



Policies & Procedures

Administrator office hours are 9am to 5pm Monday-Friday, or a Supervisor/ER Nurse is available 24 hours a day at the number on the folder.

1. I expect to receive a prompt response from the organization regarding the investigation and resolution of complaints/grievances.
2. I will contact the State Hotline to ask questions about local home health agencies for complaints about local agencies, and to lodge a complaint concerning the care, lack of respect for a person or property or lack of respect for advance directives. The telephone number of the State Hotline is (Toll Free) is 1-866-264-7145.
3. The Hotline is available 24 hours a day, 7 days a week.
4. Choose a health care provider and inform in advance of any limitations of your home health agency, anticipated outcomes and treatment, any barriers to achieving those outcomes.
5. Participate in any discussions concerning ethical issues and be informed of client rights under state law regarding formulating advanced care directives.
6. Assurance that all information about you remains confidential. You will be asked to provide written permission for release of information.
7. Examine your records according to the Notice of Privacy Practices and receive a written copy of the Notice of Privacy Practices.
8. Receive information and be communicated to in a language or form that can be reasonably understood whenever possible.
9. Be informed of any financial benefit that may occur to the organization if referred to an affiliate organization for services beyond the scope of this Agency.

We also expect you to assume certain responsibilities for your own care including:

1. To give the organization complete information about medical services you have or are about to receive.
2. To have the availability of a responsible person to assist in your care between visits of our staff, when indicated.
To inform staff of any changes in your health status.
3. To follow the plan of care developed with TOP AID HEALTHCARE, INC.
4. To have adequate facilities in your home for safe and proper care.
5. To have needs to be met with intermittent care within the scope of the home health program.
6. To promptly notify the organization in advance of any appointment you may cancel.

Client Signature: _____

Date: _____