Adult Care of Chester County
Care from the Heart that's State of the Art

Sharp Lane Center
201 Sharp Lane
Exton, PA 19341
(610) 363-8044

Southern Chester County Center
500 Old Forge Lane, Ste 503
Kennett Square, PA 19348
(610) 388-1166

Easy Checklist of Enrollment Requirements

- ☐ **Medical Report** (including TB test or Chest X-ray within past two years)
  (This form must be completed by a physician, nurse practitioner, or physician's assistant)
- ☐ **Application for Enrollment**
- ☐ **Enrollment Agreement/Authorization and Release of Information form**
- ☐ **Privacy Act form (HIPAA)**
- ☐ **Civil Rights Compliance Awareness form**
- ☐ **Copy of Living Will and Power of Attorney for Medical Situations**

Prior to or on First Day, Please send

- ☐ **If medications** are to be given at the center: Medications in original container(s), including name of medication, directions for administration, date of prescription, name of physician. Supply can be for one week or one month.
- ☐ **If appropriate:** a change of clothes that is marked and can be left at the center (or a container to transport to and from the center)

Revised 11/12 PAS

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CLIENT MEDICAL REPORT

201 Sharp Lane
Exton, PA 19341
(610) 363-8044
(610) 363-8507 fax

500 Old Forge Lane, Ste 503
Kennett Square, PA 19348
(610) 388-1166
fax (610) 388-1185

Participant Name:_____ Date of birth:_____

Primary diagnosis_____ Secondary:_____

Other pertinent diagnoses:_____

Significant history:_____

General physical exam findings:_____

_____

Additional medical information pertinent to diagnosis and treatment in case of an emergency

"None"_____ Other :_____

Physical Disabilities:_____

Assessment of health maintenance needs:_____

Is there a need for blood work at recommended intervals? No Yes, frequency_____.

Mental/emotional functioning: current level-mental capacity, orientation, behavior problems_____

_____

General sensory assessment: Vision:_____ Hearing:_____ Speech:_____

Sensory aids:_____

Physicians Orders

Medications and Treatments (include OTC drugs) *(Are medications self administered by this participant?*	Dosage	Administration Schedule *Yes*	*No)*	Reason for med

May have:

Acetaminophen 325 mg or 500 mg, 1 or 2 tabs, q 4 h for pain or headache	Yes	No
Ibuprofen 200 mg, 1 – 2 tabs, q 4 h for minor pain, inflammation or headache	Yes	No
Aspirin 325 mg, 1 – 2 tabs q 4 h for minor pain, inflammation or headache	Yes	No
Antacid, liquid (10–20 cc) or tablets (1-2) PO for stomach upset or heartburn	Yes	No
Anti-diarrhea medication, 1 – 2 tabs as directed for loose stools	Yes	No
Triple antibiotic ointment for minor first aid or skin tear	Yes	No

Medication Allergies:_____ Other Allergies:_____

Please turn page for physician orders

Adult Care of Chester County

Participant Name:_____

DIET:(please check one from each category)

Type: House_____ Diabetic_____ Low Salt_____ Low Fat_____ Lactose Free_____
Consistency: Regular_____ Chopped_____ Pureed_____
Fluids: Thins:_____ Thickened consistency:_____

Does this patient have any exercise restrictions? Yes_____ No_____
If yes, please list restrictions_____

Request evaluation and treatment for: PT OT ST (please circle and provide prescription)

Comments:_____

Diphtheria & Tetanus (date of last)_____
(*Must be within last ten years if under 60 years old; if over 60 years old, this is not mandatory)*

Mantoux tuberculin test (*required every two years***):**

Date applied:_____ by:_____
Name & credentials

Date read: _____Results:_____

Read by:_____
Name & credentials (must be nurse, CNP, PA, or physician)

If the Mantoux test is contraindicated
Please complete this section ↓
Contraindicated due to:
History of positive results_____
Allergy to tuberculin test solution_____

If the Mantoux test is positive or contraindicated, a chest x-ray must be completed.

Last Chest X-Ray date:_____ Result:_____
A chest x-ray **cannot be a substitute** for a Mantoux unless a tuberculin test is contraindicated.

The above person is free from communicable disease or has a communicable disease but is able to attend the adult day center with the following specific precautions taken that will prevent the spread of the disease to other participants:_____

I certify that I have examined this person within the last three (3) months and have reviewed his/her health history. I find him/her able to participate in the adult day services program.

PHYSICIAN SIGNATURE:_____ Date_____

Physician name_____ Phone_____
Practice name:_____
Address _____ Fax_____
City_____State_____ Zip_____ Email_____
We appreciate your prompt reply. Please include any additional information on a separate sheet. PAS 7/12

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Application for Enrollment

Exton Center
201 Sharp Lane
Exton, PA 19341
610-363-8044

Southern Chester County Center
500 Old Forge Lane, Ste 503
Kennett Square, PA 19348
610-388-1166

Name: _____ Preferred name:_____

Address:_____

City:_____ State:_____ Zip:_____ Home phone:_____

County:_____ Township:_____ Race:_____ DOB: _____

Are you a Veteran? Yes, branch_____ No Do you receive funds from the VA? Yes No

Responsible Party (person responsible for making decisions - could be participant)**:**

Name:_____ Relationship:_____

Address:_____

City:_____ State:_____ Zip:_____ Home phone:_____

Email:_____ Mobile Phone:_____

Employer:_____ Work phone:_____ Ext:_____

Is this person designated as the Medical Power of Attorney? Yes No

If yes, a copy of the Medical Power of Attorney must accompany this application.

#1 Person to Contact in an Emergency:

Name:_____ Relationship:_____

Address:_____

City:_____ State:_____ Zip:_____ Home phone:_____

Cell phone:_____ Email:_____

Work phone:_____ ext:_____ Beeper/pager:_____

#2 Person to Contact in an Emergency (second person to be called**):**

Name:_____ Relationship:_____

Home phone:_____ Cell phone:_____

Work phone:_____ ext:_____ Beeper/pager:_____

Additional family members who should receive the monthly newsletter

Name:_____ Relationship:_____ Email:_____

Name:_____ Relationship:_____ Email:_____

Name:_____ Relationship:_____ Email:_____

Billing information (name of person financially responsible for charges incurred at Adult Care of Chester County, Inc.)**:**

Name:_____ Relationship:_____

Address:_____

City:_____ State:_____ Zip:_____ Home phone:_____

Email:_____ Work phone:_____

Is there another party paying part or all of the charges incurred at Adult Care of Chester County, Inc. other than the person identified in the "Billing Information" section of this form? YES NO

If yes, identify the person or organization and for what period of time they will pay.

Person or organization (comp_____

Address:_____ City:_____ State:_____ Zip:_____

Home phone:_____ Work phone:_____ Time Period:_____

Medical problems (diagnoses):_____

_____

Is one physician responsible for oversight of all medications? ○ Yes ○ No

Hospital Preference:_____ Hospital phone:_____

Date of last hospitalization:_____ Reason(s) for hospitalization:_____

_____

Exercise/activity restrictions/limitations:_____

List all medications (those given at home and/or the center include over the counter and prescription):	Dosage	Frequency	Time to be given at adult day center

Medications and Treatments: Can applicant take medications independently? Yes No

DIET: _____

Social Security # _____ Medicare #_____ Medicare Group #_____

BC/BS#_____ Group #_____ Medicaid #_____

Other_____ Long Term Care Insurance □ Yes (if yes, company name_____ □ No

Start Date:_____ Days of attendance: M T W Th F S (please circle)

Information on this form has been provided by me or my representative and is accurate. I hereby give the person listed as responsible party or designated as medical power of attorney permission to make decisions for me.

Signature of participant:_____

I hereby accept the designation of Responsible Party.

Signature of responsible party:_____

Date:_____ Relationship:_____

Adult Care of Chester County, Inc. representative:

Signature of staff member:_____ Title:_____ Date:_____

Revised 12/2014 PAS

Authorization To Release Information

I, _____ (Participant/Responsible Party Name),

authorize Adult Care of Chester County to release medical records or other data pertinent to my care and well being, as may be requested by any physician, hospital, or other health related organization. This authorization is valid until my discharge from this program.

I understand that I can revoke this authorization at any time with written notification. I am also aware that this information may be subject to re-disclosure by the recipient of this information and may no longer be protected.

The Center will release this information for marketing purposes and it will receive remuneration for it: Yes____ No ___X___ .

Participant's Signature:_____

In the event the participant is unable to sign, a responsible person is to sign and complete below:

Signature of Responsible Party:_____
Reason Participant is Unable to Sign:_____

Date signed:_____ Witness:_____

Release For ACCC To Receive Information

I authorize any physician, hospital, or other organization or person having any records, data, or information concerning me to furnish such records, data or information as may be requested by Adult Care of Chester County, Inc., or its duly authorized representative. I understand that in executing this authorization, I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original. I further request that this information be mailed as soon as possible.

Participant's Signature:_____

Date:_____

In the event the applicant is unable to sign, a responsible person is to sign and complete below:

Signature of Responsible Party:_____

Reason Applicant is Unable to Sign:_____

Adult Care of Chester County, Inc. Representative

Staff signature:_____Date:_____

revised 7/2011 PAS

ENROLLMENT AGREEMENT

This Agreement, made this _____day of, _____20___,

between or on behalf of _____, hereinafter referred to as the "participant" and Adult Care of Chester County, Inc., hereinafter referred to as the "Center".
It is agreed as follows:

The Center accepts the participant for enrollment to its program for day services, beginning _____ subject to the following terms and conditions:

ENROLLMENT CRITERIA

Adults (18 or older) with physical, psychosocial, or mental impairments who require assistance and/or supervision. In addition, adults who need rehabilitative therapy (including restorative therapy and functional maintenance therapy) in order to restore or maintain an optimum level of functioning. The person applying shall be able to move about either independently or with the assistance of a person or an assistive device (walker, cane, wheelchair, etc.) and have needs that fall within the scope of services provided at Adult Care of Chester County, Inc. by staff or consultants. Enrollment shall not be denied to anyone because of gender, race, religion, sexual preference, creed, ability to speak or understand English, or disability. Enrollment may be denied if the President/CEO of the program feels that a particular person would endanger the health and safety of himself or others or cause an undue hardship to the facility.

MEDICAL CARE

A physician's medical evaluation report must be completed prior to enrollment to the program. Physical examination of the participant within three months prior to enrollment, or on the first day of program attendance, and at least annually thereafter, is required. Participant and/or caregiver shall agree to pay the cost of such physician visits.

The participant will remain under the medical supervision of his or her personal physician.

Medications or treatments will be administered at the Center only on the order of the participant's personal physician. Medications must be supplied by participant/caregiver with the pharmacy label including the participant's name, the name of the medication, frequency of administration, date of refill, and the prescribing physician's name. The container must be the most recently filled from the pharmacy. Over the counter medications are to be supplied by participant/caregiver. If treatments or testing is required, supplies to perform these functions must be provided by participant/caregiver.

If there are any changes in medication, even if not administered by the ACCC nurses, the participant and/or caregiver is responsible for notifying the Center's Registered Nurse, who will confirm the changes with the physician.

CARE/SERVICES PROVIDED

The Center shall provide the following care and services, included in its basic daily charges, to participants who attend the adult day center. Services may vary based on the needs and preferences of the individual and their caregiver.

Nursing service, to provide assessment, treatment, health screening, health education, medication administration, dressing changes, respiratory treatments and other care as needed. Activities program, to provide assessment, a planned schedule of recreational, motivational, social and other activities that will help the participant achieve a maximum level of functioning. Activities are provided in both group settings of various sizes and individual sessions (as dictated by the activity). Exercise programs based on the needs of each participant are a daily activity. All activities are planned with input from the participant and caregiver. The goal is for people to have fun and enjoyment while achieving desired outcomes.

Care manager assessments and services are provided to participants and caregivers.

Supervision and assistance when needed with activities of daily living, including toileting, bathing, feeding, and transferring.

Food, including therapeutic or modified diets as prescribed by a physician, to include one hot meal each day and snacks (two snacks for full day attendees, one snack for half day attendees).

SERVICES AVAILABLE (Optional)

Availability and referral to specialty services such as psychiatry, physical therapy, speech therapy, beautician services, and podiatry. Costs not included in daily fee.

PODIATRY care is available through the Center to those attending the center. This service is performed by a Consultant and the cost is separate from the Center fee. The billing arrangements will be set-up by the consultant. Please circle your choice and if the choice is yes, please complete the frequency. Note: if the insurance provider is HMO Medicare, please consult the ACCC nurses.

PODIATRY CARE: YES frequency_____ (date of last podiatry visit_____) NO

HAIR CARE is available through the Center to those attending the center. This service is performed by a Consultant and the cost is separate from the Center fee. The billing arrangements will be set-up by the consultant. Please circle your choice and if the choice is yes, please complete the frequency.

HAIR CARE: YES frequency_____ NO

SHOWERS are available at the Center by individual request. The staff or subcontractors of the Center will perform the showers. All safety precautions will be used to prevent injury. They do need to be scheduled by 8:00 AM (unless an emergency). Showers cancelled without sufficient notice or refused will be charged.

SHOWERS: YES frequency_____ NO

PERMISSION FOR TRIPS

I give permission for the participant to take short trips while in the care of the staff and volunteers of the Center.

YES NO

PERMISSION TO BE PHOTOGRAPHED, AUDIO OR VIDEO TAPED, AND OTHERWISE USED FOR MEDIA/PROMOTIONAL MEANS

Still photos, video photos, voice tapes, and other forms of print, audio and/or visual media may be used in the following ways:

- displayed on bulletin boards or in scrapbooks or in picture frames in the center
- be part of a group photo or photo album that would be given to another participant as part of a center memory
- be placed in the newsletter (the newsletter is posted on our website – last names are not given except for the Participant Spotlight)
- be part of the description about the adult day centers on the website – first names only are used
- on a display board or part of a presentation during a community/caregiver education events
- part of a presentation to a foundation or other philanthropic organization
- in materials for the annual appeal and/or annual report
- as part of an advertisement in the newspaper
- in a newspaper article
- for any other type(s) of media or print announcements in a promotional and/or informational manner

I have read this Permission Authorization and hereby give permission for the Participant to be photographed, taped and/or recorded as further described herein.

YES NO

I further understand that this Permission Authorization will remain in effect throughout the time that the Adult Care of Chester County, Inc., is in operations and will be assigned to any future owner or affiliate.

EMERGENCY CARE

In the event of an emergency, personnel of the Center are authorized to administer first aid or additional assistance as may be appropriate for the participant's welfare. The attending physician will be contacted, if possible, and his or her orders followed. If the physician can not be contacted, arrangements will be made to transfer the participant to the nearest available hospital. If necessary, an ambulance will be summoned for transportation. The participant's emergency contact person will be notified. Should the participant have a preference for a specific hospital to be utilized, attempts will be made to make arrangements for transportation to that hospital once the participant's condition has stabilized. Any expenses incurred in an emergency situation will be the responsibility of the participant and or the participant's caregiver.

In the event of illness not requiring emergency care, the caregiver or emergency contact person will be summoned to make arrangements for the participant to be picked up.

DISCHARGE/REFERRAL

Adult Care of Chester County, Inc. will follow established enrollment and discharge criteria. The discharge process will be initiated when any of the following occur: 1) the participant ceases to benefit from the program directly through engagement in activities and/or receipt of care or indirectly through respite for the caregiver, 2) the participant has or develops needs that exceed the resources (either staff or consultants) of ACCC, 3) failure to meet obligations, both financial and documentation, 4) the participant becomes a danger to self or others, 5) or the participant becomes bedridden.

If the discharge is initiated by the facility: 1) the family will be notified thirty days in advance (if at all possible) of the pending discharge. A crisis situation would preclude this step, 2) the staff will assist the family in finding proper placement for the participant to be discharged.
If the discharge is initiated by the family: 1) ACCC requests as much notice as possible, and 2) the criteria for missed days, as identified in the Payment Policy will be followed if the notification of discharge is less than 1 week.

PAYMENT POLICY

The rate will be established for each individual based on his/her care level. The following are definitions of service units:

Basic full day including lunch = more than 4 hours and up to 8 hours

Basic half day including lunch = 4 hours or less (limited slots – based on availability)

The 4 hours must be either morning or afternoon
(9:00-1:00 or 11:30-3:30 or 12:00 to 4:00 if Rover)

Extended day = more than 4 hours and less than 5 hours for half day and more than 8 hours for a full day

Late fees = stay beyond 5:30PM on weekdays and 4:30PM on Saturday

An assessment will be done quarterly on all participants. The assessment assigns numeric values that reflect the level of assistance and services needed. The total points establish the fee that will be charged. It may be necessary for a newly enrolled participant to be assessed for more than one month prior to the appropriate level being established. When charges change, the payer will receive 30 days notice of the increase.

The level of care scale is as follows:

Level I – low to moderate direct assistance and/or supervision needed
Level II- higher level of direct care and/or assistance needed
Level III - level of direct care and/or supervision needed beyond that of level II and/or require great demands on staff regarding lifting, transfers, and other aspects of care.

The amounts charged are (effective 10/1/16):

Level I - $ 93.00 Basic full day	Level I - $61.00 half day (AM or PM - max of 4 hrs)
Level II- $ 103.00 Basic full day	Level II - $67.00 half day (AM or PM - max of 4 hrs)
Level III -$ 113.00 Basic full day	Level III – half day - not available

Extended day Level I - $12.00 per hour (billed in ½ hour increments)
Extended day Level II - $13.00 per hour (billed in ½ hour increments)
Extended day Level III - $14.00 per hour (billed in ½ hour increments)
Shower - $24.00 Caregiver's Helper - $20.00 per hour from departure to return

Application Fee: There will be a $ 35.00 charge to process each application.

Deposit: a deposit will be collected that is based on the pattern of planned attendance and the level of care required. An increase in the deposit will be required when a participant increases days attending and/or when the level of care required increases. The deposit may be used toward payment for the last days of attendance when the participant is discharged from the program. Any remaining deposit will be refunded.

Payment - Invoices are sent out at the end of each month showing all charges accumulated for the month. Payment may be made by cash, check or credit card and is due by the 10th of the billing month. A $10.00 late fee will be charged for balances that are outstanding at the end of the billing month..

Cancellation/changes - All schedule changes need to be called in (or sent in by note, mail, or email to pshull@adultcareofchestercounty.org) by each Thursday at 5:30 PM for the following week's schedule. If the center is not notified of changes by Thursday at 5:30 PM the participant's regular fee will be charged for the missed day(s). This policy includes the Saturday program. If the participant is unable to attend on a scheduled day, the participant or responsible party must notify the Center as soon as possible.

We recognize that many of our folks are frail and caregivers stressed. In response to that recognition, sudden and unexpected schedule changes resulting **from illness of the participant or caregiver** or death of a family member will be excused - the charge will be waived. This will be done on the honor system.

Note: "no call/no shows" will be billed for the day.

Late fees will be charged for pick-ups after 5:30 PM Monday thru Friday and 4:30 PM on Saturday. That charge will be $15.00 for 15 minute periods for any time past 5:30 PM that a participant is picked-up. The beginning of each 15 minute period is used to calculate the late fee.

Increase in charges - If the Center's charges are increased, the Center will give thirty (30) days written notice of such increase, and the participant and/or caregiver will be required to pay the Center the new charges.

Guarantee of Payment - If payment on behalf of a participant is not made in accordance with the Center's established policies, or if any coverage which the participant may have rejects the participant's claim, or allows only part of the claim, the participant and/or caregiver shall be responsible for immediate payment of the balance due. The undersigned, both jointly and individually, shall be fully responsible for payment of the participant's Center bill, in accordance with the Center's established policies, which the participant and/or caregiver agree fair and reasonable.

NON-DISCRIMINATION

It is the policy of the Center that admissions, the provisions of services, and referrals of clients are made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age, or sex.

RECORDS

The Center assures confidential treatment of the personal medical records of all participants. The participant or the caregiver may approve or refuse the release of such records to any person outside the Center, except in the case of the participant's transfer to another institution, and except as may be required by law or third-party payment contract. The participant or responsible party, or both, will have access to the participant's own record and to the information in the records except when, in the opinion of the President/CEO, providing access to the participant, the responsible party or other parties would be potentially harmful to the health, safety or welfare of the participant, The President/CEO may deny access. The President/CEO will address these situations with the Protective Services care manager at the Department of Aging.

The Center uses a computer database for storage of participant information. The database is password secured with different levels and access to information is limited by HIPAA policy. The Family Connection resource available to family caregivers is only accessed with a logon and password unique to that individual and only that person's record is available.

PARTICIPANT WELFARE, PROPERTY

The participant and the caregiver assume all responsibility for the participant's personal property, and release and hold the Center, officers, agents, and employees completely harmless from any and all responsibilities for the welfare of the participant, for injury or death, or for damage or loss to any personal property. Removal of the participant from the Center either temporarily or permanently shall terminate any responsibility on the part of the Center and its employees.

RULES AND REGULATIONS

The participant and the caregiver will comply at all times with the rules, regulations, and policies of the Center. This includes any amendments to existing policies which may be made after commencement of the participant's enrollment.

The Center will be notified of any changes of address and/or telephone numbers of participants, responsible parties, emergency contacts or others critical to the care and safety of the participant.

GRIEVANCE PROCEDURE

The Center's grievance procedure will be explained to the participant/responsible party. If the participant is dissatisfied with the care plan or services provided by the Center, the participant may use this grievance procedure, as described in the Caregiver/participant handbook, or request a fair hearing with the Pennsylvania Department of Aging.

The participant will be given a copy of his/her rights and responsibilities. These rights and responsibilities will be explained to the participant.

TRANSPORTATION

The type of transportation used by participants to arrive and depart is the participant's and/or caregiver's choice. The Center staff can assist with the arrangement of transportation. Participants who request transportation services must adhere to the transportation policies as established by Rover Community Transit, other transportation services and/or the Center. The Center has no control over the operation of the Rover Community Transit system or any other public transportation provider. The Center cannot guarantee transportation service delivery.

BINDING EFFECT

This Agreement shall be binding on all parties involved. This Agreement cannot be modified orally and any changes must be made in writing, signed by the parties to this Agreement.

TERMINATION OF THIS AGREEMENT

The participant and/or caregiver may terminate this Agreement, provided the Center receives at least twenty-four (24) hours notice given either personally or by mail. The participant and/or caregiver shall remain responsible for all charges incurred in connection with the participant's participation at the Adult Day Center until actual discontinuance of participation (within the policy for cancellation of attendance).

AGREEMENT

I have read the above Agreement and all my questions have been answered to my satisfaction. I hereby certify that the Enrollment Agreement has been explained to me and that I have received a copy. I understand that by signing below, I consent to the terms of the Enrollment Agreement, accept financial responsibility for participation in the Center, and authorize the Center to provide daytime care and supervision.

Participant Signature:_____

Responsible Party Signature:_____

Is this person the Power of Attorney Yes No If yes, documentation is required

Relationship to Participant:_____ Date:_____

Program Director/Administrator signature:_____

Title:_____ Date:_____

Copy given to Responsible Party ☐ Staff initials:_____ Date:_____

Revised 12/8/2014 PAS

Adult Care of Chester County, Inc.

Exton Center
201 Sharp Lane
Exton, PA 19341

Southern Chester County Center
500 Old Forge Lane, Ste 503
Kennett Square, PA 19348

Participant/Caregiver Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by asking the President/CEO for one.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for provision of services, treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

The Center is permitted to call phone numbers given in the enrollment application and annual updates and leave messages on answering machines or speak with others that might answer that phone and leave messages about my health status.

The Center is permitted to send an email about my health status to the email addresses given on the enrollment application and annual updates.

The Center is permitted to assign a Family Connection login and password to those designated as a "responsible party" on the application form or with permission of a "responsible party" by way of an email requesting permission and corresponding affirmative reply.

The Center is not permitted to give health care information to the following individuals and/or organizations: _____

_____

The Center is permitted to allow the following persons visit me while at the center:

_____ if blank, no visitors will be permitted.

I have received a copy of the Notice Of Privacy Information Practices of Adult Care of Chester County.

Participant/Responsible Party Signature_____

Participant/Responsible Party Name_____

Reason Participant is Unable to Sign:_____

Witness Signature/Position_____

Date _____ Revised 7/1/2011 PAS

Adult Care of Chester County
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201 Sharp Lane, Exton, PA 19341-1402
Phone 610 363-8044 Fax 610 363-8507
www.acofcc.org

SUBJECT: Nondiscrimination in Services

TO: Participants/Caregivers

FROM: Patricia A. Shull, President/CEO

Admissions, the provisions of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age, or sex.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any participant (and /or their caregiver) who believes they have been discriminated against may file a complaint of discrimination with:

Adult Care of Chester County, Inc.
201 Sharp Lane
Exton, PA 19341

Department of Public Welfare
Bureau of Equal Opportunity
Room 223, Health & Welfare Building
PO Box 2675
Harrisburg, PA 17105

U. S. Department of Health and Human Services
Office for Civil Rights
Suite 372, Public Ledger Bldg
150 South Independence Mall West
Philadelphia, PA 19106-9111

PA Human Relations Commission
Harrisburg Regional Office
Riverfront Office Center
1101 S. Front St. 5th Floor
Harrisburg, PA 17104

Commonwealth of Pennsylvania
Department of Public Welfare
Bureau of Equal Opportunity
Southeast Regional Office
801 Market Street, Suite 5034
Philadelphia, PA 19107

Revised Feb 2013

Participant/caregiver Signature Date

Staff Signature Date

Adult Care of Chester County, Inc.

NOTICE OF PRIVACY INFORMATION PRACTICES

Effective Date: 9/15/03

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.

If you have any questions about this notice, please contact Patricia Shull (President/CEO) at 610 363-8044.

WHO WILL FOLLOW THIS NOTICE:

This notice describes our Center's practices and that of:

- Any health care professional authorized to enter information into your medical record.
- Any member of a volunteer group we allow to help you while you are in the Center.
- All employees, staff and other Center personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Center. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Center, whether made by Center personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law (HIPAA) to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to Center personnel and consultants who are involved in taking care of you at the Center. Different departments of the Center also may share medical information about you in order to coordinate the different things you need. We also may disclose medical information about you to people outside the Center who may be involved in your medical care after you leave the Center, such as family members, doctors, nurses, technicians, medical students, clergy or others we use to provide services that are part of your care.

- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive at the Center may be billed to, and payment may be collected from, you, an insurance company or a third party. For example, we may tell your health plan about the services you may receive at the Center to obtain prior approval or to determine whether your plan will cover the services.

- **For Health Care Operations**. We may use and disclose medical information about you for Center operations. These uses and disclosures are necessary to run the Center and make sure that all of our participants receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may combine medical information about many Center participants to decide what additional services the Center should offer and what services are not needed. We may disclose information to doctors, nurses, technicians, medical students, and other Center personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Centers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific participants are.

- **Health-Related Benefits and Services**. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Fundraising Activities**. We may use medical information about you to contact you in an effort to raise money for the Center and its operations. If you do not want the Center to contact you for fundraising efforts, you must notify the President/CEO in writing.

- **Center Newsletter**. We may include certain limited information about you in the Center Newsletter while you are a participant at the Center.

- **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the Center. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **As Required By Law**. We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

- **Military and Veterans**. We may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.

- **Workers' Compensation**. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks**. We may disclose medical information about you for public health activities. These activities generally include the following:
  - To prevent or control disease, injury or disability;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - To notify the appropriate government authority if we believe a participant has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **National Security and Intelligence Activities**. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Law Enforcement**. We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

- About a death we believe may be the result of criminal conduct; About criminal conduct at the Center; and
- In emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Protective Services for the President and Others**. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the President/CEO. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Center. To request an amendment, your request must be made in writing and submitted to the President/CEO. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for the Center;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the President/CEO. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month

period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a diagnosis you have.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
  To request restrictions, you must make your request in writing to the President/CEO. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at the Center or by mail.

  To request confidential communications, you must make your request in writing to the President/CEO. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE

- We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the Center. The notice will contain on the first page, in the top right-hand corner, the effective date and any dates of revision. We will provide a copy of the revised notice upon request.

COMPLAINTS

- If you believe your privacy rights have been violated, you may file a complaint with the Center or with the Secretary of the Department of Health and Human Services. To file a complaint with the Center, contact the President/CEO at 610 363-8044. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.