E v a H o m e c a r e A g e n c y , I n c .

104-70 Queens Blvd. suite 503, Forest Hills, NY 11375 Tel: 718-896-2218 Fax: 718-830-6299

SERVICE OUTLINE

Welcome to Eva Homecare Agency Inc. licensed by the N.Y.S. Dept. of Health. We believe those needing home health care should get the very best. Our goal is to provide quality personalized care through appropriate coordination of services to meet your specific healthcare needs. Under the direction of your physician, our team of qualified health care professionals will provide on-going case management, if needed that is appropriate, competent, and consistent. We are here to assist you and to meet your needs.

Sincerely,

Eva Zhang / Administrator

Our services include:

- Skilled Nurse (RN, LPN)
- Home Health Aide/Companion/Housemaid
- Approved Therapy Services

Nursing visits will consist of a complete physical assessment and evaluation of the patient condition. The skilled nurse will also instruct the patient and family/caregiver in disease process and management, medications and other pertinent topics. With case management, usually nursing visits will be frequent at first. Then as acute medical problems are resolved and home instruction completed, visit frequencies will decrease and discharge planning and teaching will begin. In some cases, the skilled nurse will make an initial visit only for admission assessment and evaluation.

Home Health Aides (HHA's) are assigned by the skilled nurse and can provide personal care, light-housekeeping duties for the patient and other care as appropriate and mandated by the state regulations for HHA's.

Your plan of care will most likely, at this time, include the following professional services and visit frequencies.

Skilled Nurse: _____

Home Health Aide: _____

Companion: _____

Other Services: _____

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NON-DISCRIMINATION POLICY

As a recipient of federal financial assistance, this Agency does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, or national origin or on the basis of disability, AIDS or AIDS related conditions, age or sexual orientation, in admission to, participation in or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by this Agency directly or through a contractor of any other entity with whom the Agency arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, 91. (Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.)

In case of questions concerning this policy, or in the event of a desire to file a complaint alleging violations of the above, please contact:

Eva Zhang / Administrator

Eva Homecare Agency, Inc.
104-70 Queens Blvd. Suite 503
Forest Hills, NY 11375
Tel: 718 896 2218

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PATIENT GRIEVANCE

Your complaints/concerns or problems are important to the Agency. We will give full consideration to a problem or complaint and make an effort to resolve the issue in an agreeable manner. We assure you that you will have the opportunity to voice grievances and recommend changes in services and/or policies without discrimination, coercion, reprisal, or unreasonable interruption of services or in any manner from the Agency.

As a home care client, you have the right to voice and submit complaints and dissatisfaction about the care and services provided or not provided by:

Eva Homecare Agency, Inc.

The procedure to submit your complaints are as follows:

1. Call the agency at (718) 896-2218
2. Ask for the Director of Patient Services
3. Explain your concerns

The agency will investigate your allegations within 15 days of receipt of complaint. Also, if dissatisfied with the outcome, you may submit an appeal to the agency's governing authority. All appeals will be reviewed within 30 days of receipt of appeal request.

In New York State, home care clients may also submit complaints to the Department of Health. If you are dissatisfied with the outcome of our complaint resolution, you may also submit the complaint to the New York State Department of Health or any outside representative of the client's choice.

NYS Department of Health
Metropolitan Regional Office
90 Church Street
New York, NY 10007
212-417-5888

The expression of such complaints by the client or client designee shall be free from interference, coercion, discrimination, or reprisal

Eva Zhang, Administrator
Eva Homecare Agency Inc.
104-70 Queens Blvd. Suite 503, Forest Hills, NY 11375
718 896 2218

THANK YOU FOR SHARING YOUR CONCERNS WITH US

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HOME CARE BILL OF RIGHTS AND CLIENT RESPONSIBILITIES:

CLIENT'S NAME: .....

As a patient of **Eva Homecare Agency, Inc.** you have the right to:

1. Be informed of your rights both verbally and in writing at the time of admission and prior to the initiation of care.
2. Receive competent, individualized care and service from Eva Homecare Agency, Inc. staff regardless of age, race, color, national origin, religion, sex, disease, disability or any other category protected by law or decisions regarding advance directives.
3. Be treated with dignity, courtesy, consideration, respect, and have your property treated with respect.
4. Be informed verbally and in writing of the services available and related charges, as they apply to the primary insurance, other payers, and self-pay coverage before care is initiated. To be informed of any changes in the sources of payment and your financial responsibility as soon as possible but no later than thirty (30) calendar days after Eva Homecare Agency, Inc. becomes aware of the change.
5. Be informed both orally and in writing, in advance of the plan of care, of any changes in the plan of care, and to be included in the planning of care before treatment begins; be informed of all treatment prescribed, when and how services will be provided, and the names and functions of any person and affiliated program providing care and services, including photo identification of agency staff and participate in the development of the discharge plan.
6. Participate in the planning of your care and be advised in advance of any changes in the plan of care.
7. Refuse care and treatment after being fully informed of and understanding the consequences of such actions and to initiate an advance directive, "living will," durable power of attorney and other directives about your care consistent with applicable law and regulations. Refuse to participate in research or experimental treatment.
8. To appropriate assessment of pain and management of his/her pain.
9. Receive information regarding community resources and to be informed of any financial relationships between Eva Homecare Agency, Inc. and other providers to which you may be referred to by the agency.
10. Be informed of the procedures for submitting patient complaints, voice complaints, and recommend changes in the policies and services to the Director of Patient Services by calling the following telephone number: _____. If dissatisfied with the outcome, you may also submit the complaint to the New York State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or patient designee shall be free from interference, coercion, discrimination, or reprisal.

1. NYS Department of Health
2. Metropolitan Regional Office
3. 90 Church Street, New York, NY 10007
4. 212-417-5888

11. Express complaints about the care and services provided or not provided and complaints concerning lack of respect for property by personnel furnishing services on behalf of Eva Homecare Agency, Inc. and to expect the agency to investigate such complaints within 15 days of receipt of complaint. Also, if dissatisfied with the outcome, you may submit an appeal to the agency's governing authority which will be reviewed within 30 days of receipt of appeal request.
12. Receive timely notice of impending discharge or transfer to another agency or to a different level of care and to be advised of the consequences and alternatives to such transfers.
13. Privacy, including confidential treatment of records and access to your records on request. Information will not be released without your written consent except for those instances required by law, regulation, or third party reimbursement.
14. In the situation when the patient lacks capacity to exercise these rights, the rights shall be exercised by and individual, guardian, or entity legally authorized to represent the patient.

CLIENT'S NAME: ……

As a home care client, you have the responsibility to:

1. Be seen by a doctor on a regular and ongoing basis.
2. Share complete and accurate health information.
3. Be responsible for following the recommended treatment plan.
4. Make it known if you do not understand or cannot follow the treatment plan.
5. Cooperate with agency staff and not discriminate against staff.
6. Notify the agency in advance when you cannot keep a scheduled appointment.
7. Notify the agency if you receive services from another agency.
8. Notify the agency in the event of change in your health status.
9. Be responsible for your actions if you refuse treatment or do not follow the agency's recommendations/directions.
10. Take responsibility for financial obligations of your care.
11. Maintain a home environment that facilitates effective home care.

Patient/Representative Signature:	Date:
Witness Signature:	Date:

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SERVICES CONSENT/STATEMENT OF SERVICES AND CHARGES
RELEASE OF INFORMATION/ACKNOWLEDGEMENT

Client: .....

( ) I authorize Eva Homecare Agency staff to provide services, as requested by myself/representative and ordered by my physician. Services provided by Eva Homecare Agency, Inc. may include nursing, home health aide, personal care aide, social worker, dietician/nutritionist, physical therapist, speech therapist, occupational therapist, audiologist, respiratory therapist, homemaker, and housekeeper.

( ) The services provided by Eva Homecare Agency, Inc. will have been explained to me and I understand that I may refuse treatment within the confines of the law after being informed of the consequences of my action.

( ) I give my consent and authorization for release of medical information to Eva Homecare Agency, Inc. by physician and other health care provider facilities.

( ) I authorize Eva Homecare Agency, Inc. and other licensing/regulatory bodies to periodically examine my medical record for the purpose of checking compliance to the applicable rules, regulations, and standards.

( ) I understand that it would be prudent and in my best interest to establish a Home Health Service Plan of Care in the event of an emergency such as a fire, hurricane, severe snowstorm, or other natural disaster. Therefore, I hereby grant Eva Homecare Agency, Inc. permission to reveal to any governmental agency, supplemental provider agency, community volunteer service, or any other providers of services, medical records regarding my nursing care, except where otherwise prohibited by law. I further understand this would be done as necessary, upon request, in order to ensure a safe and effective emergency preparedness plan of care.

( ) I acknowledge receiving verbal and written information concerning my **Rights and Responsibilities** as a home care client and the **NYS Proxy Law/Advance Directives.** In addition the agency has provided a *written procedure for submitting complaints and concerns, and directions regarding contacting the agency after hours, on weekends, and holidays.*

Service	Frequency	Hourly Fee	Weekend/Holiday Fee	Expected Insurance Coverage	Patient's Financial Responsibility

* See Agency's Rate/Fee Sheet

( ) I agree that I (or my representative) shall be directly responsible for payment for all home care services provided according to this service agreement. I understand that the invoices are rendered weekly and payable upon receipt. Late payments over 30 days will result in a 1.5% late fee charge per month.

( ) I agree to pay a sum of $2500.00 in damages to reimburse Eva Homecare Agency, Inc. for the cost of recruiting, hiring, and training, if I directly employ an employee of the company that has provided services within six months of services.

Client/Representative Signature: …… Date: ……

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INSURANCE INFORMATION

Client Name:	**DOB:**
Name of Insurance Company:	**Policy/Group #:**
Name of Policy Holder:	**Relationship to Client:**
Employer:	**Benefits Dept. Tel.:**

1. Services provided by the policy: ……
2. Does the agency have an annual deductible: ( ) No ( ) Yes
3. Amount of deductible: …… Has the deductible been met for current year: ( ) No ( ) Yes
4. Amount (%) paid by insurance: …… Amount of client co-pay (%) ……
5. Is there a maximum pay-out on the policy? ( ) No ( ) Yes
   Annual: …… Lifetime: ……..
6. What is current status of maximum pay-out to date: ……
7. Is prior hospitalization required: ( ) No ( ) Yes
   If yes, how many days after discharge must care start: .....
8. The type of agency covered: ( ) LHCSA ( ) CHHA ( ) Participating Provider ( ) Other: ……
   .
9. Is pre-authorization required: ( ) No ( ) Yes If yes, authorization #: ……

   Authorization period from: …….. To: ……
10. Is there a pre-existing condition exclusion ( ) No ( ) Yes: Length of time: ……

COVERAGE:

HOME HEALH CARE VISITS
COVERED SERVICES:

……

VISIT LIMITS:
Number of visits: Max # per day:……**Max # per year:**……

Does policy cover private duty in a facility? ( ) No ( ) Yes

BILLING INFORMATION

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Billing Address:	Attention to: Is assignment of benefits accepted: ( ) No ( ) Yes
What documentation needs to accompany the invoice: MD plan of Treatment/Medical Orders ( ) No ( ) Yes Letter of Medical Necessity ( ) No ( ) Yes Nursing Notes ( ) No ( ) Yes Service Reports ( ) No ( ) Yes Time Slips ( ) No ( ) Yes	How long does it take to process a claim: Is claim number required to appear on each invoice: Contact Person:……..

Comments:

Prepared by: …… **Date:** ……,,,,,

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ASSIGNMENT OF INSURANCE BENEFITS

Client Name:
.....

Address: .....

Client Representatives: ..... Relationship: .....

Assignment of Benefits

I authorize direct payment to Eva Homecare Agency, Inc. of any insurance benefits otherwise payable to me for home health care services. I also authorize my insurance company(ies) to furnish to an agent of Eva Homecare Agency, Inc. any and all information pertaining to my insurance benefits and status of claims submitted by Eva Homecare Agency, Inc. for services rendered. I further authorize Eva Homecare Agency, Inc. to release my insurance company(ies) any and all information pertaining to me for benefit determination.

Acknowledgment of Financial Responsibility:

While there may be insurance coverage for those services provided by Eva Homecare Agency, Inc. to me relative to my care needs, I recognize that all services may not be covered, or that reimbursement may be less than 100 percent of charges billed, in accordance with my policy coverage. Therefore, I acknowledge financial responsibility for any balance owing on my account. In addition, I agree to be responsible for the full amount of the charges if no payment has been made by 45 days from the date a claim was submitted to an insurance company or if my physician or I fail to provide within 45 days, the information necessary to submit the claim for service. I agree to transfer immediately to Eva Homecare Agency, Inc. any payment made directly to me for services provided by Eva Homecare Agency, Inc. on an assignment basis.

The undersigned certifies that he/she has read the Assignment of Insurance Benefits and Acknowledgement of Financial Responsibility, has received a copy, and is the client or is duly authorized by the client as the client's general agent to execute the above and accept its items.

Beneficiary/Representative Signature:	Date:
Witness:	Date**:**

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PREVENTING INFECTIONS AT HOME

Hand Hygiene Procedure

EQUIPMENT

1. Paper towels

2. Lotion

3. Liquid soap

4. Alcohol-based hand sanitizer or wipes,

5. Antiseptic hand scrub (optional), and an impermeable plastic trash bag

PROCEDURE

1. Use alcohol-based hand sanitizer.

2. Pour small amount of sanitizer into palm and spread over hands and fingers and rub thoroughly until dry.

3. Clean and replace equipment.

4. Discard disposable items according to Standard Precautions.

PRACTICE GOOD PERSONAL HYGIENE	•Regular bathing and hair washing •Daily tooth brushing/mouth cleaning •Preventative dental care once or twice a year •Regular trimming of finger/toe nails (not too short) •Keeping clothes clean/laundered •No sharing of toothbrushes •No sharing of razor blades
MAINTAIN A CLEAN ENVIRONMENT	•Keep all surfaces clean where food is prepared •Keep food containers properly closed or covered •Refrigerate foods requiring cold storage promptly •Clean up spills/messes right away •Mop kitchen/bathroom floor weekly or as needed •Clean all areas of bathroom, especially around the toilet base •Avoid using the same supplies for bathroom and kitchen •Do not pour used mop water into the kitchen sink

•Drain off liquid before putting garbage in a plastic lined pail

•Keep garbage in plastic-lined covered cans

•Keep yard cleared of areas where water can collect and stagnate

LIMIT EXPOSURE

•Wear gloves when cleaning birdcages, litter boxes, etc.

•Avoid crowds, especially in flu season

•Avoid close contact with people with contagious infections

•Avoid sharing food or drinks

•Cover nose/mouth with tissue when sneezing/coughing

•Avoid licking fingers or tasting from mixing spoon or bowl when cooking

Here are measures you can take to reduce falls:

1. Remove scatter rugs or use non-skid tape or backing on throw rugs
2. Tack down the edges of all carpets
3. Never leave articles around beds, stairs, or in hallways
4. Do not use a doorway, halls or stairs for storage
5. Keep pathways clear of furniture, electric cords, space heaters, etc.
6. Don’t rush when climbing up or down stairs
7. Stairs should have non-skid treads and a solid, easy to grasp handrail
8. If you must climb, use a solid step or ladder rather than a chair or box
9. When carrying objects, make sure you:
    a. Can see
    b. Get a firm grip
    c. Move slowly and evenly
    d. Lift with your legs (knees bent, back straight)
    e. Ask for help with heavy or awkward objects

General Safety Tips:

1. Avoid wearing only socks, smooth-soled shoes or slippers on non-carpeted floors
2. Avoid wet floors – wipe all spills up immediately
3. Keep kitchen floor free of grease and scraps
4. Household pets should be kept under control and out of pathways

5. To avoid dizziness, get out of your bed or chair slowly
6. In the bathroom:
    a. Be sure mats are non-skid and there are treads in the tub or shower to prevent slips
    b. Install "grab bars". Towel racks should not be used as grab bars as they are not secure enough to support body weight.

Adequate lighting will help prevent accidents:

1. Keep a lamp near the bed so you will not have to get up in the dark
2. Keep a night light in the bathroom
3. Keep hallways and steps well-lit
4. Keep a flashlight handy in case of power failure

Additional Important Safety Tips:

1. Post Emergency Numbers By Your Phone
2. If you live alone, ask a neighbor, friend, or family member to check on you each day
3. Take your time
4. Be safe
5. Do not take unnecessary risks

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MEDICATION INFORMATION

MEDICATIONS ARE MEANT TO HELP…TAKE THEM SAFELY.

1. Use caution and be aware of what you are taking.
2. Tell your physician, pharmacist and nurse about all the medications you are taking (prescription and over-the-counter) to prevent dangerous combinations or duplications.
3. Take a list of your medications to the doctor on each visit.
4. Read your medication labels and take as directed.
    a. Always take the exact dosage prescribed.
    b. Take at the times indicated.
    c. If you miss a dose, do NOT double your next dose.
    d. Always keep medication in the original container and out of reach of children.
    e. Organize your containers in one area.
    f. Appropriately discard any expired medications or those that have been discontinued by your doctor. Ask your nurse or doctor about proper disposal. DO NOT PUT IN TRASH!
    g. Never take another person's medications.
    h. BEWARE of the precautions on the label. Some drugs do not mix with alcohol, certain foods or other medications.

Your nurse will explain what each drug is for, how to take it and the side-effects you need to be aware of.

Your nurse will assist you with setting up a safe system for taking medications, if necessary. You can use a chart or container system to help you remember what medications to take, how much to take and when to take it.

REMEMBER – ALWAYS READ THE LABEL BEFORE TAKING ANY DRUG!

OXYGEN IS ALSO A PRESCRIPTION!

Make sure the equipment company instructs you in safety precautions and the correct use of ALL equipment (oxygen, walkers, monitors, Hoyer lifts, wheelchairs, etc.) If you do not understand its use, let your nurse or therapist know and they can review safety instructions with you.

In the event that narcotics are being taken, they must be monitored as closely as possible and checked to be sure that they are being taken appropriately. If the narcotic is discontinued, the patient/family have the responsibility to dispose of the used narcotics by either destroying the narcotics or arranging for the RN to dispose of the medication in the home.

Keep an updated list of your medications for emergency situations.

Have a Disaster Plan

FIRE

Protect yourself, your family and your home against fire or burns.

- Be prepared!
- Make a fire escape route and practice it.
- Make surefire exits are free of clutter.
- Keep a fire extinguisher charged and handy. Know how to use it.
- Install smoke detectors and keep them in working order.
- Don't smoke in bed or when sleepy.
- Use space heaters according to manufacturer's instructions. Keep them free from clutter, paper, curtains, etc.
- Keep flammable liquids outside of home in approved safety containers.
- Have your home electrical system checked if there are signs of a wiring problem.
- Keep all electrical appliances in good working order.
- Use extension cords properly. Do not overload them and keep them away from sinks or water.
- Keep towels, curtains, and other flammables a safe distance from the stove.

To prevent burns:

- Always check hot water temperature. Experts suggest setting hot water heaters at 120 degrees F or below.
- Wear tight fitting or short sleeves when cooking.
- Keep pot handles away from the front of the stove.
- Use potholders.

BIOMEDICAL WASTE DISPOSAL IN THE HOME

104-70 Queens Blvd. suite 503, Forest Hills, NY 11375 Tel: 718-896-2218 Fax: 718-830-6299

Recent changes in the state regulations have expanded the application of the federal OSHA (OCCUPATIONAL SAFETY AND HAZARD ADMINISTRATION) regulations regarding the disposal of biomedical waste to include the home setting. It is now illegal to put home-generated biomedical waste out with the regular trash for pick up.

Biomedical waste generated in the home must be packaged and disposed of properly to reduce the risk of exposure to waste handlers and the public at large.

What is Biomedical Waste?

Biomedical waste is defined as any solid or liquid waste that may present a threat of infection of humans. These include, but are not limited to:

1. Used, absorbent materials saturated with blood or body fluids, secretions, excretions, which are contaminated with blood, whether wet or dried. Absorbent materials include such items as bandages, gauze and sponges.
2. Non-absorbent disposable devices that have been contaminated with blood or body fluids, secretions or excretions which are contaminated with blood. Non-absorbent disposable devices include such items as sharps, syringes, lancets, IV tubing, etc.

Your home care agency is responsible for collection and removal of all biomedical waste generated while they are providing home care services. This is done through the use of OSHA approved containers: a rigid container (usually red, but not always) for sharps; and a red bag for absorbent materials. Both of these containers will be marked with a fluorescent orange biohazard or biomedical waste symbol. Upon discharge from the home care services, you will be provided with the name and phone number of local sharps and biomedical waste disposal programs in your area.

REMEMBER! IN NO CASE SHOULD A RED BAG OR A SHARPS CONTAINER EVER BE PUT OUT WITH HOUSEHOLD TRASH.

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PATIENT INSTRUCTIONS IN THE EVENT OF AN EMERGENCY

We are faced with many types of emergency situations that may cause an interruption in services.

In the event you are faced with a natural disaster, inclement weather, and/or other emergency situation, to ensure the highest level of patient care & continuity of services, it is the policy of the agency that a patient immediately call the agency to advise of the emergency situation. Please utilize the following to contact the agency:

AGENCY PHONE NUMBER: 718 896 2218

If you choose to evacuate during an emergency, you must take provisions with you. The following suggested items will make your temporary stay more comfortable:

- Foods that do not need cooking and Drinking water (1 gallon per person per day)
- Special dietary food if required
- Identification, valuable papers and photos, including medical information
- Personal hygiene items, such as: soap, deodorant, shampoo, toothbrush, toothpaste, aspirin, antacid, incontinent supplies, washcloth, towels etc.
- Utensils, such as: manual can opener, disposable plates, cups, forks, knives, spoons, napkins
- Prescription medicines, written prescription for refills & list of medications
- Books, magazines, cards, toys, and games for adults and children
- Infant care items such as formula, food, disposable diapers and toys
- Battery operated radio, flashlight & lantern, extra batteries & earphones
- First aid kit including: betadine solution, bandages, adhesive tape, band-aids, bandages, safety scissors, non-prescription medicines
- Personal aids such as: eyeglasses, hearing aids & prosthetic devices
- Change of clothing and rainwear; Sleeping bag or blanket, sheet & pillow

REMEMBER:

ALL ALCOHOLIC BEVERAGES, ILLEGAL DRUGS, PETS, AND WEAPONS

ARE PROHIBITED WITHIN EMERGENCY PUBLIC SHELTERS.

For more information, see the community reference pages in your telephone directory, or call:

New York State Emergency

Management Office

633 3rd Ave # 27B
New York, NY 10017-8161
(212) 681-4532

104-70 Queens Blvd. suite 503, Forest Hills, NY 11375 Tel: 718-896-2218 Fax: 718-830-6299

COMMUNITY RESOURCES

Emergency **911**

Access-A-Ride 1-877-337-2017

ALZHEIMER'S PROGRAMS & SERVICES : Alzheimer's is a disease that slowly causes deterioration of the brain's functions.

St. John's Episcopal Hospital 1-718-869-7000

Selfhelp Alzheimer's Resource Program 1-718-805-4230

Bereavement Group For The Recently Widowed 1-718-592-5757

Respite Care Program 1-718-366-5591

The Lighthouse 1-212-821-9200

Community Advisory Program for the Elderly 1-718-224-0566

EPIC (ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM) 1-800-332-3742

FOOD STAMPS

Jamaica Office 1-718-523-1298

Flushing Office 1-718-321-2931

Far Rockaway Office 1-718-337-6500

HEAP (Home Energy Assistance Program) 1-212-442-4327

Helen Keller Services For The Blind 1-718-522-2122

The Lexington Hearing and Speech Center 1-718-350-3170

JASA (Jewish Association for Services for the Aged) 1-718-286-1500

KEYSPAN-STAR PROGRAM 1-718-643-4050

MEDICARE 1-800-772-1213

MEDICAID

Elmhurst 1-718-476-5904

Jamaica 1-718-523-5699

Rockaway 1-718-634-6910

Woodside Senior Assistance Program 1-718-779-1234

SECTION 8 HOUSING 1-212-828-7100

SOCIAL SECURITY OFFICES 1-800-772-1213

UTILITY COMPANY COMPLAINTS

Con Edison Teletype Service 1-800-642-2308

Verizon 1-718-890-1550

PROJECT SAFE 212-577-7777

Queens Legal Services 1-718-657-8611

American Red Cross in Greater New York 1-718-558-0053

American Cancer Society 1-718-263-2224

United Lifeline 1-800-345-4571

Birth Certificate 1-212-788-4520

Citizen & Immigration Services 1-800-375-5283

FINANCIAL ASSISTANCE

Social Security Teleservice 1-800-772-1213

HRA (Human Resources Administration) Infoline 1-877-472-8411

BURIAL INFORMATION

If a senior citizen dies, leaving no money, family or friends to pay for the burial, contact:

Queens County Mortuary 1-718-883-3865

Queens Public Administrator1-718-526-5037

Queens County Medical Examiner1-718-883-3871

Brookdale Center on Aging of Hunter College 1-212-481-3780

425 East 25th Street, 13th Floor North, New York, N.Y. 10010

St. John's Episcopal Hospital South Shore 718-869-7000

327 Beach 19th Street**,** Far Rockaway, N.Y. 11691

Respite Care Program 1-718-366-5591

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59-04 Decatur Street, Ridgewood, N.Y. 11385

Use This Space to Record Your Own Frequently Called Numbers	
Name	Telephone Number

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EMERGENCY/DISASTER INFORMATION – HOME HEALTH PATIENT

KEEP THIS PLAN WHERE IT CAN EASILY BE LOCATED.
General Instructions to Patient on Use of This Form:

This information is provided to you as a quick reference source in case any emergency occurs. Keep this document where it can easily be found. Inform other persons close to you (relative, neighbor, etc.) of its location.

1. Eva Homecare Agency Inc. has a nurse on call 24 hours a day. You can reach the nurse through 718-869-9016. After office hours and on weekends, an answering service will reach the nurse and he/she will return your call, come see the patient if necessary, or simply answer any questions you may have.
2. In case of a serious medical emergency, call 911. Eva Homecare Agency Inc. does not operate as an emergency service, therefore, valuable time may be lost by contacting The Agency for an emergency such as a diabetic coma, severe chest pain, unconsciousness, etc.

In case of Medical Emergency Dial 911

The Emergency Medical Service Dispatcher will need to know:

- Your Name: _____
- Your Telephone Number: _____
- Your Address: _____

List of My Current Medications **List of My Supplies / DME**

Emergency contact Information

104-70 Queens Blvd. suite 503, Forest Hills, NY 11375 Tel: 718-896-2218 Fax: 718-830-6299

In Case of Emergency Please Notify the Following Individual:

Name: _____ Phone: _____ Relationship: _____

Disaster Plan Code

Level 1 – 1: Must be seen and/or evacuated ASAP.

Emergency contact Information

I Will:

- ☐ Stay Home
- ☐ Stay with Family or Friend — Name and Telephone #:
- ☐ Evacuate to a Shelter — Shelter's Name and Address:
  - ☐ Standard
  - ☐ Special Needs Registry
  - ☐ Medical management facility (MMF)
- ☐ Evacuate to hospital

Comments

Describe how services will continue in the event of an emergency:

Physician

Name:

Telephone Number:

Address:

Pharmacy

Name:

Telephone Number:

Address:

HURRICANE INFORMATION

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HURRICANE: IT'S NOT JUST ANOTHER STORM

Hurricane Survival Checklists

Before the Storm:

- Know your risk
- How high is your home from sea level? Consult your home's building for your first floor elevation.
- Listen to a local radio and television station for official announcements issued from the Emergency Operations Center.

Special Circumstances (anything requiring additional preparation and/or evacuation time):

- Mobile Home/recreational vehicle
- People with special needs (medical or physical condition)
- Pets
- Boats

Know the Strength of the Hurricane:

- Category One: 74-95 mph sustained winds
- Category Two: 96-110 mph sustained winds
- Category Three: 111 -130 mph sustained winds
- Category Four: 131-155 mph sustained winds
- Category Five: above 155 mph sustained winds

Determine where you will seek shelter if you have to leave and select an alternate:

- Friend’s house, if located away from risk area
- Hotel or Motel located Inland
- Emergency Public Shelter operated by the American Red Cross

OTHER IMPORTANT THINGS TO CONSIDER:

- Take a drive to your shelter choice so you know where it is located. Time the trip and multiply the time by three (3) to account for pre-storm road traffic conditions.
- Make the commitment now to evacuate when you told to do so by local or state officials.
- If you do not have flood insurance, consult your insurance agent purchase. There is a five day waiting before coverage begins.
- Prepare your hurricane evacuation kit.

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DURING THE STORM, REMAIN INSIDE:

- Blowing debris can injure or kill. Travel is extremely dangerous. Stay inside until authorities have announced your area is safe.
- Stay away from windows. Avoid using all electrical appliances. Seek refuge in a small interior, windowless area such as a closet, hallway or bathroom.

AFTER THE STORM:

- Expect the worst. Be careful of downed power lines, gas leaks, weakened structures and dangerous animals.
- Do NOT drink the water. Eat only foods you're sure are absolutely safe.
- Be extra careful in handling power tools, generators, candles, matches and gas lanterns.
- Ask your Insurance Company for financial help. Listen to local radio stations for official relief information and instructions.

STAY SAFE

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EARTHQUAKES/TORNADOES/OTHER DISASTERS

You may face potential threats from Earthquakes, Tornadoes or Other Disasters

Disaster Information:

We are constantly aware of the potential of an earthquake/tornado/other disasters creating damage and creating dangerous conditions. We need to properly prepare so that a disaster of any type will not cause greater personal damage than necessary. The items listed below may help you survive the disaster in a better way.

During the Disaster:

- STAY CALM
- Inside: Stand in an internal hallway or crouch under a desk or table, away from windows or glass dividers
- Outside: Stand away from buildings, trees, telephone and electric lines
- On the road: Drive away from underpasses/overpasses; stop in a safe area; stay in vehicle. Be aware of road conditions and do not take risks.

After the Disaster:

- Check for injuries - provide first aid
- Check for safety - check for gas, water, sewage breaks, downed electric lines and shorts; turn off appropriate utilities; check for building damage and potential safety problems
- Aftershocks from an earthquake or storm resurgence can cause cracks around the chimney, foundation, stairs
- Clean up dangerous spills
- Wear shoes
- Turn on radio and listen for instructions on travel and safety instructions
- Don't use the telephone except for emergency use

Other Important Information:

- How to turn off gas, water and electricity
- Do NOT drink water. Eat only foods you are sure are safe
- Plan for reuniting family
- Contact your insurance company regarding damage

E v a H o m e c a r e A g e n c y , I n c .

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STATEMENT OF PATIENT PRIVACY RIGHTS

As a home health patient, you have the privacy rights listed below:

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

   We are required by law to collect health information to make sure:

   a. you get quality health care, and

   b. payment for insurance patients is correct.

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

   You may be asked to tell us information about yourself so that we will know which home health services will be best for you. We keep anything we learn about you confidential. This means, only those who are legally authorized to know, or who have a medical need to know, will see your personal health information.

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

   We may need your help in collecting your health information. If you choose not to answer, we will fill in the information as best we can. You do not have to answer every question to get services.

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

   We know how important it is that the information we collect about you is correct. If you think we made a mistake, ask us to correct it.

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PRIVACY ACT STATEMENT-HEALTH CARE RECORDS

THIS STATEMENT GIVES YOU ADVICE 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.

We are required by law to maintain the privacy of individually identifiable patient health information (this information is "protected health information" and is referred to herein as "PHI"). We are also required to provide you of a copy of this policy. We will abide by the terms of this notice and notify you if we cannot agree to a requested restriction. We will accommodate requests you may have to communicate health information by alternative means or at alternative locations.

We will only use or disclose your PHI as permitted or required by applicable state law. This Notice applies to your PHI in our possession including the medical records generated by us.

Our agency understands that your health information is highly personal, and we are committed to safeguarding your privacy. Please read this Notice of Privacy Practices thoroughly. It describes how we will use and disclose your PHI.

This Notice applies to the delivery of health care by our Agency. This Notice also applies to the utilization review and quality assessment activities of our Agency.

This summary describes how we use and share information about you. This summary describes how you may see and get copies of this information.

We might use or share information about you for:

Treatment. Such as when our staff discuss your care.

Payment. Such as when we bill your insurance company for services provided to you.

Operations. Such as when we work to make the quality of the care we provide better. When we give out information about the different services we provide.

Other ways. Such as when we send disease reports to county and state health officials (this is required by law). When we provide information to law enforcement agencies, funeral directors, organ donation groups and researchers. When we share information to protect the health and safety of others or you. Or when we respond to court requests. We also may send you appointment reminders, greeting cards and newsletters.

How you may see and get copies of this information: You have the right to:

- Ask for restrictions on the ways we use and give out your information.
- Get and inspect a copy of your health record.
- Add information to your health record.
- Ask that your health information be sent to an alternate address or that you be called at an alternate phone number.

- Change your mind if you told us we could use or share your information for reasons other than those listed above.
- Get a list of the times we gave out your information. It will be a list of the times that the law requires us to keep a record of giving out your information.

Our Commitment to Respect Privacy

Our Agency is required to:

- Keep your information private.
- Let you know if we cannot do what you have asked us to do with your information.
- Try to reach you at another location or phone number, if you ask us to do so.
- Use and / or give out your information as listed above and as the law permits, unless we have your permission to do more.

If there are any changes regarding what we do with your information, we will give you a new notice at the next visit but not later than 30 days.

The agency needs your health information in order to give you quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect information also could make it hard to be sure that the agency is giving you quality services. If you choose not to provide information, there is no requirement for the home health agency on refusing you services.

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ADVANCED DIRECTIVE ACKNOWLEDGEMENT/HIPAA/HOME CARE PRIVACY RIGHTS ACKNOWLEDGEMENT *(patient copy)*

Patient's name: _____ Insurance #_____

I, **_____,** acknowledge that the Agency has provided me with information which indicates that I may accept or reject any medical treatment, including any particular care specified:

- Living Will or Out of Hospital Do Not Resuscitate (DNR)
- Statutory Power of Attorney for Health Care decisions
- Advance Directives in New York – A Health Care Directive
- HIPAA/Home Care Privacy Rights

I also understand that it is my responsibility to ask question about the information provided by the Agency. They have offered to provide a copy of the state's illustrative forms under state law if I request. I have also been advised to consult with my physician, lawyer, family, clergy, social worker or other qualified personnel for additional information or contact with a lawyer should I need assistance in changing the forms to reflect my treatment wishes or in executing a living will or statutory Power of Attorney for health care decisions.

I understand that this Agency will honor the advance directives and is willing and able to provide any procedure specified on the advance directives.

I understand that the fact that I have or have not signed a living will or Statutory Power of Attorney for Home Care decisions does not affect the medical treatment and home care to be provided by the Agency. I understand that it is the Agency's written policy to fully comply through its healthcare providers with the terms of a patient's Living Will or Statutory Power of Attorney for Healthcare decisions to fullest extent permitted by state statutory Power of Attorney for Healthcare decisions to fullest extent permitted by state law.

I have been given an explanation and acknowledge receipt of the HIPAA PRIVACY RIGHTS. I understand that I may contact the Agency at any time for questions or concerns.

PLEASE CHECK THE FOLLOWING:

_____ I Have _____ I Have not signed a Living Will

_____ I Have _____ I Have not signed a Statutory Power of Attorney for Health Care

_____ if I have the above documents, I will provide the Agency with copies for its records.

HIPAA PRIVACY RIGHTS

Patients have the right to give adequate notice concerning the use/disclosure of their PHI on the first date of service delivery, or as soon as possible after an emergency.

The Privacy Rule grants patients new rights over their PHI, including the following:

1. Receive a Privacy Notice at the time of the first delivery of service

2. Restrict use and disclosure, although the covered entity is not required to agree
3. Have PHI communicated to them by alternate means and at alternate locations to protect confidentiality
4. Inspect, correct and amend PHI and obtain copies, with some exceptions
5. Request a history of non-routine disclosures for six years prior to the request, and
6. Contact designated persons regarding any privacy concerns or breach of privacy within the facility or at HHS

Signature Patient or Representative (Signed on behalf of patient when authorized to the extent permitted by state law):

x ***patient copy (signature not required)***_____ Date: _____

Agency Witness: ***patient copy (signature not required)***_____ Date: _____

Federal law requires that this agency provide the above information.

HOME SAFETY ASSESSMENT*(patient copy)*

E v a H o m e c a r e A g e n c y , I n c .

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Patient Name: _____ MR# _____

Address: _____Patient Lives with: _____

Evaluation Completed By (PRINT): _____ Date: _____

Item No.	Description (ENVIRONMENT)	Yes	No	NA
1	Safe and adequate food and water supplies			
2	Stove and means for refrigeration present			
3	Adequate heat and ventilation			
4	Free from infestation			
5	Pathways free of obstacles such as loose rugs, furniture, etc			
6	Clean area exists in which to store medical supplies			
7	Is cautious with heating pads			
8	Has a working smoke detector			
9	If uses oxygen, appropriate signs posted			
FIRE / ELECTRICAL				
1	Fire exits available; warning devices installed			
2	No overuse of extension cords / adequate electrical outlets available			
3	Turns off oven and stove burners			
4	Emergency telephone numbers posted by phone			
5	Turns pot handles to back of stove			
6	Uses space heaters cautiously			
7	Does not smoke in bed			
8	Oxygen precautions used			
BATHROOM SAFETY				
1	No throw rugs			
2	Safety bars present and in good condition			
3	Lighting is adequate			
4	Shower chair is sturdy and in good working condition			
MEDICATION USE				
1	Keeps all medications in original bottle or med box			
2	Has a medication schedule			
3	Home Safety Instructions Given			

Recommendations: _____

_____

As of the date of this evaluation, I attest that this home is safe environment for nursing care.

X_____ Date: _____
Agency Representative Signature

Information Form:

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Agency Name: Eva Homecare Agency Inc.

State: New York

Administrator's Name: Eva Zhang

State Hotline Number: 800-628-5972

Director of Patient Services: Chen Dan

Agency's Street Address: 104-70 Queens Blvd. Suite 503, Forest Hills, NY 11375

Agency's City: Forest Hills

Agency's State Initials: NY

Agency's Zip Code: 11375

Agency's Phone Number: 718-896-2218

E v a H o m e c a r e A g e n c y , I n c .

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PATIENT ACKNOWLEDGES RECEIPT OF

PATIENT INFORMATION BOOKLET

Patient Name: _____ MR#:_____

I , _____, have received the following information from the Representative of Eva Home Health Agency Inc. prior to the beginning of care:

Patient Information Booklet, which includes:

Note:

Please indicate person approved to receive information regarding care and medical information:

_____

Note:

Please indicate person approved to receive information regarding payment for care:

_____

Patient Signature_____ Date:_____

Witness Signature_____ Date: _____