HOME HEALTH GUIDEBOOK

For Patients and Families

KLINE GALLAND
HOME HEALTH

YOUR HOME HEALTH CARE TEAM

Case Manager: _____

Other Team Members: _____

_____

_____

Home Health Clinical Manager: Nicholas Hess, PT

Benaroya Community Services Administrator: Pam Swanborn, PT

6100 4th Ave S, Suite 403, Seattle, WA 98108
(206) 805-1930, F: (206) 805-1931

Office Hours: 8:30am – 5:00pm, Monday through Friday

CALL US FIRST

Because we care!

(206) 805–1930

Stay safe and well at home. Avoid unnecessary trips to the hospital.

Call me when you:

- Get sick
- Just don't feel right
- Find it hard to stand up from a chair

We can help if we know you're in need.
(206) 805–1930
24 hrs a day/7 days a week
In the case of Emergency, call 9-1-1

A nurse is available 24 hours a day, every day. Call (206) 805-1930.

After-Hours Backup Line: (206) 741-3022
Between the hours of 5:00pm and 8:30am, Monday – Friday
and available 24 hours on Saturday and Sunday

We value your feedback

Your experience of the care we provide is important to us. There are several ways you can share your feedback:

- Give us a call at (206) 805-1930
- Send your comments to:

  Kline Galland Benaroya Community Services
  6100 4th Ave S, Suite 403
  Seattle, WA 98108
- Send us an email at: feedback@klinegalland.org
- Complete the survey. You or your family member will receive a survey in the mail. We would love to hear any feedback about the care we have provided.

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PHILOSOPHY OF KLINE GALLAND HOME HEALTH

OUR PHILOSOPHY

Kline Galland Home Health Services are driven by the philosophy of commitment to our patients. Our home health services are centered on the patient, family and caregiver. We recognize the unique physical, emotional and spiritual needs of each person and respect and respond to each individual's lifestyle, values and wishes. We strive to extend the highest level of courtesy and service to patients, families/caregivers, visitors and one another while providing state-of-the-art home care services.

OUR MISSION

A living commitment, inspired by Jewish values,
to provide exceptional senior care by exceptional people...
every day, in every way, for every one.

OUR CORE VALUES

Compassion • Respect • Excellence
Dignity • Integrity • Tradition

OUR HOME HEALTH SERVICES

- Nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Work
- Home Health Aide

HOME HEALTH Q&A

What are some of the key principles of home health?

- The primary focus of Home Heath is to enable *our patients (and/or their caregiving unit) to effectively self-manage their care*
- Patients and/or caregivers must *be engaged in the care*, and demonstrate an ability to benefit from skilled care
  - Patients/caregivers will be given instructions and/or exercise programs to be done on days when home health clinicians are not in the home
  - **If a POA is signing the consent, that person must be very active in the care provided**
  - Following through with these instructions/ programs is the key to improving health and functioning, and demonstrates engagement in the care program. (In other words, the biggest benefit from home health happens between the visits by your team of clinicians.)

How does Home Health work?

- Home Health is a *"transition service"*. This is a level of care between an inpatient facility such as a hospital or a skilled nursing facility, and outpatient services like visiting the M.D. or going to outpatient therapy. The goal is to help you stabilize in the home, so you can access outpatient services. This means you may not be at "100%" level of function at the time Home Health ends, but you have improved enough to access outpatient services
- Our first goal is safety within the home after you've returned home/were referred from (rehab/hospital/PCP). Our next goal is to provide education and/or establish a home exercise program that you can perform safely with caregivers/independently

How does scheduling work?

- The clinician who does your first visit (Start of Care) often does not see you again, as their primary role is to admit you to home health. The admitting person will "hand-off" information about your care to the primary team members who are assigned to your case. Their names are written in the Admission booklet
- The initial order from the M.D. covers each discipline for their first visit (the assessment). After each assessment the clinicians will make a recommendation for ongoing visits and your contact the M.D. The **M.D. must okay those orders and sign and get them back to the agency**. Sometimes this can take several days. If you haven't heard from a clinician in a week, please call (206) 805-1930
- Once clinicians receive the orders from the MD, they will call you individually to set up next visits
- Flexibility surrounding scheduling – while we try to schedule visits at times that work best for you, there are times that there are limited slots available on the clinicians' schedule. (When you are calling a clinic to set up an appointment, sometimes you need to take the best spot that is available.) Future visits may be able to get adjusted to better match your needs if new time slots open up
- Note: If you are a morning person, please let your team members know! We love having patients who are happy to see us early in the morning

How many visits will I receive?

- The number of visits will be dependent on your diagnosis and needs seen during evaluation.
- While the length of time on home health varies (from a few days to many months), the AVERAGE time on home health is about 60 days
- Each discipline will do an assessment to determine your individual needs, and let you know at the end of that visit how often they will come. It is not uncommon for the frequency of visits to be once/week
- Sometimes the frequency starts out higher, and then tapers as you can do more on your own
- Each discipline will do a reassessment every 30 days. Factors that influence whether home health will continue include:
  - You continue to meet the homebound requirement

- Whether your needs require the skills of a therapist or nurse
- How actively engaged in the process you are
- Whether progress is being made towards your goals

What does it mean to be homebound?

- Patients must be *homebound* to receive home health. This means that it takes considerable and taxing effort, or requires assistance from another person, to leave the house
  - Occasional outings home for things such as hair appointment or church service are permissible, if these absences are infrequent and of short duration
  - Note: If an individual chooses to leave the home on a frequent basis, even if it is considerably taxing, they no longer qualify for home health (as they could presumably access outpatient services)

What does it mean that services are "skilled"?

- A skilled service is a service which must be provided by a licensed professional (nurse, therapist or social worker)
- When symptoms and level of function are changing frequently, this may require the skills of a nurse, therapist or social worker to provide ongoing assessment and treatment changes, and therefore would be considered skilled. When your condition plateaus or stabilizes, the needs of a skilled professional are not required
- Clinicians cannot come indefinitely if they are providing the same service over and over, as Medicare would consider this no longer "skilled". Again, our goal is to enable our patients and their caregiving team to be able to manage their care needs. For example, this would include learning simple wound care to be completed by the patient and/or caregiver, or performing a home exercise program given by your therapist

What is the best way to reach a member of my care team?

- Call our main number: (**206) 805-1930** and ask for the person you are trying to reach. Our office team members will either transfer the call to our cell phone, or send us a message letting us know you need a call back
- AFTER-HOURS: You can call our office 24 hours a day. If you have an issue that you must speak to a person (e.g., you have some concerning new symptoms), let the answering service know that your call is urgent. They will take the message and have an after-hours nurse call you back. If your message is not urgent, (e.g., you want to leave a message to cancel or change an upcoming appointment), you should leave that message with the answering service and they will convey that to our team
- Sometimes a call to the after-hours team will result in a visit from the nurse. Examples of when this may occur are if you have a catheter that needs to be changed unexpectedly or have some issues with a complex wound. Sometimes the after-hours team will review your symptoms and advise you to go to the emergency room

What happens if I go to the hospital?

- Please notify us ASAP if you go to the hospital
- Home Health is on hold while you are in the hospital, but we can see you after you discharge **assuming we receive orders** to get back involved
- Our team in the office does their best to track your hospitalization and seek new orders, but this can be delayed by a day or two. So please let us know when you are home (or know of your plan to be home) as soon as you are able by calling (206) 805-1930

MEDICARE REQUIREMENTS & PAYMENT INFORMATION

There are several conditions that must be met in order to for Medicare to cover and pay for home health. You must:

A. **Be Homebound.** This means that you are unable to leave your home, that leaving your home requires a considerable and taxing effort or leaving home requires assistance from another person. Medicare's intent is to cover home health services for individuals who are not able to obtain health care outside the home. There are certain times that it is permissible for you to leave your home, if the absences are infrequent and of short duration – such as to attend church or see a hairdresser. Please discuss further questions about such absences with your health care professional.

B. **Have a Face-to-Face Visit** (encounter) with your doctor either within 90 days prior to your first home health visit, or within 30 days after admission. If you did not meet with your doctor before home health started, your home health staff can help you arrange a visit.

C. **Require Skilled Services**. A skilled service is a service which must be provided by a licensed professional (nurse, therapist or social worker). Medicare considers the inherent complexity of the service, the condition of the patient and general standard of practice in the community. Clinicians can not come indefinitely if they are providing the same service over and over, as Medicare would no longer consider this "skilled."

D. **Have Intermittent Care Needs**, meaning Medicare will not pay for the home health agency staff to stay with you for extended periods of time. If you have a need for chore services, please discuss this with the clinicians providing you with care and they can assist with identifying resources.

Medicare visits are covered 100% by Medicare as long as you meet the above criteria. The payment is made directly to the home health agency. You should receive a statement from Medicare informing you of the payments they have made to the agency. Medicare will also cover some medical supplies (specifically on Medicare guidelines) and some lab tests while you are receiving home care, provided they are related to the illness for which you are receiving care, that your physician has ordered these supplies/tests and they are obtained through a Medicare-approved provider.

If you have medical coverage other than Medicare, your home health agency care provider will review with you to determine what your insurance covers and if there will be a cost of care to you.

At the time of admission, the clinician will work with you to establish realistic health goals. These goals get recorded on a document called your "Plan of Care," which your physician signs. Once these goals have been met, you will be ready for discharge from services. The length of time this will take varies from individual to individual.

There may be other circumstances that lead to you being discharged from the home health agency, such as:

- Your physician determines that you no longer need the services
- You move to an area that the agency does not serve
- You are not participating or acting responsibly in regards to making progress towards your goals
- The home health agency determines that they can no longer meet your care needs according to their policies.

If you should be discharged or transferred to another agency, we will provide advance notice unless there is an emergency or unplanned situation. We will assure that the appropriate information is transferred to the receiving agency so that your needs can be adequately met.

PATIENT & FAMILY RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS:

Regarding the services you receive, you have the right to:

1. Receive verbal notice of your rights and responsibilities in your primary or preferred language and in a manner you understand, free of charge, with the use of a competent interpreter if necessary.
2. Have your person and property treated with respect, dignity, privacy (including visual and auditory) and security.
3. Be informed by knowledgeable staff about medical condition, to the extent known, and be given an opportunity to participate in designing a care plan that addresses your needs, preferences and updates as your condition changes.
4. Receive information about the scope of services that Kline Galland Home Health will provide and specific limitations on those services.
5. Be advised of the names, addresses and telephone numbers of the federally-funded and state-funded entities that serve the agency's service area. Please see full list on page 73 of this packet.
6. Participate in, and be informed about and consent or refuse care in advance of and during treatment with respect to:
   a. Completion of all assessments
   b. The care to be furnished, based on the comprehensive assessment
   c. Establishing and revising the Plan of Care
   d. The disciplines that will furnish the care
   e. The frequency of visits
   f. Expected outcomes of care, including patient identified goals, and anticipated risks and benefits
   g. Any factors that could impact treatment effectiveness
   h. Any changes in the care to be furnished
7. Receive all services outlined in the Plan of Care.
8. Have your reports of pain believed and have your pain managed effectively.
9. Be informed about the nature and purpose of any technical procedure that will be performed as well as who will perform the procedure.
10. Have access to the department's listing of providers and select any licensee to provide care, subject to the individual's reimbursement mechanism or other relevant contractual obligations.
11. Be free from any discrimination or reprisal for exercising your rights or for voicing grievances to the agency or outside entity.
12. Be informed of the right to access auxilary aids and language services and how to access these services.
13. Choose your attending physician.
14. Be free from mistreatment, neglect or verbal/mental/sexual/physical abuse, including injuries of unknown source, and misappropriation of patient property. And be informed of how to file an abuse or neglect report with Washington State Department of Social and Health Services: 1-866-END HARM (1-866-363-4276*, TTYaccessible).
15. Receive information addressing any beneficial relationships between the organization and referring entities.
16. Be informed about advanced directives and the Kline Galland Home Health's responsibility to implement them.
17. Refuse care and/or treatment after being fully informed, and to be told the consequences of your action.
18. Be informed within a reasonable amount of time of anticipated termination of service or transfer to another organization, according to the policy on page 15 of this packet.
19. Receive written notice, in advance, of Kline Galland Home Health reducing or terminating ongoing care.
20. Receive written notices.
21. Refuse to answer questions.
22. Provide feedback as indicated on page 33 of this packet.
23. Contact Kline Galland Home Health as soon as possible at (206) 805-1930 if you are transferred to a hospital or other facility during the course of your care.

Regarding your medical record, you have the right to:

1. Expect confidentiality of all information related to your care, including the Outcome and Assessment Information Set (OASIS) within applicable laws and regulations.
2. Have access to your medical records upon request.
3. Authorize release of information.
4. Have access to, request an amendment to and obtain information on disclosures of your health information in accordance with law and regulation.

Regarding your insurance coverage, billing, and financial liability, you have the right to:

1. Be informed, verbally and in writing, of billing and reimbursement methodologies prior to the start of care/service and as changes occur, as soon as possible, in advance of the next home health visit, including fees for services/products provided, direct pay responsibility and notification of insurance coverage.
2. Receive written notice, in advance of a specific service being furnished, if Kline Galland Home Health believes the service may be non-covered care.
3. Be informed in advance of the extent to which payment may be expected from Medicare, Medicaid or other third party payer and any costs for which you may be responsible.
4. A fully itemized billing statement upon request, including the date of each service and the charge – except managed health care plan.

Regarding concerns about your treatment, you have the right to:

1. Voice grievances or complaints, regarding anyone furnishing care on behalf of Kline Galland, about the care you have or have not received, lack of respect to your person or property or issues related to implementation of advanced directives without fear of interference, coercion, discrimination or reprisal, and have those concerns reviewed and, when possible, resolved in a timely manner. See procedure on page 33 of this packet.
2. Receive an investigation of the complaint made by you or your family/caregiver/guardian. Kline Galland will document the complaint and the resolution of this concern.
3. Be informed of the right to use hotlines to file complaints.

PATIENT RESPONSIBILITIES:

As a patient of Kline Galland Home Health, you have the responsibility to:

1. Remain under a physician's care while receiving Kline Galland Home Health services.
2. Provide Home Health with a complete and accurate health history in order to plan and carry out care.
3. Inform staff about any changes in your health status, condition or treatment.
4. Provide us with all requested insurance and financial information/records.
5. Sign or have your legal representative sign the required consents and releases for insurance billing.
6. Allow Kline Galland Home Health to act on your behalf in filing appeals of denied payment of service by thirdparty payers and to cooperate to the fullest extent possible in such appeals.
7. Notify us of any changes in treatment made by the physician or if a visit schedule needs to be changed.
8. Participate in your Plan of Care including, if appropriate, a pain management plan.
9. Ask questions about care or services.
10. Notify us if the visit schedule needs to be changed.
11. Inform us of changes made to the Advance Directives.
12. Promptly advise us of any concerns with the services provided.
13. Provide a safe environment for the home health agency staff.
14. Carry out mutually agreed-upon responsibilities.
15. Discuss pain relief options with your nurse/therapist.

16. Provide your nurse/therapist with as comprehensive information as possible about your pain and any concerns you may have about pain medications and/ or management.
17. Be available to us for home visits at reasonable times.
18. Notify us if you are going to be unavailable for a visit.
19. Treat the Kline Galland Home Health staff with respect and dignity without discrimination as to color, religion, sexual orientation, sex or national/ethnic origin.
20. Accept the consequences for any refusal of treatment or choice of noncompliance.
21. Provide our staff with a safe home environment in which your care can be provided.
22. Cooperate with your physician, our staff and other caregivers.
23. Contact Kline Galland Home Health as soon as possible (**206-805-1930**) if you are transferred to a hospital or other facility during the course of your care.

DISCHARGE OR TRANSFER CRITERIA & PROCESS

PURPOSE: To outline the process for discharging or transferring a patient from service.

POLICY: When the patient's plan of care changes and this change results in discharge or reduction of services, the patient or their representative/ caregiver, all physicians issuing orders for the home health plan of care, as well as their primary physician, will be notified and involved in planning decisions.

A discharge or transfer summary will be completed and filed in the clinical record.

DEFINITIONS:

1. Termination/Discharge: Discontinuance of all organization services by the organization.
2. Reduction of Services: A change in the patient's service plan in which one (1) or more existing services are discontinued.
3. Transfer: an admission to a hospital or skilled nursing facility.

DISCHARGE/TRANSFER OF SERVICES CRITERIA

1. Patient will only be transferred or discharged from services when the patient meets one (1) or more of the following criteria:
   a. The transfer or discharge is necessary for the patient's welfare because the agency and the physician or allowed practitioner who is responsible for the home health plan of care agree that the agency can no longer meet the patient's needs, based on the patient's acuity
      i. The agency must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the agency's capabilities
   b. The patient or payer will no longer pay for the services provided by the agency, such as:
      i. If the physician Face-to-Face encounter was not completed prior to the initial certification, and the patient or family/ caregiver refuses to obtain a Face-to- Face visit within 30 days of the start of care
      ii. There is no available payor with whom the agency is contracted
      iii. The payor is no longer authorizing services
   c. The transfer or discharge is appropriate because the physician or allowed practitioner who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with regulation have been achieved, and the agency and the physician or allowed practitioner who is responsible for the home health plan of care agree that the patient no longer needs the agency's services;
   d. The patient refuses services, or elects to be transferred or discharged;
   e. Discharge for cause will be considered only if the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the agency to operate effectively is seriously impaired
      i. The agency will only discharge for cause if and after the process described in procedure section 4 below have been followed
   f. The patient dies; or
   g. The agency ceases to operate

PROCEDURE:

1. The organization will verbally notify the patient of the decision to reduce services within one (1) visit prior to the time the change in service is to occur (i.e., prior to the last scheduled visit), and at least two (2) calendar days before covered services end. A Notice of Medicare Non-Coverage (NOMNC) will be issued when appropriate
2. Prior notice will not be necessary when services are discontinued by the patient or physician; however, action taken must be documented in the clinical record and a discharge summary completed
3. For a patient requiring continuing care, assistance will be given to the patient and family/ caregiver in order to manage continuing care needs after the organization services are discontinued. Discharge instructions will be provided

a. Discharge planning will identify needs the patient may have

b. Arrangements for such services will be coordinated by the organization when applicable

4. When discharge for cause is being considered, the organization will:

a. Advise the patient, the representative (if any), the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered;

b. Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or situation;

c. Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and

d. Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into its clinical records;

5. The decision to terminate or reduce services must be documented in the clinical record citing the circumstances and notification to the patient, the responsible family/ caregiver or representative, and the patient's physician. The Director or designee is accountable for the decision and the required documentation.

6. Each clinician making the final visit for their discipline will complete the sections of the discharge notice for discontinuing a discipline.

7. If more than one (1) discipline is providing care, the discipline being discontinued will be specified on the interim order.

8. A discharge summary will be completed for all discharged patients. The discharge summary will be sent to the primary physician, any agency that is taking over care for the patient within 5 business days. The summary will be sent to any other involved members of the patient's care upon request.

9. In the event of a transfer to a hospital or skilled facility, a transfer summary will be completed for all patients. The summary will be sent to the patient's primary physician and the receiving hospital or facility within two business days of when the agency is made aware of the transfer.

10. The clinician will update the comprehensive assessment, including required OASIS data elements, as required by regulation.

11. The Discharge record will be audited for compliance of all orders, signatures, and summaries before patient record is closed and claims are submitted.

KLINE GALLAND BENAROYA COMMUNITY SERVICES NOTICE OF PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Understand Your Health Record/Information

Kline Galland Benaroya Community Services (including Home Health, Home Care, Hospice and Palliative Care ("Kline Galland") originates, records, and maintains health information about patients describing their health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. This information, often referred to as the health or medical record, serves as:

- A basis for planning your care and treatment
- A means of communication among the many health professionals who contribute to your care
- A source of information for applying the diagnosis information to your bill
- A means by which a third-party payer (insurance companies, governmental or private entities responsible for paying a patient's bill) can verify that services billed were actually provided
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve
- A source of data for medical research
- A source of data for facility planning, fundraising and marketing
- A source of information for public health officials charged with improving the health of the nation

Understanding what is in your medical record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, where, and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

Your Health Information Rights:

Although your health record is the physical property of Kline Galland, the information belong to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the Notice of Privacy Practices upon request
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524 and RC W 70.02.030
- Amend your health record as provided in 45 CFR 164.526
- Obtain an accounting of disclosures of your health in formation as provided in 45 CFR 164.528 and RCW 70.02.020
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- Opt out of fundraising uses of your health information

Our Responsibilities:

Kline Galland is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to your legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

Below, this notice contains a number of examples of the ways in which we are permitted to and may use health information for treatment, payment and health operations, without obtaining your specific authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Chief Privacy Officer at (206) 725-8800.

If you believe your privacy rights have been violated, you can file a complaint with the Chief Privacy Officer or with The Department of Health and Human Services. There will be no retaliation for filing a complaint.

Please bring any privacy complaints you may have to the attention of the Chief Privacy Officer. The person most appropriate to address your complaint will provide you with a response in a timely manner.

A complaint may be filed with the Office of Civil Rights/Department of Health and Human Services either on paper or electronically (http://www.hhs.gov/ocr/privacy/).

Examples of Disclosure for Treatment, Payment and Health Operations Which Do Not Require Specific Authorization:

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your Care Team will be recorded in your record as well as posted in your room, as appropriate, and used to determine the course of treatment that should work best for you. Your Physician will document in your record his or her expectations of the members of your Care Team. Members of your Care Team will then record the actions they took and their observations. In that way, your Physician will know how you are responding to treatment.

We will also provide your Physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer (insurance companies. governmental or private entity responsible for paying your bill). The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contrac ts with business associates. Examples include physician services in the emergency department, and radiology or laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do (in performing a function or activity on behalf of Kline Galland) that involves the creation, use or disclosure of protected health information, and then you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriatelysafeguard your information.

Directory: Unless you notify us that you object we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, of your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Deceased individuals: We may disclose health information to funeral directors, coroners or medical examiners consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Specific Communications we may provide:

- Communications for treatment of an individual by us, including case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, healthcare providers, or settings of care to the individual;
- Communications to describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, Kline Galland, including communications about: Kline Galland's participation in a healthcare provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or
- Communications for case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of treatment.

Employee benefits: We may contact you to communicate about health insurance products offered by Kline Galland that could enhance or substitute for existing health plan coverage. This includes communications that describe a health-related product or service, or the payment for such a product or service that is provided by the facility or included in its plan or benefits.

Fundraising: We may contact you as a part of our fundraising efforts, and may use certain protected health information in doing so, as permitted under 45 CFR 164.514(f).

However, you have a right to opt-out of receiving such fundraising communications. You may exercise your right to opt out of receiving fundraising communications by notifying us at any time. Please indicate whether you wish to opt out of participating in a particular fundraising campaign, or from all Kline Galland fundraising. Should you later determine you wish to opt back in, you may also contact us by one of the following means:

in writing at:
Privacy Officer
The Caroline Kline Galland Home
7500 Seward Park Avenue S.
Seattle, WA 98118

by email at:
compliance@klinegalland.org; or

by telefax addressed to:
Privacy Officer at (206) 722-5210

Food and Drug Administration (FDA): We may disclose to the FDA health information related to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Government authority: We may disclose your health information to a government authority, including a social service or protective services agency, authorized by law, if we reasonably believe you are a victim of abuse, neglect or domestic violence.

Correctional institution: Should you be an inmate of a correctional institution we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Health oversight agency, public health authority or attorney: Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

STATEMENT OF PATIENT PRIVACY RIGHTS FROM CMS (MEDICARE)

Home Health Agency (HHA)
Outcome and Assessment Information Set (OASIS)

Statement of Patient Privacy Rights

As a home health patient, you have these privacy rights:

- **You have the right to know why we need to ask you questions.**

  We're required by law to collect health information to make sure you get quality health care, and that payment for Medicare and Medicaid patients is correct.

- **You have the right to have your personal health care information kept confidential.**

  We may ask you to tell us information about yourself so that we'll know which home health services will be best for you. We keep anything we learn about you confidential.

  This means only those legally authorized or with a medical need to know will see your personal health information.

- **You have the right to refuse to answer questions.**

  We may need your help to collect your health information.

  If you choose not to answer, we'll fill in the information as best we can. You don't have to answer every question to get services.

- **You have the right to look at your personal health information.**

  It's important that the information we collect about you is correct. If you think we made a mistake, ask us to correct it.

  If you're not satisfied with our response, you can ask the Centers for Medicare & Medicaid Services (the federal Medicare and Medicaid agency) to see, review, copy or correct your personal health information.

  See the Privacy Act Statement for more details about your privacy rights.

Need to correct your personal information?

To see, review, copy, or correct your personal health information in federal records call **1-800-MEDICARE (1-800-633-4227)** for help contacting the HHA OASIS System Manager. TTY users call 1-877-486-2048.

This is a Medicare & Medicaid Approved Notice.

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS STATEMENT GIVES YOU ADVICE REQUIRED BY LAW (the Privacy Act of 1974).

THIS STATEMENT IS NOT A CONSENT FORM. IT WILL NOT BE USED TO RELEASE OR TO USE YOUR HEALTH CARE INFORMATION.

I. AUTHORITY FOR COLLECTION OF YOUR INFORMATION, INCLUDING YOUR SOCIAL SECURITY NUMBER, AND WHETHER OR NOT YOU ARE REQUIRED TO PROVIDE INFORMATION FOR THIS ASSESSMENT

Sections 1102(a), 1154, 1861(o), 1861(z), 1863, 1864, 1865, 1866, 1871, 1891(b) of the Social Security Act.

Medicare and Medicaid participating home health agencies must do a complete assessment that accurately reflects your current health and includes information that can be used to demonstrate progress toward your health goals. The home health agency (HHA) must use the Outcome and Assessment Information Set (OASIS) when evaluating your health. To do this, the agency must collect information from every patient. This information is used by the Centers for Medicare & Medicaid Services (CMS, the federal Medicare & Medicaid agency) to be sure that the home health agency meets quality standards and gives appropriate health care to its patients. You have the right to refuse to provide information for the assessment to the home health agency. If your information is included in an assessment, it is protected under the Privacy Act of 1974 (5 U.S.C. 552a), as amended. You have the right to see, copy, review, and request correction of your information. Instructions on how to access information collected about you is included in the HHA OASIS system of records notice, located at https://www.hhs.gov/foia/privacy/sorns/09700522/index.html.

II. PRINCIPAL PURPOSES FOR WHICH YOUR INFORMATION IS INTENDED TO BE USED

The information collected will be entered into HHA OASIS System No. 09-70-0522. Your health care information will be used for the following purposes. To:

- study and help ensure the quality of care provided by home health agencies (HHA)
- aid in administration of the survey and certification of Medicare/Medicaid HHAs
- enable regulators to provide HHAs with data for their internal quality improvement activities
- support agencies of the state government to determine, evaluate and assess overall effectiveness and quality of HHA services provided in that state
- provide for the validation, and refinements of the Medicare Prospective Payment System
- aid in the administration of Federal and state HHA programs within the state; and
- monitor the continuity of care for patients who reside temporarily outside of the state.

III. ROUTINE USES

These routine uses specify the circumstances when the Centers for Medicare & Medicaid Services may disclose your information from HHA OASIS without your consent, in accordance with 5 U.S.C.552a(b)(3). Each prospective recipient of a routine use disclosure must agree in writing to ensure the continuing confidentiality and security of your information. Disclosures of the information may be to:

- support agency contractors, consultants, or grantees, to assist in the performance of a service related to this collection and who need to have access to the records.
- To assist another Federal or state agency in contributing to the accuracy of CMS's proper payment of Medicare benefits, enable such agency to administer a Federal health benefits program, fulfill a requirement of a Federal statute or regulation and/or evaluate and monitor the quality of home health care and contribute to the accuracy of health insurance operations.
- assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.
- support Quality Improvement Organizations (QIO) in order to assist the QIO to perform Title XI and Title XVIII functions relating to assessing and improving HHA quality of care.
- support national accrediting organizations with approval for deeming authority for Medicare requirements for home health services.
- support the Department of Justice (DOJ), court or adjudicatory body when the agency is a party to litigation
- assist a CMS contractor that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud, waste, or abuse in such program.
- assist another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds.

IV. EFFECT ON YOU, IF YOU DO NOT PROVIDE INFORMATION

The home health agency needs the information contained in the Outcome and Assessment Information Set in order to give you quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect information also could make it hard to be sure that the agency is giving you quality services. If you choose not to provide information, there is no federal requirement for the home health agency to refuse you services.

NOTE: This statement may be included in the admission packet for all new home health agency admissions. Home health agencies may **request** you or your representative to sign this statement to document that this statement was given to you. **Your signature is NOT required.** If you or your representative sign the statement, the signature merely indicates that you received this statement. You or your representative must be supplied with a copy of this statement.

CONTACT INFORMATION

If you want to ask the Centers for Medicare & Medicaid Services to see, review, copy, or correct your personal health information that the Federal agency maintains in its HHA OASIS System of Records: Call 1-800-MEDICARE, toll free, for assistance in contacting the HHA OASIS System Manager. TTY for the hearing and speech impaired: 1-877-486-2048.

ABOUT ADVANCE DIRECTIVES

Advance Directive is a general term for oral or written instructions about future medical care if a person becomes incapable of stating his or her wishes. In these documents, both wanted and unwanted treatment may be specified.

Please note: Advance Directives are only part of the process. Protecting your health care choices is a threestep process:

1. ***Deciding*** what you want;
2. ***Communicating*** your intentions so that others understand them; and
3. ***Committing*** your providers, family, and health care agent(s) to accept (and sometimes defend) your choices.

In Washington State, accepted Advance Directives are as follows:

Health Care Directive:

A Health Care Directive (also known as a living will, directive to physician or physician directive) is a legal statement to all your health care providers that describes your general wishes or desires for end-of life care. In particular, Health Care Directives speak to the question of whether and how you want to be kept alive by medical treatment if you are unable to make decisions. Your Health Care Directive should specifically state the life-sustaining treatments you do or do not want. These should include resuscitation, use of an artificial ventilator and artificial nutrition/ hydration. It should be in all your medical records.

When you present your Health Care Directive to your physician, ask if they will honor it. If not, find a physician who will. Most states do not require a specific form or format. In Washington, the basic form available covers only terminal illness, and End of Life Washington considers it too limited. In order to make a Health Care Directive legally binding, you must sign the document in the presence of two qualified, adult witnesses.

A Health Care Directive can prevent immense family conflict about your wishes for treatment if you become unconscious or unable to make medical decisions.

Durable Power of Attorney for Health Care:

A Durable Power of Attorney for Health Care (DPAHC) is the legal means by which you designate someone (referred to as your health care agent, surrogate decision maker, health care proxy or attorney in fact) to make health care decisions if for any reason you should lose the capacity to do so. In the event that your primary agent is unable to make decisions on your behalf, you may also name an alternate agent. Anyone over the age of 18 may make a DPAHC, provided they are competent. Additionally, any individual over 18 can act as an agent or alternate agent provided they are of sound mind and meet certain qualifications.

DPAHC is limited to health care decisions and does not affect a power of attorney you may have for financial or other matters. Washington State law does not specifically require witnessing or notarizing your DPAHC. A DPAHC stands up legally, particularly when the agent's decisions are consistent with directives contained in the patient's Health Care Directive.

Once the DPAHC is in place, you continue to make your own care decisions for as long as you are able. It is only when you cannot make your wishes known that your health care agent can act. When you are again able to make your own decisions, your agent loses power to make decisions for you. It is very important to pick someone you trust and who knows your wishes. It is also important to choose an individual you feel can be assertive in the event that caregivers or family members challenge your wishes.

It's important that your agent knows exactly what kind of care you wish to have, and what types of treatment you do not wish to have. Make clear to other family members that your health care agent(s) will have final authority to act on your behalf. If you feel that certain family members will not honor your wishes, you may include a statement directing physicians and the courts to disregard their demands and to follow only the directives of your agent(s). ***For the sake of all concerned, be sure to discuss your intentions face-to-face.***

MINIMUM HOME SAFETY REQUIREMENT FOR KG HOME HEALTH

- All guns and other weapons must in a locked cabinet/ safe/drawer during visits
- All pets should be in either a cage or another room, away from care, during visits
- Bed bugs or other pest infestations must be disclosed to team in advance of visit
- Exposure/potential exposure to someone with COVID-19, or other infectious disease must be communicated to the team prior to visits
- No active illicit drug use, sale, or exchange of illicit drugs is permitted during visits. Paraphernalia related to illicit drug use should not be visible during visits
- No smoking or vaping of any kind should occur in the home during visits
- Patients should not be under the influence of alcohol or other non-prescribed substances during visits, nor should anyone present for, or in close proximity to the visit
- Patient's home environment should be free of hostile, aggressive, or threatening language
- Patients must be appropriately clothed during visits (except when participating in planned toileting, bathing, and or dressing activities as part of home health services)
- Patient's home should meet a minimum standard of safety which includes:
  - Free of excrement and hazardous debris on floor and surfaces;
  - Appropriate disposal of any needles or other sharps;
  - Clear pathway free from obstruction from the entryway to the area in which care is provided, including unobstructed ability to enter/exit the house/room where care is provided
- If there is danger or perceived danger surrounding the perimeter of the patient's home, clinician will request joint visit with supervisor (or peer as designated by supervisor) to assess the safety concerns
- If eminent danger is perceived, clinician will leave the visit immediately and care may be discontinued entirely based on management consultation

KLINE GALLAND TELEHEALTH SERVICES

The purpose of this form is to provide you with information to enable you to make informed decisions about giving consent to receive telehealth services provided by The Caroline Kline Galland Home, Kline Galland Hospice Services and Kline Galland Home Health Services ("Kline Galland").

What are Telehealth Services? Health services such as evaluation and management visits which are conducted using interactive video, audio and telecommunications technology ("telehealth technology") through computers, tablets or smart phones, rather than in-person.

Why is Kline Galland Offering Telehealth Services? The use of telehealth services will help ensure you are able to visit with your Kline Galland health care provider or clinician without having an in-person visit.

Why is my consent required? Medicare has temporarily expanded its coverage of telehealth services. Healthcare providers and clinicians, however, must first obtain each patient's/responsible party's consent to the use of telehealth services, and document this consent in the patient's medical record.

What are some of the risks of using telehealth services? In order to encourage the use of telehealth services during the current Public Health Emergency, the federal government agreed March 17, 2020 that it would not enforce some of the HIPAA rules relating to the use and disclosure of Protected Health Information (PHI). You should be aware that PHI is at greater risk of improper disclosure during telehealth services, because:

- Your PHI, which may include medical history, examinations, x-rays, or other tests, will be discussed, including with other health professionals through the use telehealth technology.
- Assessments and physical examinations may take place via telehealth technology.
- Non-medical technical or administrative personnel may be present at our location to assist us with the operation of the telehealth technology and necessary record keeping. Video and/or digital images and audio files may be recorded during telehealth services. At your location, household members or others present may hear or see PHI while you receive telehealth services.

Other things to know:

1. **Getting Used to Telehealth Technology.** At first, you may find it difficult or uncomfortable to communicate using video images or other telehealth technology. Delivering healthcare in this way is new and may not be equivalent to direct patient-to-provider or clinician contact. Following the telehealth services visit your Kline Galland provider or clinician may recommend an in-person visit or other follow up for you.
2. **Rights.** You may withhold or withdraw consent to receiving telehealth services at any time without affecting your right to future care or treatment by Kline Galland, or risking the loss or withdrawal of any government benefits to which you would otherwise be entitled.
3. **Medical Information and Records.** Except as mentioned above, existing laws regarding patient privacy and access to medical information and obtaining copies of your medical records apply to telehealth services.

NON-DISCRIMINATION

Our commitment is to provide care and services that are accessible to all and free from discrimination. We invite you to review our Non-Discrimination Statement, below. We also provide information on Language Assistance for individuals not proficient in English. If at any time you feel our actions have not lived up to our Non-Discrimination Statement, we invite you to take advantage of our Grievance Procedure.

Non-Discrimination Statement

Kline Galland complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Nor will we exclude people or treat them differently because of race, color, national origin, age, disability or sex.

As part of this commitment...

- We provide free aids and services to people with disabilities to communicate effectively with us. For example, this includes:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio and online
- We provide access to free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need any of these services, please contact: Director, Kline Galland Benaroya Community Services, who serves as our designated Non-Discrimination Coordinator at:

Director, Kline Galland Benaroya Community Services
6100 4th Ave S, Suite 403
Seattle, WA 98108
(206) 805-1930

If you believe that we have not provided these services or that we have discriminated in any other way on the basis of race, color, national origin, age, disability or sex, you may file a grievance with our Non-Discrimination Coordinator. Please see our Grievance Procedure and Form. You may file a grievance in person, by mail, fax or email. If you need help filing a grievance, our Non-Discrimination Coordinator will be glad to help you.

You may also file a civil rights complaint with the U.S. Department of Health a nd Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal. hhs.gov/ocr/portal/lobby.jsf, or by mail or phone directed to: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, (800) 868-1019, (800) 537-7697 (TDD). Complaint forms are available at hhs.gov/ocr/office/file/index.html.

LANGUAGE ASSISTANCE

The following are published here pursuant to Section 1557 of the Affordable Care Act and implementing regulations, 45 CFR 92.8(d)(1)

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(844) 826-1042.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-(844)826-1042.

Serbo-Croatian

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-(844) 826-1042.

Lao

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ ຈຸ,ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-(844) 826-1042.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-(844) 826-1042.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-(844) 826-1042.

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-(844) 826-1042.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-(844) 826-1042.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-1-844-826-1042.رقم

Tagalog – Filipino

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-(844) 826-1042.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-(844) 826-1042.

Indonesian

PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-(844) 826-1042.

Samoan

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-(844) 826-1042.

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-(844) 826-1042.

Diné Bizaad (Navajo)

D77 baa ak0 n7n7zin: D77 saad bee y1nt7[t7 go Din4 Bizaad, saad bee 1k1'1nida'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-(844) 826-1042.

PROVIDING FEEDBACK ABOUT OUR SERVICE(S)

Kline Galland Home Health is committed to providing quality care and respecting your right to privacy of your personal health information. Should you have any concern about these issues, we want you to have the resources about how to communicate your experience. We take all feedback and complaints very seriously, and are committed to addressing situations when your expectations have not been met.

Procedure for making complaints or asking questions about Kline Galland:

If you have any complaints regarding the services that you have received from Kline Galland Home Health or questions about Kline Galland in general, you may contact:

Kline Galland Home Health Manager, Director or Administrator on call
Phone: (206) 805-1930, 24-hours a day

Department of Health Services
24-hour, toll-free hotline at (800) 633-6828

Community Health and Accreditation Partner (CHAP)
Phone: (202) 862-3413
Toll-Free: (800) 656-9656
Email info@chapinc.org

Have something positive to share about your experience?

We welcome the opportunity to hear about the things that have gone well. This helps reinforce systems we have in place and/or provide praise to well-deserving employees.

Here are some avenues for you to provide this feedback:

- Call our office (206) 805-1930 and ask to speak with the Manager or Director
- Send us a letter, attention to the Director at:

  Kline Galland Home Health,
  6100 4th Ave S, Suite 403
  Seattle, WA 98108
- Respond to our Patient Satisfaction Survey (to be mailed to your home approximately 4-6 weeks after your services).
- Email us at feedback@klinegalland.org

The Home Health staff is prohibited from accepting personal gifts and borrowing from patients/families.

We care about your home health care experience.

Kline Galland Home Health is collecting feedback from patients who use our agency. The survey asks patients like you about their home health care and if they would recommend the agency to someone else. Your feedback will help us improve our care.

If you receive a survey in the mail or a phone call from **Strategic Healthcare Programs (SHP)**, please take a few minutes to share your experience about the care you received from our agency.

Your voice matters!

- Visit medicare.gov/care-compare/ to find and compare the quality of home health care agencies across the country.

Your answers will help us improve the quality of our care and help others choose a home health agency! Your participation in the survey is voluntary and your information is kept private by law. No one will be able to connect your answers to your name.

Thank you in advance for your feedback!

KLINE GALLAND HOME HEALTH

SHP STRATEGIC HEALTHCARE PROGRAMS

SAFETY IN THE HOME SETTING

SAFETY ISSUES AT HOME

Our goal is to help keep you safe in your home environment. There are many situations that pose a threat to your personal safety. This section is designed to identify those circumstances and provide information and guidance to help prevent further problems to your health.

Preventing the Spread of Infection:

- Wash hands frequently (both before and after eating, drinking, handling food, using the toilet, covering a cough and blowing your nose – for caregivers, before and after providing care

  Tips for effective hand washing:

  1. Push up your sleeves and rinse hands in warm water.
  2. Apply soap and work hands together for approximately 20 seconds.
  3. Be sure to wash under your nails, your cuticles and your thumbs.
  4. Rinse well.
  5. Dry hands with clean towel or paper towel.
- Use extra caution around blood, body fluids and any sharp objects (such as syringes). Ask the clinicians for any special safety precautions they recommend
- If personal protective items such as gloves or masks are recommended by the home health providers, be sure to learn how to put them on and take them off correct
- Remind others visiting the home or providing care to help prevent the spread of infection by washing their hands thoroughly and at the appropriate times

Fall Prevention:

Falls are the most common cause of injury and can cause serious health problems. Our goal is to help identify the risks so you can prevent this from happening. There are four major factors that contribute to older persons having an increased risk of falling:

- **Environmental Causes** – such as throw rugs, electrical cords, wet and slippery floors, rough floor surfaces, poor lighting
- **Physical & Mental Changes** – such as eyesight, sense of balance and/or reflexes, impaired mobility, confusion, forgetfulness, stroke, Parkinson's and Alzheimer's Disease can also play a contributing role
- **Medications** – sometimes they cause dizziness, drowsiness or other side effects that make it harder to keep your balance
- **Unexpected Occurrences** – such as leaning against a door that you thought was secured but was not, or an obstacle left in your pathway that you were not anticipating

Below are some steps you can take to minimize the risk of falls:

- Keep pathways where you walk open and clear of clutter
- Install handrails (securely) in areas where you may be at risk for falling
- Remove throw rugs
- Ensure that wall to wall carpet is not loose or uneven
- Keep cords out of walking paths
- Select footwear with non-skid soles
- Be cautious of spills and liquids on the floor
- Have adequate lighting throughout your home; use nightlights
- Have a grab bar and tub mat in your shower area

Personal Safety:

- Be sure the phone works and keep it within reach
- Keep emergency phone numbers posted and/or easily accessible
- Keep doors and windows locked
- Do not open the door to strangers; ask for identification
- Keep a flashlight accessible

Fire Safety/Burn Prevention:

- Have smoke detectors in each room; check routinely; change batteries every six (6) months
- Have fire extinguishers available
- Keep hot water heater set at 120 degrees or lower
- Do not smoke in bed

- Keep pot/pan handles turned inward on the stove and check to ensure burners and oven are shut off after use
- Keep exits free of clutter
- Have an escape plan in the event of fires
- Have furnace and other potentially dangerous equipment checked annually
- Do not overload the circuits
- Do not use frayed cords or faulty switches
- Do not stretch cords across pathways

Oxygen Safety:

- Do not use oxygen by open flames such as a gas stove
- Do not smoke while using oxygen
- Do not use electric razors near oxygen tanks due to potential for sparks
- Keep portable tanks easily accessible in the event they are needed in an electrical outage
- Do not use petroleum products such as oil or grease, due to the risk of combustion (Vaseline is a petroleum-based product and should not be used for nasal irritation – use a water-based product instead, such as K-Y Jelly)
- Use oxygen only as directed by your physician (It is a drug and should be treated like any other medication)
- Post a sign in your home that is easily visible to visitors and residents notifying them of your use of oxygen
- Notify your utility company that oxygen is in use so that your home can be a priority for any power outage

Emergency/Disaster Preparedness:

It is important to plan ahead for events that you can't control related to weather and the environment, such as an earthquake or tsunami. Refer to the booklet provided in your admit packet that has been prepared by the Washington State Department of Health to help become prepared for issues that could potentially occur in our area.

To learn about local and state evacuation plans, the following resources can be accessed:

Local Emergency News from King County Emergency Management King County

kcemergency.com

kingcounty.gov/depts/emergency-management/alert-kingcounty.

aspx (sign up for alerts here)

Email: ecc.kc@kingcounty.gov (email to contact if there are issues)

Office Phone: (206) 296-3830 (not applicable for "Registration")

Toll-Free: (800) 523-5044

TTY Relay: 711

City of Seattle Emergency Management

seattle.gov/emergencymanagement

Phone: (206) 233-5076

Local Radio, Television & Online Sources

KOMO Radio News

AM 1000

FM 97.8

komonews.com

KIRO News – Channel 7

FM 97.3

Washington Emergency Management Division

mil.wa.gov/emergency-management-division

Emergency Shelter Resources

Crisis Clinic

crisisclinic.org/education/disaster-resources/

Toll-Free: (866) 427-4747

King County Community and Human Services

kingcounty.gov/depts/community-human-services/housing/services/homeless-housing/emergencyhousing. aspx

Phone: (206) 263-9010 TTY Relay: 711

Seattle-King County Medical Respite

kingcounty.gov/depts/health/locations/homelesshealth/ healthcare-for-the-homeless/services/medicalrespite. aspx

Phone: (206) 296-0100 TTY Relay: 711

Kline Galland Home Health's Role in Caring for You During an Emergency:

When you are under the care of Kline Galland Home Health, should there be a natural or man-made emergency or disaster, our goal is to help provide and/or coordinate care for you. Strategies Kline Galland utilizes to help manage your care include:

- **Develop a Triage Plan** – Each patient under the care of Kline Galland Home Health is assigned a triage code to be used during a time of emergency. These codes help your clinical team determine which patients have the most acute needs. The codes assigned are as follows:
  - Level 1 – Visit must be made within one (1) day
  - Level 1 – Oxygen use – Triage must be done to determine if patient has functioning oxygen and if not, arrangements made with local emergency officials
  - Level 1 – Dialysis – Triage must be done to determine if plans have been made for needed dialysis treatments
  - Level 2 – Visit should be made within two to three (2-3) days
  - Level 3 – Visit can be postponed three to four (3-4) days or greater
- **Arrangements with Alternative Care Providers**– Should Kline Galland Home Health face challenges with service during the time of an emergency and become unable to deliver necessary care, Kline Galland may transfer your care to another provider. This could be an alternative home health company, a skilled nursing facility, hospital or emergency shelter. Kline Galland Home Health maintains working lists of these facilities so that they can be accessed efficiently during the time of an emergency.

MEDICATION SAFETY

- Medications and treatments are ordered by your physician – take your medication exactly as your physician has prescribed it to you
- Please notify your health care provider if your prescription has been changed, but the label on the bottle has not been updated
- Be sure to follow the guidelines for safe storage of medications as indicated on the medication label
- Keep all medications together in one location if storage instructions are the same
- Dispose of discontinued medications in a safe manner
- Do not use someone else's medications
- If you miss a dose of your medication, do not "double dose" or modify the next dose unless you have consulted with a nurse, pharmacist or your physician
- Keep an accurate record of all the medication you take. This includes prescription medications, over the counter medications and any vitamins or herbal supplements you take. Also include on this list a record of any allergies or sensitivities to any medications

DISPOSAL OF UNUSED MEDICATIONS & DONATION OF MEDICAL SUPPLIES/EQUIPMENT

Any prescribed medications that are not being used should be destroyed. Health Department regulations prohibit organizations from accepting returned medications, medical supplies or equipment. We have listed some alternative below to help you chose the best way for disposing of or recycling these items.

**Please note that Kline Galland employees are not permitted to remove medications from your home to destroy or dispose of them for you.*

In Washington State, some businesses and law enforcement offices are participating in a program to take back unwanted/ expired/unneeded medications in an effort to protect children, families and the environment. To find a list of participating locations, visit the "Take Back Your Meds" website: takebackyourmeds.org/what-you-can-do/locations

If you are not able to take medications to a drug disposal location, the following steps should be followed:

- Keep the medication in its original container
- Modify the medications to discourage consumption by mixing them with kitty litter, coffee grounds, flour or sawdust
- Tape the container closed and place in a sealable bag then in a non-transparent container
- Discard the container in the garbage (not the recycling bin) and secure your trash to prevent access by children and pets
- DO NOT flush medications down the toilet or down a sink drain

Medical Equipment/Supplies

Durable Medical Equipment (DME) provided by Kline Galland must be returned upon patient discharge, and will be coordinated by the Case Manager. Privately purchased equipment or supplies may be donated at several local resources including:

Bridge Disability Ministries

bridgemin.org/medical-equipment/give-equipment/

Washington Access Fund

washingtonaccessfund.org/other-resources/

ALS Association Evergreen Chapter

webwa.alsa.org

Medication Information Resources

Should you want or need more information, here are resources for accessing data sheets on specific medications:

Medline Plus

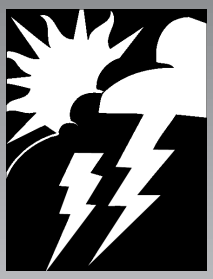
nlm.nih.gov/medlineplus/druginformation.html

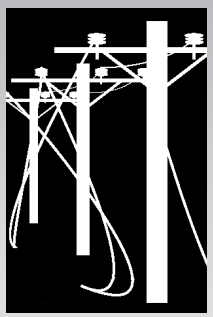
U.S. Food and Drug Administration

fda.gov/Drugs/default.htm

Prepare

Home emergency guide





Make a plan

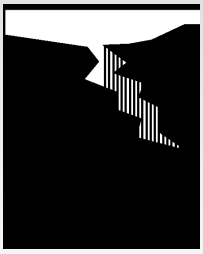
Store emergency supplies

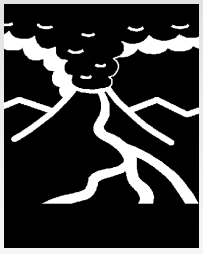
Know what to do when the power is out

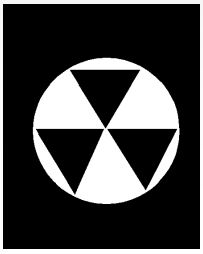
Be sure your water is safe to drink

Prevent the spread of germs

Learn about earthquakes, floods and more







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WASHINGTON MILITARY DEPARTMENT
Emergency Management Division
www.emd.wa.gov

Protect Your Health During an Emergency

Disasters such as earthquakes, floods or volcanic eruptions can cause a great deal of destruction and personal injury. These events can also damage power and water systems, leaving us without electricity or running water for many hours or days.

Without power, things we take for granted like heating our homes or cooking become much more difficult, and sometimes even dangerous. Many people die each year from carbon monoxide poisoning when they try to heat or cook in their homes with charcoal grills or gas powered devices.

Other emergencies, such as pandemic flu or disease outbreaks, also put people at risk and strain resources.

Planning ahead can help you get through any emergency, from natural disasters to disease outbreaks. The tips in this guide will help you and your family prepare.

Washington State Department of Health

DOH 821-076 June 2013

For persons with disabilities this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TTY/TDD 711).

This guide was developed by the Washington State Department of Health and made possible through funding from the National Centers for Disease Control and Prevention. Portions of this guide were developed jointly with the Washington Military Department – Emergency Management Division.

Make a Plan

Make sure all family members agree on an emergency plan, including where to meet and who to contact during an emergency. Give emergency information to caregivers.

Things you can do now

- Choose a place for your family to meet after a disaster.
- Put together an emergency supply kit for your home and workplace. If your child's school or day care stores personal emergency kits, make one for your child to keep there.
- Know how to contact and pick up your children at their school or day care after a disaster. Let the school know if someone else is authorized to pick them up. Keep your children's emergency release cards up to date.
- Know where the nearest fire and police stations are located.
- Learn your community's warning signals, what they sound like and what you should do when you hear them.
- Learn first aid and CPR. Have a first aid kit, a first aid manual and extra medicine for family members.
- Learn how to shut off your water, gas and electricity. Know where to find shut-off valves and switches.
- Keep some cash available. If the power is out, ATMs won't work.
- If you have family members who don't speak English, prepare emergency cards in English with their names, addresses and information about medications or allergies. Make sure they can find their cards.
- Conduct earthquake and fire drills every six months.
- Make copies of your vital records and store them in a safe deposit box in another city or state. Store the originals safely. Keep photos or videotapes of your home and valuables in your safe deposit box.
- Make sure those in your home know all the possible ways to get out. Keep all exits clear.

During an emergency or disaster

- Listen to your radio or television for official information and instructions.
- If ordered to evacuate, follow official directions to a safe place or temporary shelter. Take your emergency kit.
- Use the telephone for emergency calls only.

Choose Out-of-Area Contacts

Choose a person outside the immediate area for family members to contact if you get separated. The person should live far enough away so they won't be involved in the emergency.

Before disaster strikes

- Make cards with the contact person's name and phone number for all family members to carry in their wallets, purses or backpacks.
- Keep a phone that does not require electricity. Cordless phones use electricity—if the power is out, they will not work!
- Many communities have systems that will send instant text alerts or e-mails to let you know about bad weather, road closings or local emergencies. Sign up by visiting your local Office of Emergency Management website.

Contact loved ones after disasters

- All household members should call the out-of-area contact. The contact person will collect information about each family member, where they are, and how to contact them.
- It may be difficult to make local calls because large numbers of people may be using the phone lines at the same time. However, you should be able to make long distance calls.
- You may be able to send text messages to your loved ones. Keep messages short.
- You should be able to use a pay phone if your home phone does not work. Pay phones are a priority to be restored to service. Tape coins for pay phone use to your out-of-area contact card.

Store Emergency Food, Water and Supplies

Be prepared to take care of yourself and those in your home for at least three days. For events such as a flu pandemic, you may need to prepare for a week or more.

Keep the following supplies at home

- Drinking water (one gallon per person per day)
- Dry or canned food for each person
- Can opener
- First aid supplies and first aid book
- Copies of important documents such as birth certificates, licenses and insurance policies
- "Special needs" items for family members such as infant formula, eyeglasses and medications
- A change of clothing
- Sleeping bag or blanket
- Battery powered radio or television
- Flashlight and extra batteries
- Whistle
- Waterproof matches
- Toys, books, puzzles and games
- Extra house keys and car keys
- List of contact names and phone numbers
- Food, water and supplies for pets

More items that are useful during an emergency

Cooking supplies

- Barbecue and camp stove (never use these indoors!)
- Fuel for cooking, such as charcoal or camp stove fuel
- Plastic knives, forks, spoons
- Paper plates and cups
- Paper towels
- Heavy-duty aluminum foil

Sanitation supplies

- Large plastic trash bags for trash and water protection
- Large trash cans
- Bar soap and liquid detergent
- Shampoo
- Toothpaste and toothbrushes
- Feminine and infant supplies
- Toilet paper
- Household bleach with no additives, and eyedropper (for purifying drinking water)
- Newspaper—to wrap garbage and waste

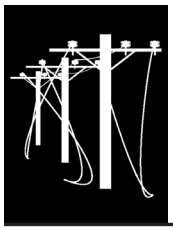
Comfort

- Sturdy shoes
- Gloves for clearing debris
- Tent

Tools

- Ax, shovel and broom
- Crescent wrench for turning off gas
- Screwdriver, pliers and hammer
- Coil of one-half inch rope
- Plastic tape and sheeting
- Knife or razor blades
- Garden hose for siphoning and fire fighting

Power Outages



Many disasters can include power outages that make it difficult to heat homes, store or cook food safely, and communicate. Here are some important things to know when the power goes off.

Before a power outage

- Register life-sustaining and medical equipment with your utility company.
- Stock your disaster preparedness kit with light sticks, flashlights and a battery-powered radio with extra batteries.
- Have a corded telephone available—cordless phones will not work when the power is out.
- If you own an electric garage door opener, know how to open the door without power.

During a power outage

- Turn off lights and electrical appliances except for the refrigerator and freezer. Even if it is dark, turn light switches and buttons on lamps or appliances to the "off" position.
- Unplug computers and other sensitive equipment to protect them from possible surges when the power is restored.
- Leave a lamp on so you will know when power is restored. Wait at least 15 minutes after power is restored before turning on other appliances.
- Conserve water, especially if you use a well.
- Candles can cause a fire. Use battery-operated flashlights or glow sticks for lighting.
- Stay away from downed power lines and sagging trees with broken limbs.
- ONLY use a generator outdoors and far from open windows and vents.
- NEVER cook or heat inside on a charcoal or gas grill.

Beware of Carbon Monoxide Poisoning When Cooking and Heating

Hundreds of people die accidentally every year from carbon monoxide poisoning caused by appliances that are not used properly or that are malfunctioning. Learn how to protect yourself and your family.

NEVER use a generator indoors, in garages or carports.
NEVER cook or heat inside on a charcoal or gas grill.

What is carbon monoxide?

- Carbon monoxide is a poisonous gas that cannot be seen or smelled and can kill a person in minutes.
- Carbon monoxide is produced whenever any fuel such as gas, oil, kerosene, wood or charcoal is burned.
- Carbon monoxide can build up so quickly that victims are overcome before they can get help.

If inhaled, carbon monoxide can cause chest pain, heart attacks in people with heart disease, or permanent brain damage.

Symptoms of carbon monoxide poisoning

Headache	Weakness	Dizziness
Confusion	Fatigue	Nausea

Prevent carbon monoxide poisoning

- Never burn charcoal inside homes, tents, campers, vans, trucks, garages or mobile homes.
- Do not burn charcoal in your fireplace.
- Never use gasoline-powered equipment indoors.
- Never use a gas oven to heat your home, even for a short time.
- Never idle a car in a garage, even when the garage door is open.
- Never sleep in a room while using an unvented gas or kerosene heater.
- Make sure that chimneys and flues are in good condition and are not blocked.
- Carbon monoxide warning devices may help protect you, but should not replace other prevention steps.

If you suspect someone has been poisoned by carbon monoxide

- Move the person to fresh air immediately.
- Take the person to an emergency room and tell emergency room staff that you've brought a potential victim of carbon monoxide poisoning.

Use your generator safely

- Never use a generator in your home, garage, carport or any enclosed or partially enclosed area. Opening doors and windows or using fans will not prevent carbon monoxide buildup in the home.
- Keep your generator away from your home's windows, doors and vents.
- Follow the directions supplied with the generator.
- If you start to feel sick, dizzy or weak while using a generator, get to fresh air right away!
- Install battery-operated carbon monoxide alarms in your home.
- Never plug the generator into a wall outlet—it's dangerous. Plug appliances into the generator using an outdoor extension cord.

Keep Food Safe When Power Is Out

When the power is out, your refrigerator, stove or microwave won't work. When food is not kept cold or is not fully cooked, bacteria can grow and make you sick. Be very careful with food such as meat, milk, eggs or seafood. Keep these foods cold and cook them to help prevent foodborne illness.

Use foods first that can spoil fast

Use meat, milk, eggs, fish or shellfish before you use foods that do not require refrigeration or cooking.

Keep food cold

If the power outage is expected to last more than a day, it is most important to keep meat, seafood and dairy products cold.

- Keep refrigerator and freezer doors closed. Freezers that are part of a refrigerator-freezer combination will keep food frozen for up to a day. A free-standing freezer will keep food frozen solid for two days if it is fully loaded. A half-full freezer will keep food frozen for a day, especially if the food is grouped together.
- Buy an ice chest.
- Find out where you can buy ice blocks or dry ice to keep your freezer or refrigerator cold.
  - Never touch dry ice with bare hands. Never taste it or put it in your mouth.
  - Ventilate well before placing dry ice in freezer and don't inhale the gas vapors.
  - Don't place dry ice directly on food or glass shelves and don't use in an operating freezer.

If you can't fit everything into the ice chest

In cold weather, items such as the following can be stored in a cardboard box in a garage or shed:

- Jams and jellies
- Ketchup, mustard, pickles, other condiments
- Butter and margarine
- Fresh uncut fruit and vegetables

Don’t store food outside during winter

Storing food outside during winter isn’t recommended because outdoor temperatures change throughout the day. The sun may thaw frozen foods or warm cold foods so that they grow bacteria.

Know what food to keep and what to throw out

If food is cold to the touch and you know it has not been above 45 degrees Fahrenheit for more than an hour or two, it is probably safe to keep, use or refreeze. Throw away all meat, seafood, dairy products or cooked foods that don’t feel cold to the touch. Even when refrigerated, many raw foods should be kept only three or four days before they are cooked, frozen or thrown away.

If in doubt, throw it out. Never taste suspicious food. It may look and smell fine, but the bacteria that cause foodborne illness may have grown on the food and will make you sick.

Be Sure Your Water is Safe to Drink

The treatments described below work only to remove bacteria or viruses from water. If you suspect the water is unsafe because of chemicals, oils, poisonous substances, sewage or other contaminants, do not drink the water. Don't drink water that is dark colored, has an odor or contains solid materials.

Storing water safely

The best source of drinking water during an emergency is water you have stored with your emergency supplies.

- Store one gallon of water per person per day—enough for at least three days.
- Store-bought, factory-sealed bottled water is best. Check for an expiration date and replace the supply as needed.
- If you choose to fill your own water containers:
  - Collect the water from a safe supply.
  - Store water in thoroughly washed plastic containers such as soft drink bottles. You can also purchase food-grade plastic buckets or drums.
  - Add two drops of household bleach per gallon to maintain water quality while in storage.
  - Seal water containers tightly, label with date and store in a cool, dark place.
  - Replace water every six months.
  - Never reuse a container that held toxic substances such as pesticides, chemicals or oil.

Purifying by boiling

If your tap water is unsafe, boiling is the best method to kill disease-causing organisms. If tap water is unavailable, the following may be considered as potential water sources. Water taken from these sources should be boiled before drinking:

- Rainwater
- Lakes
- Rivers and streams
- Natural springs
- Ponds

CAUTION: Many chemical pollutants will not be removed by boiling.

Cloudy water should be filtered before boiling. Filter cloudy water using coffee filters, paper towels, cheesecloth or a cotton plug in a funnel.

- Bring the water to a rolling boil for at least one full minute.
- Let the water cool before drinking.
- Add two drops of household bleach per gallon to maintain water quality while in storage.

Purifying by adding liquid chlorine bleach

Boiling is the preferred method of treating water taken from lakes, rivers, ponds, rainwater and other surface water sources. If surface water or unsafe tap water is the only source of water available in an emergency and boiling is not possible, the next best alternative is to treat the water with chlorine bleach.

- Treat water by adding liquid household bleach such as Clorox® or Purex®.
- Household bleach is typically between 5.25 percent and 8.25 percent chlorine. Read the label.
- Avoid using bleach that contains perfumes, dyes or other additives. Be sure to read the label.
- Cloudy water should be filtered before adding bleach.
- Place the water in a clean container. Add the amount of bleach according to the table below.
- Mix thoroughly and let stand for at least 60 minutes before drinking.

Treating water with household bleach containing 5.25 – 8.25 percent chlorine

Volume of Water to be Treated	Bleach Solution to Add
1 quart/1 liter	5 drops
1/2 gallon/2 quarts/2 liters	10 drops
1 gallon	1/4 teaspoon
5 gallons	1 teaspoon
10 gallons	2 teaspoons

CAUTION: Bleach will not kill some disease-causing organisms commonly found in surface water. Bleach will not remove chemical pollutants.

Places to Find Water in an Emergency

In an emergency, when tap water and bottled water are unavailable, you can find water in some unexpected places. Some of these places are listed below.

What are some alternative sources of water *inside* your home?

- Water can be drained from the drain spout of a water heater. Be sure the electricity and/or gas are off before opening the drain. Drain the water into a clean container.
- Water can be drained from the pipes inside your home. Open a faucet on the top floor of your home. Next, go to the faucet at the lowest point in your home. Open the faucet and drain out the water you need into a clean container.
- Water from your toilet storage or reserve tank can be used if no chemicals have been used in this tank. Do not use this water if you have added chemicals to your toilet.
- Water that has been placed in ice cube trays in the freezer can be used.

What are some alternative sources of water *outside* your home?

- Rainwater
- Lakes
- Rivers and streams
- Natural springs
- Ponds

Water taken from these outside sources should be boiled before drinking. If boiling is not possible, the next best alternative is to treat the water with chlorine bleach. See the previous page “Be sure Your Water is Safe to Drink” for information about boiling or adding bleach to your water.

Prevent the Spread of Germs

Conditions during emergencies often make it easier for germs and disease to spread. Here are some simple tips to help keep respiratory infections and many other contagious diseases from spreading at any time.

Respiratory infections affect the nose, throat and lungs; they include influenza (the "flu"), colds and pertussis (whooping cough). The germs (viruses and bacteria) that cause these infections are spread from person to person in droplets from the nose, throat and lungs of someone who is sick.

You can help stop the spread of these germs by practicing good health manners:

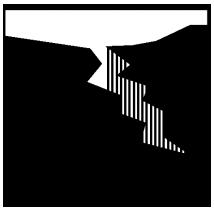
Keep your germs to yourself

- Cover your nose and mouth with a tissue when sneezing, coughing or blowing your nose.
- Discard used tissues in the trash as soon as you can.
- Always wash your hands after sneezing, blowing your nose or coughing, or after touching used tissues or handkerchiefs.
- Use warm water and soap to wash your hands. If you don't have soap and water, use alcohol-based hand gel or disposable wipes.
- Try to stay home if you have a cough and fever.
- See your doctor as soon as you can if you have a cough and fever, and follow their instructions. Take medicine as prescribed and get lots of rest.
- If asked, use face masks provided in your doctor's office or clinic's waiting room. Follow office or clinic staff instructions to help stop the spread of germs.

Keep the germs away

- Wash your hands before eating, or touching your eyes, nose or mouth.
- Wash your hands after touching anyone who is sneezing, coughing or blowing their nose.
- Don't share things like towels, lipstick, toys or anything else that might be contaminated with respiratory germs.
- Don't share food, utensils or beverage containers with others.

What to Do During a Disaster

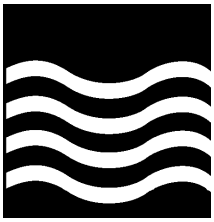


Earthquake

- **If you are indoors,** Drop, Cover and Hold when you feel the earth shake. Get under a desk or table away from windows and objects like bookcases that could fall. Hold on to the desk or table. Stay until the shaking stops.
- **If you are outdoors,** move to a clear area away from trees, signs, buildings or downed electrical wires and poles.
- **If you are in a downtown area** outside of a tall building, get into a building's doorway or lobby to protect yourself from falling bricks, glass or debris.

Tsunami

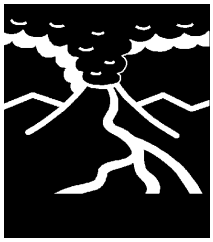
- If you are near the shore, move to higher ground or inland as far as you can go immediately if:
  - You hear a siren.
  - You feel the earth shake.
  - The ocean recedes dramatically from the shoreline.
  - A tsunami warning is issued for your area.
- Follow established tsunami evacuation routes. If no higher ground is near, go to upper levels of reinforced buildings.
- A tsunami can cause a series of waves that arrive over several hours.



Flood

- **Do not** try to walk or drive through flooded areas. Water can be deeper than it appears and water levels rise quickly. Moving water six inches deep can sweep you off your feet. Cars can be swept away in just two feet of water.
- Stay away from downed power lines.
- If your home is flooded, turn the utilities off until emergency officials tell you it is safe to turn them on. Do not pump the basement out until floodwater recedes. Avoid weakened floors, walls and rooftops.
- Wash your hands frequently with soap and clean water if you come in contact with floodwaters.

What to Do During a Disaster continued

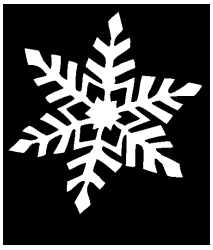


Volcano

- Be prepared to stay indoors and avoid downwind areas if ashfall is predicted.
- Be prepared to evacuate when instructed by officials if ashfall is very heavy or mud and debris flows could reach your area.
- Avoid rivers and streams that could carry mud or debris.

Disease outbreak or pandemic

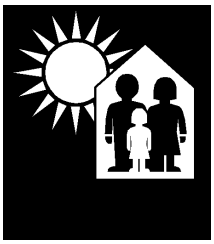
- **To protect yourself and others, cover your mouth and nose when you sneeze, wash your hands often and don't touch your eyes, nose or mouth.**
- Stay home from work when you are sick. Know work policies about sick leave, absences, time off and telecommuting. Make a plan for taking care of your children if schools are closed.
- Be prepared to get by for a week or more with the food and supplies you have at home. Stores may not be open or may have limited supplies.



Extreme cold weather

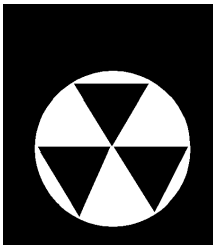
- Do not drive unnecessarily.
- Wear layers of loose-fitting, lightweight clothing rather than one layer of heavy clothing. Wear mittens rather than gloves. Wear a warm hat.
- Reduce the temperature in your home to conserve fuel. Heat only the areas of your home you are using. Close doors or curtains, or cover doors and windows with blankets.

What to Do During a Disaster continued



Extreme hot weather

- Stay indoors and in an air-conditioned area as much as possible.
- Drink plenty of fluids but avoid beverages that contain alcohol, caffeine or a lot of sugar.
- Cover windows that receive direct sunlight.
- If it is too hot to remain in your home, your local government may provide emergency cooling shelters. Listen to radio and television or read the newspaper to find out where they are located.



Radiation release

- Stay inside your home or office unless otherwise instructed by authorities. Close the windows, turn off the heating or air conditioning and stay near the center of the building. By staying inside, you will reduce any potential exposure to airborne radioactive material. Go to the basement if one is available.
- If told to evacuate, do so promptly. Take items you will need for an extended absence. Take prescription medicines, clothing, food, water and money. Experts will recommend the best ways to safely leave the area.
- Avoid drinking fresh milk or eating fruits and vegetables grown in the affected area. Wait until the Department of Health declares food and water safe to consume. Food stored in cans or bags is safe to eat. Fresh food harvested before the radiation release and stored inside is safe. Thoroughly rinse off containers before opening.
- If you suspect you are contaminated, carefully remove your outer layer of clothing and put it in a plastic bag. Take a warm shower. Use soap and shampoo to wash off any radioactive materials. Place the sealed plastic bag in a room away from people.

Resources on the Web

Washington State Department of Health

Over 50 fact sheets and other resources devoted to emergency preparedness: **www.doh.wa.gov**

Washington State Emergency Management Division

Emergency preparedness information for schools, businesses and individuals, including how-to videos: **www.emd.wa.gov**

Ready.gov

Personal, community and business preparedness information featuring an online tool you can use to create a preparedness plan: **www.ready.gov**

Adult Protective Services

Report to Adult Protective Services

REPORT ONLINE
dshs.wa.gov/altsa/reportadultabuse

REPORT BY PHONE
877-734-6277 | (TTY) 833-866-5595

LEARN MORE ABOUT APS
dshs.wa.gov/altsa/aps

Call **911 Immediately** if you think someone is in danger or needs urgent help.

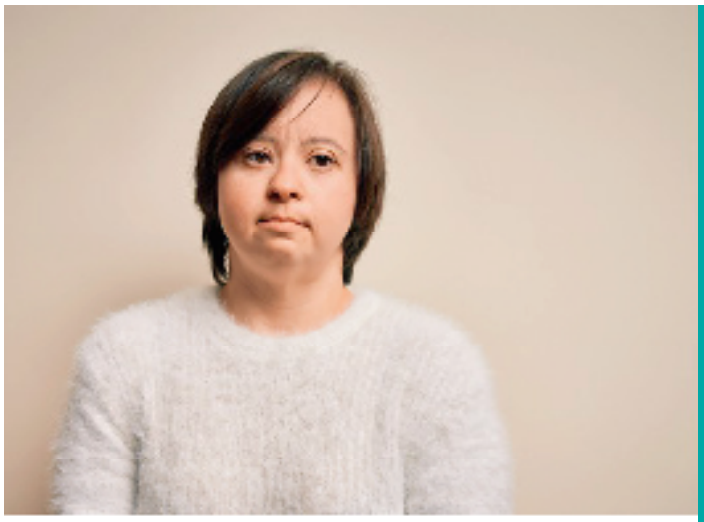
– OR –

SCAN WITH YOUR SMARTPHONE

Washington State Department of Social and Health Services
Aging and Long-Term Support Administration

Transforming lives

DSHS 22-810 (Rev. 4/24)



Adult Protective Services

We investigate allegations of abuse, neglect, abandonment, financial exploitation and self-neglect of vulnerable adults in Washington state. We collaborate with other agencies and community partners to offer protective services.

Our goal is to promote lives free of harm while respecting individual choice.

Who is considered a vulnerable adult?

A person who is:

- 60 years of age or older who has the functional, mental or physical inability to care for himself or herself; or
- Subject to guardianship or conservatorship under RCW 11.130; or
- Who has a developmental disability; or
- Admitted to any facility; or
- Receiving services from home health, hospice, or home care agencies licensed or required to be licensed; or
- Receiving services from an individual provider; or
- Who self-directs his or her own care and receives services from a personal aide.

Frequently Asked Questions

- **What information do I need to provide when making a report?**
  - *Your name and contact information (in case we have follow-up questions). You can choose not to provide your name.*
  - *The names and contact information for the vulnerable adult and the person you think is causing harm.*
  - *Description of the situation.*
  - *Any known safety concerns.*

- **I think there might be abuse or neglect happening, but I'm not sure. What should I do?**

  Make a report anyway! We'll take care of the rest.

- **Can I get in trouble if I make a report without knowing all the details first?**

  Share what you do know about the situation. It's our job to investigate the details. If you make a report in good faith, you have immunity from liability.

KNOW THE SIGNS

See. Stop. Report.

Neglect and Self-Neglect

- Lack of food and water.
- Changes in personal hygiene.
- Lack of medication, missed appointments or isolation.

Financial Exploitation

- Basic needs not met.
- Unpaid bills.
- Unexplained financial changes.

Physical Abuse

- Suspicious bruises, black eyes or welts.
- Unexplained broken bones, cuts, or sprains.
- Sudden changes in behavior.

Mental Abuse

- Threatening significant harm.
- Derogatory names, insults, profanity or ridicule.
- Harassment or humiliation.

Sexual Abuse

- Unusual bruising on thighs or chest.
- Unexplained sexually transmitted infections (STIs).
- Withdrawn from social interactions.

STRONGER TOGETHER

Reporting is a partnership

Help protect vulnerable adults

- ☐ **VISIT:** Check on your family and friends.
- ☐ **SHARE:** Tell others about APS.
- ☐ **SUPPORT:** Offer support to caregivers.
- ☐ **REPORT:** Recognize the signs and report to APS.

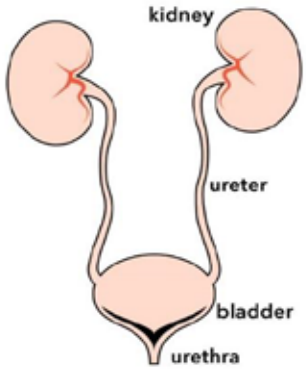
DETERMINE YOUR UTI RISK!

UTIs are the second most common type of infection in the body.

How susceptible are you?

Check all that apply:

- ☐ Age >65
- ☐ Age >85
- ☐ History of UTI
- ☐ Current catheter use
- ☐ All levels of incontinence (any use of disposable underwear/pads)
- ☐ Diagnosis of Diabetes
- ☐ Female
- ☐ Unable to walk without assistance
- ☐ Weakened immune system
- ☐ Enlarged Prostate



Scoring: Each Check = 1 point

My Score: ____

LOW RISK: 1-2

MEDIUM RISK: 3-5

HIGH RISK: 6+M

REGARDLESS OF YOUR RISK LEVEL, YOU CAN STILL WORK TO PREVENT UTIS!

TIPS for PREVENTION

- Good hygiene! Wipe front to back
- Drink plenty of water
- Do NOT wear tight pants or underwear (cotton is best)
- Urinate frequently (about every 2 hours during the day) and after intercourse
- Change pads/disposable underwear FREQUENTLY
- Do NOT use harsh soaps
- Keep catheter bag BELOW the waist (even when lying down, hang on side of bed) and OFF of the floor
- Perform proper catheter care twice daily

SIGNS/SYMPTOMS OF UTI

- Burning with urination
- Frequent urination or increased/intense urge to urinate
- Foul smelling or cloudy urine
- Increased confusion/agitation
- Fever and/or chills
- Back/lower abdominal Pain

If you are experiencing any of these symptoms, call Kline Galland at (206) 805-1930 to speak with a nurse, or contact your primary care physician

PREVENTIVE ACTIONS TO HELP PROTECT AGAINST FLU

Per the Centers for Disease Control and Prevention (CD)), the **single best way to reduce the risk of seasonal flu and its potentially serious complications is to get** vaccinated each year, but preventive actions like avoiding people who are sick, covering your cough and washing your hands also can help stop the spread of germs and prevent respiratory illnesses like flu. This also can include taking steps for cleaner air and hygiene practices like cleaning frequently touched surfaces. Seasonal flu vaccines protect against the three flu viruses that research indicates will be most common during the upcoming season.

The tips and resources below will help you learn about additional actions you can take to protect yourself and others from flu and help stop the spread of germs.

1. **Avoid close contact.**
   Avoid close contact with people who are sick. When you are sick, keep your distance from others to protect them from getting sick, too. Putting physical distance between yourself and others can help lower the risk of spreading a respiratory virus.
2. **Stay home when you are sick.**
   If possible, stay home from work, school, and errands when you're sick. You can go back to your normal activities when, for at least 24 hours, both are true:
   - Your symptoms are g etting better overall, **and**
   - You have not had a fever (and are not using fever-reducing medication).*
1. **Cover your mouth and nose.**
   Cover your mouth and nose when coughing or sneezing. It may prevent those around you from getting sick. Flu viruses are thought to spread mainly by droplets made when people with flu cough, sneeze or talk. Wearing a mask is an additional prevention strategy that you can choose to do to further protect yourself and others. When worn by a person with an infection, masks reduce the spread of the virus to others. Masks can also protect wearers from breathing in infectious particles from people around them.
2. **Clean your hands.**
   Washing your hands often will help protect you from germs. If soap and water are not available, use an alcohol-based hand rub.
3. **Avoid touching your eyes, nose or mouth.**
   Germs can be spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.
4. **Take steps for cleaner air.**
   You can improve air quality by bringing in fresh outside air, purifying indoor air or gathering outdoors. Cleaner air can reduce the risk of exposure to viruses.
5. **Practice good hygiene and other healthy habits.**
   Cleaning frequently touched surfaces, such as countertops, handrails, and doorknobs regularly can help prevent the spread of some illnesses. Also, get plenty of sleep, be physically active, manage your stress, drink plenty of fluids, and eat nutritious food.

**Above resources taken from the CDC Website, updated March 21, 2024.*

During flu season, Kline Galland Home Health nurses can administer the flu shot to you in your home. Speak to your home health team if you would like more information.

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/flu**.

NOTE: THIS SECOND PAGE OF THE PDF WAS MISSING AND WAS JUST ADDED 6.24.25 TO MAKE IT COMPLETE.

RESOURCES

AVAILABLE PUBLICLY FUNDED RESOURCES

Federally-Funded & State-Funded Agencies for King County

Washington Association of Area Agencies on Aging

agingwashington.org

Phone: (360) 485-9761
Email: info@agingwashington.org

Aging & Disability Services,

Seattle-King County
700 5th Avenue, 51st Floor
Seattle, WA 98104

Mailing Address:
PO Box 34215
Seattle, WA 98124-4215

Phone: (206) 684-0104
Fax: (206) 684-0689
Email: agingkingcounty.org

Washington State Independent Living Council - ACIL

wasilc.org/about/acil.html

Alliance of People with Disabilities Seattle (Alliance)

1120 E. Terrace, Suite 100
Seattle, WA 98122

Phone: (206) 545-7055 Relay: 711
Fax: (206) 545-7059

Outside King County: (866) 545-7055
Email: info@disabilitypride.org

Alliance of People with Disabilities East King County Office (Alliance)

1150 140th Ave NE, Suite 101
Bellevue, WA 98005

Phone: (425) 558-0993 Relay: 711
Fax: (425) 558-4773

Outside King County Toll-Free: (800) 216-3335
Email: info@disabilitypride.org

Disability Rights Washington

disabilityrightswa.org

315 5th Avenue South, Suite 850
Seattle, WA 98104

Phone: (206) 324-1521
Toll-Free: (800) 562-2702

Language interpreters are available via the AT&T Language Line. Please use 711 for Washington Relay Service (TTY).

Collect calls from correctional facilities are accepted.

DRW does not respond to voice mails requesting information, referrals or other assistance. Learn how to request services from DRW.

Fax: (206) 957-0729
Email: info@dr-wa.org

Acentra Health

Keproqio.com/bene/statepages/Washington/

5201 West Kennedy Blvd.
Suite 900
Tampa, FL 33609

Toll-free phone: (888) 305-6759
Local Phone: (216) 447-9604
TTY: 711

Qualis

medicare.qualishealth.org

10700 Meridian Ave. N., Suite 100
PO Box 33400
Seattle, WA 98133-0400

Phone: (206) 364-9700
Toll-Free: (800) 949-7536
Fax: (206) 368-2419

Washington State Department of Health

doh.wa.gov/AboutUs/

Business Hours and Locations

Kent Regional Office
20425 72nd Avenue South
Building 2, Suite 310
Kent, WA 98032

Monday - Friday, 8am to 5pm
Phone: (800) 525-0127

Department of Services for the Blind

dsb.wa.gov

Seattle Office
3411 S. Alaska Street
Seattle, WA 98118

Monday - Thursday, 7:30am - 5:30pm

Phone: (206) 906-5500
Fax: (206) 721-4103

GENERAL INFORMATION

Phone: Toll-free (800) 552-7103
Email: info@dsb.wa.gov

Office of the Deaf & Hard of Hearing

dshs.wa.gov/altsa/office-deaf-and-hard-hearing

Voice/TTY Toll-Free: (800) 422-7930
Voice: (360) 725-3450
TTY: (360) 725-3455
Videophone: (360) 339-7382
Fax: (360) 725-3456

Email: odhh@dshs.wa.gov

Washington State Health Care Authority (Apple Health)

hca.wa.gov

Cherry Street Plaza
626 8th Avenue SE
Olympia, WA 98501

Medical Assistance Customer

Service Center (MACSC)
Toll-Free: (800) 562-3022

Email: askmedicaid@hca.wa.gov

Client line: Monday – Friday, 7am to 5pm
(except state holidays)

Human Rights Commission

hum.wa.gov

Olympia Headquarters
711 S. Capitol Way, Suite 402
Olympia, WA 98504

Toll-Free: (800) 233-3247

Washington State Department of Labor & Industries

lni.wa.gov

Mailing Address:
7273 Linderson Way SW
Tumwater WA 98501-5414
PO Box 44000
Olympia WA 98504-4000

Switchboard: (360) 902-5800
Fax: 360-902-5798

TTY Toll-Free: (800) 833-6388
(Washington State Relay Service
for the hearing impaired)

Monday – Friday, 8am to 5pm

ADDITIONAL COMMUNITY RESOURCES IN KING COUNTY

Sound Generations Pathways Information and Assistance Line

Phone: (206) 448-3110 or (888) 435-3377
Interpreter services are available
Email: info@soundgenerations.org
Hours: Monday-Friday 9-5pm
Website: https://soundgenerations.org/our-programs/pathways-information-assistance/

Services:

- In-Home Services & Support
- Housing Resources
- Legal Assistance
- Medicare & Medicaid
- Transportation Services (ADA compliant)
- Home Safety and Modifications
- Food Services & Nutrition
- Health & Wellness
- Employment Resources
- Counseling Service

Description: Our highly trained staff of community support specialists are here to answer your questions and provide free, unbiased advice for aging persons, people with disabilities, and caregivers. We connect individuals to community resources to meet the most complex of situations.

King County Community Living Connections

Phone: (206) 962-8467 or toll-free (844) 348-5464 (KING)
Email: info@communitylivingconnections.org
Hours: Monday-Friday 8-6pm
Website: https://www.communitylivingconnections.org/about/

Services:

- Medicaid
- State and federal benefits
- Nutrition programs
- Family caregiver programs
- Kinship care
- Care coordination
- Medicaid case management
- Minor home repair
- Volunteer transportation
- And many more

Description: Community Living Connections provides you a caring, highly trained advocate who will give easy access to information, individual consultation and service options. We have an extensive network of community partners giving us the ability to answer questions and find the most appropriate help for you. Staff can determine if you are eligible for programs, services, and public benefits to help you or your loved one live with dignity and enjoy the best quality of life possible.

Transportation

- Access (206) 205-5000
- Eastside Friends of Seniors (425) 369-9120
- Hopelink (800) 923-7433
- Hyde Shuttle (206) 727-6262
- Volunteer Transportation (206) 448-5740

Meals & Food

- Chicken Soup Brigade (206) 957-1686
- Sound Generations Meals on Wheels (206) 448-5767
- Washington Food Help/DSHS Community Resource Customer Connection (877) 501-2233

Health Insurance / State Health Insurance Benefits Advisors (SHIBA)

- Chinese Information and Service Center (Chinese) (206) 624-5633 x4175
  - Vietnamese x4176
  - Tagalog x4183
- Korean Women's Association (Korean) (253) 535-6202
- Latino Community Fund (Spanish) (206) 397-2440
- Sound Generations (English) . (206) 727-6221

Emergency Response/Alert System

- Philips Lifeline (855) 332-7799
- Medical Care Alert (855) 661-3707
- Medical Guardian (800) 844-9693

Legal Concerns

- Eastside Legal Assistance Program (425) 747-7274
- Elder Law Legal Clinic (206) 448-5720
- King County Bar Association Neighborhood Legal Clinics (206) 267-7070
- Northwest Justice Project CLEAR * SR Help Line (888) 387-7111

Caregiver Support, Information & Assistance

- Adult Protective Services (206) 341-7660

– Residential Care Services (800) 562-6078

- Crisis Connections 211
- 24 Hour Crisis Line (866) 427-4747
- Crisis Connections Caregiver Information & Assistance (206) 436-2975
- End of Life Washington (206) 256-1636
- King County Caregiver Support Network:
  - African American Elders Program (206) 328-5639
  - Alzheimer's Association (206) 363-5500
  - Asian Counseling and Referral Service (206) 695-7600
  - Community Living Connections (206) 932-8467
  - Evergreen Community Healthcare Access Team (CHAT) (425) 899-3200
  - Jewish Family Service (206) 461-3240

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Notice to Person Executing This Document

This is an important legal document. Before executing this document you should know these facts:

- This document gives the person you designate as your Health Care Agent the power to make MOST health care decisions for you if you lose the capability to make informed health care decisions for yourself. This power is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions.
- Your Health Care Agent should be someone you trust to make health care decisions on your behalf. Your Health Care Agent may be any adult, including relatives such as your spouse, state registered domestic partner, father, mother, adult child, or adult brother or sister. Unless they are one of the relatives listed above, your Health Care Agent may not be any of your physicians or your physicians' employees, or the owners, administrators or employees of a health care facility or long-term facility (as defined by RCW 43.190.020) where you reside or receive care.
- You may include specific limitations in this document on the authority of the Health Care Agent to make health care decisions for you.
- Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the Health Care Agent GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Health Care Agent to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical condition. You can limit that right in this document.
- When exercising authority to make health care decisions for you on your behalf, the Health Care Agent will have to act consistent with your wishes, or if they are unknown, in your best interest. You may make your wishes known to the Health Care Agent by including them in this document or in another manner.
- When acting under this document the Health Care Agent GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records.

1. Creation of Durable Power of Attorney for Health Care

I intend to create a power of attorney (Health Care Agent) by appointing the person or persons designated herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so, as recognized by Washington law. This power of attorney shall become effective when I become disabled and I cannot make health care decisions for myself as determined by my attending physician or designee, such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making health care decisions. The Health Care Agent's power shall cease if and when I regain my capacity to make health care decisions.

2. Designation of Health Care Agent and Alternate Agents

If my attending physician or his or her designee determines that I am not capable of giving informed consent to health care,

I ..... , designate and appoint:

Name ..... Address .....

City..... State ..... ZIP ..... Phone .....

as my attorney-in-fact (Health Care Agent) by granting him or her the Durable Power of Attorney for Health Care recognized in Washington law and authorize her or him to consult with my physicians about the possibility of my regaining the capacity to make treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.

In the event that ..... is unable or unwilling to serve, I grant these powers to

Name ..... Address .....

City..... State ..... ZIP ..... Phone .....

In the event that both..... and .....

are unable or unwilling to serve, I grant these powers to

Name ..... Address .....

City..... State..... ZIP ..... Phone .....

3. General Statement of Authority Granted.

My Health Care Agent is specifically authorized to give informed consent for health care treatment when I am not capable of doing so. This includes but is not limited to consent to initiate, continue, discontinue, or forgo medical care and treatment including artificially supplied nutrition and hydration, following and interpreting my instructions for the provision, withholding, or withdrawing of life-sustaining treatment, which are contained in any Health Care Directive or other form of "living will" I may have executed or elsewhere, and to receive and consent to the release of medical information. When the Health Care Agent does not have any stated desires or instructions from me to follow, they shall act in my best interest in making health care decisions.

The above authorization to make health care decisions does not include the following absent a court order:

1) Therapy or other procedure given for the purpose of inducing convulsion;
2) Surgery solely for the purpose of psychosurgery;
3) Commitment to or placement in a treatment facility for the mentally ill, except pursuant to Chapter 71.05 RCW;
4) Sterilization.

I hereby revoke any prior grants of durable power of attorney for health care.

4. Special Provisions

.....

.....

.....

DATED this..... day of ..... .

GRANTOR: ..... GRANTOR'S SIGNATURE .....

NOTE: Washington state requires this directive to be witnessed by two people or acknowledged by a notary public.

WITNESS REQUIREMENTS: The witnesses to this document must be competent and must NOT be:

- Related to you or your health care agent by blood, marriage, or state registered domestic partnership.
- Your home care provider or a care provider at an adult family home or long-term care facility where you live.
- Your designated health care agent(s).

WITNESS ..... WITNESS .....

STATE OF WASHINGTON

COUNTY OF .....

This record was acknowledged before me on this day of..... , ..., ...

by .....
(name of individual)

.....
(signature of notary public)

(stamp)

.....
(title of office)

My commission expires: .....

HEALTH CARE DIRECTIVE

Directive made this.....day of ....
(year)

I, ...being of sound mind, willfully, and voluntarily make known mydesire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

A) If at any time I should have an incurable and irreversible condition certified to be a terminal condition by my attending physician, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand "terminal condition" means an incurable and irreversible condition caused by injury, disease or illness that would, within reasonable medical judgment, cause death within a reasonable period of time in accordance with accepted medical standards.

B) If I should be in an irreversible coma or persistent vegetative state, or other permanent unconscious condition as certified by two physicians, and from which those physicians believe that I have no reasonable probability of recovery, I direct that life-sustaining treatment be withheld or withdrawn.

C) If I am diagnosed to be in a terminal or permanent unconscious condition, [Choose one]
I want _____ do not want _____ artificially administered nutrition and hydration to be withdrawn or withheld the same as other forms of life-sustaining treatment. I understand artificially administered nutrition and hydration is a form of life-sustaining treatment in certain circumstances. I request all health care providers who care for me to honor this directive.

D) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family, physicians and other health care providers as the final expression of my fundamental right to refuse medical or surgical treatment, and also honored by any person appointed to make these decisions for me, whether by durable power of attorney or otherwise. I accept the consequences of such refusal.

E) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

F) I understand the full import of this directive and I am emotionally and mentally competent to make this directive. I also understand that I may amend or revoke this directive at any time.

G) I make the following additional directions regarding my care:

.....

.....

.....

.....

SIGNED: .....

Note: Washington state requires this directive to be witnessed by two people or acknowledged by a notary public.

WITNESS REQIREMENTS: The witnesses to this document must be competent and must NOT be:

- Related to you by blood or marriage.
- Entitled to any portion of your estate upon your death.
- Your attending physician or an employee of your attending physician or health care facility where you are a patient.
- Any person who has claim against any portion of your estate at the time of signature of this document.

The declarer has been personally known to me or has provided proof of identity. I believe him or her to be capable of making health care decisions.

WITNESS ..... WITNESS .....

STATE OF WASHINGTON

COUNTY OF .....)

This record was acknowledged before me on this day of..... , ..., ...

by .....
(name of individual)

.....
(signature of notary public)

(stamp)

.....
(title of office)

My commission expires: .....

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Washington POLST

Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		
DATE OF BIRTH / /	GENDER (optional)	PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: *See page 2 for complete instructions.*

MEDICAL CONDITIONS / INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

A — Use of Cardiopulmonary Resuscitation (CPR): When the individual has NO pulse and is not breathing.

CHECK ONE

☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*

☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**

When not in cardiopulmonary arrest, go to Section B.

B — Level of Medical Interventions: When the individual has a pulse and/or is breathing.

CHECK ONE

Any of these treatment levels may be paired with DNAR / Allow Natural Death above.

☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below.
Transfer to hospital if indicated. Includes intensive care.

☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below.
Transfer to hospital if indicated. Avoid intensive care if possible.

☐ **COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.** Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort.
Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional orders (e.g., blood products, dialysis): _____

C — Signatures:

Signatures: A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with:	X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)**	DATE **(mandatory)**
☐ Individual ☐ Parent(s) of minor ☐ Guardian with health care authority ☐ Legal health care agent(s) by DPOA-HC ☐ Other medical decision maker by 7.70.065 RCW	**PRINT** – NAME OF MD/DO/ARNP/PA-C **(mandatory)**	PHONE

X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**	RELATIONSHIP	DATE **(mandatory)**
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**		PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

WSMA Washington State Medical Association
Physician Driven, Patient Focused

Washington State Department of Health

All copies, digital images, faxes of signed POLST forms are valid.
See page 2 for preferences regarding medically assisted nutrition.
For more information on POLST, visit **www.wsma.org/POLST**.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL	DATE OF BIRTH / /

Additional Contact Information (if any)

LEGAL MEDICAL DECISION MAKER(S) (by DPOA-HC or 7.70.065 RCW)	RELATIONSHIP	PHONE
OTHER CONTACT PERSON	RELATIONSHIP	PHONE
HEALTH CARE PROFESSIONAL COMPLETING FORM	ROLE / CREDENTIALS	PHONE

Preference: Medically Assisted Nutrition (i.e., Artificial Nutrition)

☐ **Check here if not discussed**

This section is NOT required. This section, whether completed or not, does not affect orders on page 1 of form.

Preferences for medically assisted nutrition, and other health care decisions, can also be indicated in advance directives which are advised for all adults. The POLST does not replace an advance directive. When an individual is no longer able to make their own decisions, consult with the legal medical decision maker(s) regarding their plan of care, including medically assisted nutrition. Base decisions on prior known wishes, best interests of the individual, preferences noted here or elsewhere, and current medical condition. Document specific decisions and/or orders in the medical record.

Food and liquids to be offered by mouth if feasible and consistent with the individual's known preferences.

☐ Preference is to avoid medically assisted nutrition.

☐ Preference is to discuss medically assisted nutrition options, as indicated.*

Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).

* Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and it is associated with complications. People may have documents or known wishes to not have oral feeding continued; the directions for oral feeding may be subject to these known wishes.

Discussed with: _____ Individual _____ Health Care Professional _____ Legal Medical Decision Maker

Directions for Health Care Professionals

NOTE: An individual with capacity may always consent to or refuse medical care or interventions, regardless of information represented on any document, including this one.

Any incomplete section of POLST implies full treatment for that section. This POLST is valid in all care settings. It is primarily intended for out of hospital care, but valid within health care facilities per specific policy. The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

Completing POLST

- Completing POLST is voluntary for the individual; it should be offered as appropriate but not required.
- Treatment choices documented on this form should be the result of shared decision making by an individual or their health care agent and health care professional based on the individual's preferences and medical condition.
- POLST must be signed by an MD/DO/ARNP/PA-C and the individual or their legal medical decision maker as determined by guardianship, DPOA-HC, or other relationship per 7.70.065 RCW, to be valid. Multiple decision maker signatures are allowed, but not required.
- Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility. For examples, see FAQ at www.wsma.org/POLST.
- POLST may be used to indicate orders regarding medical care for children under the age of 18 with serious illness. Guardian(s)/parent(s) sign the form along with the health care professionals. See FAQ at www.wsma.org/POLST.

NOTE: This form is not adequate to designate someone as a health care agent. A separate DPOA-HC is required to designate a health care agent.

Honoring POLST

Everyone shall be treated with dignity and respect.

SECTIONS A AND B:

- No defibrillator should be used on an individual who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the individual should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). This may include medication by IV route for comfort.
- Treatment of dehydration is a measure which may prolong life. An individual who desires IV fluids should indicate "Selective" or "Full Treatment."

Reviewing POLST

This POLST should be reviewed whenever:

- The individual is transferred from one care setting or care level to another.
- There is a substantial change in the individual's health status.
- The individual's treatment preferences change.

To void this form, draw a line across the page and write "VOID" in large letters. Notify all care facilities, clinical settings, and anyone who has a copy of the current POLST. Any changes require a new POLST.

Review of this POLST form: <u>Use this section to update and confirm order and preferences.</u>

This meets the requirement of establishing code status and basic medical guidance for admission to nursing and other facilities.

REVIEW DATE	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME
			☐ No Change ☐ Form Voided ☐ New Form Completed

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

Copies, digital images, and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST, visit **www.wsma.org/POLST**.

FORMS USED DURING HOME HEALTH

CONSENT FOR SERVICE

I,_____, have been informed that Kline Galland Home Health (KGHH) is my primary home health agency and is licensed to provide home health services under a Plan of Care authorized by my physician. I accept treatment from KGHH and I know that I can call the agency 24-hours a day regarding my health care at 206-805-1930. I understand that this is not an emergency line. I will call 911 in an emergency.

-In the event of a medical emergency, I understand it is the policy of KGHH to provide treatment, including cardiopulmonary resuscitation (CPR), unless KGHH has received orders from my physician to the contrary. It is the policy of KGHH to call 911 for medical assistance.
-I understand that for KGHH to provide me with the best possible services, it is important I communicate my needs and concerns to the staff, including pain. I will participate in developing the plans for my care. I am aware that I have the right to refuse care/service and will be informed of the consequences.
- I shall not audio record KGHH staff, nor shall I use any video recording device in areas where care may be provided to me.

Consent to Photography: I hereby consent for KGHH to take pictures of me and the treatment being done to document my medical condition, and I consent to the release of those photographs to my physician, other care providers involved in my care, payer source or accrediting/regulatory/consulting organizations as appropriate.
Consent to Share Information: I understand that KGHH protects all clinical records from unauthorized access. I authorize KGHH to share my health information, including my Plan of Treatment and Discharge Summary, with my physician, payer, accrediting/regulatory bodies, and any facility involved in my care. Unless I provide written notice otherwise, I consent to KGHH sharing my name, contact details, and emergency contacts internally and with business associates as needed to coordinate my healthcare and communicate about current and future services..
Telehealth Services: Telehealth refers to health service visits (for the purpose of evaluation and/or management) which are conducted using interactive video, audio and telecommunications technology ("telehealth technology") through computers, tablets or smart phones, rather than in-person. Telehealth services ensure that you are able to visit with your KGHH care team without having an in-person visit, should the need for this emerge. I have been provided with detailed information about telehealth visits, and the potential risks of these services, and the ability to ask questions. I hereby consent to receive telehealth services as described by KGHH.
COVID-19 (SARS-CoV-2) TESTING:
KGHH is committed to limiting transmission of SARS-CoV-2 among our patients and staff. We request that you be tested for SARS-CoV-2 if you are exposed to a confirmed SARS-CoV-2 case, or show symptoms of SARS-CoV-2, have recently discharged from a facility (hospital, skilled nursing facility, or other congregate care setting), or if there is clinical concern that you could be carrying SARS-CoV-2 asymptomatically. I have been provided with detailed information about COVID-19 testing. I agree that KGHH can obtain testing specimens for SARS-CoV-2 by collecting samples from me via a nasal swab or other verified specimen per clinical recommendations. I also agree to allow KGHH representative(s) to receive and review my SARS-CoV-2 test results once they are available.

AUTHORIZATION FOR BILLINGS & PAYMENT:
In the event my insurance does not cover the home health charges in full, I am financially responsible to KGHH to pay the remaining charges. I also recognize that it is my responsibility to inform KGHH if my insurance coverage changes. I certify that the information provided by me regarding my insurance coverage is correct and I authorize my insurance company(s) and third party payers to pay my insurance benefits directly to KGHH.

ADVANCE DIRECTIVES

☐ I have been asked to provide a copy of my Advance Directive(s) for my medical record.
☐ I do not have Advance Directives, but I've received information regarding Advance Directives with my admission materials.

I have the following Advance Directives:

☐ Living Will ☐ Uniform Donor Pledge ☐ Durable Power of Attorney for Health Care ☐ POLST

ACKNOWLEDGMENT STATEMENT

I have read the above and understand its contents and have received:

☐ Patient Admission folder including: Patient Rights and Responsibilities, Administrator Contact Information and Transfer and Discharge Policy
☐ Notice of Right to Refuse to Answer OASIS questions ☐ Notice of Privacy Practices Practices

PATIENT/PATIENT REPRESENTATIVE SIGNATURE **DOB** **DATE**

PRINTED NAME: _____

RELATIONSHIP TO PATIENT: _____

Consent for Service (cont.)

NON-DISCRIMINATION & LANGUAGE ASSISTANCE

Kline Galland complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex.

LANGUAGE ASSISTANCE: The following are published here pursuant to Section 1557 of the Affordable Care Act and implementing regulations, 45 CFR 92.8(d)(1)

Spanish: ATENCIÓN - si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-797-9952.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-797-9952.

INSURANCE VERIFICATION

Date Prepared: _____ or Start of Services: _____

Name _____ DOB _____

- ☐ Medicare (100% coverage of Home Health visits)
- ☐ Medicaid (100% coverage of Home Health visits)
  *Max. of **six (6) Physical Therapy visits, six (6) Occupational Therapy visits and six (6) Speech Therapy Visits** per calendar year plus an evaluation and discharge visit combined between Home Health and outpatient.*
- ☐ Other (Variable coverage)

INSURANCE INFORMATION

Insurance Provider _____ **Co-Pay Responsibility ▼**

ID Number _____ Deductible_____

Group Number_____ Amount Met_____

Health Plan_____ Max. Out of Pocket_____

Coverage (e.g. 80/20) _____ Amount Met_____

Authorization Information:

Visit Authorization ☐ Yes ☐ No Auth. No. _____

Type (Visit/Certification) _____

Authorization Date Range Start Date _____ End Date _____

Number of Authorized Visits by Discipline:

☐ *Nursing* ☐ *Physical Therapy* ☐ *Occupational Therapy*

☐ *Speech Therapy* ☐ *Med/Social Worker* ☐ *Home Health Aide*

Disciplines Ordered & Frequency of Visits:

☐ Nursing _____ ☐ Physical Therapy _____ ☐ Occupational Therapy _____

☐ Speech Therapy _____ ☐ Med/Social Worker _____ ☐ Home Health Aide _____

The information provided is based on information received from your insurance provider at the Start of Services. Please be advised that deductibles, and out of pocket expenses may reset at the beginning of the year and/or according to your individual insurance provider.

Patient Signature _____ Date _____

Clinician _____ Date _____

Clinician's Signature & Printed Name

☐ ***Copy of Insurance Card Received***

EMERGENCY PREPAREDNESS PLAN

Patient Name _____ DOB _____

Clinician Name _____ Date Completed _____

ROLE/RELATIONSHIP	NAME(S)	CONTACT INFO
Home Health Agency	Kline Galland Home Health	206-805-1930
Emergency Contact		
Neighbor(s)		
Physician(s)		
Pharmacy		
DME Provider *(if applicable)*		
Emergency Response	911	Call 911 for all emergencies
24/7 Info - Critical health and available local human service	2-1-1 Call Center	Dial 211 from any phone (free)

FIRE EXIT PLAN: _____

_____

INDIVIDUALIZED EMERGENCY PLAN:

☐ **Vital Medications:** Maintain 7-day supply, e.g., insulin, Coumadin, pain meds, other _____

☐ **Vital Supplies:** Maintain 31 day supply, e.g., wound care, ostomy supplies, other _____

☐ **Electric Medical Equipment:** Consider a generator, e.g., respirators, oxygen, Bipap, air mattress, other _____

☐ **Oxygen:** Have extra tank on hand, check with your supplier about emergency plans, register with your local fire department

☐ **Air Mattress:** Assure alternate non-air mattress is available and/or identify alternative means of off-loading pressure areas

☐ **Dialysis:** Identify back-up dialysis center and action plan if dialysis is postponed

☐ **Assisted Living Residents:** Contact your administrator to learn of evacuation plan for your facility

☐ **Other Special Considerations:** _____

_____

☐ **BY CHECKING THIS BOX, I ATTEST THAT I HAVE BEEN GIVEN INFORMATION REGARDING:**

- Resources to assist with self-care if Home Health is unavailable
- State and local evacuation plans
- Kline Galland Home Health's triage plan and protocols to address care issues and/or transfer care to other agencies should Kline Galland be unable to meet your needs during an emergency

Patient Signature _____ Date _____

Clinician Signature _____ Date _____

KLINE GALLAND
HOME HEALTH

OCCUPATIONAL THERAPY CARE PLAN

Patient Name_____ DOB_____

Clinician Name_____ Date_____

Visit Frequency_____ Total # of Expected Visits_____ Next Visit Date (Expected) _____

CARE PLAN TO ADDRESS:

☐ Activities of Daily Living
- □ Self-Feeding
- □ Bathing
- □ Grooming
- □ Meal Preparation
- □ Toileting
- □ Laundry
- □ Dressing
- □ Housekeeping

☐ Equipment Needs
- □ Transfer tub bench
- □ Shower chair
- □ Grab bars
- □ Raised toilet seat

☐ Body Mechanics/Positioning

☐ Caregiver Training

☐ Environmental Modifications
- □ Remove throw rugs
- □ Clear pathways

☐ Energy Conservation

☐ Home Exercise Program
- □ Strength
- □ Range of Motion
- □ Balance
- □ Fine Motor

☐ Fall Prevention

☐ Pain Management

☐ Skin Breakdown Prevention

☐ Functional Mobility

☐ Care Coordination with MD

Comments/Other:

☐ Referral to Other Discipline(s)/Service(s) *(specify)* _____

KLINE GALLAND
HOME HEALTH

AIDE CARE PLAN

Patient Name _____ DOB _____

Clinician Completing Form & Discipline _____ Date _____

Visit Frequency _____ Total # of Expected Visits _____ Next Visit Date (Expected) _____

CARE PLAN TO ADDRESS:	FREQUENCY: *Every visit unless specified*
☐ Standard Precautions	☐ _____
☐ Fall Precautions	☐ _____
☐ Other Precautions *(specify surgical, wound and/or universal, droplet, contact, airborne etc., as applicable)* _____ _____	☐ _____
☐ Ambulation Assistance *(specify)* _____	☐ _____
☐ Transfer Assistance *(specify)* _____	☐ _____
☐ Recognize/Report Changes in Patient's Skin Condition	☐ _____
☐ Water Temperature Check	☐ _____
☐ Shower *(specify type/devices/other precautions)* _____	☐ _____
☐ Shampoo	☐ _____
☐ Perineal Hygiene	☐ _____
☐ Skin Care *(specify)* _____	☐ _____
☐ Assist with Dressing	☐ _____
☐ Home Management/Clean Bathroom after Patient Care	☐ _____
☐ Vitals	☐ _____
☐ Other _____	☐ _____

KLINE GALLAND
HOME HEALTH

SOCIAL WORK CARE PLAN

Patient Name _____ DOB _____

Clinician Name _____ Date _____

Visit Frequency _____ Total # of Expected Visits _____ Next Visit Date (Expected) _____

CARE PLAN TO ADDRESS:

- ☐ Advanced Directives/Legal Needs
- ☐ Coordination of Care Needs
- ☐ Coping - Family/Caregiver
- ☐ Emotional Needs
- ☐ Behavioral Needs
- ☐ Grief Process and Grieving Bereavement
- ☐ Resource Management
- ☐ Care Coordination with MD
- ☐ Referral to Other Discipline(s)/Service(s) *(specify)*

  _____
- ☐ Other _____

NOTES:

KLINE GALLAND
HOME HEALTH

SKILLED NURSING CARE PLAN

Patient Name _____ DOB _____

Clinician Name _____ Date _____

Visit Frequency _____ Total # of Expected Visits _____ Next Visit Date (Expected) _____

CARE PLAN TO ADDRESS:

☐ Pain Assessment and Management

☐ Medication Management
- ☐ MedMaIDE Tool
- ☐ Reminders/Resources
- ☐ Pt/CG Education
- ☐ Other

☐ Skin Care

☐ Wound Care

☐ Disease Process Management and Training
- ☐ Congestive Heart Failure (CHF) Training
- ☐ Diabetes Education and Management
- ☐ Hypertension Management
- ☐ Urinary Tract Infection (UTI) Risk and Prevention
- ☐ Other

☐ Catheter Care

☐ Anticoagulation Therapy

☐ Fall Prevention

☐ Constipation Prevention and Management

☐ Diet and Nutritional Training

☐ Care Coordination with MD

☐ Referral to Other Discipline(s)/Service(s) *(specify)*

☐ Other

START OF CARE ONLY:

Assess Risk for Re-Hospitalization/ER Visits:

Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)

☐ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)

☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months

☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months

☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months

☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months

☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months

☐ 7 - Currently taking 5 or more medications

☐ 8 - Currently reports exhaustion

☐ 9 - Other risk(s) not listed in 1-8

☐ 10 - None of the above

Overall Risk of Re-Hospitalization:

☐ Minimal ☐ Moderate ☐ High

MEDICATION NAME	DOSAGE	TIME(S) OF DAY TAKEN	PURPOSE	PHYSICIAN NAME/PHONE	PHARMACY NAME/PHONE	NOTES

KLINE GALLAND
HOME HEALTH

SPEECH LANGUAGE PATHOLOGY CARE PLAN

Patient Name _____ DOB _____

Clinician Name _____ Date _____

Visit Frequency _____ Total # of Expected Visits _____ Next Visit Date (Expected) _____

CARE PLAN TO ADDRESS:

☐ Adaptive Aids Assessment and Training

☐ Cognitive Assessment and Training
- ☐ Memory ☐ Attention ☐ Problem-Solving
- ☐ Reasoning ☐ Executive Functioning
- ☐ Other _____

☐ Communication Assessment and Training
- ☐ Reading ☐ Dysarthria ☐ Writing
- ☐ Aphasia ☐ Non-Verbal Communication
- ☐ Other _____

☐ Education on Compensatory Strategies

☐ Establish/Upgrade Home Exercise Program to Address:
- ☐ Feeding ☐ Verbal Communication ☐ Reading
- ☐ Writing ☐ Non-Verbal Communication ☐ Swallowing
- ☐ Executive Functioning Skills ☐ Aphasia ☐ Dysarthria
- ☐ Other _____

☐ Safety Awareness Training

☐ Swallow Assessment and Training

☐ Care Coordination with MD

☐ Referral to Other Discipline(s)/Service(s) *(specify)*

_____

☐ Other _____

START OF CARE ONLY:

Assess Risk for Re-Hospitalization/ER Visits:

Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)

☐ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)

☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months

☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months

☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months

☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months

☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months

☐ 7 - Currently taking 5 or more medications

☐ 8 - Currently reports exhaustion

☐ 9 - Other risk(s) not listed in 1-8

☐ 10 - None of the above

Overall Risk of Re-Hospitalization:

☐ Minimal ☐ Moderate ☐ High

KLINE GALLAND
HOME HEALTH

PHYSICAL THERAPY CARE PLAN

Patient Name _____ DOB _____

Clinician Name _____ Date _____

Visit Frequency _____ Total # of Expected Visits _____ Next Visit Date (Expected) _____

CARE PLAN TO ADDRESS:

- ☐ Aerobic Capacity/Activity Tolerance
  - □ Walking Program
- ☐ Balance/Coordination
  - □ Sitting □ Standing
- ☐ Bed Mobility
- ☐ Caregiver Training
- ☐ Disease Process Education
- ☐ Durable Medical Equipment (DME) Needs Assessment/Training
- ☐ Gait Training
  - □ Indoors □ Stairs □ Outdoors
- ☐ Pain Management
  - □ Modalities (heat/cold) □ Manual Therapy
  - □ Soft Tissue Mobilization □ NMES/TENS
- ☐ Posture Training
- ☐ Prosthetic/Orthotic Needs Assessment
- ☐ Range of Motion (ROM)
- ☐ Safety Awareness
  - □ Fall Prevention
- ☐ Skin Breakdown Prevention Education/Training
- ☐ Strengthening
- ☐ Transfer Training
- ☐ Urinary Incontinence Retraining
- ☐ Vestibular Function
- ☐ Wheelchair Mobility
- ☐ Care Coordination with MD
- ☐ Referral to Other Discipline(s)/Service(s) *(specify)*

  _____
- ☐ Other _____

START OF CARE ONLY:

Assess Risk for Re-Hospitalization/ER Visits:

Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)

- ☐ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- ☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
- ☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
- ☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- ☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ☐ 7 - Currently taking 5 or more medications
- ☐ 8 - Currently reports exhaustion
- ☐ 9 - Other risk(s) not listed in 1-8
- ☐ 10 - None of the above

Overall Risk of Re-Hospitalization:

☐ Minimal ☐ Moderate ☐ High

KLINE GALLAND
HOME HEALTH

Precautions Instructions Exercises

Patient Name _____ Provided by _____

DOB# _____ Date _____

KLINE GALLAND
HOME HEALTH

Precautions **Instructions** **Exercises**

Patient Name _____ Provided by _____

DOB# _____ Date _____

KLINE GALLAND
HOME HEALTH

Precautions **Instructions** **Exercises**

Patient Name _____ Provided by _____

DOB# _____ Date _____

KLINE GALLAND
BENAROYA
COMMUNITY SERVICES

Kline Galland Home Health and Hospice
6100 4th Ave S., Suite 403
Seattle, WA 98108
P: (206) 805-1930
F: (206) 805-1931

Notice of Medicare Non-Coverage

Patient name: **Patient number:**

Medicare Coverage of Your Current Home Health or Hospice Services Will End on: _____

Your provider and/or health plan determined that Medicare probably won't pay for your Home Health or Hospice services after the above date. You may have to pay for any services you get after this date.

Your right to appeal this decision

- You have the right to appeal the decision to end Medicare coverage of your services. This means you'll get an independent medical review right away. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. You don't have to prepare anything in writing, but you have the right to do so. The reviewer also will look at your medical records and/or other relevant information.
- Once you ask for an appeal, you'll get a notice with a detailed explanation about why your service coverage should end.
- If the independent reviewer agrees Medicare coverage for your services should end, neither Medicare nor your plan will pay for these services after the above date.
- If you stop services by the above date, you'll avoid financial liability.

How to ask for an immediate appeal

- Ask for the appeal as soon as possible. **You must ask for a timely appeal no later than noon of the day before the above date.**
- Make your request to your Quality Improvement Organization (QIO). A QIO is the independent reviewer authorized by Medicare.
- **If you miss the deadline** to ask for an immediate appeal, you may still have appeal rights.
- Call your QIO at **Acentra Health BFCC-QIQ Toll Free at 1-888-305-6759 or TTY 1-855-843-4776** to appeal, or if you have questions.

What happens next

- The QIO will let you know its decision as soon as possible, generally no later than two days after the effective date above. If you're in a Medicare health plan, the QIO generally will let you know its decision by the effective date above.
- Call your QIO at **Acentra Health BFCC-QIQ Toll Free at 1-888-305-6759 or TTY 1-855-843-4776** to learn more.

Form CMS 10123-NOMNC

OMB approval 0938-0953
Exp. 11/30/2027

Additional information (optional):

Sign below to show you received and understand this notice.

I've been notified that coverage of my services will end on the date on this notice, and that I can appeal this decision by contacting my QIO.

_____ _____

Signature of Patient or Representative Date

You have the right to get your information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit *Medicare.gov/about-us/accessibility-nondiscrimination-notice*, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Form CMS 10123-NOMNC

OMB approval 0938-0953
Exp. 11/30/2027

KLINE GALLAND
BENAROYA
COMMUNITY SERVICES

Kline Galland Home Health and Hospice
6100 4th Ave S., Suite 403
Seattle, WA 98108
P: (206) 805-1930
F: (206) 805-1931

Notice of Medicare Non-Coverage

Patient name: **Patient number:**

Medicare Coverage of Your Current Home Health Services Will End on: _____

Your provider and/or health plan determined that Medicare probably won't pay for your Home Health services after the above date. You may have to pay for any services you get after this date.

Your right to appeal this decision

- You have the right to appeal the decision to end Medicare coverage of your services. This means you'll get an independent medical review right away. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. You don't have to prepare anything in writing, but you have the right to do so. The reviewer also will look at your medical records and/or other relevant information.
- Once you ask for an appeal, you'll get a notice with a detailed explanation about why your service coverage should end.
- If the independent reviewer agrees Medicare coverage for your services should end, neither Medicare nor your plan will pay for these services after the above date.
- If you stop services by the above date, you'll avoid financial liability.

How to ask for an immediate appeal

- Ask for the appeal as soon as possible. **You must ask for a timely appeal no later than noon of the day before the above date.**
- Make your request to your Quality Improvement Organization (QIO). A QIO is the independent reviewer authorized by Medicare.
- **If you miss the deadline** to ask for an immediate appeal, you may still have appeal rights.
- Call your QIO at **Acentra Health BFCC-QIQ Toll Free at 1-888-305-6759 or TTY 1-855-843-4776** to appeal, or if you have questions.

What happens next

- The QIO will let you know its decision as soon as possible, generally no later than two days after the effective date above. If you're in a Medicare health plan, the QIO generally will let you know its decision by the effective date above.
- Call your QIO at **Acentra Health BFCC-QIQ Toll Free at 1-888-305-6759 or TTY 1-855-843-4776** to learn more.

Form CMS 10123-NOMNC

OMB approval 0938-0953
Exp. 11/30/2027

Additional information (optional):

Plan contact information:
UnitedHealthcare
P.O. Box 6106
MS CA 124-0157
Cypress, CA 90630
Phone: 1-877-262-9203, TTY: 711
Fax: 1-866-373-1081

Once complete, please return this Notice of Medicare Non-Coverage (NOMNC) to your Home & Community Care Transitions Coordinator on the same day it is issued (by email, portal, or fax: 844-244-9482).Telephone delivery does not require a representative's signature and should only occur when the member is unable to understand the NOMNC and the representative is not available to sign in person. A copy of the annotated NOMNC should be mailed to the representative the day telephone contact is made and a dated copy should be placed in the member's medical file.

The following section is to be completed by the provider delivering this NOMNC by telephone (skip if in person):

- Notice delivered by (print full name): _____Title:_____
- Call date: Call time: am / pm
- Spoke with:
  - o Full name:
  - o Telephone number:( )
  - o Relation to member: POA AOR Other (specify and complete next item):
    - If spoke with Other, explain relationship and reason why member could not sign/understand the NOMNC (e.g. neighbor, temporarily incapacitated):
- An explanation of this NOMNC and the member's appeal rights were provided as indicated above.
- Service to end: **Home Health Services** Last covered date: _____
- Date when the beneficiary's liability is expected to begin (day after LCD): _____
- To file an immediate appeal, the QIO must be called by noon on (day prior to LCD): _____
- Your QIO name and telephone number is (as indicated above on page 1):

ACENTRA HEALTH: 888-305-6759, TTY: 711

- If you miss this deadline, you may have other appeal rights and can contact your Health Plan.
- Your health plan name and telephone number is UnitedHealthcare 1-877-262-9203, or TTY: 711
- Date notice mailed to the representative(should be the same day as telephone contact): _____

- Provider's signature/title:_____ Date:

Sign below to show you received and understand this notice.

I've been notified that coverage of my services will end on the date on this notice, and that I can appeal this decision by contacting my QIO.

_____ _____
Signature of Patient or Representative Date

You have the right to get your information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit *Medicare.gov/about-us/accessibility-nondiscrimination-notice*, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Form CMS 10123-NOMNC OMB approval 0938-0953
Exp. 11/30/2027

A. Notifier: Kline Galland Home Health 6100 4th Ave S., Suite 403 Seattle, WA 98108
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

Language Assistance

The following are published here pursuant to Section 1557 or the Affordable Care Act and implementing regulations, 45 CFR 92.8(d)(1)

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-797-9952.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-797-9952.

Kline Galland does not discriminate on the basis of race, color, national origin, age, disability or sex in its health programs and activities.

Patient Name:

Patient Identification Number:

Home Health Agency: Kline Galland Home Health

Address: 6100 4th Ave S., Suite 403, Seattle, WA 98108

Phone Number: 206-805-1930

Home Health Change of Care Notice (HHCCN)

Your home health care is changing

Starting on _____, your home health agency will change the items/services listed below.

What items/services are changing?	Reason for change

Why are you getting this notice?

- ○ **Your doctor/provider changed (or didn't renew) the order for your home care.** The home health agency must follow doctor/provider orders to give you care. If you don't agree with this change, discuss it with your home health agency or the doctor/provider who orders your home care.
- ○ **Your home health agency decided to stop giving you the items/services for the reasons listed above.** If you think you still need home care, you can look for care from a different home health agency if you have a valid order. For help finding a different home health agency, contact the doctor/provider who ordered your home care. If you get care from a different home health agency, you can ask it to bill Medicare.

Get help or more information

If you have questions about these changes, contact your home health agency and/or the doctor/provider who orders your home care. You can't appeal to Medicare about payment for the items/services listed above unless you get the items/services and a Medicare claim is filed.

Optional details:

Sign below to show you understand this notice

Return this signed notice to your home health agency in person or by mail to the address above.

- ○ Check here if you're signing as an Authorized Representative and make sure your name is legible or print your name, if not legible.

Signature of patient or Authorized Representative	Date

You have the right to get your information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1196. This information collection is for the Home Health Agencies to notify original Medicare beneficiaries receiving home health care benefits of plan of care changes. The time required to complete this information collection is estimated to average less than 4 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under 42 U.S.C. 1395(bbb) and 42 CFR 484.10(c). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Language Assistance

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CONTINUATION OF CARE AGREEMENT FOR HOME HEALTH SERVICES

In order for our care to continue to be meaningful and successful, it is important that you follow the recommendations of our care team. Active participation is a vital part of your success with home health. Failure to follow through may result in discharge from Kline Galland Home Health.

We need your active participation in the following:

- ☐ Adhering to safety recommendations regarding homebound status (Please refer to Home Health Q&A sheet in Welcome Packet for current Medicare guidelines)
- ☐ Minimum Home Safety Requirements
- ☐ Participation in visits
- ☐ Safety/Fall Precautions
- ☐ Adhering to recommendations from clinical staff, including actions taken outside of visits
- ☐ Scheduling/Availability for clinical visits
- ☐ Other: _____

Additional Notes:

Patient Signature:_____ Date: _____

KG Signature:_____Date: _____

PAIN SCALE AND RATINGS

RATING OF PERCEIVED EXERTION (CARDIOVASCULAR ENDURANCE)

10	I am dead!!
9	I am probably going to die!
8	I can grunt in response to your questions and can only keep this pace for a short time period.
7	I can still talk but I don't really want to and I am sweating like a pig!
6	I can still talk but I am slightly breathless and definitely sweating.
5	I'm just above comfortable, I am sweating more and can talk easily.
4	I'm sweating a little, but I feel good and I can carry on a conversation comfortably.
3	I am still comfortable, but I'm breathing a bit harder.
2	I'm comfortable and I can maintain this pace all day long.
1	I am watching TV and eating bon bons.

KLINE GALLAND
HOME HEALTH

Compassion · Respect · Excellence · Dignity · Integrity · Tradition

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