Resident Rights

As a resident of this facility, you have the right to a dignified existence, Self-determination, and communication with and access to quality care regardless of your diagnosis, severity of condition, or payment source. This facility must protect and promote your rights as designated below.

Exercise of Rights:

- You have the right and freedom to exercise your rights as a resident of this facility and as a citizen or resident of the United States without interference, coercion, discrimination, or reprisal from the facility.
- You have the right to designate a representative to exercise your rights, in accordance with state law, if you have not been adjudged incompetent by the state court. Your representative may exercise your rights as provided by state law. You retain the right to exercise those rights not delegated to a resident representative, including the right to revoke designation of your rights to a representative.
- Same-sex spouses must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which is was celebrated.

Planning and Implementing Care:

- You have the right to be informed of your total health status and medical condition as well as to participate in your treatment in a format and language you can understand.
- You have the right to participate in the development and implementation of your person-centered plan of care, including planning, identifying persons or roles to be included in planning, request meetings, and request revisions to your plan of care.
- You have the right to participate in setting goals and outcomes of care, type, amount, frequency, and duration of care as well as other factors related to the effectiveness of your plan of care.
- You have the right to be informed, in advanced, of changes to your plan of care, receive services and items included in your plan of care, and see the care plan; including the right to sign after significant changes are made to your plan of care
- Planning for your care must include you and/or your representative and include an assessment of your strengths and needs as well as your personal and cultural preferences in developing goals.
- You have the right to be informed, in advanced, of the care to be furnished and the type of caregiver or professional that will furnish care.
- You have the right to be informed, in advanced, by the physician or other practitioner/professional, of the risks and benefits of proposed care, treatment, and treatment alternatives or options, and to choose the alternative or option you prefer.
- You have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research.

- You have the right to formulate an advanced directive.
- You have the right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate.
- You have the right to receive basic life support, including CPR, when you require such emergency care prior to the arrival of emergency medical personnel. Basic life support and CPR will be provided in accordance with your advanced directives and related physician orders.

Choice of attending Physician:

- You have the right to choose your attending physician.
- This facility must inform you if the physician you choose is unable or unwilling to meet requirements and the facility seeks alternant physician participation to assure your receive appropriate and adequate care and treatment.
- This facility must ensure that you remain informed of the name, specialty, and way of contacting your physician and other primary care professionals responsible for your care.

Respect and Dignity:

- You have the right to be treated with respect and dignity.
- You have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat your medical symptoms.
- You have the right to be free from abuse, neglect, misappropriation of your property, and exploitation. This facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.
- You have the right to keep and use your personal possessions, including furnishings and clothing, as space permits and respectful of the rights or health and safety of other residents.
- You have the right to live in this facility and receive services with reasonable accommodation of your needs and preferences except when to do so would endanger the health or safety of yourself or other residents.
- You have the right to share a room with your spouse when you both live in this facility and both of you agree to share the room.
- You have the right to share a room with a person you choose when practicable, when you both live in this facility and both of you agree to share the room.
- You have the right to receive written notice, including the reason for the change, before your room or roommate in this facility is changed.
- You have the right to refuse to transfer to another room in this facility under certain circumstances including convenience of staff. Exercising your right to refuse transfer does not affect your eligibility or entitlement to Medicare or Medicaid benefits.

Self-Determination:

- You have the right, and this facility must promote and support your right to:

    - Choose activities and schedules (including sleeping and waking times);
    - Choose health care and providers of health care services consistent with your interests, assessments, plan of care, and other choices;
    - Make choices about aspects of your life in this facility that are important to you;
    - Interact with persons from the community and participate in community activities both within and outside this facility and
    - Receive visitors you choose at the time of your choosing. You also have the right to deny visitors. Receiving and/or denying visitors must not impose on the rights of another resident.
- You have the right to organize and participate in resident groups in this facility.
- You have the right to participate in family groups. This facility must provide you with private space and take reasonable steps to make you and your family members aware of upcoming meetings in a timely manner. Staff may attend only at your invitation.
- You have the right to have family member(s) or other resident representative(s) meet in this facility with other families or resident representatives of other residents in this facility.
- You have the right to participate in other activities, including social, religious, and community activities that do not interfere with the of other residents in this facility.
- You have the right to choose to or refuse to perform work/services for this facility. All services performed must be documented in your care plan to include nature, status (voluntary or paid) of the work and any compensation you receive.
- You have the right to remain in this facility unless:
    - Transfer or discharge is necessary for your welfare and your needs cannot be met in this facility;
    - The health and safety of individuals in this facility is endangered due to your clinical or behavior status;
    - You have failed, after reasonable and appropriate notice, to pay for your stay in this facility or
    - The facility ceases to operate.
- Notice of and reasons for transfer or discharge must be provided to you in writing and in a language and formant you understand. Such notice must be given to you 30 days prior, except when the health and safety of individuals in this facility would be endangered.
- You have the right to receive written notice regarding this facility's bed-hold policy and return to the facility before you are hospitalized or go on therapeutic leave.

Protection of Resident Funds:

- You have the right to manage your own financial affairs including the right to know, in advance, what charges a facility may impose against your personal funds. You are not required to deposit personal funds within this facility.
- This facility must manage your deposited funds with your best interest in mind. Your money will not be commingled with facility funds. This facility must hold, safeguard, manage, and account for your personal funds on a quarterly basis or at your/your

representative's request. This facility must inform you of procedures for protecting personal funds.

- This facility must refund within 30 days of your discharge, death, or eviction any remaining funds and a final accounting.
- This facility must not charge you for any items or services you do not request or are included in your Medicare or Medicaid payment. This facility must tell you what the charge will be for any requested items or services.

Information and Communication:

- You have the right to be informed of all of your rights as well as all rules and regulations regarding your conduct and responsibilities while you live in this facility.
- You have the right to access personal and medical records that pertain to you. You can obtain a copy of those records upon request.
- This facility must post a list of names, addresses (mailing and e-mail), and telephone numbers of all State regulatory and informational agencies, advocacy groups such as the State Survey Agency, State Licensure office, State Long-Term Care Ombudsman program, adult protective and advocacy services, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit. This facility must also post a statement that you may file a complaint with the State Survey Agency concerning any suspected violation of state or federal regulations including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property, non-compliance with advance directive requirements and requests for information about returning to the community.
- You have the right to reasonable access to a telephone, including TTY and TDD services. You have the right to make calls without being overheard. You also have the right to keep and use a cellular phone at your own expense.
- You have the right to reasonable access to the internet, to the extent the service is available to this facility.
- You have the right to reasonable access to stationary, postage, writing implements, and the ability to send and receive unopened mail.
- You have the right to examine the results of the most recent Federal or state survey as well as this facility's plan of correction. These documents must be posted in an accessible location.
- You have the right to contact external entities and resident advocate agencies and to receive information from them.

Privacy and Confidentiality:

- You have the right to personal privacy and secure, confidential personal and medical records.
- You have the right to refuse the release of your personal and medical records except as provided at §483.70(i)(2) or other applicable Federal or state laws.

Safe Environment:

- You have the right to a safe, clean, comfortable, and homelike environment including:
    - Safe care and services and a physical layout that maximizes your independence and does not pose a safety risk;
    - The use of your own personal belongings to the extent possible;
    - Reasonable care and protection of your property from loss or theft;
    - Clean bed and bath linens that are in good condition;
    - Private closet space in each room;
    - Adequate and comfortable lighting levels in all areas;
    - Comfortable and safe temperature levels and
    - Maintenance of comfortable sound levels.

Grievances:

- You have the right to voice grievances to this facility or other agency concerning your care, treatment, behavior of staff and/or other residents, as well as other concerns about your stay without fear of discrimination or reprisal.
- You have the right to information on how to file a grievance or complaint
- You have the right to prompt resolution of grievances.

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.

I. Our Duty to Safeguard Your Protected Health Information

We are committed to preserving the privacy and confidentiality of your health information whether created, received, or transmitted by us, or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information, including electronic health information. Copies of our privacy policies and procedures are maintained in the business office. We are required by state and federal regulations to abide by the privacy practices described in this notice including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Individually identifiable information about your past, present, or future health or condition, the provisions of health care to you, or payment for the health care treatment, or services you receive is considered protected health information (PHI). As such, we are required to provide you with this Privacy Notice that contains information regarding our privacy practices that explains how, when, and why we may use or disclose your protected health information and your rights and our obligations regarding any such uses or disclosures. Except in specified circumstances, we must use or disclose only the minimum necessary protected health information to accomplish the intended purpose of the use or disclosure of such information. We are required by law to notify all affected individuals should there be a breach of unsecured protected health information.

We reserve the right to change this notice at any time and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise/change this Privacy Notice, we will post a copy of the new/revised Privacy Notice in the main lobby and/or on our website, if applicable. You may also request and obtain a copy of any new/revised Privacy Notice from the business office.

Should you have questions concerning our Privacy Notice, the names, addresses, telephone numbers, etc., of whom you should contact are available through the business office and are listed on the last page of this document.

II. How We May Use and Disclose Your Protected Health Information

We use and disclose protected health information for a variety of reasons. We have a limited right to use and/or disclose your health information for purposes of treatment, payment, or for the operations of our organization. For other uses, you must give us your written authorization to release your protected health information unless the law permits or requires us to make the use or disclose without your authorization.

Should it become necessary to release your protected health information to an outside party or business associate, we will require the party or business associate to have a signed agreement with us that they will extend the same degree of privacy protection to your information as we do. The privacy law permits that us to make some uses or disclosures or your protected health information without your consent or authorization. The following describes each of the different ways that we may use or disclose your protected health information. Where appropriate, we have included examples of the different types of uses or disclosures these include:

1. Uses and Disclosures Related to Treatment:

We may disclose your protected health information to those who are involved in providing medical and nursing care services and treatments to you. For example, we may release health information about you to our burses, nursing assistants, medication aides/technicians, medical and nursing students, therapists, pharmacists, medical records personnel, consultants, physicians, etc. We may also disclose your protected health information to outside entities performing other services relating to your treatment; such as diagnostic laboratories, home health/hospice agencies, family members, etc.

2. Uses and Disclosures Related to Payment:

We may use or disclose your protected health information to bill and collect payment for services or treatments we provided to you. For example, we may contact your insurance provider, health plan, or another third party to obtain payment for services we provided to you.

3. Users and Disclosures Related to Health Care Operations:

We may use or disclose your protected health information should it become necessary in performing certain functions within our organization to ensure that you and others continue to receive quality care and services. For example, we may take your photograph for medication identification purposes or use your health information to evaluate the effectiveness of the care and services you are receiving. We may disclose your protected health information to out staff (nurses, nursing assistants, physicians, staff consultants, therapists, etc.) for auditing, care planning, treatment, and learning purposes. We may also combine your health information with information from other health care providers to study how we are performing in comparison to like organizations or what we can do to improve the care and services we provide to you. When information is combined we remove all information that would identify you so that others may use the information in developing research on the delivery of health care services without learning your identity.\

4. Uses and Disclosures Related to Fundraising Activities:

We may use a limited amount of your protected health information when raising money for our organization and its operations. We may also disclose this information to a foundation related to the organization so that the foundation may contact you to raise money on our behalf. The information we may use will be limited to your name, address, telephone number, and dates for which you received treatment or services through our organization. If you do not wish to be

contacted for participation in fundraising activities or have this information provided to out affiliated foundation, you may elect not to receive fundraising communications. There is no cost to you to opt out of fundraising communications. You may use our **Request to Restrict the Use and Disclosure of Protected Health Information** form to submit your opt-out request to us. Copies of this form are available in the business office. The name of the person to contact and the method of contacting him/her are listed on the last page of this notice.

5. Use and Disclosures Related to Treatment Alternatives, Health-Related Benefits and Services:

We may use or disclose your protected health information for purposes of contacting you to inform you of treatment alternatives or health-related benefits and services that may be of interest to you. For example, a newly released medication or treatment that has a direct relationship to your treatment or medical condition.

III. Uses and Disclosures Requiring Your Written Authorization

For uses and disclosures of your protected health information beyond treatment, payment, and operations purposes, we are required to have your written authorization, except as permitted by law. You have the right to revoke authorization at any time to stop future uses or disclosures of your information except to the extent that we have already undertaken an action in reliance upon your authorization. Your revocation request must be provided to us in writing. The name, address, telephone number of the person to contact is located on the last page of this document. You may use our **Authorization for Use or Disclosure of Protected Health Information** form and/or our **Revocation of an Authorization** form to submit your request to us. Copies of these forms are available in the business office. Uses or disclosures that require your written authorization include, but are not limited to, the following:

1. Psychotherapy Notes:

We are required to have your written authorization for the use or disclosure of your psychotherapy notes (if applicable) except to carry out treatment, to obtain payment, or to carry out health care operations; or for a use or disclosure that is permitted or required by law.

2. Marketing:

We are required to have your written authorization for the use of your protected health information for marketing purposes, except if communication is in the form of face-to-face communication between you and our facility, or if you are provided a promotional gift of nominal value by our facility. If the marketing purposes for which we obtain written authorization involve financial compensation to us from a third part, this information will be stated in your authorization.

3. Sale of Protected Health Information:

We are required to obtain your written authorization for the sale of your protected health information. If the sale of your protected health information results in financial compensation to this organization, this information will be stated in your authorization.

4. Other Uses and Disclosures Not Described in this Notice.

We are required to obtain your written authorization for any uses or disclosures of your protected health information other than those described in this notice.

IV. Uses or Disclosures of Information Based Upon Your Verbal Agreement

In the following situations, we may disclose a limited amount of your protected health information if we provide you with an advanced oral or written notice and you do not object to such release or such release is not otherwise prohibited by law. However, if there is an emergency situation and you are unable to object (because you were not present, or you were incapacitated, etc.), disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. When a disclosure is made based on these or emergency situations, we will only disclose health information relevant to the person's involvement in your care. For example, if you are sent to the emergency room, we may only inform the person that you suffered and apparent heart attack, stroke, etc., and/or we may provide information on your prognosis or progress. You will be informed and given an opportunity to object to further disclosures of such information as soon as you are able to do so.

1. Information Used to Disclose in the Facility/Community Directory: (Only applicable for nursing and assisted living facilities.)

We may use or disclose your name, unit or room number, and religious affiliation in our facility/community directory. We may also disclose your religious affiliation to a member of the clergy. Information concerning your general condition or room location may be provided to callers or visitors when they ask for you by name. You may object to the release of this information. You may use our **Request to Restrict The Use or Disclosure of Protected Health Information** form to notify us of your objection or your objection may be made orally. The name, address, and telephone number of the person to whom you may make your objection is listed on the last page of this document.

2. Information Disclosed to Family Members, Friends or Others Involved in Your Care:

We may disclose your protected health information to your family members and friends who are involved with your care or who help pay for your care. In the case of your death, we may disclose to a family member, friend, or others involved with your care, protected health information that is relevant to such a person's involvement, unless doing so is inconsistent with any prior expressed preferences. We may also disclose your protected health information to a disaster relief organization for the purposes of notifying your family and/or friends about your general condition, location, and/or status (i.e., alive or dead). You may object to the release of this information, You may use our **Request to Restrict The Use or Disclosure of Protected**

Health Information form to notify us of your objection or your objection may be made orally. The name, address, and telephone number of the person to whom you may make you objection is listed on the last page of this document.

V. Uses and Disclosures of Information That Do Not Require Your Consent or Authorization

State and federal laws and regulations either require or permit us to use or disclose your protected health information without your consent or authorization. The uses or disclosures that we may make without your consent or authorization include the following:

1. When Required by Law:

We may disclose your protected health information when a federal, state, or local law requires that we report information about suspected abuse, neglect, or domestic violence, reporting adverse reactions to medications or injury from a health care product, or in response to a court order or subpoena.

2. For Public Health Activities for the Purpose of Preventing or Controlling Disease, Injury or Disability:

We may disclose your protected health information when we are required to collect information about diseases or injuries (e.g., your exposure to a disease or your risk for spreading or contracting a communicable disease or condition, product recalls, or to report vital statistics (e.g., births/deaths) to the public health authority).

3. For Health Oversite Activities:

We may disclose your protected health information to a health oversight agency such as protection and advocacy agency, the state agency responsible for inspecting our organization, or to other agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents or to ensure that we are in compliance with applicable state and federal laws and regulations and civil rights issues.

4. To Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations or Tissue Banks:

We may disclose your protected health information to a coroner or a medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We may also disclose your health information to a funeral director for the purposes of carrying out your wishes and/or for the funeral director to perform his/her necessary duties.

If you are an organ donor, we may disclose your protected health information to the organization that will handle your organ, eye, or tissue donation for the purposes of facilitating your organ or tissue donation or transplantation.

5. For Research Purposes:

We may disclose your protected health information for research purposes only when a privacy board has approved the research project. However, we may use or disclose your protected health information to individuals preparing to conduct an approved research project in order to assist such individuals in identifying persons to be included in the research project. Researchers identifying persons to be included in the research project will be required to conduct all activities onsite. If it becomes necessary to use or disclose information about you that could be used to identify you by name, we will obtain your written authorization before permitting the researcher to use your information. Researchers will be required to sign a Confidentiality and Non-Disclosure Agreement form before being permitted access to health information for research purposes. A sample copy of this agreement may be obtained from the business office.

6. To Avert a Serious Threat to Health or Safety:

We may disclose your protected health information to avoid a serious threat to your health or safety or to the health or safety of others. When such disclosure is necessary, information will only be released to those law enforcement agencies or individuals who have the ability or authority to prevent or lessen the threat of harm.

7. For Specific Government Functions:

We may disclose protected health information of military personnel and veterans, when requested by military command authorities, to authorized federal authorities for the purposes of intelligence, counterintelligence, and other national security activities (such as protection of the President), or to correctional institutions.

VI. Your Rights Regarding Your Protected Health Information

You have the following rights concerning the use or disclosure of your protected health information that we create or that we may maintain on our premises:

1. Your Right to Request Restrictions on Uses and Disclosures of Your Protected Health Information:

You have the right to request that we limit how we use or disclose your protected health information for treatment, payment, or health care operations.

For example:

a. You have the right to request a restriction on certain disclosures to your health plan if the disclosure is purely for carrying out payment or for healthcare operations, AND the restriction you are requesting is for services paid for by you out-of-pocket.

b. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care or services. For example, you could request that we not disclose to family members or friends information about a medical treatment you received

Should you wish a restriction placed on the use and disclosure of your protected health information, you must submit such request in writing. You may submit such request using our **Request to Restrict the Use and Disclosure of Protected Health Information** form. Copies of this form are available in the business office. The name, address, and telephone number of the person to whom the request is to be submitted is listed on the last page of this document.

We are not required to agree to your restriction request. However, should we agree, we will comply with your request not to release such information unless the information is needed to provide emergency care or treatment to you.

2. You Right to Inspect and Copy Your Medical and Billing Records:

You have the right to inspect and copy your health information, such as your medical and billing records that we use to make decisions about your care and services. In order to inspect and/or copy your health information you must submit a written request to us. If you request a copy of your medical information, we may charge you a reasonable fee for paper, labor, mailing, and/or retrieval costs involved with filing your requests. We will provide you with information concerning the cost of copying your health information prior to performing such a service.

The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document. You may submit your requests on our **Request for Inspection/Copy of Protected Health Information** form. Copies of these forms are available in the business office.

We will respond within thirty (30) days of receipt of such requests. Should we deny your request to inspect and/or copy your health information, we will provide you with written notice of our reasons of the denial and your rights for requesting a review of our denial. If such a review is granted or is required by law, we will select a licensed health care professional not involved in the original denial process to review your request and our reasons for denial. We will abide by the reviewer's decision concerning your inspection/copy requests. You may submit your denial review requests on our **Denial of Inspection/Copy of Protected Health Information** form. Copies of these forms are available in the business office.

3. Your Right to Amend or Correct Your Health Information:

You have the right to request that your health information be amended or corrected if you have reason to believe that certain information is incomplete or incorrect. You have the right to make such requests of us as long as we maintain/retain your health information. Your requests must be submitted to us in writing. We will respond within sixty (60) days of receiving the written request. If we approve your request, we will make such amendments/corrections and notify those with a need to know of such amendments/corrections.

We may deny your request is:

a. Your request is not submitted in writing;

b. Your written request does not contain a reason to support your request;

c. The information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

d. It is not a part of the health information kept by or for our organization;

e. It is not part of the information which you would be permitted to inspect and copy; and/or

f. The information is already accurate and complete.

If your request is denied, we will provide you with a written notification of the reason(s) of such denial and your rights to have the request, the denial, and any written response you may have relative to the information and denial process appended to your health information.

The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document. You may submit your amendment/corrections requests on our **Request for Amendment/Correction of Protected Health Information** form. Copies of these forms are location in the business office.

4. Your Right to Request Confidential Communications:

You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you may request that we not send any health information about you to a family member's address. We will agree to your request as long as it is reasonable easy for us to do so. You are not required to reveal nor will we ask the reason for your request. To request confidential communications you must:

a. Notify us in writing;

b. Indicate what information you want to limit;

c. Indicate whether or not you wish to limit or restrict our use or disclosure of such information; and

d. Identify to whom the restrictions apply (e.g., which family member(s), agency, etc.).

The name, address, and telephone number of the person to whom you may file you request is listed on the last page of this document. You may submit your requests on our **Request for Restriction of Confidential Communications** form. Copies of these forms are available in the business office.

5. Your Right to Request an Accounting of Disclosures of Protected Health Information:

You have the right to request that we provide you with a listing of when, to whom, for what purpose, and what content of your protected health information we have released over a specific period of time. This accounting will not include any information we have made for the purposes of treatment, payment, or health care operations or information released to you, your family, or

the facility/community directory, disclosures made for national security purposes, or any releases pursuant to your authorization.

Your request must be submitted to us in writing and must indicate the time period for which you wish the information (e.g., May 1, 2003 through August 31, 2005). Your request may not include releases for more than six (6) years prior to the date of your request and may not include releases prior to April 14, 2003. Your request must indicate in what form (e.g., printed copy or email) you wish to receive We will respond to your request within sixty (60) days of the receipt of your written request. Should additional time be needed to reply, you will be notified of such extension. However, in no case will such extension exceed thirty (30) days. The first accounting you request during a twelve (12) month period will be free. There may be a reasonable fee for additional requests during the twelve (12) month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document. You may submit your requests on out **Request for and Accounting of Disclosures of Protected Health Information** form. Copies of these forms are available in the business office.

6. Your right to Receive a Paper Copy of This Notice:

You have the right to receive a paper copy of this notice even though you may have agreed to receive an electronic copy of this notice. You may request a paper copy of this notice at any time or you may obtain a copy of this information from our website (as applicable). The name, address, and telephone number of the person to whom you may obtain a paper copy of this notice is listed below.

VII. How to File a Complain About Our Privacy Practices

If you have reason to believe that we have violated your privacy rights, violated our privacy policies and procedures, or you disagree with a decision we made concerning access to your protected health information, etc., you have the right to file a complaint with us or the Secretary of the Department of Health and Human Services. Complaints may be filed without fear of retaliation in any form.

The name, address, and telephone number of the person to whom you may file your complain is listed below. You may submit your complaint on our Privacy Practices Complaint form. Copies of these forms are available in the business office.

PROVIDER/PRIVACY CONTACT INFORMATION:

Name of Person to Contact

Provider Name

Address

Telephone Number Fax Number

YOU MAY ALSO FILE COMPLAINTS WITH:

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.

Washington, D.C. 20201

(202) 619-0257

Toll-Free 1-877-696-6775

REQUST FOR MEDICARE INTERMEDIARY REVIEW

I do want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

You are not required to pay for services, which could be covered by Medicare, until a Medicare decision has been made.

If you do not receive a formal Notice of Medicare determination within 90 days of this request, you should contact: Anthem Health Plans of NH, Inc., 3000 Goffs Road, Manchester, NH 03111-0001.

I **do not** want my bill submitted to the intermediary for a Medical decision

I understand that I do not have Medicare appeal rights if a bill is not submitted.

VERIFICATION OF RECEIPT OF NOTICE

This acknowledges that I received this notice of non-coverage of services under Medicare on

(Signature of Beneficiary or person acting on Beneficiary's behalf)

This is to confirm that you were advised of the non-coverage services under Medicare on

(Name of Beneficiary or Representative contacted)

(Signature of Administrative Officer)

Date:

To: RE:

HICN:

Admission Date:

On , we reviewed you medical information available at the time of, or prior to your admission, and we believe that the services needed did not meet the requirements for coverage under Medicare. The reason is:

Medicare covers medically necessary skilled nursing/physical therapy care as needed on a daily basis after a three-day stay in the hospital in the nursing home. As you did not meet this requirement, you are not qualified for skilled services that are reimbursed by Medicare in the Vermont Veterans' Home.

This decision has not been made by Medicare. It represents our judgement that the services you need do not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request that a bill be submitted. Furthermore, if you want to appeal this decision, you must request that a bill be submitted. If you request that a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination, you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for non-covered services determined to be custodial care or necessary unless you had reason to know the services were non-covered. You are considered to know that these services were non-covered effective with the date of this notice.

If you have questions concerning your liability for payment for services you received prior to the date of this notice, you must request that a bill be submitted to Medicare.

We regret that this may be your first notice of the non-coverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes on the reverse side to indicate whether or not you want your bill submitted to Medicare and sign the notice receipt.

Sincerely,

Administrative Officer

Name of Client Date **Notice of Privacy Practices**

Record of Acknowledgement

We are committed to preserving the privacy and confidentiality of your health information whether created, received, or transmitted by us, or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information, including electronic health information. Copies of our privacy policies and procedures are maintained in the business office. We are required by state and federal regulations to abide by the privacy practices described in this notice including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Effective Date of This Privacy Notice

The effective date of this Privacy Notice is

Changes or Revisions to Our Privacy Notice

We reserve the right to change our *Privacy Notice* at any time and to make the revised or changed notice effective for health information we already have abut you as well any information we receive in the future about you. Should we revise or change our *Privacy Notice*, we will post a copy of the new or revised notice in out main lobby. You may obtain a copy of the new/revised *Privacy Notice* from the business office or download a copy from our website (as applicable).

Our Privacy Notice was revised on . No Changes since the effective date listed above.

Privacy Notices, Information Restrictions, Record Amendments/Corrections, Disclosures of Information, Revoking an Authorization, Inspection and Copying of Records, Confidential Communications, Filing Complaints, Etc.

Should you have any questions concerning our privacy practices, obtaining copies of our privacy notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your health information, obtaining a listing of the information we disclosed concerning your health information, requests to inspect or copy your medical information, requests that we communicate information about your health matters in a certain way, denial of access to your health information, filing complaints, or any other concerns you may have relative to our privacy practices, please contact:

PROVIDER/PRIVACY CONTACT INFORMATION:

Name of Person to Contact

Provider Name

Address

Telephone Number Fax Number

YOU MAY ALSO FILE COMPLAINTS WITH:

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.

Washington, D.C. 20201

(202) 619-0257

Toll-Free 1-877-696-6775

Acknowledgment

I certify that I received a copy of the provider's *Privacy Notice* and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the provider is committed to protecting my health information.

Date Signature of Client Printed Name of Client

Date Signature of Witness

I certify that I am the authorized representative of ,

And that I have received the *Privacy Notice* on behalf of this individual and that the provider provided me with an opportunity to review this document and ask questions to assist me in understanding his/her privacy rights. I am satisfied with the explanations provided to me and I am confident that the provider is committed to protecting his/her health information.

Date Signature of Representative Printed Name of Representative Relationship to Client

Date Signature of Witness

A copy of this document must be provided to the person to whom the *Privacy Notice* was provided and a copy must be filed in the Medical Record.