SPARK HOME HEALTH - CONSENT FOR TREATMENT

Patient Name: _____ **Start of Care Date:** _____
Last First MI

I consent and authorize Spark Home Health ("the Agency"), its agents and associates to provide care and treatment to me in my home as prescribed by my physician and per Agency policy. I understand that I am required to have an attending physician at all times and that my plan of treatment may change depending on my physician's orders. I have received an explanation of the services that will be provided to me, including disciplines and proposed frequency of visits. I understand I have the right to participate in developing the plan of care. Initial services are as follows:

SERVICES AND/OR SUPPLIES	FREQUENCY AND DURATION	CHARGE PER VISIT	SERVICES AND/OR SUPPLIES	FREQUENCY AND DURATION	CHARGE PER VISIT
Skilled Nursing			Occupational Therapy		
Speech Therapy			Medical Social Worker		
Certified Nurse Aide			Other: (List)		
Physical Therapy					

Clinical Manager & Administrator: Jenny Vail-Stencel, MA, CCC-SLP Contact Phone Number: 720-479-8952

Authorization for Release of Information

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

The patient has the following commercial insurance:_____

Statement to Permit Payment for Home Health Services

I hereby request that payment of authorized medical home health services be made on my behalf to the Agency. I understand that agency will bill _____ Medicare _____ Medicaid _____ Patient _____ Insurance Co. ____ Other:_____ for the services being provided to me by the Agency. I understand that I will be responsible for the following amount:_____

Acknowledgements

I have received verbal and written information on the following all information has been explained to me:

1. Outline of Services to be Provided
2. Patient Grievance Policy and Patient Bill of Rights
3. Discharge and Transfer Policy
4. Information on Abuse, Neglect and Exploitation
5. Medical Information (Including Preventing Infections in the Home and Biomedical Waste Disposal)
6. Emergency/Disaster Management (Actions to Take in the Event of an Emergency Including: Fire, Blizzards, Tornado, Floods etc.)
7. Notice of Privacy Practices
8. Home Care Agency Outcome and Assessment Information Set (OASIS) Statement of Privacy Rights
9. Privacy Act Statement- Health Care Records
10. Written Notice of Home Care Consumer Rights (Colorado)
11. Colorado Agency Disclosure Notice
12. Authorization, Agreement and Acknowledgments
13. Advanced Directive Acknowledgment/HIPAA/Home Care Privacy Rights Acknowledgement

Patient Elected Representative:_____ **Relationship:**_____

Acknowledgment of receipt of patient rights and transfer/discharge policy to Patient Elected Representative:_____
Inital

Advance Directives

I have an Advance Directive ____ Yes ____ No
If yes, I have the following ____ Living Will ____ Medical Durable Power of Attorney ____ Do Not Resuscitate Order
Other Advanced Directives ____ Yes ____ No Explain:_____
Copy obtained ____ Yes ____ No Name and phone number of MDPOA: _____
I have requested and received more information: _____ Yes _____ No

I certify that I have read and agree with the information on this document and have been provided a copy for my records. I have participated in the formation of the plan of care. The visit schedule has been provided in writing.

_____ _____
Patient/Authorized Representative Signature of Patient/Authorized Representative Date

_____ _____
Agency Representative Signature of Agency Representative Date

SPARK HOME HEALTH MISSED VISIT POLICY

Spark Home Health's missed visit policy ensures our ability to provide high quality treatment and service to every patient. Our therapists are required to maintain the frequency of visits ordered by your child's physician to ensure optimal functional outcomes. Your dedicated therapist is committed to the services he or she provides and we ask that you make every effort to keep scheduled appointments.

While we understand that illness, scheduling conflicts and unforeseen circumstances arise we respectfully request you:

- Provide your therapist with at least 24-hours notice prior to changing or cancelling a scheduled appointment. Your therapist will make every effort to do the same.

- Cancel appointments only when unavoidable or unforeseen circumstances arise. We reserve the right to discharge your child from Spark Home Health after three no-shows or cancellations within a 60-day certification period. This policy helps ensure our therapy team is able to accommodate every child requesting therapy services.

We take the safety of your family seriously. If you miss an appointment and have not previously notified your nurse or therapist we will make every effort to contact you. The nurse/therapist will call your emergency contact within 12-hours of your original appointment if he/she has not heard from you. If safety has not been confirmed within 48-hours of your initial missed visit, we will contact your local police department to perform a well check.

Our entire Spark Home Health team appreciates your cooperation with this policy. We look forward to working together so that your child may attain patient centered goals and optimize function throughout their home and community.

_____

Patient Last Name Patient First Name Patient DOB

_____

Signature of Patient or Legally Authorized Representative Relationship to Patient

_____

Printed Name of Authorized Representative Date

HOME HEALTH FACE TO FACE ENCOUNTER AGREEMENT

Colorado Medicaid implemented a Face-to-Face encounter as a requirement of home health services for all admissions after July 1, 2017. Spark Home Health must have documentation stating that each patient has seen his or her Physician/Nurse Practitioner/Clinical Nurse Specialist/Certified Nurse Midwife or Physician Assistant 90 days prior to, or 30 days after the Start of Care. The primary reason the patient is receiving home health services must be documented in the provider's clinical note. The documentation needs to be sufficient to make the link between the individual's health condition, the services ordered and actual service provision.

If the patient has had an appointment with his/her physician, nurse practitioner, or physician assistant regarding the need for home health therapy services within the last 90 days, there is no need to make another appointment. A "well child" check up qualifies if you also discussed your concerns for your child's development and this is documented in the medical record. Our therapists can help you contact your doctor's office to determine if a recent appointment with your physician meets this requirement.

If you have not had a recent appointment with your physician regarding concerns in development, please schedule the equivalent of a sick child visit to review the patient's health and development and need for home health therapy services.

I understand the Face-To-Face requirements set forth by Colorado Medicaid. I understand if my child has not had an appointment with his/her physician/nurse practitioner/clinical nurse specialist/ certified nurse midwife or physician's assistant within the past 90 days satisfying the Face-To-Face requirement that I must see my qualified clinician within 30 days of admission to Spark Home Health. If my qualified clinician is not able to produce documentation of a Face-To-Face visit within 30 days of my admission, I understand and agree that my child will be discharged from Spark Home Health, LLC.

_____

Patient Last Name First Name MI **Date of Birth**

_____

Signature of Patient or Legally Authorized Representative **Relationship to Patient**

_____

Printed Name of Patient or Authorized Representative **Date**

HIPAA EMAIL CONSENT FORM

General Information About HIPAA:

- HIPAA stands for the Health Insurance Portability and Accountability Act.
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored within our Electronic Medical Record (EMR) system is encrypted.
- Most popular email services (ex. Hotmail, Gmail, Yahoo) do not utilize encrypted e-mail.

  When we send you an e-mail, or you send us an e-mail, the information that is sent is NOT encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the e-mail is received by you, someone may be able to access your e-mail account and read it.
- E-mail Is a very popular and convenient way to communicate, so in their latest modification to the HIPAA act, the federal government provided guidance on e-mail and HIPAA.
- The guidelines state that if a patient has been made aware of the risks of unencrypted e-mail, and that same patient provides consent to receive health information via e-mail, then a health entity may send that patient personal medical information via unencrypted e-mail.

☐ **ALLOW** UNENCRYPTED E-MAIL

I understand the risks of unencrypted e-mail and do hereby give permission to my nurse/therapist working for Spark Home Health to send me personal health information via unencrypted e-mail.

Preferred E-mail Address: _____

☐ **DO NOT ALLOW** UNENCRYPTED E-MAIL

☐ I do not wish to receive health information or agency communication via e-mail.

_____

Patient Last Name **First Name** **MI** **Date of Birth**

_____

Signature of Patient or Legally Authorized Representative **Relationship to Patient**

_____

Printed Name of Legally Authorized Representative **Date**

AUTHORIZATION FOR SMS TEXT MESSAGE COMMUNICATION

The convenience of communicating via text message makes it a widely requested and preferred method of communication between our patients and clinicians. However, using text messages may put your Protected Health Information (PHI) at risk.

The HIPAA Privacy Rule protects most "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or medium, whether electronic, on paper, or oral. The Privacy Rule calls this information *protected health information* (PHI)[2]. Protected health information is information, including demographic information, which relates to:

- The individual's past, present, or future physical or mental health or condition,
- The provision of health care to the individual, or
- The past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Protected health information includes many common identifiers (e.g., name, address, birth date, Social Security Number) when they can be associated with the health information listed above. (https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html#protected)

The HIPAA Security Rule requires healthcare providers to implement controls to ensure the protection of PHI. The risks in PHI disclosure through text messages include:

- If the sender or receiver loses their device, the messages could be accessed by an unauthorized individual.
- If messages are sent through un-encrypted text messages, the messages could be accessed by an unauthorized individual.
- Although entire patient records are not shared via text message, there is a possibility of including information that constitutes PHI throughout the history of text messaging to coordinate care for yourself or your child.

☐ I understand what constitutes Personal Health Information (PHI) and I understand that I am responsible for the content of text messages generated from my device.

Please choose an option below:

☐ I refuse to send/receive communication with my clinician including, but not limited to: scheduling, appointment reminders/rescheduling, and care coordination via text message. I understand I may communicate with my therapist via the encrypted message platform within my Patient Portal or over a phone call.

☐ I consent to send/receive communication with my clinician regarding my care including but not limited to: scheduling, appointment reminders/rescheduling, and care coordination via text message. By checking this box, I acknowledge that some PHI may be communicated in a non-encrypted medium and therefore may be at risk of being accessed by an unauthorized individual.

_____

Patient Last Name **First Name** **MI** **Date of Birth**

_____

Signature of Patient or Legally Authorized Representative **Relationship to Patient**

_____

Printed Name of Legally Authorized Representative **Date**

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Many of our patients allow individuals such as relatives, daycare providers or others to be present during services and speak with our clinical team regarding care and home programming. Under the requirements of HIPAA, we are not allowed to provide information to anyone without the patient or legally authorized representative's consent. If you wish to have your medical information discussed with additional individuals or organizations, you must sign this form. Signing this form will only allow verbal information to the individuals or organizations indicated below. The individuals named may also sign the clinical documentation as required to confirm the patient visit has been completed.

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

Consent:

I understand I have the right to revoke this authorization at any time and that I have the right to direct and specify the protected health information to be disclosed. I understand that information disclosed to any of the above recipients is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing. I further understand that no information will be transmitted to the above recipients in writing or via email or other electronic means.

_____

Patient Last Name **First Name** **MI** **Date of Birth**

_____

Signature of Patient or Legally Authorized Representative **Relationship to Patient**

_____

Printed Name of Legally Authorized Representative **Date**

SPARK HOME HEALTH PATIENT DATABASE ACCESS

Access to your child's updated clinical record is important to his or her continued progress toward therapeutic goals. Your child's updated plan of care, medication list/instructions, therapy program, home exercises, individual goals, schedule, emergency plan, and admission documents are available in written paper format or through Pt Pal, a patient database application. You must request to receive information electronically.

By signing below, I am requesting written information to be provided electronically.

I acknowledge I have received information about Pt Pal including information on how to download, login and navigate the application to access my child's updated plan of care and schedule, and review my emergency plan and admission packet at any time.

In order to login to your account, please download the PtPal Pro App to your smart phone. You can also access via the website: https://www.healthtechpal.com/login.php and select "Login as Patient"

Username:

Password:

_____ _

Patient Last Name Patient First Name Patient DOB

_____

Signature of Patient or Legally Authorized Representative Relationship to Patient

_____

Printed Name of Authorized Representative Date

Consent for the Use of Telemedicine for Live Video Visits

Thank you for your interest in using Telemedicine as service delivery method for you and your child. Colorado law requires that consent be signed prior to the start of services delivered via Telemedicine. Please read the consent information below. You will be provided a copy for your records.

Parent(s)/Guardian Acknowledgment and Statement of Consent
I understand that my child and family may receive srvices via Telemedicine. I understand that Colorado law requires that I consent to the following:

1. I retain the option to refuse the delivery of healthcare services via telemedicine at any time without affecting my child's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which my child would otherwise be entitled.
2. All applicable confidentiality protections shall apply to the services.
3. The services provided via Telemedicine shall meet the same standard of care as in-person visits.
4. The member(s) shall have access to all medical information resulting from the telemedicine services as provided by applicable law for member access to his or her medical records. [C.R.S. 2018, 25.5-5-320(4)]and
5. The above shall not apply in an emergency.

I give my consent for the use of Telemedicine

_____ _____

Patient Last Name Patient First Name

_____ _____

Authorized Patient/Representative Signature Date

Written Notice of Home Care Consumer Rights

As a consumer of home care and services you are entitled to receive notification of the following rights both orally and in writing. **You have the right to exercise the following rights without retribution or retaliation from agency staff:**

1. Receive written information concerning the agency's policies on advance directives, including a description of applicable state law;

2. Receive information about the care and services to be furnished, the disciplines that will furnish care, the frequency of proposed visits in advance and receive information about any changes in the care and services to be furnished;

3. Receive care and services from the agency without discrimination based upon personal, cultural or ethnic preference, disabilities or whether you have formulated an advance directive;

4. Authorize a representative to exercise your rights as a consumer of home care;

5. Be informed of the full name, licensure status, staff position and employer of all persons supplying, staffing or supervising the care and services you receive;

6. Be informed and participate in planning care and services and receive care and services from staff who are properly trained and competent to perform their duties;

7. Refuse treatment within the confines of the law and be informed of the consequences of such action;

8. Participate in experimental research only upon your voluntary written consent;

9. Have you and your property to be treated with respect and be free from neglect, financial exploitation, verbal, physical and psychological abuse including humiliation, intimidation or punishment;

10. Be free from involuntary confinement, and from physical or chemical restraints;

11. Be ensured of the confidentiality of all of your records, communications, and personal information and to be informed of the agency's policies and procedures regarding disclosure of clinical information and records;

12. Express complaints verbally or in writing about services or care that is or is not furnished, or about the lack of respect for your person or property by anyone who is furnishing services on behalf of the agency.

If you believe your rights have been violated you may contact the agency directly:

Jenny Vail-Stencel, MS, CCC-SLP - Administrator
Spark Home Health, LLC
1325 S. Colorado Blvd, Suite B312
Denver, CO 80222
(720) 479-8952 (Phone) (888) 981-8064 (fax) jenny@sparkhomehealth.com

You may also file a complaint with the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment via mail or telephone:

4300 Cherry Creek Drive South
Denver, CO 80246
303-692-2910 or 1-800-842-8826

I attest to verbal and written receipt of the aforementioned notice of rights:

_____ _____

Consumer or Authorized Representative Signature **Date**

_____ _____

Agency Representative Signature **Date**

AGENCY DISCLOSURE NOTICE

Agency Type: ☐ Home Care Placement **X Home Health Care** ☐ Personal Care or Non-Medical

Each home care agency or home care placement agency is required to provide the consumer information as to the responsibilities of the agency, the home care worker, and the consumer regarding the employment and duties of each.

X Agency is the employer of record for all staff providing direct care services and is responsible for all items listed below.

Responsibilities are delineated below:

Consumer	Worker	Agency	
		X	Employer of the home care worker.
		X	Supervision of the home care worker.
		X	Scheduling of the home care worker.
		X	Assignment of duties to the home care worker.
		X	Hiring, firing and discipline of the home care worker.
X		X	Provision of supplies or materials for use in providing services to the consumer.
		X	Training and ensuring qualifications that meet the needs of the consumer.
		X	Liability for the home care worker while in the consumer's home.
Consumer	Worker	Agency	Payment of:
		X	Wages to the home care worker.
		X	Employment taxes for the Home Care Worker.
		X	Social Security taxes for the Home Care Worker.
		X	Unemployment insurance for the Home Care Worker.
		X	General liability insurance for the Home Care Worker.
		X	Worker's Compensation for the Home Care Worker.
		X	Bond Insurance (if provided).

The above information and areas of responsibility have been explained and any questions have been answered in regard to responsibilities held by the consumer, the home care worker and the agency.

Consumer or Authorized Representative: Date:

Home Care Worker: **N/A** Discipline: **N/A** Date: **N/A**
(if not employee or contractor to the agency where the agency holds full responsibility)

Agency Representative: Title: Date:

Printed Name of Consumer: Start of Care Date:

COLORADO
Department of Health Care Policy & Financing

Colorado Medicaid
Change of Provider Form

This form must accompany the new Prior Authorization Request (PAR) Form when a client has a current and active PAR with another provider.

Client Information

Client Name:	Medicaid ID#:
Date of Birth:	Current PAR Number (if known):

Previous Provider Information

Name:	Last Day of Services:

New Provider Information

Name: **SPARK HOME HEALTH, LLC**	Provider ID#: **1659724227**
Client Start Date of Service:	Provider Signature:

This notice is to inform you that I, _____
(Client's name)

have changed providers effective: _____
(Date)

I am changing from provider: _____
(Provider's name)

to provider: Spark Home Health, LLC
(New provider's name)

The following services/equipment will be affected by this change:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

_____ _____
Client's Signature or (Guardian if client cannot sign) (Date)

Client's address: _____
(Address line 1)

_____
(Address line 2)

_____
(City, State and Zip Code)

Revision date: March 2015

PATIENT EMERGENCY PREPAREDNESS PLAN

Patient Name: Date of Birth: Date of Plan:
Primary Language:
Interpreter Name/Contact:
Primary Patient Caretaker/Relation: Phone:
Emergency Contact Name/Relation: Phone:
Emergency Contact Name/Relation: Phone:
Emergency Contact Name/Relation: Phone:
Other Agencies involved with patient/caregivers:

Patient Level of Emergency/Evacuation: ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4

In the event of an evacuation, Patient will take the following actions:

☐ Go to Shelter Evacuate to Nearest Hospital (Name):

☐ Go to Family or Other Location

Location Name:

Location Address:

Patient has emergency bag in accessible location ☐ Yes ☐ No
Patient has generator in case of necessity to shelter in place ☐ Yes ☐ No
Patient has adequate food/water in case of necessity to shelter in place ☐ Yes ☐ No

List Any Medical or DME Supplies & Equipment:

Medical and/or DME Supplier:

Name: Phone:
Name: Phone:
Name: Phone:

Patient plan to obtain vital medications in event of emergency:

Other Notes Regarding Emergency Preparedness Plan:

Instructions after crisis for continuation of care:

Agency will utilize triage procedure to contact all patients/caregivers to assess safety and needs. Will coordinate continuation of care within 24-72 hours.

• IN THE EVENT OF AN IMMEDIATE EMERGENCY, PLEASE CALL 911 •

Spark Home Health, LLC
1325 S. Colorado Blvd, Suite B312
Denver, CO 80222
720-479-8952(Direct)
888-981-8064 (Fax)

Emergency Preparedness Information Included in Patient Admission Packet:

- ☑ Medication Information
- ☑ Biomedical Waste Disposal
- ☑ What to do in case of Fire
- ☑ Snow Storm/Blizzards
- ☑ Preventing Infection
- ☑ Patient Instructions in the Event of an Emergency
- ☑ Earthquake/Tornado/Flash Flood/Other Disasters
- ☑ Local Emergency Contact Information

Additional Resources in the Event of Emergency:

American Red Cross of Colorado- Local Chapters and Phone Numbers

Location	Phone Number
Mile High Area	303-722-7474
Southeastern Colorado	719-632-3563
Western Colorado	970-242-4851
Northern Colorado	970-226-5728

In the event of an emergency please go to the following website to find open and available Red Cross shelters:
https://www.redcross.org/get-help/disaster-relief-and-recovery-services/find-an-open-shelter.html

Excel Energy

Electric Outages: 800-895-1999

Gas Emergency: 800-895-2999

Colorado Department of Transportation

For Current Road/Traffic Conditions: www.cdot.gov

Headquarters: 303-759-2368

North/Northeastern Colorado: 970-350-2368

Northwestern Colorado: 970-243-2368

South/Southeastern Colorado: 719-562-5568

Southwestern Colorado: 970-385-1423

FEMA- Federal Emergency Management Agency

www.fema.gov

www.Disasterassistance.gov

1(800) 621-FEMA (1-800-621-3362)

IN THE EVENT OF IMMEDIATE LIFE-THREATENING EMERGENCY PLEASE CALL 911