TOP AID
HEALTHCARE, INC

CONSENT FOR SERVICES AND FINANCIAL AGREEMENT

CLIENT NAME: _____ **DATE:** _____

CONSENT TO RECIVE SERVICES:

I hereby authorize_____to render appropriate AFC services to me at my residence. I have been fully informed of the Agency's assessment, evaluation of my needs and the plan of care. I accept the proposed plan of care and authorize services to be provided by the agency in accordance with the orders of my physician, and supervision to be done by agency personnel, also understand that; My participation in the program is voluntary, I have a right to refuse/terminate services at any time by notifying the agency office, the agency may terminate services by notifying me of termination and reason.

AUTHORIZATION FOR PAYMENT TO PROVIDER:

I authorize_____to release all medical information for the purpose of submitting medical claims as client in Adult Foster Care Program. I request that payment as authorized be made on my behalf to the Agency. This authorization and request shall apply to the certification period starting_____, until the order is discontinued by either myself, the agency, insurance, Physician, or I am ineligible to participate in the program.

CLIENT LIABILITY FOR PAYMENT:

I have the right to be advised, before initiated, of the extend to which payment for services may be expected from Medicaid or other sources. I have been fully informed that, services provided are paid for in full by medicaid. No cost to the client. CLIENT'S RIGHT/EMERGENCY PLAN/COMPLAINT PROCEDURE:

I have been informed of my rights and received a copy of the client's bill of Rights and Rights of the elderly prior to the start of care procedure, Advanced Directives, Emergency Plan, Abuse/Neglect/exploitation. I have been allowed to participate in planning of my care and have received a copy of the State's Toll-Free Home Health Agency Hotline Number for Massachusetts 800-468-5540 which receives complaints or grievances 24 hours a day, seven days a week.

CONFIDENTIALITY:

It is the Agency's policy to protect all medical records against loss, defacement, tampering and use by unauthorized persona(s). All patient identifiable information in the medical record, including MDS data, remains confidential and is not released to the piblic. MDS data will be electronically transmited the state. The client's written consent shall be required for the release of medical . information to persons not otherwise authorized by law (Federal and State) to receive this information. Authorized persons who may review the clinical records include surveyors, Physicians, Center for Medicaid Services (CMS), and external and internal Auditing personnel.

RELEASE OF RECORDS:

I understand the agency policy regarding confidentiality and release of records prohibits access to my records by persons other than personnel involved in care. I therefore give written consent for release of medical records to Health care providers in my treatment care.

_____

CLIENT OR AUTHORIZED AGENT SIGNATURE: **RELATIONSHIP TO CLIENT** **Date:**

_____ _____ _____