YORK
HEALTHCARE
120-34 Queens Boulevard, Suite 340
Kew Gardens, NY 11415
Tel: (718) 460-4200 / Fax: (347) 368-4828

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YORK HEALTHCARE

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Client Name:
Address:

USE AND DISCLOSURE OF HEALTH INFORMATION

YORK HEALTHCARE may use your health information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. Your health information may be used or disclosed only after the Agency has obtained your written consent. The Agency has established policies to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AFTER YOU HAVE PROVIDED YOUR WRITTEN CONSENT

To Provide Treatment. The Agency may use your health information to coordinate care within the Agency and with others involved in your care, such as your attending physician and other health care professionals who have agreed to assist the Agency in coordinating care. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications. The Agency also may disclose your health care information to individuals outside of the Agency involved in your care including family members, pharmacists, suppliers of medical equipment or other health care professionals.

To Obtain Payment. The Agency may include your health information in invoices to collect payment from third parties/managed care/Medicaid for the care you receive from the Agency. For example, the Agency may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or the Agency. The Agency also may need to obtain prior approval from your insurer and may need to explain to the insurer your need for home care and the services that will be provided to you.

To Conduct Health Care Operations. The Agency may use and disclose health information for its own operations in order to facilitate the function of the Agency and as necessary to provide quality care to all of the Agency's patients. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Protocol development, case management and care coordination.
- Contacting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment.
- Professional review and performance evaluation.
- Training programs including those in which students, trainees or practitioners in health care learn under supervision.
- Training of non-health care professionals.
- Accreditation, certification, licensing or credentialing activities.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.

- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Agency.
- Fundraising for the benefit of the Agency and certain marketing activities.

For example the Agency may use your health information to evaluate its staff performance, combine your health information with other Agency patients in evaluating how to more effectively serve all Agency patients, disclose your health information to Agency staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you as part of general fundraising and community information mailings (unless you tell us you do not want to be contacted).

For Appointment Reminders. The Agency may use and disclose your health information to contact you as a reminder that you have an appointment for a home visit.

For Treatment Alternatives. The Agency may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED WITHOUT FIRST RECEIVING YOUR WRITTEN CONSENT

When Legally Required. The Agency will disclose your health information when it is required to do so by any Federal, State or local law.

When There Are Risks to Public Health. The Agency may disclose your health information for public activities and purposes in order to:

- Prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations and interventions.
- Report adverse events, product defects, to track products or enable product recalls, repairs and replacements and to conduct post-marketing surveillance and compliance with requirements of the Food and Drug Administration.
- Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.
- Notify an employer about an individual who is a member of the workforce as legally required.

To Report Abuse, Neglect Or Domestic Violence. The Agency is allowed to notify government authorities if the Agency believes a patient is the victim of abuse, neglect or domestic violence. The Agency will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

To Conduct Health Oversight Activities. The Agency may disclose your health information to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Agency, however, may not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. The Agency may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Agency makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by State law, the Agency may disclose your health information to a law enforcement official for certain law enforcement purposes as follows:

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- As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant, subpoena or summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the Agency has a suspicion that your death was the result of criminal conduct including criminal conduct at the Agency.
- In an emergency in order to report a crime.

To Coroners and Medical Examiners. The Agency may disclose your health information to coroners and medical examiners for purposes of determining your cause of death or for other duties, as authorized by law.

To Funeral Directors. The Agency may disclose your health information to funeral directors consistent with applicable law and if necessary, to carry out their duties with respect to your funeral arrangements. If necessary to carry out their duties, the Agency may disclose your health information prior to and in reasonable anticipation of your death.

For Organ, Eye or Tissue Donation. The Agency may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.

In the Event of a Serious Threat To Health Or Safety. The Agency may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Agency, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, the Federal regulations authorize the Agency to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

For Worker's Compensation. The Agency may release your health information for worker's compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than is stated above, the Agency will not disclose your health information other than with your written authorization. If you or your representative authorizes the Agency to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Agency maintains:

Right to request restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Agency's disclosure of your health information to someone who is involved in your care or the payment of your care. However, the Agency is not required to agree to your request. If you wish to make a request for restrictions, please contact the agency's Privacy Officer.

Right to receive confidential communications. You have the right to request that the Agency communicate with you in a certain way. For example, you may ask that the Agency only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential

communications, please contact the agency's Privacy Officer. The Agency will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

Right to inspect and copy your health information. You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to the agency's Privacy Officer. If you request a copy of your health information, the Agency may charge a reasonable fee for copying and assembling costs associated with your request.

Right to amend health care information. You or your representative have the right to request that the Agency amend your records, if you believe that your health information is incorrect or incomplete. That request may be made as long as the information is maintained by the Agency. A request for an amendment of records must be made in writing to the agency's Privacy Officer. The Agency may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by the Agency, if the records you are requesting are not part of the Agency's records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of the Agency, the records containing your health information are accurate and complete.

Right to an accounting. You or your representative have the right to request an accounting of disclosures of your health information made by the Agency for any reason other than for treatment, payment or health operations. The request for an accounting must be made in writing to the agency's Privacy Officer. The request should specify the time period for the accounting starting on or after _____ / _____ / _____. Accounting requests may not be made for periods of time in excess of six (6) years. The Agency would provide the first accounting you request during any 12-monlh period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

Right to a paper copy of this notice. You or your representative have a right to a separate paper copy of this Notice at any time even if you or your representative have received this Notice previously. To obtain a separate paper copy, please contact the agency's Privacy Officer.

DUTIES OF THE AGENCY

The Agency is required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of its duties and privacy practices. The Agency is required to abide by the terms of this Notice as may be amended from time to time. The Agency reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information that it maintains. If the Agency changes its Notice, the Agency will provide a copy of the revised Notice to you or your appointed representative. You or your personal representative have the right to express complaints to the Agency and to the Secretary of DHHS if you or your representative believe that your privacy rights have been violated. Any complaints to the Agency should be made in writing to the agency's Privacy officer. The Agency encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Agency has designated the agency's Privacy Officer, as its contact person for all issues regarding patient privacy and your rights under the Federal privacy standards. You may contact this person by calling:

Tel: (718) 460-4200

Address: _____

EFFECTIVE DATE

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This Notice is effective: _____ / _____ / _____

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE AGENCY'S DIRECTOR OF PATIENT SERVICES OR PRIVACY OFFICER.

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I (Print Name): _____ acknowledge that I have received a copy of the agency's Notice of Privacy Practices.

Patient's Signature:	Date:

Personal Representative Signature:	Relationship:	Date:

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Authorization for Use or Disclosure of Information

I hereby authorize YORK HEALTHCARE ("The Provider") to use or disclose the following protected health information:(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)_____
The protected health information may be disclosed to:
(Insert name of person or entity who may have receive the information) _____
_____
This protected health information being used or disclosed for the following purposes: (List specific purposes here, the patient may indicate that the information to be is "at the patient's request" if the patient does not choose to provide an explanation of the purpose of the request)
_____
This authorization shall be in force and effect until: (check one of the following)

- Date: _____
- The happening of the following expiration event. _____
- End of research study
- No expiration (can only be used if authorization is for creation of research database or research repository) at which time this authorization to use or disclose this protected health information expires.

I understand that, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

YORK HEALTHCARE
Attn. Privacy Officer

I understand that a revocation is not effective to the extent that the provider has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Check One of the Following:

- I understand that the provider will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- I understand that the health care provided by the
- Provider is solely for the purposes of creating protected health information for _____ and that my authorization is a condition of this treatment. I understand that if I do not sign this authorization, then the Provider will not provide health care services to me.
- I understand that the treatment being provided for the provider is related to research and that my authorization of disclosures for research related purposes is a condition of this treatment. f understand that if I do not sign this authorization, then the Provider will not provide research related treatment to me.

Optional- check box if applicable:

- I understand that the provider may receive remuneration from a third party for the disclosure

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

_____ _____

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Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative/Relationship

POLICY SUMMARY
THE HOME CARE CLIENT'S RIGHT TO
FORMULATE AN ADVANCE DIRECTIVE

In accordance with the Federal Client Self-Determination Act of 1990 and the New York State laws governing health care decision YORK HEALTHCARE provides written information to each adult client admitted to the agency for care and services. The materials provide information and guidance for implementing your right to make health care decisions and to execute an advance directive.

The agency respects the rights of each adult to participate in health care decision making to the maximum extent of his/her ability and respects all rights consistent with NY State Law and has instituted specific policies and procedures to ensure that a client's health care decisions are followed.

A specific type of Advance Directive is the request of a "**DO NOT RESUSCITATE**" directive. The agency's staff will follow these orders as long as these orders fulfill the requirements of applicable state laws. However, the agency recognizes that such staff may be limited in their ability to implement these orders on individual conscience. In such cases, the agency will assist the client in obtaining care through another staff member or if necessary through another agency that will honor such directives. In all cases it is not the policy of the agency to initiate Cardio-Pulmonary Resuscitation in the home, nor will agency staff participate in any other way with the withdrawal of life sustaining care service.

INFORMATION TO CLIENTS

The agency will provide the following written information (pamphlets) to each adult at the time of admission to the agency for care:

1. Do Not Resuscitate-A guide for Client and Family
2. Planning in Advance for Your Medical Treatment
3. Appointing Your Health Care Agency-NYS Proxy Law
4. This policy summary describing the agency's policy regarding the right of each adult to make health decisions and formulate advance directives.

Definitions:

1. **Advance Directive:**	A written instruction relating the provision of health care when an adult becomes incapacitated including, but not limited to, a health proxy, a living will and consent to or request for the issuance of an order not to resuscitate.
2. **Health Care Proxy:**	A document delegating to another adult known as a health care agent, the authority to make health care decisions on behalf of the individual making the appointment if that individual in the future becomes incapable of making his or her own health care decisions.
3. **Living Will:**	A document which contains specific instructions concerning an individual's wishes about the type of health care choices and treatments

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that he or she does not want to receive, but which does not designate an agent to make health care decisions.

4. **DNR (Do Not Resuscitate Order):** A living will that consents to or requests a doctor's order not-to-resuscitate. Under such an order, health care providers are not to attempt cardiopulmonary resuscitation (CPR) in the event the client suffers cardiac or respiratory arrest. A request for such an order can be expressed in a health care proxy or living will.

5. **Documentation:** Notation in the client's medical record whether or not the client has executed an advance directive. If the document is made available to the agency, a copy shall be included in the client's medical record.

6. **Compliance with the Law:** The agency shall comply with all applicable NYS law regarding advance directives, including statutes and court decisions.

7. **Non-Discrimination:** The agency shall not condition the provision of care or otherwise discriminate against any individual based on whether or not the individual has executed an advance directive.

8. **Education:** The agency provides education to staff and the community on issues regarding client decision making.

PLANNING IN ADVANCE FOR YOUR MEDICAL TREATMENT

Your Right to Decide About Treatment

Adults in New York State have the right to accept or refuse medical treatment, including life-sustaining treatment. Our Constitution and state laws protect this right. This means that you have the right to request or consent to treatment, to refuse treatment before it has started and to have treatment stopped once it has begun~

Planning In Advance

Sometimes because of illness or injury people are unable to talk to a doctor and decide about treatment for themselves. You may wish to plan in advance to make sure that your wishes about treatment will be followed if you become unable to decide for yourself for a short or long time period. If you don't plan ahead, family members or other people close to you may not be allowed to make decisions for you and follow your wishes.

In New York State, appointing someone you can trust to decide about treatment if you become unable to decide for yourself is the best way to protect your treatment wishes and concerns. You have the right to appoint someone by filling out a form called a Health Care Proxy. A copy of the form and information about the Health Care Proxy are available from your health care provider.

If you have no one you can appoint to decide for you, or do not want to appoint someone, you can also give specific instructions about treatment in advance. Those instructions can be written, and are often referred to as a Living Will.

You should understand that general instructions about refusing treatment, even if written down, may not be effective. Your instructions must clearly cover the treatment decisions that must be made. For example, if you just write down that you do not want -heroic measures: the instructions may not be specific enough. You should say the kind of treatment that you do not want, such as a respirator or chemotherapy, and describe the medical condition when you would refuse the treatment, such as when you are terminally ill or permanently unconscious with no hope

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of recovering. You can also give instructions orally by discussing your treatment wishes with your doctor, family members or others close to you.

Putting things in writing is safer than simply speaking to people, but neither method is as effective as appointing someone to decide for you. It is often hard for people to know in advance what will happen to them or what their medical needs will be in the future. If you choose someone to make decisions for you, that person can talk to your doctor and make decisions that they believe you would have wanted or that are best for you, when needed. If you appoint someone and also leave instructions about treatment in a Living Will, in the space provided on the Health Care Proxy form itself, or in some other manner, the person you select can use these instructions as guidance to make the right decision for you.

Deciding About Cardiopulmonary Resuscitation

Your right to decide about treatment also includes the right to decide about cardiopulmonary resuscitation (CPR). CPR is emergency treatment to restart the heart and lungs when your breathing or circulation stops.

Sometimes doctors and patients decide in advance that CPR should not be provided, and the doctor gives the medical staff an order not to resuscitate (DNR) order. If your physical or mental condition prevents you from deciding about CPR, someone you appoint, your family members or others close to you can decide.

Do-Not-Resuscitate (DNR) Orders
A Guide for Patients and Families

What do CPR and DNR orders mean?

CPR cardiopulmonary resuscitation refers to the medical procedures used to restart a patient's heart and breathing when the patient suffers heart failure. CPR may involve simple efforts such as mouth-to-mouth resuscitation and external chest compression. Advanced CPR may involve electric shock, insertion of a tube to open the patient's airway, injection of medication into the heart and in extreme cases, open chest heart massage.

A do-not-resuscitate (DNR) order tells medical professionals not to perform CPR. This means that doctors, nurses and emergency medical personnel will not attempt emergency CPR if the patient's breathing or heartbeat stops.

DNR orders may be written for patients in a hospital or nursing home, or for patients at home. Hospital DNR orders tell the medical staff not to resuscitate the patient if cardiac arrest occurs. If the patient is in a nursing home or at home, a DNR order tells the staff and emergency medical personnel not to perform emergency resuscitation and not to transfer the patient to a hospital for CPR.

Why are DNR orders issued?

CPR, when successful, restores heartbeat and breathing and allows a patient to resume his/her previous lifestyle. The success of CPR depends on the patient's overall medical condition. Age alone does not determine whether CPR will be successful, although illnesses and frailties that go along with age often make CPR less successful.

When patients are seriously ill or terminally ill, CPR may not work or may only partially work, leaving the patient brain-damaged or in a worse medical state than before the heart stopped. In these cases, some patients prefer to be cared for without aggressive efforts at resuscitation.

Can I request a DNR order?

Yes. All adult patients can request a DNR order. If you are sick and unable to tell your doctor that you want a DNR order written, a family member or close friend can decide for you.

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Is my right to request or receive other treatment affected by a DNA order?

No. A DNR order is only a decision about CPR and does not relate to any other treatment.

Are DNR orders ethically acceptable?

It is widely recognized by health care professionals, clergy, lawyers and others that DNR orders are medically and ethically appropriate under certain circumstances. For some patients, CPR offers more burdens than benefits, and may be against the patient's wishes.

Is my consent required for a DNR order?

Your doctor must speak to you before entering a DNR order if you are able to decide, unless your doctor believes that discussing CPR with you would cause you severe harm. In an emergency, it is assumed that all patients would consent to CPR. However, if a doctor decides that CPR will not work, it is not provided.

How can I make my wishes about DNR known?

During hospitalization, an adult patient may consent to a DNR order orally or in writing, if two adult witnesses are present. When consent is given orally, one of the witnesses must be a physician affiliated with the hospital. Prior to hospitalization, consent must be in writing in the presence of two adult witnesses, In addition, the Health Care Proxy Law allows you to appoint someone you trust to make decisions about CPR and other treatments if you become unable to decide for yourself.

Before deciding about CPR, you should speak with your doctor about your overall health and the benefits and burdens CPR would provide for you. A full and early discussion between you and your doctor will assure that your wishes will be known.

If I request a DNR order, must my doctor honor my wishes?

If you don't want CPR and you request a DNR order, your doctor must follow your wishes or:

1. Transfer your care to another doctor who will follow your wishes
2. Begin a process to settle the dispute if you are in a hospital or nursing home.

If the dispute is not resolved within 72 hours, your doctor must enter the order or transfer you to the care of another doctor.

If I am not able to decide about CPR for myself, who will decide?

First, two doctors must determine that you are unable to decide about CPR. You will be told of this determination and have the right to object.

If you become unable to decide about CPR, and you did not tell your doctor or others about your wishes in advance, a DNR order can be written with the consent of the person highest on the following list:

1. Your health care agent the person chosen by you to make health care decisions under New York's Health Care
2. Proxy Law (if you have appointed one)
3. A court appointed guardian (if there is one)
4. Your closest relative (spouse, child, parent, sibling)
5. A close friend

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How can I select someone to decide for me?

The Health Care Proxy Law allows adults to select someone they trust to make health care decisions for them when they are no longer able to do so themselves, including decisions about CPR. You can name someone by filling out a health care proxy form.

Under what circumstances can a family member or close friend decide that a DNR order should be written?

A family member or close friend can consent to a DNR order only when you are unable to decide for yourself and you have not appointed a health care agent to decide for you. Your family member or friend can consent to a DNR order when:

1. You are terminally ill
2. You are permanently unconscious
3. CPR will not work (would be medically futile)
4. CPR would impose an extraordinary burden on you given your medical condition and the expected outcome of CPR.

Anyone deciding for you must base the decision on your wishes, including your religious and moral beliefs, or if your wishes are not known, on your best interests.

What if members of my family disagree?

In a hospital or nursing home, your family can ask that the disagreement be mediated. Your doctor can request mediation if he or she is aware of any disagreement among your family members.

What if I lose the ability to make decisions about CPR and do not have anyone who can decide for me?

A DNR order can be written if two doctors decide that CPR would not work or if a court approves of the DNR order. It would be best if you discussed your wishes about CPR with your doctor in advance.

Who can consent to a DNR order for children?

A DNR order can be entered for a child with the consent of the child's parent or guardian. If the child is old enough to understand and decide about CPR, the child's consent is also required for a DNR order.

What happens if I change my mind after a DNR order has been written?

You or anyone who consents to a DNR order for you can revoke consent for the order by telling your doctor, nurses or others of the decision.

What happens to a DNR order if I am transferred from a nursing home to a hospital or vice versa?

The DNR order will continue until a doctor examines you and decides whether the order should remain or be canceled. If the doctor decides to cancel the DNR order, you or anyone who decided for you will be told and can ask that the DNR order be entered again.

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If I am at home with a nonhospital DNR order, what happens if a family member or friends panics and calls an ambulance to resuscitate me?

If you have a nonhospital DNR order and family members show it to emergency personnel, they will not try to resuscitate you or take you to a hospital emergency room for CPR.

What happens to my DNR order if I am transferred from a hospital or nursing home to home care?

The order issued for you in a hospital or nursing home will not apply at home, You, your health care agent or family member must specifically consent to a nonhospital DNR order. If you leave a hospital or nursing home without a nonhospital DNR order, a DNR order can be issued by a doctor for you at home.

HEALTH CARE PROXY

Appointing Your Health Care Agent in New York State

The New York Health Care Proxy Law allows you to appoint someone you trust - for example, a family member or close friend - to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can a/so decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

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Appointing Your Health Care Agent
NEW YORK STATE'S PROXY LAW

A law called the New York Health Care Proxy Law allows you to appoint someone you trust - for example, a family member or close friend – to decide about treatment if you lose the ability to decide for yourself. You can do this by using a Health Care Proxy form like the one inside, to appoint your "health care agent".

This law gives you the power to make sure that health care professionals follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own.

You can give the person you select, your health care agent, as little or as much authority as you want. You can allow your agent to decide about all health care or only certain treatments. You may also give your agent instructions that he or she has to follow.

Why should I choose a health care agent?

If you become too sick to make health care decisions, someone else must decide for you. Health care professionals often look to family members for guidance. But family members are not allowed to decide to stop treatment, even when they believe that is what you would choose or what is best for you under the circumstances. Appointing an agent lets you control your medical treatment by:

- Allowing your agent to stop treatment when he or she decides that is what you would want or what is best for you under the circumstances
- Choosing one family member to decide about treatment because you think that person would make the best decisions or because you want to avoid conflict or confusion about who should decide
- Choosing someone outside your family to decide about treatment because no one in your family is available or because you prefer that someone other than a family member decide about your health care

How can I appoint a health care agent?

All competent adults can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer, just two adult witnesses. You can use the form printed here, but you don't have to.

When would my health care agent begin to make treatment decisions for me?

Your health care agent would begin to make treatment decisions after doctors decide that you are not able to make health care decisions. As long as you are able to make treatment decisions for yourself, you will have the right to do so.

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Kew Gardens, NY 11415
Tel: (718) 460-4200 / Fax: (347) 368-4828

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any treatment decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accord with your wishes and interests. If your health care agent is not aware of your wishes about artificial nutrition and hydration (nourishment and water provided by feeding tubes), he or she will not be able to make decisions about these measures. Artificial nutrition and hydration are used in many circumstances, and are often used to continue the life of patients who are in a permanent coma.

How will my health care agent make decisions?

You can write instructions on the proxy form. Your agent must follow your oral and written instructions, as well as your moral and religious beliefs. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interests.

Who will pay attention to my agent?

All hospitals, doctors and other health care facilities are legally required to honor the decisions by your agent. If a hospital objects to some treatment options (such as removing certain treatment) they must tell you or your agent IN ADVANCE.

What if my health care agent is not available when decisions must be made?

You can appoint an alternate agent to decide for you if your health care agent is not available or able to act when decisions must be made. Otherwise, health care providers will make treatment decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel the proxy, to change the person you have chosen as your health care agent or to change any treatment instructions you have written on your Health Care Proxy form. Just fill out a new form. In addition, you can require that the Health Care Proxy expire on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent and you get divorced or legally separated, the appointment is automatically cancelled.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for treatment decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Is a health care proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care treatment. It is generally used to declare wishes to refuse life sustaining treatment under certain circumstances. In contrast, the health care proxy allows you to choose someone you trust to make treatment decisions on your behalf. Unlike a living will, a health care proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known

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would have to be made. The health care proxy is just as useful for decisions to receive treatment as it is for decisions to stop treatment. If you complete a Health Care Proxy form, but also have a living will, the living will provides instructions for your health care agent, and will guide his or her decisions.

Where should I keep the proxy form after it is signed?

Give a copy to your agent, your doctor and any other family members or close friends you want. You can also keep a copy in your wallet or purse or with other important papers.

APPOINTING A HEALTH CARE AGENT IS A SERIOUS DECISION. MAKE SURE YOU TALK ABOUT IT WITH YOUR FAMILY, CLOSE FRIENDS AND YOUR DOCTOR. DO IT IN ADVANCE, NOT JUST WHEN YOU ARE PLANNING TO ENTER THE HOSPITAL.

FILLING OUT A HEALTH CARE PROXY IS VOLUNTARY. NO ONE CAN REQUIRE YOU TO DO SO.

About the Health Care Proxy Form

This is an important legal document. Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.

3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.

4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.

5. You do not need a lawyer to fill out this form.

6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.

7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

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9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.

10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.

11. Appointing a health care agent is voluntary. No one can require you to appoint one.

12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

About the Health Care Proxy

This is an important legal form. Before signing this form, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or provide life-sustaining treatment.
3. Unless your agent knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse or consent to those measures for you.
4. Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

If I become terminally ill, I do/don't want to receive the following treatment

If I am in a coma or unconscious, with no hope of recovery then I do/don't want

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want

I have discussed with my agent my wishes about_____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list of the treatments about which you may leave instructions.

- Artificial respiration
- Artificial nutrition and hydration

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- Nourishment and water provided by feeding tube
- Cardiopulmonary resuscitation (CPR)
- Antipsychotic medication
- Electric shock therapy
- Antibiotics
- Psychosurgery
- Dialysis
- Transplantation
- Blood transfusions
- Abortion
- Sterilization

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker, before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy.

You do not need a lawyer to fill out this form.

You can choose any adult (over 18), including a family member, or close friend, to be your agent. If you select a doctor as your agent, he or she may have to choose between acting as your agent or as your attending doctor; a physician cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask staff at the facility to explain those restrictions.

You should tell the person you choose that he or she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object You can cancel the control given to your agent by telling him or her or your health care provider orally or in writing.

Filling Out the Proxy Form

Item (1) Write your name and the name, home address and telephone number of the person you are selecting as your agent.
Item (2) If you have special instructions for your agent, you should write them here. Also, if you wish to limit your agent's authority in any way, you should say so here. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment. You may also state your wishes about organ or tissue donation(s).
Item (3) You may write the name, home address and telephone number of an alternate agent.
Item (4) This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire.
Item (5) You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Two witnesses at least 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.

Frequently Asked Questions

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Why should I choose a health care agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. However, in New York State, only a health care agent you appoint has the legal authority to make treatment decisions if you are unable to decide for yourself. Appointing an agent lets you control your medical treatment by:

- Allowing your agent to make health care decisions on your behalf as you would want them decided
- Choosing one person to make health care decisions because you think that person would make the best decisions
- Choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?

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Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

How will my health care agent know my wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- Whether you would want life support initiated/continued/removed if you are in a permanent coma
- Whether you would want treatments initiated/continued/removed if you have a terminal illness
- Whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances

Can my health care agent overrule my wishes or prior treatment instructions?

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What If I change my mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur.
Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

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Is a Health Care Proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

When should I keep my Health Care Proxy form after it is signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ and or tissue donation?

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.

Can my health care agent make decisions for me about organ and/or tissue donation?

No. The power of a health care agent to make health care decisions on your behalf ends upon your death. Noting your wishes on your Health Care Proxy form allows you to clearly state your wishes about organ and tissue donation.

Who can consent to a donation if I choose not to state my wishes at this time?

It is important to note your wishes about organ and/or tissue donation so that family members who will be approached about donation are aware of your wishes. However, New York Law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf They are listed in order of priority: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death, or any other legally authorized person.

Item (1)
Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)
If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)
Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

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Item (4)
If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make health care decisions that you could have made, including the decision to consent to or refuse life sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/ don't want the following types of treatments

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there no hope that my condition will improve, I do/don't want the following types of treatments

I have discussed with my agent my wishes about_____ and I want my agent to make all decisions about these measures

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- Artificial respiration
- Artificial nutrition and hydration (nourishment and water provided by feeding tube)
- Cardiopulmonary resuscitation (CPR)
- Antipsychotic medication
- Electric shock therapy
- Antibiotics
- Surgical procedures
- Dialysis
- Transplantation
- Blood transfusions
- Abortion
- Sterilization

Item (5)
You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)
You may state wishes or instructions about organ and/or tissue donation on this form. A health care agent cannot make a decision about organ and/or tissue donation because the agent's authority ends upon your death. The law does provide for certain individuals in order of priority to consent to an organ and for tissue donation on your behalf: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death, or any other legally authorized person.

Item (7)
Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

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Health Care Proxy

(1) I, _____ here by appoint (name, home address and telephone number): _____

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint (name, home address and telephone number): _____

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here) This proxy shall expire (specify date or conditions): _____

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary): _____

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know

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your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification (please print)

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

- ○ Any needed organs and/or tissues
- ○ The following organs and/or tissues _____
  _____
- ○ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses (Witnesses must be 18 years of age Dr.'s older and cannot he the health care agent or alternate.)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____

Name of Witness 1 (print) _____

Signature _____

Address _____

Date _____

Name of Witness 2 (print) _____

Signature _____

Address _____

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State of New York
Department of Health

Nonhospital Order Not to Resuscitate
(DNR Order)

Patient's Name _____

Date of Birth ___ / ___ / _____

Do not resuscitate the person named above.

Physician's Signature _____

Print Name _____

License Number _____

Date ___ / ___ / _____

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It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day period.

DOH – 3474 (04/09)

Patient Copy

State of New York
Department of Health

Nonhospital Order Not to Resuscitate
(DNR Order)

Patient's Name _____

Date of Birth ___ / ___ / _____

Do not resuscitate the person named above.

Physician's Signature _____

Print Name _____

License Number _____

Date ___ / ___ / _____

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It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day period.

DOH – 3474 (04/09)

Office Copy

HOME CARE BILL OF RIGHTS

CLIENT'S NAME: _____

As a patient of YORK HEALTHCARE you have the right to:

1. Be informed of your rights both verbally and in writing at the time of admission and prior to the initiation of care.
2. Receive competent, individualized care and service from YORK HEALTHCARE staff regardless of age, race, color, national origin, religion, sex, disease, disability or any other category protected by law or decisions regarding advance directives.
3. Be treated with dignity, courtesy, consideration, respect and have your property treated with respect.
4. Be informed verbally and in writing of the services available and related charges, as they apply to the primary insurance, other payers, and self-pay coverage before care is initiated, To be informed of any changes in the sources of payment and your financial responsibility as soon as possible but no later than thirty (30) calendar days after YORK HEALTHCARE becomes aware of the change.
5. Be informed both orally and in writing, in advance of the Plan of Care, of any changes in the Plan of Care, and to be included in the planning of care before treatment begins; be informed of all treatment prescribed, when and how services will be provided, and the names and functions of any person and affiliated program providing care and services, including photo identification of agency staff and participate in the development of the discharge plan.
6. Participate in the planning of your care and be advised in advance of any changes to the plan of care.
7. Refuse care and treatment after being fully informed of and understanding the consequences of such actions and to initiate an Advance Directive, "Living Wilt, durable power of attorney and other directives about your care consistent with applicable law and regulations. Refuse to participate in research or experimental treatment.
8. To appropriate assessment of pain and management of his/her pain.
9. Receive information regarding community resources and to be informed of any financial relationships between YORK HEALTHCARE and other providers to which you may be referred to by the agency.

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10. Be informed of the procedures for submitting patient complaints, voice complaints and recommend changes in the policies and services to Director of Patient Services by calling the following telephone number: (718) 460-4200. If dissatisfied with the outcome, you may also submit the complaint to the New York State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or patient designee shall be free from interference, coercion, discrimination or reprisal.

NYS Department of Health
Metropolitan Regional Office
90 Church Street
New York, New York 10007
212-417-5888

11. Express complaints about the care and services provided or not provided and complaints concerning lack of respect for property by personnel furnishing services on behalf of YORK HEALTHCARE and to expect the agency to investigate such complaints within 15 days of receipt of complaint. Also, if dissatisfied with the outcome, may submit an appeal to the agency's governing authority which will be reviewed within 30 days of receipt of appeal request.
12. Receive timely notice of impending discharge or transfer to another agency or to a different level of care and to be advised of the consequences and alternatives to such transfers.
13. Privacy, including confidential treatment of records and access to your records on request. Information will not be released without your written consent except for those instances required by law, regulation or third party reimbursement.
14. In the situation when the patient lacks capacity to exercise these rights, the rights shall be exercised by an individual, guardian or entity legally authorized to represent the patient.

HOME CARE BILL OF RIGHTS AND RESPONSIBILITIES

CLIENT'S NAME: _____

As a Home Care Client, you have the responsibility to:

1. Be seen by a doctor on a regular and ongoing basis.
2. Share complete and accurate health Information.
3. Be responsible for following the recommended treatment plan.
4. Make it known if you do not understand or cannot follow the treatment plan.
5. Cooperate with agency staff and not discriminate against staff.
6. Notify the agency in advance when you cannot keep a scheduled appointment.
7. Notify the agency if you receive services from another agency.
8. Notify the agency in the event of change in your health status.
9. Be responsible for your actions if you refuse treatment or do not follow the agency's recommendations/directions.
10. Take responsibility for financial obligations of your care.

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11. Maintain a home environment that facilitates effective home care.

Patient/Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____

SERVICES CONSENT/STATEMENT OF SERVICES AND CHARGES
RELEASE OF INFORMATION/ACKNOWLEDGEMENT

Client: _____ Telephone #: _____

Social Security No: _____ DOB: _____

I authorize YORK HEALTHCARE staff to provide services, as requested by myself/representative and ordered by my physician. Services provided by the Agency may include Nursing, Home Health Aide.

The services provided which YORK HEALTHCARE will provide have been explained to me and I understand that I may refuse treatment within the confines of the law after being informed of the consequences of my action.

I give my consent and authorization for release of medical information to YORK HEALTHCARE by physician and other health care providers, facilities.

I authorize YORK HEALTHCARE and other licensing/regulatory bodies to periodically examine my medical record for the purpose of checking compliance to applicable rules, regulations and standards.

I understand that it would be prudent and in my best interests to establish a Home Health Service Plan of Care in the event of an emergency such as a fire, hurricane, severe snowstorm, or other natural disaster. Therefore, I hereby grant YORK HEALTHCARE permission to reveal to any governmental agency, supplemental provider agency, community volunteer service or any other providers of services, medical records regarding my nursing care, except where otherwise prohibited by law. I further understand this would be done as necessary, upon request, in order to insure a safe and effective emergency preparedness plan of care.

YORK HEALTHCARE

120-34 Queens Boulevard, Suite 340
Kew Gardens, NY 11415
Tel: (718) 460-4200 / Fax: (347) 368-4828

I acknowledge receiving verbal and written information concerning my Rights and Responsibilities as a home care client and the **NYS Proxy Law/Advance Directives**. In addition the agency has provided a written procedure for submitting complaints and concerns, and directions regarding containing the agency after hours, on weekends and holidays.

SERVICE	FREQUENCY	HOURLY FEE	WEEKEND/ HOLIDAY FEE	EXPECTED INSURANCE COVERAGE	PATIENT'S FINANCIAL RESPONSIBILITY

I agree that I (or my representative) shall be directly responsible for payment for all home care services provided according to this service agreement. I understand that the invoices are rendered weekly and payable upon receipt.

Client/Representative Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

Client Name: _____
Address: _____
Client Representative: _____ Relationship: _____

Assignment of Benefits:

I authorize direct payment to YORK HEALTHCARE of any insurance benefits otherwise payable to me for Home Health Care Services. I also authorize my insurance company(ies) to furnish to an agent of YORK HEALTHCARE any and all information pertaining to my insurance benefits and status of claims submitted by YORK HEALTHCARE for services rendered. I further authorize YORK HEALTHCARE to release to my insurance company(ies) any and all information pertaining to me for benefit determination.

Acknowledgement of Financial Responsibility:

While there may be insurance coverage for those services provided by YORK HEALTHCARE to me relative to my care needs. I recognize that all services may not be covered, or that reimbursement may be less than 100 percent of charges billed, in accordance with my policy coverage. Therefore, I acknowledge financial responsibility for any balance owing on my account. In addition, I agree b be responsible for the full amount of the charges if no payment has been made by 45 days from the date a claim was submitted to an insurance company or if my physician or I fail to provide within 45 days the information necessary to submit the claim for service. I agree to transfer immediately to YORK HEALTHCARE any payment made directly to me for services provided by YORK HEALTHCARE on an assignment basis.

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HEALTHCARE
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The undersigned certifies that he/she has read the Assignment of Insurance Benefits and Acknowledgement of Financial Responsibility, has received a copy, and is the client or is duly authorized by the client as the client's general agent to execute the above and accept its items.

_____ _____
Beneficiary (or Parent/Guardian/Agent Signature) Date

_____
Relationship to the client (if applicable)

_____ _____
Witness Date