SAINT FRANCIS
ADULT DAY HEALTH

37 Thorne Street, Worcester MA 01604
Telephone (508) 752-2546

Welcome to Saint Francis Adult Day Health,

We are pleased you have chosen us to provide daytime care and support for you or your loved one. Our experienced team is dedicated to providing quality medical and social care in an enriching environment where you or your loved one can engage with others from the community.

We are committed to enriching the quality of life for all our participants throughout their day by encouraging independence, assisting with medical management and providing socialization through engaging activities. Our nursing team will work with your physician and caregivers in the community to ensure all your needs are met.

Saint Francis Adult Day Health is part of the Saint Francis continuum of care that includes the sub-acute rehabilitation and nursing center located upstairs from the Adult Day Health Program. If at any time you require rehabilitation following a hospitalization, Saint Francis Nursing and Rehabilitation can provide that care and upon return to our program you may continue to receive therapy with the rehabilitation team you are familiar with. Please contact me directly whenever there is a hospitalization and I will connect you with our Nurse Liaison to assist you in navigating a hospital stay.

Thank you for choosing Saint Francis Adult Day Health!

Sincerely,

Judy Fowler

Program Director

SAINT FRANCIS
ADULT DAY HEALTH

37 Thorne Street, Worcester MA 01604
Telephone (508) 752-2546

ENROLLMENT AGREEMENT

The **ENROLLMENT APPLICATION** must be on file prior to completing this Enrollment Agreement.

This is an Enrollment Agreement for Saint Francis Adult Day Health (ADH). It is a legally binding document, creating rights and obligations for each person or party signing the Agreement. Please read the Agreement carefully before you sign it. If you do not understand any provision of this Agreement, you should not sign it until you obtain clarification of the provision(s) you do not understand.

TABLE OF CONTENTS

ATTACHMENT LISTING

SAINT FRANCIS
ADULT DAY HEALTH

37 Thorne Street, Worcester MA 01604
Telephone (508) 752-2546

ENROLLMENT AGREEMENT

The **ENROLLMENT APPLICATION** must be on file prior to completing this Enrollment Agreement.

(A) SERVICES

The ADH is licensed by the Massachusetts Department of Public Health ("DPH") and open to adults over the age of 18 who have physical, cognitive, or behavioral health impairments. We use a medical model and provide nursing services, supervision and health related support services in a structured group setting including, but not limited to, individual, group and family counseling and referrals to community agencies when appropriate. Certified Nursing Assistants (CNAs) are available to provide assistance with eating, toileting and personal care as needed.

The Program is set up to address the needs of participants with Alzheimer's disease and related disorders, including operating within a secure inside and outside spaces and our staff undergo national Alzheimer Association training annually in accordance with DPH regulations. As required, we will arrange for and coordinate rehabilitation services by licensed physical, occupational, and speech, hearing and language therapists. Accordingly, the Program is affiliated with the outpatient therapy program at Saint Francis Rehabilitation and Nursing Center as discussed further in Section (J) below.

We serve breakfast and lunch as well as an afternoon snack daily and participate in the federal nutrition program to ensure a balanced diet. We are also able to accommodate special diets upon advanced request.

Our activities are varied and provide mental stimulation and physical exercise. Weather permitting; we hold activities outside in both our secured courtyard as well as our spacious enclosed patio.

Participants can attend Catholic Mass and non-denominational services, which are held daily in our on-site beautiful chapel. Pastoral care is available for spiritual needs.

(B) HOURS OF OPERATION

1. Our program is open daily during the following hours:

Monday	7:30 AM – 3:30 PM
Tuesday	7:30 AM – 3:30 PM
Wednesday	7:30 AM – 3:30 PM
Thursday	7:30 AM – 3:30 PM
Friday	7:30 AM – 3:30 PM
Saturday	7:30 AM – 3:30 PM

2. Adult Day Health is closed for the following holidays:
   - New Year's Day
   - Memorial Day
   - Independence Day
   - Labor Day
   - Thanksgiving Day
   - Thanksgiving Friday
   - Christmas Day

37 Thorne Street, Worcester MA 01604
Telephone (508) 752-2546

ENROLLMENT AGREEMENT

The **ENROLLMENT APPLICATION** must be on file prior to completing this Enrollment Agreement.

(C) NOTICE OF PROGRAM CLOSURE

Kiessling Transportation determines when the Program will close due to disaster or inclement weather. We trust their expertise to make the determination for weather and driving capabilities. If there is a weather concern, we will alert you of closures by 6:00 AM that morning. Our alert will be by a phone call using Voice Friend, a system that is much like a Public Service Announcement. We will require 100% compliance with this system to ensure that all Participants and families are properly notified of any closing. A secondary communication will go out by email, if this is provided when completing **Attachment (A)**.

(D) EMERGENCY PROCEDURES

Upon admission, every participant is required to provide two (2) emergency contacts and his/her Primary Care Physician contact information. You must include addresses, telephone numbers, and email address, if preferred method of contact. Should an emergency arise, every effort will be made to communicate with individuals listed as contacts. At least one of the emergency contacts must have authority (e.g. Healthcare Proxy) to determine treatment procedures for a participant. ADH program emergency procedures will be followed, accordingly.

This information should be updated if there are any changes in the future. Please note, it is the participant's and/or the participant's responsible party to communicate in writing any necessary change in a participant's emergency contact information.

(E) TRANSPORTATION

If you choose or we determine through our participant assessment evaluation that you need transportation to and from the Program, transportation is available for a separate charge through Kiessling Transportation.

Please note, Saint Francis Adult Day Health is never responsible for transportation needs regardless of the provider you choose. However, it is discouraged to use an outside transportation service via taxi or other services (i.e., Uber, Lyft, etc.). These alternative transportation services do not ensure the safety and well-being of you or your loved one.

Our preferred transportation vendor, Kiessling Transportation, provides safe and reliable transportation. Kiessling Transportation Drivers are First Aid Certified, Gait Belt Trained and have CORI checks on file with Saint Francis ADH. Therefore, we strongly encourage using their transportation services when needed.

In the event of an emergency while attending the Program, you will be transported to a local hospital emergency room. Please see **Attachment (B).**

(F) PARTICIPANT REQUIREMENTS & COMMITMENTS

1. To enroll in our Program, the participant must have a written order from his or her primary care provider who has determined that ADH care is appropriate to meet the participant's needs.

2. All participants must have a physical examination by their physician within twelve (12) months prior to admission to the ADH program and annually thereafter. *If the individual has been hospitalized in the preceding three months of admission, a complete discharge summary may be used to fulfill the physical examination requirement*

ENROLLMENT AGREEMENT

The **ENROLLMENT APPLICATION** must be on file prior to completing this Enrollment Agreement.

Your physician's physical must document the following:

a. Diagnoses and associated conditions;
b. Known allergies;
c. Pertinent findings of physical exam;
d. Significant medical history;
e. Assessment of physical capability, including activities of daily living (ADLs);
f. Assessment of cognitive status; and
g. TB screening.

3. As part of the physical examination or separately, within three (3) months prior to enrollment, all participants will need a pre-enrollment TB history and risk assessment. After admission, a TB risk assessment, symptom review, and education with additional screening are required on an annual basis.

4. Participants or families will and **should contact the Program by 8:00am** in the morning, or if possible the day before, **when the person is unable to attend the program**.

5. Participants receiving medical assistance MUST attend the program at least TWICE a week.

(G) PARTICIPANT DISCHARGE

1. A participant may choose to discontinue enrollment at a Program at any time. We encourage a participant to provide at least five (5) days prior written notice of any termination.

2. The Program may discharge a participant upon five (5) days written notice if one or more of the following conditions has been met:
   a. The discharge is necessary for the participant's welfare or the participant's needs can no longer be met by the ADH Program;
   b. The participant's health has improved and he or she no longer requires ADH services;
   c. The safety of other participants in the Program is endangered;
   d. The health of other participants in the Program is endangered;
   e. The participant has failed, after reasonable and appropriate notice, to pay for services at the Program or to have services paid by any public or private insurer; or
   f. The Program ceases to operate.

3. Any participant that is absent from the program, planned or unplanned, greater than six (6) months will be discharged. If applicable, upon return, an admission assessment and other necessary documentation will be required.

(H) PERMISSION FOR INFORMATIONAL RELEASE

1. The Program may release my personal health information to other integrated agencies when the Program makes referrals on my behalf for consultation and/or treatment as detailed in **Attachment (C).**

2. If my services are being covered by a third-party payer, I agree to allow information to be shared with the payer source. Third party payers currently accepted by the Program include, MassHealth, Veterans Administration, Elder Services of Worcester (Navicare, Evercare) and Fallon. We request each

ENROLLMENT AGREEMENT

The **ENROLLMENT APPLICATION** must be on file prior to completing this Enrollment Agreement.

participant with a MassHealth ID complete a Permission to Share (PSI) form. This allows MassHealth to share information with our staff. See **Attachment (D).**

3. By signing the attached release, I authorize my photograph to be taken and used for a slide presentation, brochure or publicity as seen fit by the Program as described in **Attachment (E).**

(I) ADVANCE DIRECTIVE

It is the right of all Participants to share in their own health care decision-making, including the right to decide whether they wish to accept or refuse life-prolonging measures or other treatments. You have the right to make advance directives about his or her medical care. **Attachment (F)** is our Advance Directive Communication form. We request a copy of any form that you may have (i.e., Legal Guardianship, Health Care Proxy).

(J) REHABILITATION SERVICES

As part of our Program, we arrange for or coordinate rehabilitation services by licensed physical, occupational, and speech, hearing and language therapists for participants in need of these services. Accordingly, the Program is affiliated with the outpatient therapy program at Saint Francis Rehabilitation and Nursing Center which is located on the same premises. You can choose to authorize the Program to coordinate both evaluation and treatment, if determined necessary, with the Outpatient Department at Saint Francis Rehabilitation and Nursing, to provide physical, occupational and speech therapy services. Please complete **Attachment (G)** for Outpatient Therapy Release.

(K) BARBERING AND HAIRDRESSING

Upon request, our staff can assist transporting Participants for barbering and hairdressing services at Saint Francis Rehabilitation and Nursing Center. Payment on the day of service is expected. Appointments can be made by calling 508-755-8605 x134.

Rates are current rates as of 01/01/2017 and subject to change without notice.

Color with Set	$28.00
Color with Set, & Haircut	$33.00
Perm with Cut and Set	$45.00
Men/Women's Haircut	$12.00
Set Only	$12.00
Weekly Rinse	$5.00
Conditioning Treatment	$5.00

(L) DAYS OF THE WEEK PARTICIPANT WILL ATTEND PROGRAM:

PLEASE CHECK THE DAYS YOU PREFER TO ATTEND					
MON	TUE	WED	THU	FRI	SAT

37 Thorne Street, Worcester MA 01604
Telephone (508) 752-2546

ENROLLMENT AGREEMENT

The **ENROLLMENT APPLICATION** must be on file prior to completing this Enrollment Agreement.

(M) MEALS AND SNACKS

Included in our daily program fees, we serve breakfast, lunch and an afternoon snack. Menu calendars are printed and sent home each month. We follow your doctor's orders regarding your diet requirements. Saint Francis Adult Day Health is open to all participants regardless of race, color, national origin, sex, age, or disability. Our center participates and is reimbursed through the Department of Education and the CACFP (Child and Adult Care Food Program). A signed Meal Benefit form may be required upon admission. See **Attachment (H)**

(N) PROGRAM SERVICE FEES

The current rates, with inclusions and exclusions are described in **Attachment (I)**. We accept private payment via cash/check and credit cards. We are contracted with Medicaid/ MassHealth, Veterans Administration, and through Elder Services of Worcester (Fallon/ Navicare, Evercare).

(O) STATEMENT OF RIGHTS FOR ADULT DAY HEALTH PARTICIPANTS

The Program follows the basic tenants while providing services to our participants without regard to race, color, religion, national origin, ancestry, sex, or financial status.

1. The right to be treated with respect and dignity, and free from harm, including unnecessary physical or chemical restraint, isolation, excessive medication, abuse or neglect.
2. The right to participate or be represented and to be supported in developing one's own plan of care.
3. The right to participate or decline participation in the programmed activities, and to accept or refuse treatments outlined in the care plan.
4. The right to privacy and confidentiality.
5. The right to a safe, secure and clean environment.
6. The right to be free from interference, coercion and voice grievances without discrimination or reprisal with respect to care and treatment that is (or is not) provided.
7. The right to be fully informed of the cost of the program and any additional services.
8. The right to be informed of the reason for discharge from the program or to end participation in the program at any time.

<u>Participants have the following rights regarding free choice</u>:

1. To informed consent.
2. To refuse treatment and medication.
3. To make advanced directives about his or her medical care.
4. To be fully informed in a language that the participant can understand of his or her total health status, including but not limited to, his or her medical condition.
5. To refuse to be examined, observed, or treated by students or any other Program personnel.
6. To refuse to serve as a research subject and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic.
7. To refuse to perform services for the Program

SAINT FRANCIS
ADULT DAY HEALTH

37 Thorne Street, Worcester MA 01604
Telephone (508) 752-2546

ENROLLMENT AGREEMENT

The **ENROLLMENT APPLICATION** must be on file prior to completing this Enrollment Agreement.

This Agreement shall be interpreted and enforced in accordance with the laws of the Commonwealth of Massachusetts. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the validity or enforceability of the remaining provisions. However, instead of such invalid or unenforceable provision, the parties agree that a court may add as part of this Agreement a provision as similar in terms to such illegal, invalid, or unenforceable provision as may be possible and as may be legal, valid, and enforceable. This Agreement and the Appendices and the Addenda to this Agreement constitute the entire agreement and understanding between you and us with respect to the subject matter of this Agreement and supersede all prior agreements and understandings relating to the subject matter of this Agreement. There are no agreements, understandings, restrictions, warranties, or representations between you and us other than those set forth in this Agreement, or incorporated in this Agreement by reference. This Agreement may be amended only by a document in writing signed by you and us, and no act or omission of any employee or agent of our Adult Day Health Program shall alter, change or modify any of the provisions of this Agreement. The waiver by any party to this Agreement of any breach or default of this Agreement by any other party shall not operate as a waiver of any subsequent breach or default by the other party.

The participant has the right to revoke any consent, authorization or release of information. This must be done in writing and must be added to the Patient's permanent record as an addendum.

THE UNDERSIGNED CERTIFY THAT THEY HAVE READ AND AGREE TO THE FOREGOING, TO THE WHOLE AND ENTIRE AGREEMENT BETWEEN THE PARTIES, AND THAT THEY HAVE RECEIVED A COPY OF THIS AGREEMENT.

Participant Name (Print)_____ DOB _____

Participant or Responsible Party Signature _____ Date _____

Adult Day Health Staff Name (Print)_____ Title _____

Adult Day Health Staff Signature _____ Date _____

SAINT FRANCIS
ADULT DAY HEALTH

37 Thorne Street, Worcester MA 01604
Telephone (508) 752-2546

Attachment (A)

NOTICE OF PROGRAM CLOSURE – VOICE FRIEND

Dear Participant/Family Member,

Saint Francis Adult Day Health Program is excited to introduce our partnership with Voice Friend. Voice Friend will assist us with our communication to you regarding closures due to weather i.e. snowstorms and other related emergency updates. Voice Friend will allow Saint Francis Adult Day Health Program to send one message and reach all Participants and family members. **This will be our primary form of communication when the Adult Day Health program will be closed due to weather or any other emergency situations.**

Below, please share with us the best way to communicate with you. Please note, that the Voice Friend solution is an additional means of communication and will in no way replace the direct communications when necessary. All contact information will remain confidential and will be used solely for communications by Saint Francis Adult Day Health Program. Contact information will never be sold or shared with third party marketing companies.

Should you have any questions, please do not hesitate to contact me.

Sincerely,

Program Director

Important: Please print all information below legibly and include Area Code of your phone number. Thank you.

Participant Name: _____

Please provide your preferred way to receive communications from St. Francis Adult Day Health:

- ☐ **Call** my Cell Phone Number: _____
- ☐ **Call** my Home Phone Number: _____
- ☐ Send **Email to**: _____

Participant or Responsible Party Signature _____ Date _____

VoiceFriend

September 2017

SAINT FRANCIS
ADULT DAY HEALTH

37 Thorne Street, Worcester, MA 01604
Telephone (508) 752-2546

Attachment (B)

EMERGENCY TRANSPORTATION & MEDICAL TREATMENT FORM

TRANSPORTATION

I give the staff of Saint Francis Adult Day Health to transport the participant to a local hospital emergency room for treatment in the event a medical emergency should arise while in attendance at the day program or on an outing sponsored by the center.

I understand that the participants being transported for emergency medical treatment is financially responsible for any costs incurred for such transportation and treatment. If the medical emergency occurs I would prefer transportation to _____hospital for needed emergency care.

I understand that the staff of the Saint Francis Adult Day Health will make every effort to notify the participant's designated responsible party of any event requiring emergency treatment as soon as possible after emergency medical personnel take over the care of the participant.

MEDICAL TREATMENT

I agree to medical treatment by nursing staff approved by Saint Francis Adult Day Health if such treatment has been ordered, in writing by the participant's physician and is included in his/her treatment plan in use by the day center.

Participant or Responsible Party Signature _____ Date _____

ADH Staff Signature _____ Date _____

SAINT FRANCIS
ADULT DAY HEALTH

37 Thorne Street, Worcester, MA 01604
Telephone (508) 752-2546

Attachment (C)

Disclosure of Participant Health Information Authorization Form

I hereby authorize Saint Francis Adult Day Health to use or disclose the below named participant's health information as described below.

Participant Name: _____ Date of Birth: _____

Address: _____

Guardian or Legal Representative: _____

I authorize Saint Francis Adult Day Health to use or disclose my health information to the following individual(s) or organization:

_____

The health information to be used or disclosed is as follows [describe dates or service and information to be disclosed]:

_____

_____

Unless otherwise revoked, this authorization will expire on the following date, event or condition that relates to the use or disclosure:

_____

I understand that I have the right to revoke this authorization at any time. To revoke this authorization, I must present a written revocation to Saint Francis Adult Day Health's privacy officer. A more detailed description of the right to revoke and authorization and how to exercise that right can be found in Saint Francis Adult Day Health's Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment, payment, enrollment, or eligibility for benefits.

I understand that there is the potential for information used or disclosed under this authorization to be redisclosed by the recipient and that the re-disclosure may not be protected by the federal health information privacy regulations.

If I have questions about the disclosure of my health information, I can contact the Saint Francis Adult Day Health's Privacy Officer.

Participant or Responsible Party Signature _____ Date _____

ATTACHMENT (D)

MASSHEALTH PERMISSION TO SHARE INFORMATION (PSI)

SECTION 7 Signature/Legal guardian

Fill out the following section if this form is being filled out by someone who has the legal authority to act on behalf of the applicant or member (such as the parent of a minor child, an eligibility representative, or a legal guardian).

Printed name of person filling out this form

Signature of person filling out this form

Date

Address

Telephone number

Authority of person filling out this form to act on behalf of the applicant or member:*

** If this form is being filled out by someone who has been appointed by a court as a legal guardian or conservator, or who has power of attorney or health-care proxy, a copy of the applicable legal document must be attached.*

Where to send this form

Please follow the instructions below.

- If you are **applying for health benefits** and wish to submit a PSI, send it to

  MassHealth Enrollment Center
  Central Processing Unit
  P.O. Box 290794
  Charlestown, MA 02129-0214

- If you are **already getting health benefits** and wish to submit a PSI, send it to

  MassHealth Enrollment Center
  P.O. Box 1231
  Taunton, MA 02780

- If you are **authorizing only specific information to be shared (such as your claims information or application file)**, and have checked off the second, third, or fourth box in Section 2, send the PSI to

  Privacy Office
  600 Washington Street
  Boston, MA 02111

PSI (Rev. 02/13)

MASSHEALTH

Permission to Share Information (PSI) Form

- **Use this form** if you want MassHealth to share the information we have about you with another person or organization, such as
  - a family member, friend, or other relative;
  - someone who helps take care of you;
  - someone who helps you fill out MassHealth forms; or
  - a social worker, lawyer, or health-care advocacy group.

- **Do not** use this form if you want
  - information about yourself;
  - information about your children under age 18 (You can usually get this without filling out any forms.); or
  - your eligibility and payment information to be shared with your health-care provider. (Your health-care provider can get information about your MassHealth eligibility and payment for services provided to you without you filling out any forms.)

- **Important:** If you decide that you do need to fill out this form, you must fill out all sections completely. Please print clearly.

MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

SECTION 1 Name of MassHealth applicant or member

Permission is given for MassHealth and its representatives to share information listed in **Section 2** about

(name of applicant or member whose information is to be shared)

Street

City/State/Zip

Date of birth Telephone number

MassHealth ID number

Please Note: If you do not have a MassHealth ID number, please use your social security number, if one has been issued, unless you are applying for or getting only MassHealth Limited, Children's Medical Security Plan (CMSP), or Healthy Start benefits.

SECTION 2 What information do you want shared?

Check the box or boxes that apply.

☐ I am giving MassHealth permission to share eligibility notices and information about eligibility for, and access to, MassHealth benefits, with the person or organization listed in **Section 3**. Please note such notices may contain financial information. Check this box only if you want the person or organization in **Section 3** to be able to contact MassHealth to get eligibility information and copies of your eligibility notices.

Please Note: Eligibility notices include information about all members of a household. If you check this box, a separate PSI form must be submitted and signed by each member of your household who is 18 years or older. If we do not get forms signed by each member of your household who is 18 years or older, we will not be able to honor your request.

☐ a summary of my MassHealth claims from _____ (month/year) to _____ (month/year)

☐ MassHealth's file containing my applications and related information

☐ other (please be specific):

By giving MassHealth this permission to share information, are you also giving MassHealth permission to share drug and alcohol treatment information?

☐ Yes. Share drug and alcohol treatment information.

☐ No. Do not share drug and alcohol treatment information.

SECTION 3 Whom do you want us to share information with?

List the name of ONLY ONE person or organization in this section. You must fill out another PSI form if you want to name more than one person or organization.

MassHealth may share the information listed in **Section 2** with

St Francis ADH

Name of person or organization

Aggie Czelusniak

In care of (name of person in organization to whom mail should be sent)

37 Thorne Street

Street

Worcester, MA 06014

City/State/Zip

508-752-2546

Telephone number

SECTION 4 Why do you want us to share your information?

Tell us why you want to share the information listed in **Section 2**. If you leave this section blank, we will assume you mean "at my request."

to assist with ongoing eligibility

SECTION 5 End of permission

This PSI will end in 18 months unless you specify an end date here. 07/27/2028

SECTION 6 Your signature

I understand the following.

- When the person or organization named in **Section 3** gets this information from MassHealth, that person or organization may be able to share it with others without my permission. If they do so, federal and state privacy laws may not protect the information.
- I need to send this PSI to the appropriate address on the back page of this brochure.
- I may cancel this permission at any time by sending a letter to Privacy Office, 600 Washington Street, Boston, MA 02111.
- If I cancel this permission, MassHealth cannot take back any information that it shared when it had my permission to do so.
- If I do not give MassHealth permission to share information, or if I cancel my permission to share information with the person or organization named in **Section 3**, my MassHealth benefits will not be affected in any way.
- In certain circumstances, MassHealth may not honor my request to share information.

Name of applicant or member

Signature of applicant or member Date

(*See other side.*)

SAINT FRANCIS
ADULT DAY HEALTH

37 Thorne Street, Worcester, MA 01604
Telephone (508) 752-2546

Attachment (E)

ADVANCED DIRECTIVE COMMUNICATION FORM

Participant Name: _____

1. Does the participant have a **Health Care Proxy**?
   - ☐ No
   - ☐ Yes. Who is Health Care Proxy? _____

   Is the Health Care Proxy *invoked*? ☐ Yes ☐ No
2. Does the participant have a **Massachusetts Rogers**?
   - ☐ No
   - ☐ Yes. Expiration date _____
3. Does the participant have a signed **Durable Power of Attorney**?
   - ☐ No
   - ☐ Yes. Who is Power of Attorney? _____
4. Does the participant have a **Legal Guardian**?
   - ☐ No
   - ☐ Yes. Who is the Legal Guardian? _____
5. Has the participant completed a **MOLST** form?
   - ☐ No
   - ☐ Yes

Thank you for the completion of this form.

Please ATTACH copies of the documents for which you check "YES."

Participant or Responsible Party Signature _____ Date _____

ADH Staff Signature _____ Date _____

SAINT FRANCIS
ADULT DAY HEALTH

37 Thorne Street, Worcester MA 01604
Telephone (508) 752-2546

Attachment (F)

HIPAA MARKETING RELEASE FORM

Consent for the Use and Disclosure of Images, Voice, and/or Written Testimonials
By signing below, I am authorizing Saint Francis Adult Day Health Program (the "Program") to take and to use my photograph, video, sound recordings, or other testimonials of me and/or my name (collectively, the "Materials") for video presentations, press releases, newspaper articles, brochures, newsletters, annual reports, audio-visual presentations, websites and other educational, marketing, or promotional materials (collectively, "Marketing") produced by the Program.

The Program shall be the sole owner of the Materials, free from any rights and permission by me, with the right to publish or otherwise use or disclose the Materials, and I will not have any right to compensation, notification, or review relating to the Program's use or disclosure of the Materials.

This consent is voluntary and as such, I hereby agree to release the Program and its representatives, **successors, and assigns from any causes of action and liability arising out of the interviewing, photographing, video, or audio recording, and/or any subsequent Marketing or other publication or broadcasting of the Materials.**

✓ Participant or Responsible Party Signature _____ Date _____

HIPAA Authorization
I hereby authorize Saint Francis Adult Day Health Program (the "Program") to use and disclose the limited protected health information contained in the Materials to other organizations and the public for Marketing and similar purposes, which may involve financial remuneration from a third party. I understand that once this information has been disclosed, the Program cannot guarantee that the recipient will not re-disclose the information to another party who may not be required to comply with state and/or federal laws governing the use and disclosure of protected health information, and in such case, the information described above may be re-disclosed and would no longer be protected by laws governing the privacy of such information.

This authorization is valid for five (5) years. However, I understand that I may revoke this authorization at any time by providing written or electronic notice to the Program Director. Once such a revocation is received, the Program will remove or amend the relevant Marketing as soon as practicable. In some circumstances, however, it may be impossible to retract the information because the Program will have already used and/or disclosed it in reliance on this authorization.

I understand that I may refuse to sign this authorization, and that my refusal to sign or my revocation of this authorization will not affect my ability to obtain services from the Program.

✓ Participant or Responsible Party Signature _____ Date _____

37 Thorne Street, Worcester MA 01604
Telephone (508) 752-2546

Attachment (G)

CONSENT TO THERAPY EVALUATION AND TREATMENT

I hereby consent to evaluation and/or treatment of my condition by licensed therapist employed by or under contract with Saint Francis Nursing & Rehabilitation Outpatient Clinic.

The therapist has fully explained to me the nature and purposes of the evaluation, procedures, and course of treatment, and has witness my signature of this consent in his or her presence. The therapist has informed me of expected benefits and possible complications or discomfort, which may result from skilled therapy care. In addition, the therapist has explained to me the risks of receiving no treatment.

The therapist has explained that there is not a guarantee that the proposed course of treatment will improve my condition and that is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. I have been given on opportunity to ask questions and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed evaluation and treatment have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

✓ Participant or Responsible Party Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received a Notice of Privacy Practices for protected health information from Saint Francis Nursing and Rehabilitation Outpatient Clinic.

✓ Participant or Responsible Party Signature _____ Date _____

Complete below ONLY if the form is not signed by the participant or responsible party.

DOCUMENTATION OF GOOD FAITH EFFORT TO OBTAIN WRITTEN ACKNOWLEDGMENT

I made a good faith effort to obtain the patient's written acknowledgment of our Notice of Privacy Practices for protected health information by (check all that apply):

- ☐ Showing the Participant the Notice of Privacy Practices posted in our office.
- ☐ Giving the Participant the Notice of Privacy Practices to read prior to receiving any treatment for service.
- ☐ Asking the Participant to sign this Acknowledgment form.
- ☐ Other (explain in detail) _____

I was unable to obtain the patient's written Acknowledgment because (check all that apply):

- ☐ The Participant refused to sign this form.
- ☐ The Participant would not sign the form because the patient said he/she did not understand the Notice.
- ☐ Other (explain in detail) _____

Saint Francis ADH Staff Signature _____ Date _____

SAINT FRANCIS
ADULT DAY HEALTH

37 Thorne Street, Worcester, MA 01604
Telephone (508) 752-2546

Attachment (H)

PROGRAM SERVICE FEES

ADULT DAY HEALTH RATES –

Effective 01/01/2017

The current rate for our adult day health program is **$65.00/day**.
This includes breakfast, lunch and an afternoon snack.

Should transportation be needed, we are happy to assist in arranging for that service.
The current private rate for van transportation is **$18.50/trip ($37.00 roundtrip).**

Participant or Responsible Party Signature _____ Date _____

ADH Staff Signature _____ Date _____

ATTACHMENT (I)

MEAL BENEFIT FORM

Meal Benefit Income Eligibility Application Packet
Adult Day Health

Document Index

This document contains the following information:

Massachusetts Department of Elementary and Secondary Education

75 Pleasant Street, Malden, Massachusetts 02148-4906 Telephone: (781) 338-3000
TTY: N.E.T. Relay 1-800-439-2370

MEMORANDUM

To: **Child and Adult Care Food Program Sponsors and Institutions**

From: **Robert M. Leshin, Director**
Office for Food and Nutrition Programs

Date: **July 1, 2018**

Subject: **Meal Benefit Income Eligibility Applications**

Attached are the updated prototype materials for households applying for free or reduced price meals in the Child and Adult Care Food Programs. The *Healthy, Hunger-Free Kids Act of 2010*, the child nutrition federal reauthorization law, made several changes to eligibility. Based on input from several sources, we have designed a Massachusetts Family Household application that streamlines the application and instructions. USDA application packages are available in multiple languages at https://www.fns.usda.gov/documents-available-other-languages.

This package, available online in the Online Document and Reference Library, includes forms and letters for Sponsors and institutions to use.

Reminders:

- The Civil Rights Nondiscrimination Statement has been revised by USDA. The 2019 application has the current language requirement.
- The last four digits of the social security number for the adult signing the application needs to be listed rather than the entire social security number if the Total Household Gross Income grid is completed.

Please note that the prototype application and letter to participant/guardians include the reduced price income eligibility guidelines chart.

The current Income Eligibility Guidelines for determining eligibility for free or reduced price meals have been issued and is a separate document in the Online Document and Reference Library.

If you have any questions or need further assistance, please call Nutrition staff at 781-338-6480 or email nutrition@doe.mass.edu.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

MEAL BENEFIT INCOME ELIGIBILITY FORM

Instructions for Child and Adult Care Food Program Centers and Sponsoring Organizations

This packet contains prototype forms:

Required information that *must* be provided to households:

- Letter to Households: Adult Day Care
- Meal Benefit Income Eligibility Form: Adult Day Care (with Instructions)

The pages are designed to be printed on 8½" by 11" paper. Some pages may be printed front and back. The **[bold bracketed fields]** indicate where you need to insert your specific contact information for assistance and where to submit the completed form(s).

This prototype package also includes information regarding the exclusion of housing allowance for those in the Military Housing Privatization Initiative and pricing programs. If these sections are not pertinent, you may remove them.

Massachusetts Department of Elementary and Secondary Education
Office for Food and Nutrition Programs
75 Pleasant Street
Malden, MA 02148

Dear Participant/Guardian:

The CACFP offers meal reimbursements to adult day care facilities which provide structured comprehensive services to nonresidential adults who are functionally impaired, or aged 60 and older. By completing the attached Meal Benefit Income Eligibility Form, the centers will be able to receive reimbursement, which is based on the number of enrolled participants that are eligible for free or reduced price meals.

1. Do I need to fill out a Meal Benefit Form for each adult in day care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for the adults enrolled in day care in your household **only** if they are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: [(Center) at name, address, phone number].**

2. Who can get free meals? Adults in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp), Food Distribution Program on Indian Reservations (FDPIR), Supplemental Security Income (SSI) or Medicaid benefits can get free meals. Adults in households participating in WIC may be eligible for free meals.

3. Who can get reduced price meals? Adults can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on this application. Adults in households participating in WIC may be eligible for reduced price meals.

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or the adult in your care do not have to be U.S. citizens to qualify for meal benefits offered at the center.

5. Who should I include as members of my household? You must only include the adult in your care, his or her spouse, and his or her dependents who share income and expenses.

6. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the adult day care will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or proof of benefits as supported by a current SNAP, FDPIR case number or a SSI or Medicaid assistance number, you will remain eligible for those benefits for a period not to exceed 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility standards.

7. What if my income is not always the same? List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.

8. We are in the military, do we include our housing allowance as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call **[phone number].**

Sincerely,

[signature]

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Follow these instructions, if your household gets SNAP or if the adult participant gets SSI or Medicaid:

Part 1: List only the adult participants' names.
Part 2: List the case number for any household member receiving SNAP or SSI or Medicaid benefits.
Part 3: Skip this part.
Part 4: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 5: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, follow these instructions:

Part 1: List only the adult participants' names. For any participant with no income, you must check the "No Income" Box.

Part 2: Skip this part.

Part 3: Follow these instructions to report total household income form this month or last month.

Column A – Name: List the first and last name of the adult participant, his or her spouse and his or her dependent(s) living in your household who share income and expenses.

Column B – Gross Income and How Often it was Received: For each **household member who is the participant, his or her spouse, or a dependent of the participant,** list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you.
Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. Report income after expenses in Box 1 only if self employed. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 4: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 5: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

Part 1. All Household Members

Name of Enrolled Adult(s):

Names of Adult Participants (First, Middle Initial, Last)	CHECK IF NO INCOME
	☐
	☐
	☐

Part 2. Benefits: If any member of your household received SNAP or if the adult participant(s) receives SSI or Medicaid, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: _____

Part 3. Total Household Gross Income—You must tell us how much and how often

	B. Gross income and how often it was received			
A. Name (List **only** the participant(s), spouse and dependent children of participant(s))	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 4. Signature and Last Four Digits of Social Security Number

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-____ ☐ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical Eligibility: ___ Eligibility: Free___ Reduced___ Denied___

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care

The participant in the adult care facility may qualify for free or reduced price meals if their household income falls within the limits on this chart.

Effective July 1, 2018 to June 30, 2019

Household size	Yearly
1	22,459
2	30,451
3	38,443
4	46,435
5	54,427
6	62,419
7	70,411
8	78,403
Each additional person:	+7,992

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race,
color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

ATTACHMENT (J)
HEALTH DRIVE CONSENT FORM

Dear Participant/Family Member,

HealthDrive Medical & Dental Practices are the primary providers of Eye Care, Audiology, Podiatry and Dental services, provided in a fully functioning clinic set up in the comfort of our facility. HealthDrive is a local group dedicated exclusively to serving the needs of the elderly. These are extremely important services and would once again like to provide you with an opportunity to enroll. It is important to note although HealthDrive is the "in-house" service provider for these services, you may continue to choose an outside Provider if that is your preference.

It is extremely important that you complete this form indicating your decision regarding Dental, Eye, Podiatry and Audiology services and return it in the envelope provided, or bring it with you next time you visit our center. If you currently receive any of these services already from HealthDrive, be sure to check them in addition to any other "NEW" service you may choose.

Massachusetts State guidelines mandate that the facility must maintain this form in your medical record. **This will not affect the services provided by any Attending Physician.** If you have any questions or are unable to complete the form, please call HealthDrive toll-free number at **1-888-964-6681** and ask to speak with an enrollment specialist. They will be happy to answer questions and assist you any way possible. Please help us ensure that your loved one receives the care they need and deserve.

Sincerely,

Judy Fowler

Judy Fowler

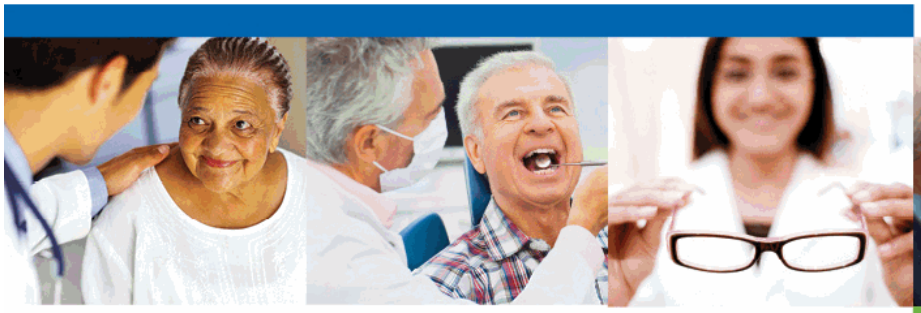
Program Director

Please check each service you would like to receive from Health Drive

while at St Francis Adult Day Health:

SERVICE **HOW LONG SINCE YOUR LAST VISIT?** **DOCTOR'S NAME**	☐ Eye Care	☐ Audiology	☐ Podiatry	☐ Dental

PARTICIPANT NAME: _____



Quality Healthcare Services Provided On-Site with Compassion and Care:

Dental

- Examinations and cleanings
- Simple extractions & fillings
- Examination for oral cancer and other diseases
- Denture fabrication, relining, repair and engraving

Optometry

- Glaucoma and overall eye health testing
- Vision testing using trial lenses specialized for the elderly
- Eyeglass fabrication, repair and engraving
- Low-vision aids for the partially sighted

Podiatry

- Comprehensive evaluations and regular nail and foot care
- Complete wound care management with close monitoring and follow-up
- Custom orthotics and shoes

Audiology

- Comprehensive diagnostic audiological exams
- Hearing aid evaluation and repair
- Dispensing and adjusting new state-of-the-art digital hearing aids

To learn more about HealthDrive's on-site healthcare services call us at 888-964-6681 or visit HealthDrive.com

HealthDrive
bringing integrated healthcare to you

Important Healthcare Services for the People You Care Most About

For more than 24 years, HealthDrive's health professionals have been dedicated to bringing the highest caliber dental, optometry, podiatry and audiology services directly to residents of extended care facilities.

For Residents

We are your direct connection to highly skilled physicians and dentists. Our local professionals are knowledgeable but just as important – they are caring individuals who are committed to making your quality of life the very best it can be.

For Family Members

We know how important the health and well-being of your family and loved ones are to you.

HealthDrive Providers:

- Use state-of-the-art technologies in their diagnosis and treatment,
- Follow strict infection control protocols,
- Adhere to rigorous quality of care guidelines, and
- Treat each patient on-site with dignity and respect.

Through skilled assessment, we develop treatment plans that are medically appropriate, well documented and effective in enhancing your loved one's quality of life.

HealthDrive
bringing integrated healthcare to you

REQUEST FOR SERVICE

Saint Francis Adult Day Health #809 37 Thorne St, Worcester, MA 01604 (508)752-2546

Resident information:

1

Prefix: First Name: Middle:

Last Name:

Suffix: DOB: Male Female

Insurance information (Please include a copy of front and back of insurance cards):

2

SSN: Other Insurance name:

Medicare #: Other Insurance #:

Medicaid #:

3 Requested services:

YES - I request to be seen for the following services: ☐ Audiology ☐ Dental ☐ Eye Care ☐ Podiatry

NO - I will make alternate arrangements for these services: ☐ Audiology ☐ Dental ☐ Eye Care ☐ Podiatry

Legal Responsible Party

4

Relationship to resident (Check all that apply)

☐ Self ☐ Health Care Agent ☐ Legal Guardian ☐ Spouse
☐ Brother/Sister ☐ Son/Daughter ☐ Other:_____

First name: MI:

Last name:

Street Address:

City/Town: State: Zip:

Preferred Phone #: ☐ Work ☐ Home ☐ Cell

Financial Responsible Party

5

☐ Same as Section 4

First name: MI:

Last name:

Street Address:

City/Town: State: Zip:

Preferred Phone #: ☐ Work ☐ Home ☐ Cell

6

I consent to the services requested above, including examinations, radiographs, cleanings, and fillings if I have requested Dental, and I hereby assign all health insurance benefits for the services provided to the Resident to HealthDrive's professionals. This assignment includes benefits payable by Medicare, Medicaid, Medigap, and all other health insurance programs of which I am/the Resident is a beneficiary. I acknowledge that I received a benefits summary and understand that some services may not be covered by my insurance, including Medicare and/or Medicaid, and I may receive a bill. For Dental Services provided to Medicaid patients with access to Patient Paid Amounts (PPA), I consent to adjustment of the PPA to pay for medically necessary non-covered dental services which include but are not limited to fluoride varnish application and periodontal scaling. If I control the PPA funds, I agree to submit payment of the adjusted amount upon receipt. I authorize the release of all information from all sources necessary to secure payment for services rendered.

By signing below, I acknowledge that I am authorized to sign on behalf of the resident.

Signature of Resident Representative or the Patient:_____ Date:____/____/____

7

X **Please initial the box to the left** to acknowledge your receipt of HealthDrive's Notice of Privacy Practices included as part of this enrollment packet. You can also view our Notice at http://www.healthdrive.com

Please fax this Request for Service Form & Face Sheet toll-free to (888)662-0859

To enroll patients within 48 hours of a scheduled visit, please use the Enrollment Hotline Fax-(781)694-6024

Questions? Call HealthDrive toll-free at (888)964-6681, Option 3

HealthDrive
bringing integrated healthcare to you

Notice 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.

This "Notice of Privacy Practices" **("NPP")** describes how we may use and disclose your Protected Health Information, as well as your rights to access and control your Protected Health Information. "Protected Health Information" **("PHI")** is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health and related health care.

We are required to safeguard your PHI, to provide you with notice of our legal duties and privacy practices and to abide by the terms of this Notice of Privacy Practices.

This notice takes effect on September 6, 2013 and will remain in effect until we replace or modify it. A revised Notice of Privacy Practices can be obtained by calling our office to request a copy be sent to you in the mail. You can also view this Notice of Privacy Practices at our website **http://www.healthdrive.com**.

USES AND DISCLOSURES OF PHI

Uses and Disclosures of PHI for Treatment, Payment and Healthcare Operations

Your PHI may be used and disclosed by your healthcare provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services, to pay your health care bills and/or to support the operation of our practice. Below are some examples of the types of uses and disclosures we may make. These examples are not meant to be exhaustive or all-inclusive.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination of your health care with the healthcare personnel at the facilities at which we treat you.
For example, we would disclose your PHI, as necessary, to a nursing facility that provides care to you. We would also disclose PHI to other physicians who may be treating you. We may also disclose your PHI to obtain durable medical equipment for you (e.g., eyeglasses or hearing aids).

Payment: Your PHI will be used, as needed, to obtain payment for your health care services, through billing, claims management and collection activities. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities, including preauthorization of services.
For example, a claim submission to your insurer would require your condition and services rendered to be disclosed to the insurer for payment.

Healthcare Operations: We may use or disclose, as needed, your PHI to support our business activities. These activities include, but are not limited to, quality assessment, employee review and licensing. We may use or disclose your PHI, as necessary, to contact your facility to remind you or the staff of your scheduled care.
We may share your health information with third party "business associates" that perform various activities (e.g., billing) for the practice. Any arrangement with a business associate involving the use or disclosure of your PHI, will have a written contract that contains terms to safeguard your PHI.

Uses & Disclosures of PHI with Your Written Authorization

Uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI, may only be made with your written authorization.
Other uses and disclosures of your PHI not described in this NPP will be made only with your written authorization, unless otherwise required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that HealthDrive has taken an action in reliance on the use or disclosure indicated in the authorization.

Permitted or Required Uses & Disclosures with Your Opportunity to Object

Others Involved in Your Healthcare**:** Unless you object, we may disclose your PHI to a member of your family, a close friend or any others who are involved in your healthcare or help pay for your care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
Emergencies: We may use or disclose your PHI in an emergency treatment situation, without your authorization.
Communication Barriers: We may use and disclose your PHI if we attempt to obtain consent from you but are unable to due to substantial communication barriers and the provider determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Uses & Disclosures without Your Authorization

We may use or disclose your PHI in the following situations without your consent or authorization. These situations include:
· as required by Law;
· for public health activities;
· to report adult abuse, neglect, or domestic violence;
· to health oversight agencies;
· in response to court and administrative orders and other legal proceedings;
·to law enforcement officials pursuant to subpoenas and other lawful processes;
·to coroners, medical examiners, funeral directors, and organ procurement organizations;
· to avert a serious threat to health or safety;
· in connection with certain research activities;
· to the military and federal officials for lawful intelligence, counterintelligence and national security activities;
· as authorized by state worker's compensation laws.
Required Uses & Disclosures: Under the law, we must make disclosures to 1) you and 2) the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

YOUR RIGHTS

You have the right to access and receive copies of your PHI. You must request this in writing. HealthDrive may charge a fee to cover certain costs.
Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.
Please contact our Privacy Officer about accessing your medical record.

You have the right to request a restriction of the use and disclosure of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations.This also includes your right to restrict certain disclosures of PHI to a health plan where you pay out-of-pocket in full for a health care item or service. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply.

HealthDrive is not required to agree to any restriction requested, with the exception of a restriction to a health plan when you pay out-of-pocket in full. If we believe it is in your best interest to allow use and disclosure of your PHI, your PHI will not be restricted. If we agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with our Privacy Officer.

You have the right to receive confidential communications from us. We will accommodate reasonable requests to communicate by alternative means. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your PHI amended. You must request this in writing. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. You also have the right to be notified if there is a breach of any unsecured PHI that affects you.
You have the right to obtain a paper copy of this notice from us, upon request.

COMPLAINTS

HealthDrive takes your privacy very seriously. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer at (617) 964-6681. We will not retaliate against you for filing a complaint.

To complain to the Office of Civil Rights, please see the appropriate address below.

For Connecticut, Massachusetts, New Hampshire, or Rhode Island: Region I, Office for Civil Rights, U.S. Department of Health and Human Services, Government Center, J.F. Kennedy Federal Building--Room 1875, Boston, Massachusetts 02203. Voice phone (800) 368-1019.

For Wisconsin or Indiana: Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, Illinois 60601. Voice Phone (800) 368-1019.

For Pennsylvania, Maryland, Delaware or DC: Region III, Office for Civil Rights, U.S. Department of Health and Human Services, 150 S. Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, Pennsylvania 19106-9111. Voice Phone (800) 368-1019.

For Texas: Region VI, Office of Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202. Voice Phone (800) 368-1019

For New Jersey or NewYork: Region II, Office for Civil Rights, U.S. Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza--Suite 3312, New York, New York 10278. Voice Phone (800) 368-1019.

HealthDrive is comprised of the corporate entities doing business as an affiliated covered entity under HIPAA.
HealthDrive Dental Group • HealthDrive Eye Care Group • HealthDrive Podiatry Group • HealthDrive Audiology Group

HealthDrive
bringing integrated healthcare to you

Benefits Summary
Massachusetts

Audiology

Service	Coverage				
	Medicare Only	Medicare/ Medicaid	Medicaid Only	Commercial Insurance (i.e. BCBS, Humana, Evercare)	Self Pay (no insurance coverage)
Audiological Consult - The audiologist will assess hearing related challenges and symptoms as requested by the Attending Physician. Depending on the results, further services may be recommended based on medical necessity and level of hearing loss/impairment.	Medicare will cover 80% of the allowable charges.	Medicare as a primary insurance with Medicaid as a secondary insurance will have no co-payment.	Medicaid will cover 100% of the allowable charges.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$39 - $96 Price dependent on type of hearing test performed.
Hearing Aid(s) - available in digital, programmable, behind the ear and in the ear models to provide amplification for patients with hearing loss.	Not covered by Medicare, self-pay options are available.	Covered 100%, some coverage criteria applies. Call office for details.	Covered 100%, some coverage criteria applies. Call office for details.	Varies by plan, contact HealthDrive office to confirm individual plan details.	Varies by device, contact HealthDrive office to confirm details.
Hearing Aid Checks - The audiologist will check the fit and function of the aid as well as provide documentation of specifics of the aid including battery size. Based on the outcome of the fit and function check, further services may be recommended.	Not covered by Medicare, self-pay options are available.	Medicare as a primary insurance with Medicaid as secondary insurance will have no copayment.	Medicaid will cover 100% of the allowable charges.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$49 - $59 Price dependent on the number of aids checked.

Other Services & Medical Items

The following items are among the services considered medically necessary and/or recommended as a plan of care for handling diagnosed medical conditions: hearing aid related services, such as hearing aid checks, repairs, batteries, as well as amplified assistive listening devices may be covered by Medicaid and some commercial insurance plans. The coverage of these items may vary from the details above. Contact the HealthDrive office at 888-964-6681 to confirm individual plan detail. Coverage guidelines listed here are effective as of January 1, 2011 and are subject to change without notice.

PLEASE NOTE: Actual procedures may vary on an individual basis as the healthcare provider establishes a plan of care given the medical conditions and/or medical history of the individual whom they are treating.

HealthDrive
bringing integrated healthcare to you

Benefits Summary
Massachusetts

Dental

Service	Coverage				
	Medicare Only	Medicare/ Medicaid	Medicaid Only	Commercial Insurance (i.e. BCBS, Humana, Evercare)	Self Pay (no insurance coverage)
Initial Exam - Upon enrollment the Dentist will perform an initial exam to evaluate the oral health of the patient and to determine a plan of continued care for any outstanding issues.	Not covered by Medicare, self-pay options are available.	Medicaid will cover 100% of the cost of the initial exam.	Medicaid will cover 100% of the cost of the initial exam.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$89
Annual Exam - A patient is eligible for an annual exam. This exam includes a complete visual and physical assessment of the oral cavity, including the teeth, tongue and gums.	Not covered by Medicare, self-pay options are available.	Medicaid will cover 100% of the cost of the annual exam.	Medicaid will cover 100% of the cost of the annual exam.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$79
Prophylaxis (cleaning) - A patient is eligible for a tooth cleaning every 6 months. This service is provided by a Registered Dental Hygienist or Dentist.	Not covered by Medicare, self-pay options are available.	Medicaid will cover 100% of the cost of the cleaning.	Medicaid will cover 100% of the cost of the cleaning.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$99
Extended Care Facility Visit - charge associated with dental visit which covers facility on-site services (house call) billed in addition to all services provided.	Not covered by Medicare, self-pay options are available.	Medicaid will cover 100% of the charge.	Medicaid will cover 100% of the charge.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$97
Dentures - custom prosthetic device fabricated to aid in chewing ability, facial appearance and support for the oral cavity.	Not covered by Medicare, self-pay options are available.	Medicaid will cover 100% of the charge once every 7 years. If dentures are medically necessary & within the 7 year frequency limitation, *PPA & self-pay options are available.	Medicaid will cover 100% of the charge once every 7 years. If dentures are medically necessary & within the 7 year frequency limitation, *PPA & self-pay options are available.	Varies by plan, contact HealthDrive office to confirm individual plan details.	Full Upper or Lower denture: $1,979 each Partial denture or Repair: price varies by scope of treatment.
Denture Adjustments -	Not covered by Medicare, self-pay options are available.	Not covered by Medicare or Medicaid, *PPA & self-pay options are available.	Not covered by Medicare or Medicaid, *PPA & self-pay options are available.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$107

Other Services & Medical Items

The following items are among the services considered medically necessary and/or recommended as a plan of care for handling diagnosed medical conditions: denture related services, such as repairs, relines and adjustments, as well as restorations, extractions, and fluoride treatments. The coverage of these items may vary from the details above. Contact the HealthDrive office at 888-964-6681 to confirm individual plan detail. Coverage guidelines listed here are effective as of August 10, 2015 and are subject to change without notice.

PLEASE NOTE: Actual procedures may vary on an individual basis as the healthcare provider establishes a plan of care given the medical conditions and/or medical history of the individual whom they are treating.

HealthDrive
bringing integrated healthcare to you

Benefits Summary
Massachusetts

Eye Care

Service	Coverage				
	Medicare Only	Medicare/ Medicaid	Medicaid Only	Commercial Insurance (i.e. BCBS, Humana, Evercare)	Self Pay (no insurance coverage)
Initial Comprehensive Exam - Upon requesting services the eye doctor will perform an initial exam to evaluate specific eye conditions and disease of the patient and to determine a plan of continued care.	Medicare will cover 80% of the allowable charges for non-routine exams.	Medicare as a primary insurance with Medicaid as a secondary insurance will have no co-payment.	Medicaid will cover 100% of the allowable charges.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$190
Comprehensive Exam - An exam includes various tests to help evaluate the chambers of the eye to aid in the treatment and evaluation of relevant eye conditions requiring attention and medically necessary follow up. Follow up exams that are medically necessary may be provided.	Medicare will cover 80% of the allowable charges for non-routine exams.	Medicare as a primary insurance with Medicaid as a secondary insurance will have no co-payment.	Medicaid will cover 100% of the allowable charges.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$158
Refraction - procedure generally done in conjunction with the Comprehensive Exam to evaluate visual acuity.	Not covered by Medicare, self-pay options are available.	Medicare as a primary insurance with Medicaid as a secondary insurance will have no co-payment.	Medicaid will cover 100% of the allowable charges.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$47
Eyeglasses -	Medicare generally does not cover eyeglasses except with some specific conditions related to cataract surgery. Call office for details.	Covered 100%, some coverage criteria applies. Call office for details.	Covered 100%, some coverage criteria applies. Call office for details.	Varies by plan, contact HealthDrive office to confirm individual plan details.	Varies by device, contact HealthDrive office to confirm details.

Other Services & Medical Items

The following items are among the services considered medically necessary and/or recommended as a plan of care for handling diagnosed medical conditions: exams for glaucoma and various other eye conditions and eyeglass related services, such as repairs. The coverage of these items may vary from the details above. Contact the HealthDrive office at 888-964-6681 to confirm individual plan detail. Coverage guidelines listed here are effective as of January 1, 2011 and are subject to change without notice.

* Medicare generally does not cover eye glasses unless the patient warrants a specific condition related to cataract surgery.

PLEASE NOTE: Actual procedures may vary on an individual basis as the healthcare provider establishes a plan of care given the medical conditions and/or medical history of the individual whom they are treating.

HealthDrive
bringing integrated healthcare to you

Benefits Summary
Massachusetts

Podiatry

Service	Coverage				
	Medicare Only	Medicare/ Medicaid	Medicaid Only	Commercial Insurance (i.e. BCBS, Humana, Evercare)	Self Pay (no insurance coverage)
Initial Exam - Upon requesting services, the podiatrist will perform an initial exam to evaluate the podiatric conditions of the patient and to determine a plan of continued care for any outstanding issues.	Medicare will cover 80% of the allowable charges for a medically necessary exam.	Medicare as a primary insurance with Medicaid as a secondary insurance will have no co-payment.	Medicaid will cover 100% of the allowable charges.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$64 - $124 Price varies depending on exam complexity.
Routine Foot Care - A patient is eligible for routine foot care every 60 calendar days. Nail care is performed when the nails are elongated.	Medicare will cover 80% of the allowable Medicare fee providing the patient has the medical conditions or issues established by Medicare and/or Medicaid.	Medicare as a primary insurance with Medicaid as a secondary insurance will have no co-payment, providing the patient has a medical conditions or issues established by Medicare and/or Medicaid.	Medicaid will cover 100% of the allowable charges once every 6 months providing the patient has a medical condition or issues established by Medicaid.Call office for details.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$80 - $103 Price varies depending on treatment rendered. (Trimming of nails, corns & calluses)
Podiatry Exam - subsequent exam for a specific podiatric complication, complaint or issue.	Medicare will cover 80% of the allowable charges.	Medicare as a primary insurance with Medicaid as a secondary insurance will have no co-payment.	Medicaid will cover 100% of the allowable charges.	Varies by plan, contact HealthDrive office to confirm individual plan details.	$64 - $99 Price varies depending on exam complexity.
Shoes & Custom Inserts - Patients who are diabetic with additional qualifying podiatric conditions are eligible for extra-depth therapeutic shoes and custom molded inserts. Footwear is dispensed directly to the patient by a Certified Pedorthist or the Podiatrist.	Covered 80%, but some coverage criteria applies. Call office for details.	Medicare as a primary insurance with Medicaid as a secondary insurance will have no co-payment.	Medicaid coverage is NOT available. Call office for details and payment options.	Varies by plan, contact HealthDrive office to confirm individual plan details.	Varies by item, contact HealthDrive office to confirm details.

Other Services & Medical Items

The following items are among the services considered medically necessary and/or recommended as a plan of care for handling diagnosed medical conditions: trimming of nails, debridement of calluses and ulcerations, treatment of blisters, shoes and custom inserts. The coverage of these items may vary from the details above. Contact the HealthDrive office at 888-964-6681 to confirm individual plan detail. Coverage guidelines listed here are effective as of January 1, 2011 and are subject to change without notice.

PLEASE NOTE: Actual procedures may vary on an individual basis as the healthcare provider establishes a plan of care given the medical conditions and/or medical history of the individual whom they are treating.

HOW TO APPLY FOR MASSHEALTH / MEDICAID

MassHealth may provide health and dental coverage for individuals, families, and people with disabilities. Benefits are offered to you directly or by paying part or all of your other health insurance premiums. Explore their website to learn more about applying, view coverage types and covered services, and to find help enrolling in a health plan. You will also find information about related programs and benefits, including **Adult Day Health.** If you need help with personal care and/or nursing services provided in a medically supervised, structured day program setting, adult day health may be right for you.

For applicants and members with disabilities who need accommodations:
MassHealth Disability Accommodation
Ombudsman
617-847-3468 (TTY: 617-847-3788)
100 Hancock Street, 6th floor
Quincy, MA 02171
ADAAccommodations@state.ma.us.

IF YOU ARE UNDER THE AGE 65:	**IF YOU ARE OVER THE AGE 65:**
By mail: MassHealth Program P.O. Box 120045 Boston, MA 02112 - 9912 **By fax:** You can fax your MassHealth Health Plan Enrollment Form to (617) 988-8903. **By phone:** Monday through Friday, from 8 a.m. to 5 p.m. (800) 841-2900 TTY: (800) 497-4648) **Online:** The fastest way to enroll in a health plan is online.	**By mail:** MassHealth Enrollment Center Central Processing Unit P.O. Box 290794 Charlestown, MA 02129-0214 **By fax:** You can fax your MassHealth Health Plan Enrollment Form to (617) 887-8799 **Hand deliver to:** MassHealth Enrollment Center Central Processing Unit / The Schrafft Center 529 Main Street, Suite 1M Charlestown, MA 02129. **Where to call:** Call us at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled)

To apply in person, you can go to any one of the four following enrollment centers listed below Monday through Friday from 8:45 a.m. to 5 p.m. Do not send an application to any of these enrollment centers.

MassHealth Enrollment Center 45 Spruce Street **Chelsea**, MA 02150	MassHealth Enrollment Center 88 Industry Avenue, Suite D **Springfield**, MA 01104
MassHealth Enrollment Center 21 Spring Street, Suite 4 **Taunton**, MA 02780	MassHealth Enrollment Center 367 East Street **Tewksbury**, MA 01876