinue home health services or transition to another provider.
4. **Safety Concerns** – If the patient or household environment poses a threat to staff safety or the ability to provide adequate care.
5. **Non-Payment or Insurance Issues** – If the patient or their insurance provider no longer covers the services provided and alternative arrangements are not made.
6. **Non-Adherence to Plan of Care** – If the patient refuses treatment, does not follow the prescribed plan of care, or repeatedly declines scheduled visits, making effective care delivery impossible.
7. **Agency Closure** – If Evergreen Home Health ceases operations.

What to Expect During Discharge or Transfer:

- The patient and/or representative will be informed in writing of the planned discharge or transfer.
- Patients discharged from services will receive information on community resources and follow-up care recommendations.
- If transferred, Evergreen Home Health will coordinate with the receiving facility or provider to ensure continuity of care.
- A discharge or transfer summary will be documented in the patient's medical record and sent to the appropriate provider, if applicable.

Acknowledgment & Signature:

By signing below, I acknowledge that I have been informed of Evergreen Home Health's discharge and transfer policies. I understand the possible reasons for discharge or transfer and have had the opportunity to ask questions.

Patient/Representative Signature: _____ **Date:** _____

PATIENT ELECTRONIC COMMUNICATION AND SIGNATURE CONSENT FORM

Introduction

Evergreen Home Health offers secure electronic communication and digital signature options to enhance the efficiency and accessibility of patient care. This document outlines the use of electronic communication methods and the consent required for electronic signatures.

I. Electronic Communication Consent

By signing this form, you acknowledge and consent to the use of electronic communication for healthcare-related purposes. The following communication methods may be used:

1. **Email:** Secure messages regarding care plans, visit schedules, medication updates, and other health-related information.
2. **SMS Messaging:** Time-sensitive notifications, appointment reminders, and urgent updates.
3. **Patient Portal:** Secure access to health documents, care plans, and important notices.

Patient Portal Access & Included Documents:

Evergreen Home Health utilizes **Spruce** as our secure communication platform and patient portal. Spruce is a fully HIPAA complaint communication platform. Through Spruce, you will have access to important healthcare information and the ability to securely text, email, send pictures, and video chat with our team.

You will receive an invitation via email or SMS with the following message:

> *"Hello – this is Evergreen Home Health. We'd like to invite you to sign up for the Spruce app to communicate with us about your medical care. With Spruce, you can securely text, email, send pictures, and even video chat! Follow this link to download the Spruce app and get connected: **https://spruce.care/evergreenhcg**"*

How to access Spruce:

- **If using a mobile device (iOS or Android):**
  1. Click the link: **https://spruce.care/evergreenhcg**
  2. A mobile browser will open to Evergreen's Spruce Organization Profile.
  3. Tap "Connect" at the bottom of the page to be redirected to your device's app store.
  4. Download and open the Spruce app.
  5. Tap "Continue" to confirm you're connecting with Evergreen Home Health.
  6. Select "Create a new account" and follow the prompts to set up your patient account.
- **If using a desktop or laptop web browser:**
  1. Click the link: https://spruce.care/evergreenhcg
  2. The browser will open Evergreen's Organization Profile page.
  3. Click "Connect with Evergreen Home Health" at the top of the page.
  4. A new window will appear – click "Get Started."
  5. Create your patient account using your phone number and email address.

Once connected, you will have access to the following documents:

- Visit Schedule (Expected visit dates and times)
- Patient Rights and Responsibilities
- Physician Signed Plan of Care (POC) including goals, treatments, and care instructions
- Medication List (Current medications, dosages, and administration instructions)
- Emergency Contact Information
- Advance Directives (If applicable)
- Home Safety & Emergency Preparedness Plan
- Written Instructions for Care
- Infection Control Guidelines
- Equipment Use Instructions (If applicable)
- Initial Patient Admission Packet
- Coverage Notices

II. Electronic Signature Consent

By signing this form (electronically or physically in ink), you acknowledge and agree that electronic signatures are legally equivalent to handwritten signatures. This includes:

- Signing healthcare documents electronically.
- Granting permission for electronic storage of signatures.
- Using electronic signatures for all required patient documentation unless otherwise requested.

You affirm that your electronic signature is given with full knowledge and consent and is legally binding under applicable laws. Evergreen Home Health reserves the right to retain electronic signatures for record-keeping purposes and replace any illegible handwritten signatures where verification is available.

Patient Acknowledgment & Agreement

I acknowledge that I have read, understand, and agree to the terms of this Electronic Communication and Signature Consent Form. I authorize Evergreen Home Health to use electronic communication and signatures as described above. I understand that I may request paper copies of my documents or revoke consent by notifying Evergreen Home Health in writing.

Patient Name: _____ Date: _____

Patient / Authorized Representative Signature: _____

Authorized Representative: _____ Relationship: _____

Home Safety Tips for Older Adults

With a growing number of older adults living independently, it's increasingly important to make sure that they're safe at home. Falls, burns, and poisonings are among the most common accidents involving older people. Older adults who live alone may also become the victims of criminals who target older people. If you're an older adult living on your own, or care for an older person living alone, here's what you need to do to stay safe.

Keep emergency numbers handy

Always keep a list of emergency numbers by each phone. Write this information in large enough print that you can read it easily if you are in a hurry or frightened. Be sure to list numbers for:

- 911
- Poison Control: 1-800-222-1222
- Family member or friend to call in case of emergency
- Healthcare provider's office

Prevent falls

- **If you have difficulty with walking or balance,** or have fallen in the past year, talk to your healthcare provider about having a special falls risk assessment.
- **Ask your provider** if you would benefit from an exercise program to prevent falls.
- **If you have fallen before, or are scared of falling,** think about buying a special alarm that you wear as a bracelet or necklace. Then, if you fall and can't get to the phone, you can push a button on the alarm that will call emergency services for you.
- **Don't rush to answer the phone.** Many people fall trying to answer the phone. Either carry a cordless or cell phone or let an answering machine pick up.
- **When walking on smooth floors,** wear non-slip footwear, such as slippers with rubber/no-slip bottoms or flat, thin-soled shoes that fit well.
- **If you have a cane or a walker,** use it at all times instead of holding onto walls and furniture.

Safety-proof your home

- **Make sure all hallways, stairs, and paths are well lit and clear** of objects such as books or shoes.
- **Use rails and banisters when going up and down the stairs.** Never place scatter rugs at the bottom or top of stairs.
- **Tape all area rugs to the floor** so they do not move when you walk on them.

Protect against fire and related dangers

- If there is a fire in your home, don't try to put it out. Leave and call 911. Know at least two ways to get out of your apartment or home.
- When you're cooking, don't wear loose clothes or clothes with long sleeves
- Replace appliances that have fraying or damaged electrical cords.
- Don't put too many electric cords into one socket or extension cord.
- Install a smoke detector and replace the battery twice a year.
- Never smoke in bed or leave candles burning, even for a short time, in an empty room.
- Make sure heaters are at least 3 feet away from anything that can burn, such as curtains, bedding, or furniture. Turn off space heaters when you leave the room.

Avoid bathroom hazards

- Set the thermostat on the water heater no higher than 120°F to prevent scalding.
- Have grab bars installed in the shower and near the toilet to make getting around easier and safer.
- Put rubber mats in the bathtub to prevent slipping.
- If you are having a hard time getting in and out of your tub, or on and off the toilet, ask your provider to help you get a special tub chair or bench or raised toilet seat.

Prevent poisoning

Carbon Monoxide

- Never try to heat your home with your stove, oven, or grill since these can give off carbon monoxide—a deadly gas that you cannot see or smell.
- Make sure there is a carbon monoxide detector near all bedrooms, and be sure to test and replace the battery twice a year.

Medications

- Keep all medications in their original containers so you don't mix up medicines.
- Ask your pharmacist to put large-print labels on your medications to make them easier to read.
- Take your medications in a well-lit room, so you can see the labels.
- Bring all of your pill bottles with you to your healthcare provider's appointments so he or she can look at them and make sure you are taking them correctly.

Cleaning products

- Never mix bleach, ammonia, or other cleaning liquids together when you are cleaning. When mixed, cleaning liquids can create deadly gases.

Protect against abuse

- Keep your windows and doors locked at all times.
- Never let a stranger into your home when you are there alone.
- Talk over offers made by telephone salespeople with a friend or family member.
- Do not share your personal information, such as social security number, credit card or bank information, or account passwords, with people you don't know who contact you.
- Always ask for written information about any offers, prizes, or charities and wait to respond until you have reviewed the information thoroughly.
- Do not let yourself be pressured into making purchases, signing contracts, or making donations. It is never rude to wait and discuss the plans with a family member or friend.

Evergreen HC Group Inc DBA Evergreen Home Health
403 W Main Street Suite A1
Gaylord, MI 49735

For Our Patients and Their Visitors:

Help Prevent Infections

Sometimes a patient develops an infection while being treated in the hospital or other medical facility. It could be an infection from germs that enter the body at a surgery site. It could be an infection that develops from germs carried on a piece of medical equipment. There are many possible causes.

Infections like these are called healthcare-associated infections, or HAIs, and we take them very seriously.

The good news is that we can prevent many of them, and you can help.

SHEA The Society for Healthcare Epidemiology of America

U.S. Department of Health and Human Services Centers for Disease Control and Prevention

IDSA Infectious Diseases Society of America

APIC Association for Professionals in Infection Control and Epidemiology

The Joint Commission

American Hospital Association

CS 287739

What are the common signs of healthcare-associated infections (HAIs)?

- Fever
- Nausea
- Unexpected pain, tenderness, redness, or swelling at the surgical site or the place where medical equipment like an IV has been inserted

Common HAIs include:

- Infections caused by *C. difficile* or Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Infections that occur at the places where you've had surgery or where a catheter or IV has been inserted into your body
- Lung infections (pneumonia) caused by using a ventilator

HAIs can happen any time you're getting medical care whether it's in a hospital, at a rehab facility, or at home.

If you think you have an HAI, tell your doctors or nurses immediately. Having one or more of these symptoms might not mean you have a healthcare-associated infection, but you want to be sure.

How are HAIs treated?

If you get one of these infections, your doctor is likely to prescribe an antibiotic. It's important that you take antibiotics exactly as the doctor tells you.

Here's how you can help prevent HAIs.

In the hospital:

- Did you see your doctor or nurse clean their hands? If not, ask them to wash their hands with soap and water or an alcohol-based hand rub (hand sanitizer) before they start working with you.
- Ask your visitors to clean their hands every time they enter your room. And ask them to follow any special instructions from your doctors and nurses.
- Clean your own hands often with soap and water or hand sanitizer, especially after using the bathroom.
- If you cough or sneeze, cover your mouth and nose with a tissue and discard the tissue right away. Then clean your hands.
- If your treatment involves a medical device like a urinary catheter, ask the doctors and nurses why it's needed and when it will be removed.
- Report any symptoms you have to your doctors or nurses.

Here's how you can help prevent HAIs.

At home:

- You'll use many of the same precautions at home that you will in the hospital.
- If your doctor has prescribed antibiotics, take them exactly as your doctor tells you to.
- Keeping your hands clean is important. Clean your own hands often with soap and water or alcohol-based hand rubs (hand sanitizer), especially before touching any medical equipment, before eating, and after using the bathroom.
- Ask your visitors and the people who live with you to keep their hands clean, too. If they're assisting with your care by doing things like changing a dressing, they must wash their hands or use a hand sanitizer every time.
- Understand how to care for any medical device like a catheter you are using at home. Ask questions if you're unsure.
- Keep a list of medical professionals to contact if you have questions or problems. If you have symptoms, contact your doctor or a nurse immediately.
- If you smoke, talk to your doctor about quitting. Patients who smoke get more infections.

Common HAIs: What to Look for/What to Do

C. difficile, often called *C. diff*

Clostridium difficile is a germ that can cause cases of diarrhea ranging from mild to deadly.

In addition to the common signs of an HAI, an infection with *C. diff* can cause the following symptoms:

- Watery diarrhea
- Belly pain and tenderness
- Loss of appetite

If I have *C. diff*, what can I do?
Follow the general advice on how to reduce the chance of getting an HAI, but also:

- Ask your doctors and nurses if they should be wearing gowns while they're treating you.
- At home, use your regular laundry detergent and the hottest water temperature recommended to wash your clothes and bed linens.
- Use a separate bathroom or be sure the bathroom is well-cleaned if someone with diarrhea has used it.

Central Line-Associated Bloodstream Infection (CLABSI)

"Central line" refers to the lines used to administer fluids or medications directly to the patient's bloodstream, or to collect blood for medical tests. They're inserted into a major vein close to the heart so they're different from IVs (intravenous injections) that administer fluids to a vein near the skin's surface. Germs can enter the bloodstream from the line itself or its dressing and cause infection.

In addition to the common signs of an HAI, a patient with a CLABSI may have chills.

What can I do to help prevent a CLABSI infection?
Follow the general advice on how to reduce the chance of getting an HAI, but also:

- Tell your doctor or nurse if the bandage covering where the tube enters your skin comes off, gets wet, or is dirty.
- Ask if you can shower with the lines in place and what precautions you should take while bathing.
- Ask when the tube can be removed and keep asking.
- Ask your doctors and nurses to wash their hands with soap and water or use an alcohol-based hand rub (hand sanitizer) before handling the lines.

Ventilator-Associated Pneumonia (VAP)

A ventilator is a machine that helps a patient breathe. The ventilator gives the patient oxygen through a tube placed in the nose or mouth, or through a hole in the front of the neck. Patients on a ventilator can develop pneumonia, an infection of the lungs.

What can I do to help prevent pneumonia?
A patient's loved ones and visitors should follow the general advice on how to reduce the chance of the patient getting an HAI, but also check to see that the precautions to prevent pneumonia are in place. It's ok to ask:

- If the head of the patient's bed should be raised.
- When the patient can try breathing on his/her own.
- When the patient can get out of the bed and start moving around. The sooner a patient is awake and out of bed, the lower the chance they'll develop pneumonia.

Methicillin-Resistant *Staphylococcus aureus* (MRSA)

MRSA is a type of staph bacteria that often enters the body through a break in the skin. Staph is a very common germ that most often causes skin infections. But in some cases, it can cause infection of the lungs (pneumonia), or infections of the blood. If left untreated, MRSA infections can become severe and cause sepsis, which is a life-threatening reaction to severe infection in the body.

In addition to the common signs of an HAI, a patient with MRSA may have a bump or infected area on the skin that's red, swollen, or full of pus or discharge. These bumps are sometimes mistaken for spider bites.

What can I do to reduce the chance of spreading MRSA?
Follow the general advice on how to reduce the chance of getting an HAI. You can also:

- Ask that your visitors, doctors, and nurses all wash their hands or use hand sanitizer every time they enter your room. Be very careful to wash your own hands as well.
- Tell anyone treating you in the hospital, at home, or at a doctor's office that you have MRSA.

Catheter-Associated Urinary Tract Infection (CAUTI)

This is an infection of the bladder or kidneys caused by a urinary catheter (the thin tube placed in the bladder to drain urine). The longer the catheter is in, the greater the chance you can develop a CAUTI.

In addition to the common signs of an HAI, a CAUTI can cause the following symptoms:

- Burning or other pain in the area below the stomach
- Bloody urine
- Burning while urinating after the catheter is removed
- Increased frequency of urinating after the catheter is removed

What can I do to help prevent a CAUTI infection?
Follow the general advice on how to reduce the chance of getting an HAI, but also:

- Ask when the catheter can be removed and keep asking.
- Make sure the catheter bag is always below the level of your hips.
- Do not twist, tug, or pull on the catheter tubing.

Surgical Site Infection (SSI)

Most patients who have surgery do well, but a small number will develop an infection in the part of the body operated on. That's called a surgical site infection or SSI.

In addition to the common signs of an HAI, a patient with a surgical site infection may have cloudy fluid drain from their surgical wound.

What can I do to help prevent getting a surgical site infection?
Follow the general advice on how to reduce the chance of getting an HAI, but also:

- Be sure your doctor knows about all your medical conditions since some health problems like diabetes can affect your surgery and your treatment.
- Before the surgery, don't shave in the area where you'll be having surgery. Shaving can irritate the skin and increase the chance you'll get an infection.
- Ask if your hair will be removed in the area where you're going to have surgery, and if so that it be done with electric clippers and only right before the surgery.
- Ask your doctor if there are bathing instructions you should follow before you have surgery. You may be asked to take a bath or shower using a special antiseptic. Make sure you follow these instructions.
- Ask if you will get antibiotics during your operation to protect against SSI and how long you will be taking the antibiotics.
- Do not let visitors touch your surgical wound or your dressing.
- Let your doctors and nurses know right away if you develop a fever, your wound starts draining, your surgical site is red and swollen, or you develop diarrhea.

PATIENT BINDER REQUIREMENTS

- **Visit Schedule** – Outline of expected visit dates and times.
- **Patient Rights and Responsibilities** – Written notice provided at admission.
- **Plan of Care (POC)** – Includes goals, treatments, and care instructions.
- **Medication List** – Current medications with dosage and administration instructions.
- **Emergency Contact Information** – How to reach the agency and emergency services.
- **Advance Directives Information** – If applicable, including patient preferences.
- **Home Safety & Emergency Preparedness Plan** – Instructions for emergencies.
- **Written Instructions for Care** – Includes specific patient care instructions, treatments, and interventions.
- **Infection Control Guidelines** – Instructions on maintaining hygiene and preventing infections.
- **Equipment Use Instructions** – If medical equipment is required, instructions must be provided.