CONSUMER DIRECT CARE NETWORK ARIZONA

This packet is designed for single-sided paper printing.

Clear Form

PRIVATE PAY DATA FORM

Enrollment Date:_____

Agency Name: Consumer Direct Care Network Arizona

Customer Name:_____ _____ ___
First *Last* *MI*

Mailing Address:_____
Street

_____ _____ _____
City *State* *Zip*

Email Address: _____ SSN: ___-___-____

Phone(Home)_____ (Cell)_____ (Fax)_____

We may reach out to you via SMS/Text Messaging concerning your services with CDCN. Please note that CDCN will never request sensitive personal information, such as your Social Security Number, banking details, address, or date of birth through text messages. If you receive an SMS message from CDCN and would like to opt-out from future SMS messages, please respond to the initial message with "STOP"

DOB:_____ Gender: ☐ M ☐ F Primary Language:_____

How did you hear about us?_____

Representative Name (if applicable): _____

Relationship: _____ Phone: _____

Email Address:_____

Address: _____
Street

_____ _____ _____
City *State* *Zip*

Financial Guarantor Name (if different than Customer): _____

Address:_____
Street

_____ _____ _____
City *State* *Zip*

Phone:_____ Alternate Phone/Fax: _____

Email Address: _____ SSN: ___-___-____

Service Coordinator Name: _____

CONSUMER DIRECT CARE NETWORK

MEMBER ENROLLMENT CHECKLIST

_____

Print Member's Name

Please check off the following after completion.

Forms completed with the Member:

- ☐ Customer Service Agreement
- ☐ Guarantor Service Agreement
- ☐ Direct Payment Plan Authorization
- ☐ Disclosure Statement
- ☐ Advance Directives Disclosure
- ☐ Member Emergency & Backup Plan
- ☐ Unite Us Network Registration

Supplemental Materials Reviewed and Provided to the Member:

- ☐ Notice of Privacy Practices

Forms completed upon return to office:

- ☐ Service Initiation Fax

Signatures:

CDCN Representative: _____ _____ _____

Name *Signature* *Date*

CUSTOMER SERVICE AGREEMENT

This Agreement is between Consumer Direct Services for Arizona, LLC, doing business as Consumer Direct Care Network Arizona ("CDCN" or "Agency") and the following person:

☐ Check here if you are the **Customer.**

My name is _____. I will be directing my services under this Agreement.

☐ Check here if you are the Customer's **Representative.**

My name is _____. I will be directing the Customer's services under this Agreement.

The Customer's name is _____.

A. Introduction

In this Agreement:

- "Customer" is the individual who will receive private pay personal assistance services from CDCN.
- "You" refers to the person directing the Customer's services, either the Customer or the Customer's Representative.
- "Party" shall mean either You or CDCN individually. "Parties" shall mean You and CDCN together.
- "Employee" refers to an individual hired to provide personal assistance services to the Customer.

B. Customer/Representative Responsibilities – You agree to:

1. Review, understand and follow this Agreement and the following:
   - Guarantor Agreement.
   - Disclosure Statement.
   - Contingency Plan.
   - Associated written materials.
2. Approve and submit employee timesheets by Monday at midnight for the previous week.
3. Report to CDCN:
   - Any health or safety concerns.
   - Any change in the Customer's health status or living situation (hospitalization, decline in health status, change of address or phone number).
   - Employee issues or changes in status (excessive absence, resignation, job performance).
   - Dissatisfaction with services.

4. Report to authorities – abuse, neglect and exploitation, threats of violence.
5. Work with CDCN to develop a Contingency Plan as described under Terms and Conditions.
6. Confirm your auto insurance policy will cover costs associated with any accident, damage, or injury that might occur if your personal car is driven by You or the employee when used for services.
7. Pay CDCN for services provided, according to the Guarantor Agreement.

C. Customer/Representative Acknowledgement – You acknowledge:

Receiving (please initial):

_____ CDCN's Notice of Privacy Practices

_____ Copy of Service and Cost Plan

CDCN does not provide emergency services. You or an employee will call 911 if there's an emergency.

D. Agency Responsibilities – CDCN agrees to:

1. Work with You to develop a Service and Cost Plan that outlines services to be provided and the monthly cost.
2. Provide You with employee options to choose from. You select employee(s) who can best meet the Customer's needs.
3. Ensure employees meet qualifications and training provisions as described in the Disclosure Statement.
4. Perform administrative and payroll tasks, including:
   - Issue payroll checks and report payroll information.
   - Process federal and state income tax contributions.
   - Provide workers' compensation and unemployment insurance.
   - Follow federal and state wage and hour law requirements.
   - Keep a record of all services provided to the Customer.
   - Maintain employee personnel files.
   - Perform employee background checks.
5. Meet with You quarterly to make sure services and employee performance are meeting Customer's needs.

E. Terms and Conditions

Contingency Plan: There may be times an employee does not arrive for a scheduled visit. For this event, You are responsible for maintaining a comprehensive Contingency Plan. You will contact individuals listed on the Contingency Plan to assist the Customer with services.

If the Contingency Plan does not address the scheduled service need, notify CDCN during business hours. CDCN will assist You with best efforts to find alternate care at the earliest availability but cannot guarantee a replacement employee will be provided. You agree to hold CDCN harmless for any incident that may occur if an employee does not arrive for a scheduled visit.

Term and Termination: This Agreement starts when it is signed by You and CDCN. Both Parties can end the Agreement at any time by thirty (30) days written notice.

In addition, CDCN reserves the right to terminate services immediately for:

- Failure to make payment in a timely manner.
- Unsafe work environment for CDCN staff.
- Any other reason determined by CDCN.

Any unpaid charges at the time of termination shall be paid by the Customer/Representative or the Guarantor. You agree ending the Agreement means services from CDCN will stop.

Term of Prohibition on Staff Solicitation: While services are being provided, and for 180 days after services have ended, You will not hire or receive services from a current CDCN employee, except through contract with CDCN. If You do so, You must pay CDCN, as liquidated damages, $2,500.00 or 20% of the annualized salary (whichever is greater) for each employee hired or used.

Partial Invalidity: If part of this Agreement is found to be wrong, it does not mean the whole Agreement is not correct. The rest of the Agreement must be followed.

Arbitration: A dispute about this Agreement is handled by an independent arbitrator at the CDCN office in Arizona. Parties will split the cost of the arbitrator. Each Party will handle their own legal fees. Parties may agree to another arbitration process.

Governing Law: This Agreement shall follow the laws of Arizona in all ways.

Indemnification and Hold Harmless: Both Parties agree to hold each other harmless from, any liability, loss, cost, injury, expense or damage to any person or property by one Party's act, neglect, default or omission. If a lawsuit is filed, both Parties agree to Indemnify each other, which means the indemnifying Party may have to pay for all damages and legal fees for both Parties, based on the Court's decision.

Waiver of Terms and Conditions: Failure to enforce, failure to exercise the benefit of, or waiving the breach of one or more of the Agreement Terms and Conditions does not mean this action will continue in the future. Going forward, both Parties understand the rights and privileges of the Agreement are in full effect.

Timely Notification: Both Parties agree all notices must be given timely and in writing (in-person delivery, prepaid overnight express service, facsimile with electronic confirmation, certified mail). The written notice will have the return receipt requested to the following:

Agency	Customer/Representative
Consumer Direct Care Network Arizona	
50 North Alvernon Way	
Tucson, AZ 85711	

With a copy to: Consumer Direct Care Network
Attn: Contracts Department
100 Consumer Direct Way
Missoula, MT 59808

Entire Agreement: This Agreement, the Guarantor Agreement, the Disclosure Statement, and the Confidentiality and Release of Information describe the complete understanding between You and CDCN. The Agreement may be changed only in a separate writing which is signed by both Parties. The Agreement only applies to You and CDCN. Agreement rights, privileges, and responsibilities cannot be assigned to others.

By signing, You and CDCN agree to follow the Responsibilities and Terms and Conditions stated above.

Customer or Representative Name	Signature	Date
CDCN Representative Name	Signature	Date

CONSUMER DIRECT CARE NETWORK ARIZONA

GUARANTOR AGREEMENT

Customer Name	Guarantor Name (if different than Customer)

Insurance: Y N (please attach insurance info)

Are you prepaying for services? *If so, check here* _____.

If you plan to pay for services through direct ACH payment from a checking or savings account, complete the *Direct Payment Plan Authorization* form.

If you plan to pay for services with a credit card:

Name on Card	
Card Number	Billing zip code of card holder
Expiration Date	Security Code

REQUEST AND CONSENT FOR SERVICE

The following services are voluntarily requested and authorized by the above-listed Customer/Representative to be provided by Agency. Customer/Representative hereby gives permission for personnel of Agency to perform services as requested by Customer/Representative. Agency provides community based personal care services and supports to those who choose to live independently in their homes.

TYPE OF SERVICE	GENERAL RATE[1]	NET RATE[2]
Support Services		
Approx Hours/Week:_____ Effective Date:_____	$_____	$_____
Service Initiation Fee	$ 40.00	$ 40.00

[1] General rates are for customers who are billing insurance and not providing an up-front deposit.
[2] Net rates are formulated for clients paying a deposit up-front.

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TERMS AND CONDITIONS

1. **Parties:** The customer named above (the "Customer") is the individual receiving services from Consumer Direct Services for Arizona, LLC doing business as Consumer Direct Care Network Arizona (the "Agency").[3] The financial guarantor named above (the "Guarantor") is the individual responsible for paying for the services Customer receives from Agency, should Customer be unable to pay Agency in full.

2. **Visit Cancellations:** Customer may cancel or reschedule Support Service and Service Coordination visits up to 24 hours prior to the scheduled time of visit without penalty. Visits cancelled less than 24 hours before the visit, at the sole discretion of Agency, will be charged the full amount for the hours scheduled that day.

3. **Term and Termination:** This Guarantor Agreement (the "Agreement") will be effective on the date noted on the last page of the Agreement and will continue until terminated. Both Agency and Guarantor have the right to terminate this Agreement at any time. Agency reserves the right to terminate services immediately for failure to make payment in a timely manner, or with 30-days notice when circumstances are deemed unsafe for Agency staff, customer(s), worker(s), or for any other reason as determined by Agency in its sole discretion. If the Agency terminates this agreement, Agency will notify Customer by email or by regular US mail. Any outstanding charges for services rendered through the date of termination that remain owing shall be paid by Guarantor. Agency will require a new Agreement if there are changes in service including rate increases.

4. **Deposit:** Guarantor will pay a deposit equivalent to the projected charges for one month of service which will be held by Agency until all services, fees and/or penalties have been paid in full (minimum deposit $100.00).

    a. Upon termination of services and receipt of final payment, Agency will, within 30 days, return the deposit less any outstanding funds due, including but not limited to outstanding balances, cost of collection, attorney's fees, interest, and late fees.

    b. This deposit payment will be deposited in Agency's business checking account, and Agency will pay no interest on this deposit.

    c. The deposit payment will be collected upon signing of this agreement. Services will be invoiced separately.

    d. The deposit amount is subject to change depending upon service utilization. A twenty-five percent (25%) or more increase in service utilization will result in a corresponding increase to the amount of deposit.

    e. Services begin when the deposit is received. If a deposit check defaults, there will be a $100.00 service fee.

[3] Customer may be represented by another individual (the "Representative"). If so, Representative must provide proof of the legal relationship (e.g. Power of Attorney, living will, guardianship papers, etc.) to Agency.

5. **Billing Period:** Agency will bill Guarantor for services performed in the previous billing period. Guarantor will be billed monthly.

6. **Payment Responsibility:** Guarantor understands and agrees that Guarantor is responsible for all charges incurred by Agency for services rendered, and certifies that all information provided to Agency for payment is correct.

    a. Agency requests that payment of any authorized benefits be made on Customer's behalf directly to Agency.

    b. Guarantor hereby assigns any insurance benefit for personal care services to Agency.

    c. Guarantor understands that he/she is financially responsible to Agency for charges not covered by this assignment of insurance benefits or any other payer sources.

    d. General rates are for customers who are billing insurance and not providing an up-front deposit. Net rates are formulated for customers paying a deposit up-front.

    e. A minimum of two hours are charged per visit.

    f. Agency will bill for all time worked as authorized on the timesheets signed by Customer or Representative and the employee(s) of Customer (the "Employee").

    g. Overtime hours – defined as working more than forty hours in a work week – will be billed at time and one-half rate (1.5 x regular rate).

    h. Rates are subject to change. Notification will be provided at least 60 days prior to any change in hourly rates.

7. **Payment and Collections:**

    a. Payment may be made via check or money order from a US bank, by credit/debit card, or via automatic withdrawal (separate authorization form required). CDCN does not accept cash for payment nor accept payments at our Arizona office locations.

    b. Payment is due upon receipt of the invoice. If paying by automatic withdrawal (ACH), payment will be processed within seven days of the invoice date. If paying by check, payment should be received within 14 days of invoice date. Payment will be considered late if not received within these time parameters.

    If payment is rejected for non-sufficient funds, account closure, credit/debit card rejection or any other reason, CDCN will attempt to process the charge again, and/or contact you for a different payment method. A $10.00 late-payment fee per invoice may be charged on late balances at Agency's discretion. If a payment for service paid by check defaults, there will be a $100 service fee.

    c. Interest may be charged on the balance of any late invoice at the rate of .42% interest per month (Annual Percentage Rate of 5%).

    d. In the event any unpaid balance is placed for collections with any third-party collection agency, a fee of 50% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect

amounts owed under this Agreement, such as court costs, attorney fees, late fees and any other fees so stated elsewhere. The authorized fee of 50% and the additional costs and charges listed above represent the actual costs incurred by Agency to collect amounts under this Agreement and a corresponding decrease in expected revenue resulting from the Guarantor's failure to pay as specified in this Agreement.

8. **Partial Invalidity:** Any portion of this Agreement contrary to State or Federal law and later found to be invalid, will be severed from this Agreement, leaving the remaining provisions intact and binding.

9. **Entire Agreement:** This Guarantor Agreement, the Service Agreement and associated written materials constitute the complete understanding between Guarantor and Agency. No verbal agreements are effective or binding to either party.

I have read and understand the above information. I have been given the opportunity to ask questions. I agree to abide by the above stated terms and conditions.

Guarantor Name	Signature	Date
Agency Representative Name	Signature	Date

CONSUMER DIRECT CARE NETWORK

DIRECT PAYMENT PLAN AUTHORIZATION

The Direct Payment Plan is a repetitive, automatic payment between you and Consumer Direct Care Network (CDCN).

Instructions

1. Check the box to indicate whether payment will be deducted from a checking or savings account.
2. Fill in the date, financial institution information and your name.
3. Sign the Authorization.
4. Attach a voided check for verification of account number, routing number and financial institution information. For savings accounts, attach a document from your bank with exact numbers. Do not attach a deposit slip because it does not have all the necessary numbers.

Authorization for Direct Payment

I authorize CDCN to initiate electronic debit entries to my (check one):

☐ checking account or ☐ savings account

for payment of my home care services. I acknowledge that the origination of the ACH transactions to my account must comply with provisions of U. S. law. This authority will remain in effect until I have cancelled it in writing.

Date: _____

Financial Institution Name: _____

Account Number at Financial Institution: _____

Financial Institution Routing/Transit Number: _____

Financial Institution City and State: _____

Customer Name: _____

Customer Signature: _____

Please keep a copy of this Authorization for your records

Attach voided check/bank document here.

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CONSUMER DIRECT CARE NETWORK

DISCLOSURE STATEMENT

Customer Name	Representative (if applicable)

Consumer Direct Care Network Arizona (Agency) provides non-medical, in-home services to clients who desire or require assistance with their daily living activities. It is not within the scope of Agency's license to manage the medical and health conditions of its customers should they become unstable or unpredictable.

Direct Care Worker (DCW) Qualifications and Training Requirements
DCWs employed by Agency will have:

- Current certification in CPR and First Aid, criminal background checks, Adult Protective Services & OIG Registry checks, and for customers who require the DCW to drive or provide transportation assistance, a valid Arizona driver's license and current automobile insurance.
- Training in the following topics:
    - Arizona State mandated Direct Care Worker Training
    - Abuse, Neglect and Exploitation
    - Fraud
    - Blood born Pathogen

Charges for Services & Billing
Customers will be charged and billed as described in the Agency Guarantor Agreement. Payment is due upon receipt of bills. Payment can be made by auto payment, credit card, or check/money orders made payable to Consumer Direct Care Network as described on the Guarantor Agreement.

Termination of Services
Agency might terminate services for reasons that may include, but are not limited to: severe deterioration of customer health, unsafe environment, and inability to remit payment. Agency will give customers and/or their family adequate notice of intention to terminate services.

Contacting Administrator
Agency maintains a 24 hours per day, 7 days per week phone line for injury reporting. Agency offices are open Monday-Friday 8 a.m. – 5:00 p.m. except on holidays. Calling the Agency office number on record during business hours will allow the customer to reach a coordinator. The coordinator can reach the administrator or an administer designee, who carries a cell phone, and request the administrator or designee contact the customer who wishes to speak with him/her.

Client/Customer Rights
Customer rights include but are not limited to:

- Speaking to any person who advocates for the rights of the customer of Agency.
- Receiving considerate and respectful care that recognizes the inherent worth and dignity of each customer.

- Participating in the development of a service plan and receiving an explanation of the personal care services provided pursuant to the service plan and receiving a copy of the plan.
- Receiving from Agency, within the limits set by the service plan established for the customer and within program criteria, responses to reasonable requests for assistance.
- Receiving information, upon request, concerning the policies and procedures of Agency, including, but without limitation, the policy and procedures of Agency related to charges, reimbursements, and determinations concerning service plans.

Grievance Procedure

Customers can report a grievance per instructions provided in supplemental materials. Customer grievances should be reported to Service coordinators who will resolve the grievance or elevate the report to the administrator or a designee. The administrator or designee will investigate the grievance in a timely manner. The customer will be notified of the action taken in response to the grievance, or given a reason why no action needed to be taken. If a DCW fails to provide service in accordance with the service plan, the customer should follow the above grievance procedure. If a customer needs assistance in scheduling their DCW or need additional assistance, they should call Agency to request assistance and every effort will be made to accommodate the customer.

Permitted Duties

DCW duties include, but might not be limited to:

- Assist with activities of daily living such as dressing, bathing, grooming, eating, routine hair and skin care
- Assistance with toileting needs
- Assistance with transfer activities and ambulation
- Medication reminders
- Assistance with meal preparation. Examples of meal preparation include meal planning, storing, preparing, and serving food
- Assistance with housekeeping duties. Examples of housekeeping duties include, but are not limited to changing bed linens, laundering, washing dishes, shopping, and light Housekeeping. Housekeeping tasks do not include basic homemaker services that maintain an entire household or family
- Grocery shopping, transportation, and errands

Services <u>Not</u> Permitted

- Insertion or irrigation of catheters
- Irrigation of any body cavity, including without limitation, irrigation of the ear, insertion of an enema, or vaginal douche
- Application of dressing involving prescription medication or aseptic techniques, including, without limitation, the treatment of moderate or severe conditions of the skin
- Administration of injections of fluids into veins, muscles, or the skin
- Administration of medication, including, without limitation, the insertion of rectal suppositories, the application of prescribed lotions for the skin, or the administration of drops in the eyes

- Performing physical assessments
- Monitoring vital signs
- Using specialized feeding techniques
- Performing a digital rectal examination
- Trimming or cutting toenails
- Massage
- Providing specialized services to increase the range of motion of a customer
- Providing medical case management, including, without limitation, accompanying a customer to the office of a physician to provide medical information to the physician concerning the customer or to receive medical information from the physician concerning the client

Prohibited Activities

In addition to the above not permitted services, DCW are prohibited from:

- Loaning, borrowing, or accepting gifts of money or personal items from a customer
- Accepting or retaining money or gratuities from a customer, other than money needed for the purchase of groceries or medication for the client
- Becoming the legal guardian of a client or being named as an attorney-in-fact in a power of attorney executed by the customer

Acknowledgment of Receipt of Agency Disclosure Statement

I have read and understand the preceding pages of the Agency Disclosure Statement, which cover the following topics:

- Scope of license of Agency
- DCW qualifications and training requirements
- Charges for personal care services
- Description of billing and payment
- Termination of services
- Contacting the administrator
- Customer Rights
- Grievance Procedure
- Missed visit/additional visits
- DCW permitted duties
- Services NOT permitted
- Prohibited Activities

_____ _____

Customer or Customer Representative Signature Date

CONSUMER DIRECT CARE NETWORK

ADVANCE DIRECTIVES DISCLOSURE

_____

Print Consumer's Name

ADVANCE DIRECTIVES

It is important for all consumers to know about their right to formulate advance directives. You have a right to make decisions about your health care. You also have a right to execute a living will. You have a right to grant power of attorney to another individual. You will not be discriminated against based upon your choices concerning advance directives.

Please take a moment to provide information regarding your decisions on advance directives.

1. I (consumer) have already formulated an advance directive (please check all that apply):

   Living Will ☐ Yes ☐ No

   Durable or Medical Power of Attorney for Health Care Decisions ☐ Yes ☐ No

   If yes, name(s): _____.

   Durable Power of Attorney for Financial Decisions. ☐ Yes ☐ No

   If yes, name(s): _____.

   If you answered "Yes" to any of the above, are you providing copies to Consumer Direct Care Network (CDCN)? ☐ Yes ☐ No

   If yes, which document(s): _____.

2. I have received written information (this may be included in a Training Manual) regarding my right to make decisions about my health care. This includes the right to accept or refuse medical or surgical treatment. It also includes my right to formulate advance directives.

   ☐ Yes ☐ No

Comments: _____

_____

I understand that it is my responsibility to inform my caregiver(s) about my advance directives. This includes any **Do Not Resuscitate – Out of Hospital** orders, if such exist in the state where I live. If I change my advance directives, I will tell my caregiver(s) right away.

_____ _____

Consumer/Personal Care Representative Signature *Date*

_____ _____

CDCN Representative Signature *Date*

CONSUMER DIRECT CARE NETWORK

MEMBER EMERGENCY AND BACKUP PLAN

Member Name	Personal or Legal Representative Name (if applicable)

According to regulation 7AAC 43.751 you, the Member/Personal Representative (PR) must be informed of the following issues concerning your Backup Plan:

1. Consumer Direct Care Network (CDCN) will assist you with the development of a backup plan that is used if your regularly scheduled Direct Care Worker (DCW) cannot provide your personal care.
2. It is your/Personal Representative responsibility to use, change, update, or decide whether the back up plan is effective.
3. It is your responsibility to immediately report a gap in service to CDCN.
4. **In the case of an emergency call 911 or activate your life line.**
5. Emergency contact and number: _____.

A. Backup DCWs - Please list below who you will call if your current DCW(s) fails to report for his/her shift (may include friends, family, past DCWs, church members, other volunteers):

Name	City and State	Relationship	Phone

B. I (Member/PR) will talk with backup DCWs before an emergency arises about employment, pay, their availability and my personal care needs. I know that my back-up DCW(s) must be trained in order to be paid through CDCN.

C. It may be helpful to identify the DCW tasks that must be performed in a given day because they are essential to your health and safety. I (Member/PR) will keep my list of essential needs current, updated and accessible in my home.

D. If I believe I am at risk of harm for abuse, neglect or exploitation, I know that I should contact the Adult Protective Services hotline at: 877-767-2385 (*TDD 877-815*-8390) or (if applicable) the child abuse hotline at 888-SOS-CHILD.

_____ _____ _____ _____

Member/Representative Signature Date CDCN Representative Signature Date

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CONSUMER DIRECT CARE NETWORK

TASK AND HOURS/MEMBER SERVICE PLAN

☐ Initial ☐ Revised (Revision Date: _____)

Member Name: _____ Program Coordinator: _____

Contingency Plan Level: _____

Approved Service Plan			
Task	**Notes**	**Task**	**Notes**
☐ Nutrition/Meal Prep ☐ Meal Prep/Clean Up ☐ Partial Assist – Cut Up ☐ Full Assist w/ Feeding		☐ Special Appliances ☐ Walker ☐ Wheelchair ☐ Cane ☐ Other (specify in notes)	
☐ Bathing/Showering ☐ Standby ☐ Full assist ☐ Bed Bath		☐ Transfers ☐ Gait Belt ☐ Slide Board ☐ Assisting ☐ Hoyer ☐ Manual ☐ Automatic	
☐ Dressing ☐ Partial assist ☐ Full assist		☐ Mobility/Ambulation ☐ Standby walking assist	
☐ Grooming ☐ Brushing teeth/hair ☐ Nail Care - Filing		☐ Laundry ☐ Offsite	
☐ Incontinence ☐ Changing Briefs ☐ Ostomy bag ☐ Catheter		☐ Shopping	
☐ Toileting ☐ Partial assist ☐ Full assist		☐ Medical Escort	
☐ Light Housekeeping		☐ Other:	
☐ Medication Reminder		☐ Other:	

CONSUMER DIRECT CARE NETWORK

TASK AND HOURS/MEMBER SERVICE PLAN

The chart below reflects the hours per day authorized.

The approved hours are based upon client request. Any changes must be approved through the Program Office.

Approved Hours*			
	Hours Per Day	Schedule	Service Code
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

Total hours approved per week: _____

_____ _____ _____ _____

Member/PR Signature Date DCW Signature Date

☐ DCW notified of schedule verbally.

_____ _____

Support Coordinator Signature Date

If a change in authorization only (phone review): _____ _____

Support Coordinator Signature Date

Consent to Participate in the Unite Us Network

By consenting, you agree to share information with a Network of health and social service partners powered by Unite Us software. This Network is made up of entities and individuals who are directly involved in your care or payment of care. Your personal information may be shared securely on the Network in accordance with privacy laws to connect you with services.

This consent covers all information shared by you or by anyone that has the right to share information on your behalf and is relevant to the recipient's involvement in your care or payment for your care. You can always limit the information you provide on the Network by requesting to have it removed.

To understand how your information may be used and kept safe on the Network, please see uniteus.com/privacy.

If you no longer want your information shared on the Network, you can email consent@uniteus.com or ask any Network partner.

Client:

Name: _____

Signature: _____

Date: _____

Personal Representative or Guardian (only if applicable):

Name: _____

Signature: _____

Date: _____

Relationship to Client: Unrelated _

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Your Information. Your Rights. Our Responsibilities.

This notice is being provided on behalf of the Covered Entity, and tells you how medical information about you may be used and disclosed. It also tells you how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- If we say “no” to your request, we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone). You can also ask us to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask. This will include who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201. You can also call 1-877-696-6775, or visit **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.
- Most sharing of psychotherapy notes.

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways. This is usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it. This includes with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- This notice is effective April 1, 2020.
- Our Privacy Officer can be reached at infoprivacy@consumerdirectcare.com. They may also be reached at (877) 532-8530.
- We never market or sell personal information.
- This notice applies to all companies in the Consumer Direct Care Network which operate in the following states: Alaska, Arizona, Delaware, Maryland, Michigan, Montana, Nevada, New Mexico, Washington, Wisconsin.