GRACIOUS GROUP CARE AGENCY, LLC
(Dba GGCA)
449 W. CENTENNIAL STREET
SPARTANBURG, SC 29303
Ph: 864-804-6061 Fax: 864-450-9060

Dear Client,

The entire management and staff of GRACIOUS GROUP CARE AGENCY wish to welcome you to the GRACIOUS GROUP CARE AGENCY Family. We are here to contribute in whatever way possible to help make life worth living; as our motto states, “Perfection is our standard.”

Please pay attention to the following information as it pertains to your care:

CASE MANAGER

Your case manager throughout the duration of your care with us is _____, RN. You can reach _____ by calling_____. For after-hour emergencies, please call_____.

COMPLAINTS AND PROCEDURE

We strive to deliver care in a more timely and professional manner. But should you have any complaints regarding any area of our service delivery, please call our compliance Manager, Emmanuel Igwe, at 864-444-0493. As soon as Emmanuel Igwe receives your complaint, our complaint management process is triggered.

Our complaint process involves an investigation by contacting all parties by telephone, office meeting, or home visit to determine the root cause. Once the root cause is selected, we take the next step to resolve and prevent re-occurrence, which could involve reporting the incident to the appropriate state agencies. In all these, we ensure that your interest is always protected.

If you need to contact the state agency to follow up on issues raised in this complaints/grievances system, please call_____.

CRITICAL HEALTH ISSUES

Your Caregiver has been trained on what to do in case of critical health issues. But in the absence of your caregiver, should your blood pressure go up to 150/99, please call 911 immediately and call the office at _____ to speak with the Nurse Supervisor. Also, if your blood sugar exceeds 350, inform the office immediately.

EMERGENCY PREPAREDNESS

Your admission packet includes emergency preparedness information detailing the steps to protect yourself and how to reach our office and the appropriate state agencies in case of weather and other critical situations. Your case manager has taken the time to walk you through it. Please keep it handy for future reference. Again, Welcome!

GRACIOUS GROUP CARE AGENCY Management.

Client _____

GRACIOUS GROUP CARE AGENCY (Dba GGCA)

REGULATIONS CONCERNING IN-HOME AIDE SERVICES

The following procedures and regulations will apply to your In-Home Aide worker. Please review and keep this information handy.

In-Home Aide's Tasks: The aide will only be required to conduct those activities outlined in the Service Plan, including specific time frames and on particular days. The aide will assist with personal care services and home management tasks. If the aide completes the listed tasks, the aide will provide socialization and companionship to the client. The aide is assigned to the client, not to be a housekeeper or caregiver for other family members.

Substitute Aides: If an aide is away from work (e.g., illness, vacation, holidays, training, etc.), the agency will try to provide a substitute aide if the client desires. WE CANNOT GUARANTEE THAT A SUBSTITUTE AIDE WILL ALWAYS BE AVAILABLE; IN THE EVENT A SUBSTITUTE IS NOT AVAILABLE, WE ASK THAT CLIENTS UTILIZE INFORMAL SUPPORT SYSTEMS SUCH AS FAMILY, FRIENDS, NEIGHBORS, CHURCH MEMBERS, ETC. The agency will notify you if your aide cannot report to work and will inform you about the availability of a substitute aide. Remember that a substitute aide may not be able to provide services in the same quantity and at the same time as a regularly assigned aide.

Supervision of Aides: A supervisor will visit your home the first week your aide begins work, again near the end of the month, and again periodically. The home visits are unannounced to observe the aides performing their routine duties. The supervisor will ask your aide to show the rooms in your home that the aide is responsible for cleaning. The agency's RN supervisor will also perform unannounced home visits to observe the aide providing personal care services. Please get in touch with the agency immediately if your aide does not report to your home at the

scheduled time. Please get in touch with the agency if your aide is routinely late or fails to perform the assigned duties satisfactorily.

Client's Absence from the Home: You may be out of the home during the aide's scheduled work hours. In these instances, please adhere to the following:

1. If you are not home during the time designated for the In-Home Aide services, you may…
    a. Request that the aide remain in your home to complete regular housework duties while you are away. The aide and the client should be comfortable with this decision.
    b. Notify your aide beforehand that you will be out of the home.
    c. IN ALL CASES, THE AIDE IS TO NOTIFY THE AGENCY IN ADVANCE THAT YOU WILL BE OUT OF THE HOME.
2. If you are hospitalized, please notify the agency immediately. The agency requires that the aide not work in your home while hospitalized. When you are discharged from the hospital, contact the agency so that we may authorize your aide to return to your home.

Cleaning Solutions/Restrictions: The client is responsible for providing cleaning supplies for the aide to complete their tasks. Please ensure that disinfectant supplies are available for the aides to clean the bedside commode, bathroom, etc. The aides are only required to perform routine cleaning as defined in the service plan. The aides cannot perform heavy chores such as cleaning ovens, washing windows, cleaning carpets, etc. The aides must maintain both feet on the floor at all times. This is to ensure that aides are not injured on the job.

Personal Care Supplies: The aides must wear gloves when assisting clients with personal care tasks. The agency provides these supplies.

Food and Drink: You are not expected to provide food and drink for your aide. The aides know they are not allowed to eat your food or drinks. The aides should eat their meals while you are dining since they do not otherwise take a lunch break. We ask that you allow them to store their food in your refrigerator. You are not obligated to allow the aide to utilize your refrigerator. Please notify the aide if they are not permitted to use your refrigerator. We respect your right not to allow this. Aides are not allowed at any time to smoke in your home. If this presents a problem, contact the office immediately at 864-804-6061.

_____

Client's Signature Date

Client_____

GRACIOUS GROUP CARE AGENCY (Dba GGCA)

Note: All clients must receive a copy of these regulations.

CLIENT RIGHTS & RESPONSIBILITIES

To encourage awareness of client rights and responsibilities, provide guidelines to assist clients in making service decisions, and actively participate in service planning.
Each client will be an active, informed participant in the service delivery plan. To ensure this process, the client will be empowered with certain rights and responsibilities as described below:

1. The client will be informed at admission and on an ongoing basis, as needed, of their rights and responsibilities, which include the rights to:

   A. Be fully informed in advance about care/service to be provided, including the disciplines that furnish care/service and the frequency of visits, as well as any modifications to the plan of care/service

   B. Be informed, both orally and in writing, in advance of care/service being provided, of the charges, including payment for maintenance/service expected from third parties and any charges for which the client/patient will be responsible

   C. Receive information about the scope of services that the organization will provide and specific limitations on those services

   D. Participate in the development and periodic revision of the plan of care/service

   E. Refuse care or treatment after the consequences of refusing care or treatment are fully presented

   F. Be informed of client rights under state law to formulate an Advance Directive, if applicable

   G. Have their property and person treated with respect, consideration, and recognition of the client's dignity and individuality

H. Be able to identify visiting organization personnel through proper identification

I. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source and misappropriation of client property

J. Confidentiality and privacy of all information contained in the client record and of Protected Health Information (PHI)

K. Be advised on the organization's policies and procedures regarding the disclosure of client records

L. Choose a health care provider, including choosing an attending physician

M. Receive appropriate care/service without discrimination by physician orders

N. Be informed of any financial benefits when referred to **GRACIOUS GROUP CARE AGENCY (GGCA)**

O. Be fully informed of their responsibilities.

P. Voice grievances regarding treatment or care that is (or fails to be) furnished or regarding the lack of respect for property by anyone who is providing services on behalf of the organization and must not be subjected to discrimination or reprisal for doing so

Q. Receive an investigation by the organization of complaints made by the patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished or regarding lack of respect for the patient's property by anyone providing services on behalf of the organization, and must document both the existence of the complaint and the resolution of the complaint

R. Understand the value or purpose of any care that will be performed, including the benefits, risks, and the person who will perform the care

S. Formulate Advance Directives with their medical provider

T. The right to have communication needs met

2. Client/caregiver/family responsibilities will be explained upon admission and on an ongoing basis as needed

3. The client/caregiver/family is responsible for:

A. Providing accurate and complete information about present complaints and other matters relating to the client's overall status and mobility

B. Reporting unexpected changes in the client's status

C. Feedback regarding services, needs, and expectations

D. Asking questions regarding care or services

E. Following instructions

F. Understanding and accepting the consequences for outcomes if the care plan or recommended services are not followed

G. Following the organization's policies and procedures concerning client care and conduct

H. Showing respect and consideration for the organization's personnel and property

I. Meeting financial commitments by promptly meeting any financial obligation agreed to with the organization

4. Upon admission, the care coordinator or designee will provide each client and representative with a written copy of the client's rights and responsibilities.

5. The client's rights and responsibilities will be explained and distributed to the client before initiating services. This explanation will be in a language that the client can reasonably be expected to understand.

6. The client will be requested to sign a Client Rights and Responsibilities Form. The original will be kept in the client record. The client will maintain a copy. Should a client refuse to sign the form, the client's refusal, including the reason for the rejection, will be documented in the client's record.

7. The care coordinator or designee will document that the client has received a copy of the Client Rights and Responsibilities Form.

   A. A client's inability to understand the rights and responsibilities will be documented in the client's record

   B. If a communication barrier exists, special devices or interpreters will be made available, if possible

8. The family or guardian may exercise the client's right when a client is incompetent or a minor.

9. If a client's representative signs the Client Rights and Responsibilities Form, an explanation of the representative's relationship with the client will be documented in the client record.

10. Organization personnel will be oriented to the client's rights and responsibilities during orientation and annually afterward.

11. Supervisory visits with employees will be conducted to ensure the rights are honored according to organization policy.

As a client or a family member of the client receiving home care services, you possess the following fundamental rights and responsibilities:

The Right To:

- Be informed of your rights and responsibilities before initiation of care.

- Be informed in advance about the care to be provided, the disciplines that will furnish the care, the frequency of visits, and any modifications to the care plan.
- Receive information about the scope of services provided by the GRACIOUS GROUP CARE AGENCY (GGCA) and specific limitations on those services.
- Be treated with dignity, respect, and consideration by qualified staff.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse.
- Receive appropriate care without discrimination by physician orders if applicable.
- Have your property treated with respect, dignity and privacy.
- Be informed beforehand of the extent to which payment may be expected from third-party payers and what costs you will be responsible for. Be advised orally and in writing no later than 30 calendar days from the date the agency becomes aware.
- Be informed of your rights to formulate an Advance Directive.
- Refuse all or part of your care to the extent permitted by law and be informed of the expected consequences of such action.
- Be informed of any financial benefit to the organization resulting from my referral to another organization, service, or individual.
- Be informed within a reasonable time of the anticipated termination of services, what services you will need, and where you can obtain that care.
- Review your client record upon written request.
- Voice grievances regarding care of lack of respect without being subject to discrimination or reprisal by contacting the Administrator and being informed of the resolution within fourteen (14) days.
- Be able to identify visiting personnel members through proper identification.

The Responsibility To:

- Provide accurate and complete information that may affect your care.
- Sign the required consents and releases for insurance billing.
- Provide all requested insurance, financial records, and copies of any executed Advance Directive.
- Pay for charges the organization informed you that you were responsible for.
- Notify the organization and your physician when changes occur in your condition.
- Participate in establishing and revising your service delivery plan of care.

- Request further information concerning anything that you do not understand.
- Accept the consequences when you refuse care or are non-compliant.
- Provide a safe environment in which your care can be given.
- Cooperate with the caregivers and the organization's staff.
- Choose a health care provider, including choosing an attending physician, if applicable.
- Treat the organization's staff with dignity, respect, and consideration.
- Notify the organization if you are unable to keep an appointment.
- Notify the organization if you are dissatisfied with GRACIOUS GROUP CARE AGENCY's services or its affiliate.

Client Name ----------

Client Signature---------- Date ----------

Agency---------- Date ----------

Client _____

GRACIOUS GROUP CARE AGENCY(GGCA)

Authorization to Use and Disclose Specific Protected Health and Related Information

Client Name:_____
SSN:_____

Date of Birth:_____

By signing this Authorization, I, at this moment, direct the use or disclosure by:

_____("the agency") certain medical information about my health care, or me.

This authorization concerns the following medical information about me:

1. Hospital records, x-rays, x-ray readings and reports, all tests of any type and pieces thereof, and any documents about hospitalization, history, condition, or treatment, including emergency room care diagnosis, prognosis, etiology, or expenses.
2. All medical records, including client's record cards, x-rays, x-ray readings and reports, all lab records, all accounts, all tests and pieces thereof, statements of changes, and any my records about medical care, prognosis, etiology, and expense. This includes explicitly Medicaid information, including legibility, financial services, case records, and similar records relating to services provided to me or my family.
3. Complete statements of charges for all services.

This information may be used or disclosed by the agency and any Nurse Health Record Administration, Scheduler, Aide, or CNA employed by the agency. It may be revealed to them at the following addresses:

Spartanburg, SC 29303
Telephone: 864-804-6061

I understand that I have the right to revoke this Authorization at any time except to the extent that the agency and any Nurse, Health Record Administrator, Scheduler, Aide, or CNA employed by them have already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the Privacy Officer at the agency. Authorization may be subjected to re-disclosure by the recipient and no longer subject to the privacy protections provided by law.

I understand that my written authorization is not required for the agency to use my protected health information for treatment, payment, and healthcare operations.

I understand that I have the right to inspect and copy the information to be used or disclosed as part of this Authorization. The agency requests the Authorization of any Nurse, Health Record Administrator, Scheduler, Aide, or CNA employed by them for the following purpose(s): Assessment for and provision of personal care or other licensed home health services.

I acknowledge that I have read the Authorization provisions and have the right to refuse to sign this Authorization. I understand and agree to its terms.

Signature:_____ Date:_____

Relationship to
Client:_____

Witness:_____ Date:_____

Client _____

GRACIOUS GROUP CARE AGENCY (GGCA)

Authorization and Consent for Care

(Please check or circle the one that applies to you)

MEDICAID: I authorize the release of all records from the Agency required to facilitate the collection of payment for services rendered under title XIX of the Social Security Act. I agree that if I no longer qualify for Medicaid benefits in the future, I will notify the Agency immediately. I understand that if I continue to receive care from the Agency after the Medicaid benefits have expired, I will be fully responsible for any payment amounts that Medicaid will not cover.

INSURANCE: I authorize the release of all records from the Agency required to facilitate the collection of payment for services rendered under _____ Insurance Company. I further authorize _____ Insurance Company to pay the Agency directly all fees due for services rendered. The client or responsible party will be responsible for the percentage not covered by insurance.

PRIVATE PAYMENT: I agree to pay privately for services rendered by the Agency outside my coverage at $60 per hour. I agree to pay weekly on Friday starting the duration of the service. The payment date may be adjusted only to the agreement of both parties. If services are not needed for a specific scheduled day, I must notify the agency two (2) days in advance. Otherwise, I may be billed for that day. At any time services are to be terminated, either party must notify the client/Agency 14 days in advance. I understand that the rate may be higher if I request services on holidays or overnights.

CLIENT'S REQUEST AND AUTHORIZATION FOR CARE:
I, with this request, care Agency and consent to such care as agreed upon in my care plan. At this moment, I authorize the release of medical information pertinent to my care for the Agency and the referral agency. I understand that if I am in such a condition as to need hospitalization or special services not provided by the Agency, such services must be arranged by me, my case manager, or my physician. The agency shall not be responsible for failure to provide the same and is released from any liability arising from the fact that I am not provided with such additional care. I authorize the release of medical information to the physician proving my care in emergencies and the absence of my attending physician.

ACCESS TO MEDICAL RECORDS: I understand that I may object in writing to the inspection of my medical records by any person except representatives of the South Carolina Department of Health and Human Services or the Centers for Medicare and Medicaid Services.

_____ _____

Date Client

_____ _____

Date Agency

Client _____

GRACIOUS GROUP CARE AGENCY (GGCA)

Advance Directives

I have received and reviewed information regarding my right to accept or refuse my requests to formulate Advance Directives. I understand that I am not required to have an Advance Directive to receive homecare services from_____("the agency"); and that the terms of any Advance Directives that I have executed will be followed by the agency and my caregivers to the extent permitted by law.

_____ I have an Advance Directive and provided a copy to the agency.

_____ I have an Advance Directive but still need to provide a copy to the agency.

_____ I agree that the agency can only implement this directive if a copy is provided to the agency.

_____ I have not executed an Advance Directive.

_____ _____

Client's Signature Date

_____ _____

Agency Signature Date

Client _____

GRACIOUS GROUP CARE AGENCY (GGCA)

Questionnaire Regarding Advance Directives

Client's Name: _____

1. Do you have a formal agreement, or is it stated in writing regarding decisions concerning your health care if you need to be more competent to do so?

Yes _____ No _____

If yes, who makes the decisions?

Name: _____

Address:

_____

Phone Number: _____

Note: **The staff Certified Nurse Aide will resuscitate or use a life-sustaining mechanism if there is no formal written agreement in the medical record.**

2. Do you want to be resuscitated? Yes _____ No _____

3. Do you want other life-sustaining mechanisms used? Yes _____ No _____

(If no, a written agreement must be provided for the record.)

If you would like to pursue further, please contact your attorney.

_____ _____

Signature Date

Client _____

GRACIOUS GROUP CARE AGENCY (GGCA)

NOTICE OF PRIVACY PRACTICES

Effective January 1, 2005

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 will tell you how we may use and disclose your protected health information. Protected Health Information means any health information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In this notice, we call all that Protected Health Information medical information.

This notice also will tell you about your rights and our duties concerning medical information about you. In addition, it will tell you how to complain to us if you believe we have violated your privacy rights.

How We May Use and Disclose Medical Information

We use and disclose medical information about you for several different purposes. Each of those purposes is described below.

For Treatment

We may use medical information about you to provide, coordinate, or manage your health care and related services by both us and other healthcare providers. We may disclose medical information about you to doctors, nurses, hospitals, and other health facilities who become involved in your care. We may consult with other healthcare providers concerning you as a part of the consultation and share your medical information with them. Similarly, we may refer you to another healthcare provider and share medical information about you with that provider as part of the referral. For example, we may conclude your need to receive services from a physician's office and provide medical information about you so they have the information they need to offer services to you.

For Payment

We may use and disclose your medical information to be paid for our services. This can include billing you, your insurance company, or a third-party payer. For example, we may need to inform your insurance

company about the health care services we provide so your insurance company will pay us for those services or reimburse you for the amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your medical condition and the health care you need to receive to determine if that insurance or program covers you.

For Health Care Operations

We may use and disclose your medical information for our healthcare operations. These are necessary for us to operate Agency Medical Services. Services and to maintain quality healthcare for our patients. For example, we may use medical information about you to review the services we provide and the performance of our employees in caring for you. We may disclose medical information about you to train our staff, volunteers, and students working in Agency Medical Services. We also may use the information to study ways to manage our organization more efficiently. Disagreement, if any, and rebuttal will then be appended to the medical information involved or otherwise linked. All of that will be included with any subsequent disclosure of the data, or at our election, we may have a summary of any of the information.

If you do not submit a statement of disagreement, please include your request for amendment and our denial with any fixture disclosures of the information. We will have your request for amendment and our disclaimer (or a summary of that information) with any subsequent disclosure of the medical information involved.

You Have the Right to Complain or Deny Your Request

Right to an Accounting of Disclosure(s)

You have the right to receive an accounting of disclosures of medical information about you. The accounting may be for up to six (6) years before the date you request the accounting but after June 1, 2005.

Certain types of disclosures are not included in such an accounting. **Disclosure:**

- To carry our treatment, payment, and healthcare operations
- Of your medical information made to you
- That You are incident to another use or disclosure
- Disclosures you have authorized
- For national security or intelligence purposes
- To correctional institutions or law enforcement officials having custody of you
- Disclosures that are part of a limited data set for purposes of research, public health, or health care operations (a limited data

set is where things that would directly identify you have been removed)

- Disclosures made before June 1, 2005

Under certain circumstances, your right to an accounting of disclosures to a law enforcement official or a health oversight agency may be suspended. Should you request an accounting during the period your right is broken, the accounting would not include the disclosures to a law enforcement official or a health oversight agency.

To request an accounting of disclosures, you must submit a "request" to Agency Medical Services in writing. **Attention: PCS Program Manager**

Your request must state a period for the disclosures. It may be up to six years from receiving your request.

Usually, we will act on your request within 60 calendar days after we receive your request. Within that time, we will either provide the accounting of disclosures to you or give you a written statement of when we will provide the accounting and why the delay is necessary.

There is no charge for the first accounting we provide you in twelve months. We may charge you for additional accountings for providing the list. If there is a charge, we will notify you of the costs involved and allow you to withdraw or modify your request to avoid or reduce the fee.

Right to a Copy of this Notice
You have a right to obtain a paper copy of our Notice of Privacy Practices. You may request a copy of this notice at any time.

To obtain a copy, contact the Agency**,** Monday –Friday between 8:00 am-4:00 pm, at the Phone number.

_____ _____
Client Signature Date

_____ _____
Signature of Representative/Relationship to Client Date

_____ _____

Agency Representative Date
Client _____

GRACIOUS GROUP CARE AGENCY (GGCA)

Transportation Waiver

The maintenance and safety of the employee's vehicle is beyond our control. We cannot accept any responsibility for accidents resulting from The Company's employee transporting you in an employee's vehicle for your car.

When our employee is transporting you in the employee's vehicle, whether owned or rented, you agree to accept full responsibility for bodily injury that may be caused as a result of an accident.

When our employee is asked to drive your vehicle, owned or rented, you agree that the employee will drive vehicles for which you have appropriate insurance and accept full responsibility for the vehicle and its contents, as well as for bodily injury, property damage, fire, theft, collision, and public liability claims, any of which may be caused as a result of any accident taking place. In contrast, your vehicle is in the care of an employee of the company.

Your signature indicates your agreement to accept full responsibility as outlined above. You agree to provide a complete copy of all insurance information before an employee may transport you.

At the Company's request, an agreement from the insurance company to the above provisions must be obtained before the employee is allowed to drive the client's vehicle.

I, at this moment, agree to accept full responsibility as outlined above. My insurance company agrees to the provisions listed above:

Client: _____ Date:_____

Agency_____ **Date** _____

Client _____

GRACIOUS GROUP CARE AGENCY (GGCA)

Client Acknowledgement

I _____acknowledge I have been given a copy of
Client's Name

The Resident Rights and Responsibilities.

_____ _____
Client/Responsible Party Signature Date

_____ _____
Registered Nurse Signature Date

****

I _____ have participated and agree with the
Client's Name

Assessment and the plan of care that the physician has developed

Approval.

_____ _____
Client/Responsible Party Signature Date

_____ _____
Registered Nurse Signature Date