

# Practical Care Continuum Customer Information Booklet Table of Contents

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# Practical Care Continuum Employee Responsibilities

## Homemakers May Provide:

- Companionship
- Stand-by assistance with walking
- Planning and preparation of meals
- Light housekeeping\*/Laundry
- Stand-by assistance with toileting, bathing and dressing
- Reminding of medications that are set up in a pill divider
- Transportation

## Personal Attendants May Provide Assistance with:

- Ambulation, transferring, turning & exercise
- Bathing, dressing, grooming & toileting
- Oral hygiene
- All of the above as well as Homemaker Duties

**Employees are not allowed due to our license with the State of Texas, non-medical parameters therein, and our insurance policies too:**

- Perform Medical Procedures such as
  - Giving shots or injections
  - Administering Wound Care
  - Assisting with enemas
  - Adjusting Oxygen levels
  - Diabetic Foot Care
- Deep clean your home (We are not housekeeping/maid service. Should you require deep cleaning of your home then please contact the office for a referral to a company that provides this service.)
  - We do not mop whole houses but will spot mop kitchens and bathrooms as needed for cleanup after meal preparation or bathing.
  - Sweeping, vacuuming, and dusting areas are generally fine.
  - We do not wash windows, baseboards, or clean any areas requiring the use of a ladder or movement of furniture.
  - Provide housekeeping services for family members who do not use services
- Provide transportation for children
- Move furniture
- Do yard work
- Climb ladders
- Schedule Changes (All changes must be made through the Agency)
- Work privately for you
- Assist with financial matters
- Give out their phone numbers

# **Practical Care Continuum Customer Responsibilities**

## **Customers agree to:**

- Refrain from asking PCC employees to do any tasks they are prevented by policy or law from doing.
- Provide the agency with a complete and accurate health history.
- Accept the responsibility for any refusal of services.
- Participate in your care by asking questions and expressing concerns.
- Participate in the planning and revising of your Service Plan.
- Provide a safe home environment in which your care can be given, including restraining animals who may pose a threat to our employees.
- Refrain from offering Practical Care Continuum employees' money.
- Treat each Practical Care employee with respect and consideration.
- Be willing and able to care for yourself or have a reliable caregiver (voluntary or paid) help with your care, when Practical Care Continuum staff are not present.
- Inform Practical Care of any changes in a customer's condition.
- Inform Practical Care of cancellations at least 12 hours in advance in person or by text.
- Follow Practical Care's Customer Responsibilities.
- Pay bills within a timely manner.
- Understand that services will be terminated for non-payment of fees.
- Tell us if you have problems with your care or are dissatisfied with our service.

Should a customer have questions on any of these responsibilities they may contact the Administrator Samantha Young at (512) 400-4331

## **Chapter 102 - Rights of the Elderly...Effective June 1, 2020**

### **Sec. 102.00 1. Definitions**

In this chapter:

- (1) "Convalescent and nursing home" means an institution licensed by the Texas Department of Human Services under Chapter 242, Health and Safety Code.
- (2) "Home health services" means the provision of health service for pay or other consideration in a patient's residence regulated under Chapter 142, Health and Safety Code.
- (3) "Alternate care" means services within an elderly individual's own home, neighborhood, or community including:
  - a. Day care;
  - b. Foster care;
  - c. Alternative living plans, including personal care services; and
  - d. Supportive living services, including attendant care, residential repair, or emergency response services.
- (4) "person providing services" means an individual, corporation, association, partnership, or other private or public entity providing convalescent and nursing home services, home health services, or alternate care services.
- (5) "Elderly individual" means an individual 60 years of age or older.

### **Sec. 102.002. Prohibition**

- (a) A person providing services to the elderly may not deny an elderly individual a right guaranteed by this chapter.
- (b) Each agency that licenses, registers, or certifies a person providing services shall require the person to implement and enforce this chapter. A Violation of this chapter is grounds for suspension or revocation of the license, registration, or certification of a person providing services.

### **Sec. 102.003. Rights of the Elderly**

- (a) **An elderly individual has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States**, except where lawfully restricted. The elderly individual has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.
- (b) **An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment.** This means that the elderly individual:
  - (1) has the right to make the individual's own choices regarding the individual's personal affairs, care, benefits, and services;
  - (2) has the right to be free from abuse, neglect, and exploitation; and
  - (3) if protective measures are required, has the right to designate a guardian or representative to ensure the right to quality stewardship of the individual's affairs.
- (c) **An elderly individual has the right to be free from physical and mental abuse, including corporal punishment or physical or chemical restraints that are administered for the purpose of discipline or convenience** and not required to treat the individual's medical symptoms. A person providing services may use physical or chemical restraints only if the use is authorized in writing by a physician or the use is necessary in an emergency to protect the elderly individual or others from injury. A physician's written authorization for the use of restraints must specify the circumstances under which the restraints may be used and the duration for which the restraints may be used. Except in an emergency, restraints may only be administered by qualified medical personnel.

**(d) An elderly individual with an intellectual disability who has a court-appointed guardian of the person may participate in a behavior modification program involving use of restraints or adverse stimuli only with the informed consent of the guardian.**

**(e) An elderly individual may not be prohibited from communicating in the individual's native language** with other individuals or employees for the purpose of acquiring or providing any type of treatment, care, or services.

**(f) An elderly individual may complain about the individual's care or treatment.** The complaint may be made anonymously or communicated by a person designated by the elderly individual. The person providing services shall promptly respond to resolve the complaint. The person providing service may not discriminate or take other punitive action against an elderly individual who makes a complaint.

**(g) An elderly individual is entitled to privacy while attending to personal needs and a private place for receiving visitors or associating with other individuals unless providing privacy would infringe on the rights of other individuals.** This right applies to medical treatment, written communications, telephone conversations, meeting with family, and access to resident councils. **An elderly person may send and receive unopened mail, and the person providing services shall ensure that the individual's mail is sent and delivered promptly.** If an elderly individual is married and the spouse is receiving similar services, the couple may share a room.

**(h) An elderly individual may participate in activities of social, religious, or community groups** unless the participation interferes with the rights of other persons.

**(i) An elderly individual may manage the individual's personal financial affairs.** The elderly individual may authorize in writing another person to manage the individual's financial affairs. The elderly individual may choose the manner of a money management program, a representative payee program, a financial power of attorney, a trust, or a similar method, and the individual may choose the least restrictive of these methods. A person designated to manage an elderly individual's financial affairs shall do so in accordance with each applicable program policy, law, or rule. On request of the elderly individual or the individual's representative, the person designated to manage the elderly individual's financial affairs shall make available the related financial records and provide an accounting relating to the financial management. An elderly individual's designation of another person to manage the individual's financial affairs does not affect the individual's ability to exercise another right described by this chapter. If an elderly individual is unable to designate another person to manage the individual's financial affairs and a guardian is designated by a court, the guardian shall manage the individual's financial affairs in accordance with the Estates Code and other applicable laws.

**(j) An elderly individual is entitled to access to the individual's personal and clinical records.** These records are confidential and may not be released without the elderly individual's consent, except that the records may be released:

- (1) to another person providing services at the time the elderly individual is transferred; or
- (2) if the release is required by another law.

**(k) A person providing services shall fully inform an elderly individual, in language that the individual can understand, of the individual's total medical condition and shall notify the individual whenever there is a significant change in the person's medical condition.**

**(l) An elderly individual may choose and retain a personal physician and is entitled to be fully informed in advance about treatment or care that may affect the individual's well-being.**

**(m) An elderly individual may participate in an individual plan of care that describes the individual's medical, nursing and psychological needs and how the needs will be met.**

(n) **An elderly individual may refuse medical treatment after the elderly individual:**

- (1) is advised by the person providing services of the possible consequences of refusing treatment; and
- (2) acknowledges that the individual clearly understands the consequences of refusing treatment.

(o) **An elderly individual may retain and use personal possessions, including clothing and furnishings, as space permits.** The number of personal possessions may be limited for the health and safety of other individuals.

(p) **An elderly individual may refuse to perform services for the person providing services.**

(q) Not later than the 30th day after the date the elderly individual is admitted for service, a person providing services shall inform the individual:

- (1) whether the individual is entitled to benefits under Medicare or Medicaid; and
- (2) which items and services are covered by these benefits, including items and services for which the elderly individual may not be charged.

(r) A person providing services may not transfer or discharge an elderly individual unless:

- (1) the transfer is for the elderly individual's welfare, and the individual's needs cannot be met by the person providing services;
- (2) the elderly individual's health is improved sufficiently so that services are no longer needed;
- (3) the elderly individual's health and safety or the health and safety of another individual would be endangered if the transfer or discharge was not made;
- (4) the person providing services ceases to operate or to participate in the program that reimburses the person providing services for the elderly individual's treatment or care; or
- (5) the elderly individual fails, after reasonable and appropriate notices, to pay for services.

(s) Except in an emergency, a person providing services may not transfer or discharge an elderly individual from a residential facility until the 30th day after the date the person providing services provides written notice to the elderly individual, the individual's legal representative, or a member of the individual's family stating:

- (1) that the person providing services intends to transfer or to discharge the elderly individual;
- (2) the reason for the transfer or discharge listed in Subsection (r);
- (3) the effective date of the transfer or discharge;
- (4) if the individual is to be transferred, the location to which the individual will be transferred; and
- (5) the individual's right to appeal the action and the person to whom the appeal should be directed.

(t) An elderly individual may:

- (1) make a living will by executing a directive under Subchapter B, Chapter 166, Health and Safety Code;
- (2) execute a medical power of attorney under Subchapter D, Chapter 166, Health and Safety code; or
- (3) designate a guardian in advance of need to make decisions regarding the individual's health care should the individual become incapacitated.

#### **Sec.102.004. List of Rights**

(a) A person providing services shall provide each elderly individual with a written list of the individual's right and responsibilities, including each provision of Section 102.003, before providing services or as soon after providing services as possible, and shall post the list in a conspicuous location.

(b) A person providing services must inform an elderly individual of changes or revisions in the list.

#### **Sec. 102.005.Rights Cumulative**

The rights described in this chapter are cumulative of other rights or remedies to which an elderly individual may be entitled under law.

## Client Rights and Responsibilities

**Policy:** All persons receiving care from the Agency shall receive a written copy and a verbal explanation of client rights and responsibilities at time of admission.

**Approach:**

1. The client has the right to use the agency of his/her choice
2. At the time of admission, the admitting staff will inform the client of his/her rights and responsibilities.
  - a. The client will be informed verbally of his/her rights and responsibilities.
  - b. The client will be given a written copy of his/her rights and responsibilities. This copy should be left in the client's home.
  - c. The agency will maintain documentation in the client's record that the client received a copy of the client's rights and responsibilities.
3. At the time of admission, the admitting staff will also inform the client of the procedure to follow for filing a complaint. The client will also be given the 1-800 number for filing a complaint/concern with the Texas Department of Aging and Disabilities Services.
4. The Agency will accept persons for care regardless of age, sex, race, religion, color, or disabling condition.
5. Prior to collecting OASIS data, the client will be given the applicable statement of client privacy rights.
6. The client will be advised in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.
7. Clients 60 years old and older will be advised of their rights as an elderly client.
8. The client has the right to be informed in advance about the care to be furnished, the plan of care, expected outcomes, barriers to treatment, and any changes in the care to be furnished. The agency will ensure that written informed consent that specifies the type of care and services that may be provided by the agency has been obtained for every client, either from the client or their legal representative. The client or the legal representative will sign or mark the consent form.
9. The client has the right to participate in the planning of the care or treatment and in planning changes in the care or treatment.
  - a. The agency will furnish advance directive information at the time of the first home visit.
10. The client or legal representative has the right to be advised or consulted in advance of any changes in the plan of care.
11. The client has the right to refuse care and services.
12. The client has the right to be informed, before care is initiated, of the extent to which payment may be expected from the client, third-party payers, and any other source of funding known to the agency.
13. The agency will protect and promote a client's rights.
14. A client has the right to have assistance in understanding and exercising his or her rights.
15. The client has the right to exercise his or her rights as a client of the agency.

16. In the case of a client adjudged incompetent, the rights of the client are exercised by the person appointed by law to act on the client's behalf.
17. In the case of a client who has not been adjudged incompetent, any legal representative may exercise the client's rights to the extent permitted by law.
18. The client has the right to have his or her person and property treated with consideration, respect, and full recognition of his or her individuality and personal needs.
19. The client has the right to be free from abuse, neglect and exploitation by an Agency employee or contractor.
20. The client has the right to confidential treatment of his or her personal and medical records.
21. The client has the right to voice grievances regarding treatment or care that is or fails to be furnished or regarding the lack of respect for property by anyone who is furnishing services on behalf of the agency and must not be subjected to discrimination or reprisal for doing so.
22. A. Patients cared for by the Agency have the following rights with respect to the privacy of their health information:
  1. To receive a paper copy of the agency's Notice of Privacy Practices
  2. To lodge complaints about the agency's privacy practices
  3. To request restrictions on the uses and disclosures of health information
  4. To request to receive confidential communication
  5. To request access to their protected health information for inspection and/or copying
  6. To request to amend their health care information
  7. To request an accounting of disclosure of health information
- B. The privacy policies of the Agency detail the requirements for each of these rights and provide procedures for implementation.

## **Practical Care Continuum's Notification of Privacy Practices**

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

### **A. OUR COMMITMENT TO YOUR PRIVACY**

Our Agency is dedicated to maintaining the privacy of your medical information. In conducting our business, we will create records regarding you and the treatment and services we provide for you.

These records are our property. However, we are required by law:

- To maintain the confidentiality of your medical information.
- To provide you with this notice of our legal duties and privacy practices concerning your medical information
- To follow the terms of our notice of privacy practices in effect at the time.

To summarize, this notice provides you with the following important information:

- How we may use and disclose your medical information.
- Your privacy rights in your medical information.
- Our obligations concerning the use and disclosure of your medical information.

### **CHANGES TO THIS NOTICE**

The terms of this notice apply to all written and electronic records containing your medical information that are created or retained by us. We reserve the right to revise, change, or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of the information that we already have about you, as well as any of your medical information that we may receive, create, or maintain in the future. Our Agency will post a copy of our current notice on our internet website, [www.practicalcarecontinuum.com](http://www.practicalcarecontinuum.com), in a prominent location in our offices and you may request a copy of our most current notice by calling or visiting our offices.

### **B. USE AND DISCLOSURE OF HEALTH INFORMATION**

**Practical Care** may use your health information, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for purposes of providing you with treatment, obtaining payment for your care and conducting health care operations. The Agency has established policies to guard against unnecessary disclosure of your health information.

The protection of your private information is of the utmost importance under HIPAA as well as the policy of Practical Care Continuum. Private information is divided into three separate categories: health information, individually identifiable health information and protected health information.

Health information is any information, whether oral or recorded in any form or medium, that has been created or received by a health care provider, health plan, public health authority, employer, life insurer, or healthcare clearinghouse that relates to the past, present or future of an individual or the provision of healthcare or payment information. Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual and is created or received by a healthcare provider and relates, to the past, present, or future physical or mental health or condition of an individual. Protected health information is all individually identifiable information that is transmitted electronically, maintained in any electronic medium, or transmitted or maintained in any other form or medium.

**THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED.**

**To Provide Treatment** the Agency may use your health information to coordinate care within the Agency and with others involved in your care, such as your attending physician and other healthcare professionals who have agreed to assist the Agency in coordinating care. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications or equipment. The Agency also may disclose your health care information to individuals outside of the Agency involved in your care including family members, pharmacists, suppliers of medical equipment or other health care professionals.

**To Obtain Payment** the Agency may include your health information in invoices to collect payment from third parties (insurance carriers) for the care you receive from the Agency. For example, the Agency may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or the Agency. The Agency also may need to obtain prior approval from your insurer and may need to explain to the insurer your need for home care and the services that will be provided to you.

**To Conduct Health Care Operations** the Agency may use and disclose health information for its own operations in order to facilitate the function of the Agency and as necessary to provide quality care to all of the Agency's patients. Healthcare operations include such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Policy/Procedure development, case management and care coordination.
- Contacting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment.
- Professional review and performance evaluation.
- Training programs including those in which health care providers learn under supervision.
- Accreditation, certification, licensing, or credentialing activities.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Agency.

For example, the Agency may use your health information to evaluate its staff performance, combine your health information with other Agency patients in evaluating how to more effectively serve all Agency patients, disclose your health information to agency staff and contacted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you as part of community information mailing (**unless you tell us you do not want to be contacted**)

**For Appointment Reminders** the Agency may use and disclose your health information to contact you as a reminder that you have an appointment for a home visit.

**For Treatment Alternatives** the Agency may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY ALSO BE USED AND DISCLOSED**

**When Legally Required** the Agency will disclose your health information when it is required to do so by any Federal, State, or local law.

**When There Are Risks to Public Health** the Agency may disclose your health information for public activities and purposes in order to:

- Prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations, and interventions.
- Report adverse events, product defects, to track products or enable product recalls, repairs and replacements and to conduct post-marketing surveillance and compliance with requirements of Food and Drug Administration.
- Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.
- Notify an employer about an individual who is a member of the workforce as legally required.

**To Report Abuse, Neglect, OR Domestic Violence** the Agency is allowed to notify government authorities if the Agency believes a patient is the victim of abuse, neglect or exploitation. The Agency will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

**To Conduct Health Oversight Activities** the Agency may disclose your health information to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Agency, however, may not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

**In Connection With Lawsuits and Similar Proceedings** The Agency may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Agency makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

**For Law Enforcement Purposes** As permitted or required by State law, the Agency may disclose your health information to a law enforcement official for certain law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant, subpoena or summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the Agency has a suspicion that your death was the result of criminal conduct including criminal conduct at the Agency.
- In an emergency in order to report a crime.

**To Coroners and Medical Examiners.** The Agency may disclose your health information to coroners and medical examiners for purposes of determining your cause of death or for other duties, as authorized by law.

**To Funeral Directors** the Agency may disclose your health information to funeral directors consistent with applicable law and if necessary, to carry out their duties with respect to your funeral arrangements.

**For Organ, Eye or Tissue Donation** the Agency may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.

**For Research Purposes** the Agency may, under very select circumstances, use your health information for research. Before the Agency discloses any of your health information for such research purposes, the project will be subject to an extensive approval process.

**In the Event of a Serious Threat to Health or Safety** the Agency may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Agency, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**For Specified Government Functions** In certain circumstances, the Federal regulations authorize the Agency to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

**For Worker's Compensation** the Agency may release your health information for worker's compensation or similar programs.

**\*Note: It is the standard practice of the Agency to use fax machines to transmit health information. However, it is the policy of Practical Care to call the intended recipient of faxed health information prior to transmitting that information in order to verify that the fax number is correct, in an effort to maintain your privacy.**

### **AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Other than what is stated above, the Agency will not disclose your health information other than with your written authorization. If you or your representative authorized the Agency to use or disclose your health information, you may revoke that authorization in writing at any time.

### **YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION**

You have the following rights regarding your health information that the Agency maintains:

**Right to request restrictions** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Agency's disclosure of your health information to someone who is involved in your care or the payment of your care. However, the Agency is not required to agree to your request. If you wish to make a request for restrictions, please contact **the Administrator**

**Right to receive confidential communications** You have the right to request that the Agency communicate with you in a certain way. For example, you may ask that the Agency only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential communication, please contact **the Administrator**. The Agency will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

**Right to inspect and copy your health information** You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to **the Administrator**. If you request a copy of your health information, the Agency may charge a reasonable fee for copying and assembling costs associated with your request.

**Right to Electronic Records** In the event your health information is an electronic record, you have the right to access the electronic form and format (if the requested format is available to the Agency) You may be charged a fee for the labor and supply cost for creating an electronic copy and for postage to transport portable media.

**Right to amend health care information** You or your representative has the right to request that the Agency amend your records, if you believe that your health information is incorrect or incomplete. That request may be made as long as the information is maintained by the Agency. A request for an amendment of records must be made by writing to **the Administrator**. The Agency may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by the Agency, if the records you are requesting are not part of the Agency's records, if the health information you wish to amend is not part of the health information you or your representative are permitted to

inspect and copy, or if, in the opinion of the Agency, the records containing your health information are accurate and complete.

**Right to an accounting** You or your representative have the right to request and accounting of disclosures of your health information made by the Agency for certain reasons, including reasons related to public purposes authorized by law and certain research. The request for an accounting must be made in writing to **the Administrator**.

The request should specify the time period for the accounting starting on or after June 1, 2020. Accounting requests may not be made for periods of time in excess of six (6) years. The Agency would provide the first accounting of your request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

**Right to a paper copy of this notice** You or your representative has the right to a separate paper copy of this Notice at any time even if you or your representative has received this Notice previously. To obtain a separate paper copy, please contact **the Administrator**. [You may also obtain a copy of the current version of the Agency's Notice of Privacy Practices at its website, [www.practicalcarecontinuum.com](http://www.practicalcarecontinuum.com)]

**Right to file a Complaint** You or your personal representative have the right to express complaints to the Agency and the Secretary of DHHS if you or your representative believe that your privacy rights have been violated. Any complaints to the Agency should be made in writing to **the Administrator**. The Agency encourages you to express any concerns you may have regarding the privacy of your information. You will not be penalized for filing a complaint. You may also file written complaints with the Director at the Office for Civil Rights of the U.S. Department of Health and Human Services.

**Right to Provide an Authorization for Other Uses and Disclosures** Our Agency will obtain your written authorization for uses and disclosures that are not identified by this notice or are not permitted by law. Any authorization you provide to us regarding the use and disclosure of your medical information may be revoked at any time in writing. After revoking your authorization, we will no longer use or disclose your medical information for the reasons described in the authorization. Of course, we are unable to take back any disclosures that we have already made with your permission. Please note that we are required to retain records of your care.

**Right to be Notified of a Data Breach** In the event of a data breach, our Agency will notify you.

#### **DUTIES OF THE AGENCY**

The Agency is required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of its duties and privacy practices. If the Agency changes its Notice and you are still receiving services, the Agency will provide a copy of the revised Notice to you or your appointed representative. You may also obtain a new notice by contacting the Corporate Compliance Officer.

#### **CONTACT PERSON**

The Agency has designated the **Administrator** as its contact person for all issues regarding patient privacy and your rights under Federal privacy standards.

**Samantha Young, Administrator (512) 400-4331**

**Effective Date** This notice is effective June 1, 2020

# Policy on Abuse, Neglect & Exploitation

## Purpose

To identify suspected or alleged victims of abuse, neglect, and exploitation (ANE) and establish appropriate protocols for reporting and/or referring abuse, neglect, and/or exploitation of a client to the appropriate state agency.

## Definitions

**Adult Abuse:** The negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain to an elderly or disabled person by the person's caretaker, family member, or other individual who has an ongoing relationship with the person.

**Sexual Abuse** of an elderly or disabled person, including any involuntary or non-consensual sexual conduct that would constitute an offense under Section 21.08, penal Code (indecent exposure) or Chapter 22, Penal Code (assaultive offenses), committed by the person's caretaker, family member, or other individual who has an ongoing relationship with the person.

**Adult Neglect:** The failure to provide for oneself the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide such goods or services.

**Adult Exploitation:** The illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disable person using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain without the informed consent of the elderly or disabled person.

## PROCEDURES

1. Agency will educate clients at admission and annually on the process to ensure understanding of who to contact in such situations. Consumers can file a complaint:
  1. Online at <https://txhhs.force.com/complaint/s?>, or
  2. Email CII at [ciicomplaints@hhs.texas.gov](mailto:ciicomplaints@hhs.texas.gov), or
  3. Call 1-800-458-9858 between the hours of 7:00 am and 7:00 pm, Monday through Friday.
2. The Agency must self-report an incident of alleged ANE by:
  1. Submitting a report online at <https://txhhs.force.com/TULIP/s>, or
  2. Emailing CII at [ciicomplaints@hhs.texas.gov](mailto:ciicomplaints@hhs.texas.gov) or
  3. Call 1-800-458-9858 between 7:00 am and 7:00 pm, Monday through Friday.
3. An incident report must be completed as well as HHSC Form 3613
4. Staff members suspected of abusing/neglecting/exploiting a client will be suspended from service pending the completion of an investigation.
5. Per the results of the investigation the employee will be:
  - a. Returned to work if no evidence is found to substantiate the claim or
  - b. Terminated and reported to the proper authorities if the claim is substantiated.

# Information Sheet on Drug Testing of Employees

## **POLICY**

The Agency is a drug-free, safe workplace. The misuse and abuse of drugs and alcohol pose serious threats to the agency, its employees and its patients.

## **DEFINITIONS**

Illegal Drug means any drug that is a.) not legally obtainable with a prescription or b.) legally obtainable but that has not been specifically prescribed to the individual.

Legal Drug means legally obtained by prescription and over-the-counter drugs that are being used for the purpose for which they were prescribed or manufactured.

Possession means to have on one's person, in one's personal effects, in one's vehicle or otherwise under one's care, custody or control.

## **APPROACH**

1. Private pay applicants with potential direct client contact may be subject to a post-offer drug and alcohol test.
2. Applicants who have a positive drug screen or who refuse to undergo testing, will be ineligible for employment.
3. Drug testing may be required when a.) an employee can reasonably be suspected of using or being under the influence of drug(s) or alcohol while performing their job, with Administrator approval or b.) when a controlled substance is missing or the count is incorrect.

### DECLARATION FOR MENTAL HEALTH TREATMENT

The declaration is considered to be an advanced directive because it allows a competent person to proclaim their preference in advance for mental health treatment with psychoactive medications, electroconvulsive or convulsive treatments, or emergency medical care should the person be declared incapacitated.

The declaration may also supersede a Medical Power of Attorney if it is signed after the Medical Power of Attorney.

The declaration becomes effective when the person becomes incapacitated. Incapacity is determined by a court in a guardianship or medication hearing.

#### **Practical Care Continuum maintains advance directive forms. Email or call the office for copies of the forms.**

Signing these forms is OPTIONAL. If you and your family decide to exercise these rights, please make sure that a copy of each form is given to Practical Care Continuum so that we may be aware of your decision, and have a means to contact your agent if needed. Also, we recommend that copies be given to your physician, hospital, and any other health care provider you feel may need this information.

### INFECTION CONTROL INFORMATION

THE FOLLOWING GUIDELINES ARE PROVIDED TO HELP ENSURE YOU AND YOUR FAMILY'S SAFETY:

INFECTION CONTROL IN THE HOME	GENERAL INFECTION CONTROL
<p>Hands should be washed at the following times:</p> <ul style="list-style-type: none"> <li>• before and after eating.</li> <li>• after blowing or wiping your nose.</li> <li>• after combing your hair.</li> <li>• before and after using the restroom.</li> <li>• after contact with trash or dirty laundry.</li> <li>• whenever hands are visibly soiled or whenever in doubt.</li> </ul>	<ul style="list-style-type: none"> <li>• Store all medical supplies in a clean, dry place and safely away from children and pets.</li> <li>• Keep clean and dirty items separate.</li> <li>• Wash heavily soiled linen in hot soapy water.</li> <li>• Notify an exterminator at the first sign of infestation.</li> </ul>

**Hand washing is the single most important way to prevent the spread of infection.**

**But it is only effective if done regularly and correctly.**

#### HOW TO PROPERLY WASH HANDS

When using bar soap, use a soap dish with a strainer. This will help to keep soap dry and prevent the growth of bacteria.

Wash all surfaces of the hands, including palms, back of hands, fingers, and wrists using running water at a comfortable temperature. Experts suggest about 10 circular strokes for each surface.

Do not touch fingertips to the inside of sink. Keep hands pointing downward into sink to prevent contaminated water from running up the arms. Allow water to continue running.

Rinse hands thoroughly under a moderate stream of running water at a comfortable temperature.

When drying, begin with the wrists and move down along the hands. Gently pat the skin so that you avoid chapping and eventual cracking. Hand lotion will also help to prevent hands from chapping. Use dry paper towels to turn off the faucet.

#### Disposal Tips for Home Health Care

You can help to prevent injury, illness, and pollution by following some simple steps when you dispose of sharp objects and contaminated materials you use in administering health care in your home. You can place needles, syringes, lancets and other sharp objects in a hard plastic or metal container with a screw-on or tightly secured lid, or you may purchase a mail-back service with containers specifically designed for the disposal of medical waste sharps or purchase home needle destruction devices. Do not throw loose needles in the garbage. Do not flush used needles down the commode. Do not put sharp objects in any container you plan to recycle or return to a store, and do not use glass or clear plastic containers.

- Follow federal, state and local regulations for disposal of medical waste.
- Do not overfill containers. Discard container when 2/3 full.
- Make sure that you keep all containers with sharp objects out of the reach of children and pets.
- Place items such as soiled bandages in securely fastened plastic bags before you put them in the garbage with other trash.

**SAFETY INFORMATION**

**THE FOLLOWING GUIDELINES ARE PROVIDED TO HELP ENSURE YOU AND YOUR FAMILY'S SAFETY:**

<b>BASIC HOME SAFETY</b>	<b>FIRE SAFETY AND PREVENTION</b>	
<ul style="list-style-type: none"> <li>• Keep your home well-lit with night-lights in bedrooms, bathrooms or stairways, as needed.</li> <li>• In case of emergency, telephone numbers of police, fire department, poison control, doctor and neighbor should be near or taped to the phone where they can be easily seen.</li> <li>• If the patient is bed-bound, a phone should be within reach.</li> <li>• Always use the assistive equipment prescribed for you when you are walking in your home.</li> <li>• Use skid-proof mats in the bathtub or shower and handrails in the tub and around the toilet for added safety.</li> <li>• Remove throw rugs and loose carpeting or anchor in place.</li> <li>• Remove excess clutter from rooms to allow for easier mobility.</li> <li>• Always watch your step when cats and dogs are in the house.</li> </ul>	<ul style="list-style-type: none"> <li>• Never smoke in bed!!!</li> <li>• Installation of smoke detectors between living and sleeping areas is your best early warning system.</li> <li>• Test smoke detectors each month and replace batteries twice a year. A good way to remember this is to change batteries when clocks are changed in the spring and fall.</li> <li>• Keep flammable materials away from stoves, heaters, or other heat sources.</li> <li>• Place space heaters at least three (3) feet from walls and furniture.</li> <li>• Do not cover or tuck in electric blankets.</li> <li>• Do not set electric blankets on high.</li> <li>• To prevent personal injury, never fall asleep using a heating pad.</li> <li>• Know the best way to get out of your home if a fire starts.</li> <li>• Be sure your plan includes assisting people who cannot get outside without help.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>GET DOWN, CRAWL LOW</b> If you smell smoke or see flames, drop to the floor and crawl to the nearest exit.</li> <li>• <b>STOP, DROP AND ROLL</b> If your clothes catch on fire, stop everything. Drop to the ground. Cover your face, then roll over and over to smother the flames.</li> <li>• <b>GET OUT, STAY OUT</b> Never return to a burning building for anything!</li> <li>• Telephone the Fire Department (911) from an outside telephone</li> </ul>

## Grievance/Complaint Information

You, as a client of Practical Care Continuum, have the right to voice grievances or complaints with respect to services rendered. We want you to be 100% satisfied with our services, please let us know if we are not meeting your expectations and we will do all that we can to meet them.

You have the right of confidentiality and the right to have one's property treated with respect.

### Complaint and Grievance Process:

1. Client or client representative reports a complaint/grievance to any staff member.
2. Staff member receiving complaint or grievance reports issue to Administrator immediately
3. Administrator or designee documents the complaint and investigates the complaint/grievance within 5 days of receipt of the complaint. The agency will complete the investigation and documentation within 14 days after the Agency receives the complaint unless the Agency has any documents reasonable cause for delay.
4. Notify the client when appropriate action has been taken or that the problem has been resolved.
5. Document the action taken and resolution on the Complaint Form. Any information on the possible disciplinary action taken against an employee is considered confidential information and will not be disclosed to the client.

Health and Human Services  M-F -- 7:00 am to 7:00 pm 1-800-458-9858	Email: <a href="mailto:ciicomplaints@hhs.texas.gov">ciicomplaints@hhs.texas.gov</a> Or online at <a href="http://txhhs.force.com/complaint">txhhs.force.com/complaint</a>	Practical Care Continuum  Talk or Text 512-400-4331
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## **TRANSPORTATION SERVICES PROGRAM**

### **Purpose**

Practical Care Continuum's ("PCC") mission is to assist elder and disabled adults with the activities of daily living including transportation. In this regard, PCC offers its clients transportation to doctor's visits, pharmacy for prescription refill, bill paying and personal errands. The objectives of the Transportation Services Program are to:

- Provide an organized framework for monitoring transportation services and driver quality
- Implement actions which reduce or minimize issues affecting and impacting client and employee safety.

### **Policy**

The Transportation Services Program will be developed and implemented by the Administrator and will be reviewed and updated on an as need basis, but usually annually, by the Quality Assurance Team.

Management personnel will ensure compliance by employees and clients with state and agency regulations.

### **Employee Obligations**

Employees may choose whether or not to participate in the Transportation Services Program. Employees participating in the Transportation Services Program acknowledge that PCC does not maintain automobile insurance or insurance coverage on Employee's personal automobile. It is the Employee's choice as to whether to transport a client in the Employee's personal vehicle. Some clients may choose to be transported in their own personal vehicle. It is the Employee's choice as to whether or not to transport the client in the client's vehicle.

Employees who agree to participate in the Transportation Services Program (whether transporting the client in their personal automobile or in the client's personal automobile) agree to abide by the following conditions in order to participate in the Transportation Services Program:

- 1) Authorize PCC to perform a criminal background check on the employee. Employee agrees to facilitate signing consents and other documents as necessary in order to perform the criminal background check;
- 2) Authorize PCC to periodically review the employee's motor vehicle record, said review will usually be twice a year, but may be more often at PCC's discretion;
- 3) Maintain a valid state's driver's license for the class of vehicle being operated. Employee must self-report the loss or suspension of their state driver's license (for whatever reason) to PCC. Failure to report the loss or suspension of the state driver's license may result in disciplinary action against the Employee, including termination;
- 4) Self report any on-the-job as well as off-the-job moving violations, collisions and citations. Failure to report such violations may result in disciplinary action against the employee and may jeopardize employee's employment with PCC;

5) Maintain personal Automobile Liability Limits of at least \$50,000 on their personal vehicle. Employees will be required to provide proof of said coverage at various times (see PCC Personnel Policies and Procedures Manual) and upon request from management personnel. This may require that Employee's automobile insurance company provide coverage information to PCC.

6) Employee has the responsibility of informing their automobile insurance company that Employee is using their personal vehicle for work purposes.

7) Maintain a safe and operating vehicle and perform routine maintenance on their vehicle as necessary. Employees will be required to provide PCC with a copy of their state vehicle inspection at least annually.

8) Submit their mileage records as required by the PCC Personnel Policies and Procedures Manual. Employees will be paid for participating in the Transportation Services Program as stated in the PCC Personnel Policies and Procedures Manual.

9) As the Program is voluntary, an employee may withdraw from participation in the Program at any time they choose by submitting a written withdrawal to the Administrator. Said withdrawal shall be deemed withdrawal from the Program only and not a resignation from employment unless otherwise specified in the written document.

10) Sign and complete the Employee Acknowledgement of Transportation Services Program agreeing to participate in the program.

PCC retains the right to not allow an Employee to participate in the Transportation Services Program by driving their personal vehicle if the Employee has not provided PCC with proof of current liability, collision, and comprehensive insurance coverage on the vehicle. An Employee may be allowed to drive the client's car so long as the rest of the requirements of the Transportation Services Program have been met by the Employee.

Employees are encouraged to enroll and participate in a defensive driving course at least once a year. If an employee chooses to participate in a defensive driving course, PCC will reimburse the Employee for the course upon completion and proof of completion of said course.

An Employee who continues to provide transportation services to a client without the approval of PCC is subject to disciplinary action, including termination.

### **PCC's Obligations**

As part of the Transportation Services Program, PCC will comply with all other regulatory requirements and perform the following for each employee participating in the Transportation Services Program:

- 1) Perform a criminal background check on the employee.
- 2) Periodically review the employee's motor vehicle record, said review will usually be at least twice a year.
- 3) Review that the employee has and maintains a valid state driver's license for the class of vehicle being operated.
- 4) Review that the employee has liability, collision and comprehensive insurance coverage on their personal vehicle.
- 5) Reimburse the employee's participation in a defensive driving course every year, upon completion of the course and proof of participation.

6) Review the employee's state vehicle inspection on their personal vehicle on a regular basis.

7) Obtain a signed Employee and/or Client Acknowledgment regarding the Transportation Services Program.

PCC reserves the right to not allow an employee to participate or continue to participate in the Transportation Services Program if the employee has any DWI's or DUI's on their driving record. PCC may, in their discretion, disallow an employee from participating or continuing to participate in the Transportation Services Program if the employee has several traffic or moving violations.

### **Client's Obligations**

Client is informed and acknowledges that PCC does not carry automobile insurance or insurance coverage on its employee's personal automobiles and that by participating in PCC's Transportation Services Program; client agrees to waive and release PCC for any injury which is the result of participation in the Transportation Services Program. In order to participate in PCC's Transportation Services Program, the client agrees to the following:

1) Pay mileage to PCC at the Internal Revenue Service rate for mileage.

2) Sign the waiver and release agreement supplied by PCC and required in order to participate in the Transportation Services Program.

3) If the client chooses to be transported in their own personal vehicle, the client may do so as long as the client has provided PCC with a copy of the insurance coverage on their vehicle. Maintain personal Automobile Liability Limits of at least \$50,000 on their personal vehicle. Said proof of coverage may require that Client's insurance company provide PCC with proof of the coverage. Clients may be required to provide proof of said coverage periodically at the request of PCC.

# State of Texas emergency/disaster event 211 information

Do you or anyone you know need some form of assistance during times of an emergency/disaster event? The State of Texas offers Texans the option to register with the STEAR program, a FREE registry that provides local emergency planners and responders with additional information on the needs in their community.

**Texas communities use the registry information in different ways. Registering yourself in the STEAR registry DOES NOT guarantee that you will receive a specific service during an emergency. Available services will vary by community. For more information on how your community will use information in the STEAR registry, contact your local emergency management office.**

## **Who Should Register?**

- People with Disabilities
- People with access and functional needs such as people who have:
  1. limited mobility
  2. communication barriers
  3. additional medical assistance needs during an emergency event
  4. requirements with transportation assistance
  5. requirements with personal care assistance

## **How to Register**

- <https://STEAR.dps.texas.gov>
- Dial 2-1-1 or use your video phone relay option of choice to contact 211
- Printed or electronic forms (contact your local government)

## **Required Information to Register**

- Name
- Address
- Phone Number
- Primary Language

## **Additional questions asked to capture vital information for local emergency planners and responders:**

- Emergency Contact Information
- Caregiver Information
- Pets
- Transportation assistance for home evacuation
- Communication Barriers
- Disability, Functional or Medical Needs

**Registration is voluntary and completely confidential**

# Practical Care Continuum Service Agreement

**LICENSURE:** I have been informed that Practical Care Continuum is licensed to provide Personal Assistance Services according to the Individual Service Plan (ISP) established by the staff and the client/caregiver. I have agreed to accept services from Practical Care Continuum and understand that I am responsible for payment of all fees for services provided as a result of this agreement.

I understand that Practical Care Continuum assigns staff based on client needs and considerations related directly to the care/services provided. I understand that services and employees are provided regardless of race, ethnicity, religion, sex, age, and veteran or handicap status.

**INDIVIDUAL SERVICE PLAN (ISP):** A representative of this organization has explained my ISP and all of my questions have been answered satisfactorily. I understand that the ISP may change and, if so, these changes will be discussed with me.

I further understand I and/or my family/caregiver will receive instructions to assist with my care and that my care will therefore become my responsibility in the absence of Practical Care Continuum Staff in my place of residence. I agree to notify Practical Care Continuum of any significant events relating to my healthcare.

**NON-MEDICAL STAFF:** As employees of Practical Care Continuum our non-medical staff members are bonded and insured. The agency triple screens new employees and checks each employee on an annual basis and as needed.

I understand that staff members are not trained as medical professionals. Their training is limited to the basic principles of care for the elderly/disabled, communication skills, physiological/ psychological aspects of aging, emergency procedures, safety precautions for routine visits, and the specific activities and duties related to care as defined by Texas law. Staff members are not licensed as physicians or nurses but may be certified Home Health Aides.

I further understand that the Staff will be in the home to care for **THE CLIENT(s) ONLY** and that the Staff are not responsible for the care of any other people (OR AREAS OF THE HOUSEHOLD) who may be in the home at the same time.

**EMERGENCY MEASURES:** I have fully disclosed to Practical Care Continuum all the necessary information about the needs of THE CLIENT for supervision. I will give the Staff all the necessary information concerning where I can be reached, as well as the names and phone numbers of other relatives or friends to be contacted, and the doctor and hospital to call in the event of an emergency. I understand that in the event of an emergency, it is the policy of Practical Care Continuum to require the Staff to dial 911 for emergency medical personnel to come to the home and administer whatever life-saving care is necessary for THE CLIENT. If you wish for the Staff to follow some other course of action in the event of a medical emergency, please explain in your own handwriting, what that course of action is here:

\_\_\_\_\_ I understand that if the Staff follows the above instructions regarding what actions to take in the event of a medical emergency, Practical Care Continuum's Staff will not be held responsible or liable in any way whatsoever for any injuries or death that occur following a medical emergency.

**RELEASE OF INFORMATION:** I have been provided with a Notice of Privacy Rights that details the various ways that information about me may be disclosed for treatment, payment, healthcare operations and other purposes permitted or required by law as applicable.

**EMERGENCY PREPAREDNESS:** It is your personal responsibility to develop a preparedness plan for your home. In the event of a disaster, Practical Care Continuum will attempt to contact you, if possible. If you are relocating, attempt to contact Practical Care Continuum, if able. Listen to emergency alerting systems, weather radio, local television or radio for public service announcements and instructions. Practical Care Continuum is not responsible for your physical evacuation or transport.

**AFTER HOURS ACCESS:** I have received and understand information on how to access the staff of Practical Care Continuum in the event of an emergency or staffing problem after hours. Call 9-1-1 in the event of a medical emergency.

I further understand that the Staff will be in the home to care for **THE CLIENT(s) ONLY** and that the Staff is not responsible for the care of any other people (OR AREAS OF THE HOUSEHOLD) who may be in the home at the same time.

**BACKUP SERVICES:** I understand that in the event the regularly assigned Practical Care Continuum staff member is unavailable to perform the services in my Service Plan, Practical Care Continuum will provide another Practical Care Continuum staff member to perform the services in a timely manner. I may choose to designate another person to perform the services on these occasions (“Designee”). If I designate another person, it is my responsibility to notify my Designee of the need for services on a particular day. Practical Care Continuum will attempt to provide me with as much notice as possible when back-up services are necessary.

**POLICIES and RIGHTS:** I have received a copy and explanation of the **Bill of Rights, Rights of the Elderly, Agency’s policy on abuse, neglect, and exploitation, drug testing and infection control, hazardous waste policies and Release of Information /Privacy Rights.**

**GRIEVANCE/COMPLAINTS:** I have been given information on Practical Care Continuum’s Grievance/Complaint Policy. We are committed to offering superior quality service to our clients regardless of race, ethnicity, religion, sex, age, Veteran, or handicap status.

If you need to voice a grievance or recommend changes, please follow the steps outlined below. Notify the Administrator at the number listed on the front of this booklet. The staff will take immediate action to resolve all problems brought to their attention and keep the client informed of the resolution.

If you are still not satisfied, notify the Health and Human Services Hotline at 1-800-458-9858.

**ADVANCED DIRECTIVE INFORMATION:** I have been offered an information sheet on advanced directives.

**CPR:** Agency Staff will respond to cardiac arrest situations by contacting 9-1-1, unless an Out of Hospital DNR exists and is within the Staff member’s visual presence. **Agency Staff DO NOT perform CPR unless specifically requested by the client in writing.** Only caregivers with CPR certification are allowed to perform CPR and are not required to possess CPR certification as employees of Practical Care Continuum. In the event of an emergency agency staff will contact client’s emergency contact person and management staff immediately.

## FINANCIAL AGREEMENT

**Hourly Minimum:** There is a (2) hour minimum for Services.

**Cancellations:** If a scheduled visit is not canceled with 24 hours' advance notice, the client will be billed for the entire visit. This does not apply in the event of the client's death or unexpected hospitalization.

**Mileage:** There will be a mileage charge for any transportation provided by the worker in the worker's automobile. This charge will be the current rate as defined by the IRS.

**Two Person Care:** An Additional fee of \$5 per hour will be added when providing care for two individuals within the same house.

**Employee Solicitation:** Client agrees not to solicit employees of Practical Care Continuum for direct employment by Client either: 1) while the Services Agreement with Practical Care Continuum is in effect; or 2) within ninety (90) days after the Services Agreement is terminated by either party for any reason.

In the event the Client employs an employee directly the Services Agreement with Practical Care Continuum terminates immediately, except for the penalty fee to be assessed.

**A Finder's Fee of \$15,000 shall be assessed against the client for employing an employee directly either while the Services Agreement is in effect or within ninety (90) days after the Services Agreement is terminated. This fee can be considered as a buyout if the client would like to buy out the employee contract.**

**Billing:** Practical Care Continuum is a private agency which only accepts clients on a private pay basis. Billing for services will occur on a semi-monthly basis or monthly. **Payments will be made directly to Practical Care Continuum.** The Client will not pay staff members directly, nor will the Client attempt to make financial arrangements with staff members apart from Practical Care Continuum. Services will be suspended for those Clients who do not pay their bill within 15 days of receipt. Client agrees that Client is personally responsible for any amounts owed to Practical Care Continuum that have not been approved for payment by a third party.

**Third Party Payment:** If services have been approved for payment by a third-party contract, Client understands that client will be responsible for any services beyond what has been authorized.

**Outstanding Balances:** Balances not paid within 15 days of receipt will be considered overdue and outstanding regardless of whether payment is to be made by a third-party payer. Client agrees that Client is personally responsible for any amounts owed to Practical Care Continuum. Practical Care Continuum reserves the right to hand over any accounts with outstanding balances more than thirty (30) days old to a collection agency and/or to take legal action for payment of outstanding balances. In addition, in the event that Practical Care Continuum must seek legal action to recover payment, Practical Care Continuum also reserves the right to seek legal fees and expenses as a result of the legal action.

**Verification of Services:** I understand that each employee who renders services uses an application called Axis Care which uses GPS technology to verify both attendance and task completion.

**Schedule of Rates:** A list of the agencies' fees will be given to the client at the time of initial registration and as needed when rates change.

## Practical Care Continuum Signature Page *client copy*

Client Name: \_\_\_\_\_

A. I have received written information from Practical Care Continuum pertaining to the OBRA “90 Law which enacted the Patient Self-Determination Act on Advance Directives. I understand I have the right to appoint an agent to make health care decisions for me, execute advanced directives and appoint a Medical Power of Attorney for Health Care.

B. I have received “Notice of Privacy Practices” and consent to the agency’s use and/or disclosure of protected health information for payment, treatment, Agency’s Health Care Operations, or when legally required.

C. The emergency preparedness information has been explained to me, and I agree with the priority classification that has been assigned to me. I understand that I should notify Practical Care Continuum of any changes in my condition that could affect my emergency preparedness classification.

D. I have read, understand, and had explained to me the PRACTICAL CARE CONTINUUM Service Agreement which contains the Financial Agreement and Customer Responsibilities and agree to the terms and conditions stated. I understand that I am responsible for payment of all services rendered by Practical Care Continuum on my behalf.

E. I have also received a copy of the following: Rights of the Elderly, Statement of Client Rights and Responsibilities, Complaint Procedures, Abuse, Neglect or Exploitation Policy, Drug Testing Policy, Declaration of Mental Health Treatment, and Medical Waste/Disposal of Needles policy.

F. Additionally, I understand either party may terminate this agreement at any time.

I have been provided information on Practical Care Continuums’ Back-Up Services policy.

\_\_\_\_ I have agreed to allow Practical Care Continuum to provide back-up services.

\_\_\_\_ I have not agreed to allow Practical Care Continuum to provide back-up services. Instead, I have designated the following person to provide back-up services for me and the person has agreed:

Designee \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_  
Designee’s Signature (if applicable) / Date

\_\_\_\_\_  
Client/Responsible Party Sig. – Date

\_\_\_\_\_  
Agency Representative - Date

\_\_\_\_\_  
(Optional) Financially Responsible Party/Co-signer/Insured Party Signature - Date

# CLIENT AGREEMENT

## Related to Transportation Services Agreement (*client copy*)

I, \_\_\_\_\_, a client of Practical Care Continuum (“PCC”) have received a copy of PCC’s Transportation Services Program (the “Program”). I have read my copy of PCC’s Transportation Services Program and by signing this agreement agree to abide by the terms and conditions of the Program.

I understand and acknowledge that PCC does not provide automobile or insurance coverage on its employees’ personal automobiles.

I hereby agree for myself, my heirs, executors, administrators, trustees, and assigns, that in consideration for being permitted to participate in the Program, I will hold harmless and waive and release any claims and liability against PCC or its affiliated entities, agents, directors, owners, employees, associates, successors or insurers for any actions or inactions of employees of PCC who perform said transportation services for me as part of the Program, regardless of whether such services are performed in the employees personal automobile or my own and agree not to sue PCC or its affiliated entities, agents, directors, owners, employees, associates, successors or insurers for any claims released.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

*Reviewed 6/2025*

## Release of Liability for Non-Encrypted Transmission of Information *(client copy)*

I, \_\_\_\_\_, a client of Practical Care Continuum (“PCC”), understand that according to PCC’s Policy and Procedure regarding HIPAA law, all client information which is transmitted electronically must be sent using an encryption service in order to protect client confidentiality.

\_\_\_\_ *I choose to use encryption services for all my communication with Practical Care Continuum*

I have been provided information on Practical Care Continuum’s Privacy Practices and I choose to wave the use of encryption services under the following circumstances.

When information is sent to:

\_\_\_\_ myself or designated family members listed below.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_ staff members within Practical Care Continuum’s office.

\_\_\_\_ caregivers who have been assigned to care for me.

By signing below, I recognize that when information is transmitted via email without encryption services, my personal information cannot be protected from other entities.

\_\_\_\_\_  
Signature Client/Responsible Party/Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Responsible Party Relationship *(POA/MPOA)*

\_\_\_\_\_  
*Responsible party address/phone number*

\_\_\_\_\_  
*If client cannot sign please list reason above*

NOTES:

## Practical Care Continuum's Signature Page *agency copy*

Client Name: \_\_\_\_\_

A. I have received written information from Practical Care Continuum ("PCC") pertaining to the OBRA "90 Law which enacted the Patient Self-Determination Act on Advance Directives. I understand I have the right to appoint an agent to make health care decisions for me, execute advanced directives and appoint a Medical Power of Attorney for Health Care.

B. I have received "Notice of Privacy Practices" and consent to the agency's use and/or disclosure of protected health information for payment, treatment, Agency's Health Care Operations, or when legally required.

C. The emergency preparedness information has been explained to me, and I agree with the priority classification that has been assigned to me. I understand that I should notify PCC of any changes in my condition that could affect my emergency preparedness classification.

D. I have read, understand, and had explained to me the Practical Care Continuum Service Agreement which contains the Financial Agreement and Customer Responsibilities and agrees to the terms and conditions stated. I understand that I am responsible for payment of all services rendered by Practical Care Continuum on my behalf.

E. I have also received a copy of the following: Rights of the Elderly, Statement of Client Rights and Responsibilities, Complaint Procedures, Abuse, Neglect or Exploitation Policy, Drug Testing Policy, Declaration of Mental Health Treatment, and Medical Waste/Disposal of Needles policy.

F. Additionally, I understand either party may terminate this agreement at any time.

I have been provided information on Practical Care Continuum's Back-Up Services policy.

\_\_\_\_ I have agreed to allow Practical Care Continuum to provide back-up services.

\_\_\_\_ I have not agreed to allow Practical Care Continuum to provide back-up services. Instead, I have designated the following person to provide back-up services for me and the person has agreed:

Designee \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_  
Designee's Signature (if applicable) / Date

\_\_\_\_\_  
Client/Responsible Party Sig. – Date

\_\_\_\_\_  
Agency Representative - Date

\_\_\_\_\_  
(Optional) Financially Responsible Party/Co-signer/Insured Party Signature - Date

# CLIENT AGREEMENT

## Related to Transportation Services Agreement *(agency copy)*

I, \_\_\_\_\_, a client of Practical Care Continuum (“PCC”) have received a copy of PCC’s Transportation Services Program (the “Program”). I have read my copy of PCC’s Transportation Services Program and by signing this agreement agree to abide by the terms and conditions of the Program.

I understand and acknowledge that PCC does not provide automobile or insurance coverage on its employees’ personal automobiles.

I hereby agree for myself, my heirs, executors, administrators, trustees, and assigns, that in consideration for being permitted to participate in the Program, I will hold harmless and waive and release any claims and liability against PCC or its affiliated entities, agents, directors, owners, employees, associates, successors or insurers for any actions or inactions of employees of PCC who perform said transportation services for me as part of the Program, regardless of whether such services are performed in the employees personal automobile or my own and agree not to sue PCC or its affiliated entities, agents, directors, owners, employees, associates, successors or insurers for any claims released.

\_\_\_\_\_  
Signature Client/Responsible Party

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

## Release of Liability for Non-Encrypted Transmission of Information *(agency copy)*

I, \_\_\_\_\_, a client of Practical Care Continuum (“PCC”), understand that according to Practical Care Continuum’s Policy and Procedure regarding HIPAA law, all client information which is transmitted electronically must be sent using an encryption service in order to protect client confidentiality.

\_\_\_\_ *I choose to use encryption services for all my communication with Practical Care Continuum*

I have been provided information on Practical Care Continuum’s Privacy Practices and I choose to wave the use of encryption services under the following circumstances.

When information is sent to:

\_\_\_\_ myself or designated family members listed below.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_ staff members within Practical Care Continuum office.

\_\_\_\_ caregivers who have been assigned to care for me.

By signing below, I recognize that when information is transmitted via email without encryption services, my personal information cannot be protected from other entities.

\_\_\_\_\_  
Signature Client/Responsible Party/Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Responsible Party Relationship *(POA/MPOA)*

\_\_\_\_\_  
*Responsible party address/phone number*

\_\_\_\_\_  
*If client cannot sign please list reason above*

