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Face to Face
X Able to Sign   Unable to Sign

2600 Philmont Ave., Suite 203, Huntingdon Valley, PA 19006
Tel: 215.677.2007 | Fax: 215.698.6153

ACKNOWLEDGMENT OF:
PARTICIPANT CENTERED PLANNING TEAM MEETING

Annual Contact

MRS. / MS. / MR. Example Training HAS BEEN PROVIDED THE FOLLOWING INFORMATION DURING THE ASSESSMENT PROCESS:

WELCOME PACKET AND ID CARD HAVE BEEN RECEIVED BY THE PARTICIPANT: ☒ YES ☐ NO

PROVIDE TO & REVIEW WITH PARTICIPANT:

☒ PARTICIPANT HANDBOOK
☒ COMMUNITY RESOURCES (9 – 28)
☒ STATEMENT OF NON-DISCRIMINATION (37)
☒ LANGUAGE ASSISTANCE (28, 105)
☒ PARTICIPANT RIGHTS & RESPONSIBILITIES (36 – 39)
☒ PHW BENEFITS & ACCESS TO BENEFITS (42, 46 – 50)
☒ REPORTING FRAUD, WASTE, ABUSE, NEGLECT AND EXPLOITATION (44)
☒ COVERED SERVICES (47 – 50)
☒ VALUE ADDS (DENTAL & VISION) (58 – 59)
☒ PARTICIPANT CHOICE (69 – 80)
☒ CENT ACCOUNT BENEFIT (70)
☒ SERVICE COORDINATOR ROLE (76 – 77)
☒ ADVANCE CARE PLANNING/DIRECTIVES (86 – 87)
☒ PARTICIPANT DIRECTED OPTION (PDO) (81)
☒ COMPLAINTS, GRIEVANCE, APPEAL AND FAIR HEARING (91 – 107)

REVIEWED & SIGNED:

☒ ACKNOWLEDGEMENT FORM
☒ AUTHORIZATION TO USE AND DISCLOSE HEALTH
X INFORMATION
☒ COMPREHENSIVE NEEDS ASSESSMENT CHECKLIST
☒ EXTERNAL DSNP MEDICARE HEALTH RISK ASSESSMENT
☒ INTERRAI
☒ MEMBER CONTACT ASSESSMENT
☒ MEMBER NEEDS ASSESSMENT
☒ OLTL FREEDOM OF CHOICE FORM
☒ PARTICIPANT HIPAA CONSENT FORM
☒ PERSON CENTERED SERVICE PLAN
☒ REPRESENTATIVE FORM
☒ SERVICE PROVIDER CHOICE FORM
☒ WAIVER CONTROL OPTIONS

Example Signature   11/24/2021
PARTICIPANT SIGNATURE   DATE

     11/24/2021
SERVICE COORDINATOR SIGNATURE   DATE

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PARTICIPANT HIPAA CONSENT FORM

I, Example Training hereby authorize **AMCORD CARE INC**. it's professional, non-professional and office staff to provide services as deemed necessary and in accordance with the policies and procedures of the agency. I further consent to the agency's policies and procedures disclosing and obtaining my protected health information in order to coordinate my long-term care. I understand that as part of the provision of my services by **AMCORD CARE INC.,** information will be collected, compiled and maintained in the agency's records.

I acknowledge that I have been informed of my rights to full disclosure of information and understand that I have the right to review such prior to signing this consent form.

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this consent form.

I understand that I have the right to revoke this consent in writing at any time, except to the extent that **AMCORD CARE INC.** has already taken action in reliance on the consent.

The undersigned certifies that I have read the above, have the authority to execute this document and accept its terms.

Example Signature 11/24/2021

PARTICIPANT SIGNATURE

RESPONSIBLE PARTY/REPRESENTATIVE SIGNATURE

11/24/2021

SERVICE COORDINATOR SIGNATURE

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REPRESENTATIVE FORM

PARTICIPANT NAME: Example Training

Legal representatives, representative payee, power of attorneys, spouses, and children under 18 years of age are not eligible to work as aides for the consumer.

- **REPRESENTATIVE** – An individual that represents the client and makes all of the legal, medical, and other decisions.
- **REPRESENTATIVE PAYEE** – Payee is appointed to manage social security funds for another person who is not able to manage their own finances. This individual acts as a financial decision maker.
- **POWER OF ATTORNEY** – A legally appointed person that handles the affairs of an individual who is unable to do so.
- **RESPONSIBLE PARTY** – In the occurrence of individual being unable to provide a signature, he/she has given consent to a responsible party to be his/her witness during the release of information and verbal consent and furthermore, authorized the individual to sign on behalf of the participant.

WILL YOU BE MAKING DECISIONS FOR YOURSELF? ☒ Yes ☐ No

Do you have a **REPRESENTATIVE**? ☒ Yes ☐ No
If yes, name of individual: John Doe
Relationship to participant: Son

Do you have a **POWER OF ATTORNEY**? ☐ Yes ☒ No
If yes, name of individual: ______
Relationship to participant: ______

Do you have a **REPRESENTATIVE PAYEE**? ☐ Yes ☒ No
If yes, name of individual: ______
Relationship to participant: ______

Do you have a **RESPONSIBLE PARTY**? ☒ Yes ☐ No
If yes, name of individual: Jane Doe
Relationship to participant: Daughter-in-law/Direct Care Worker

Example Signature — 11/24/2021
PARTICIPANT SIGNATURE — **DATE**

11/24/2021
SERVICE COORDINATOR SIGNATURE — **DATE**

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PARTICIPANT SELECTION OF PERSONAL CARE OPTIONS

My Coordinator has informed me and given me options to choose regarding how much control I want over the provision of my personal care waiver services. I understand that these options are offered to me by the Pennsylvania waiver program to allow me to exercise my right to choose to direct my provided service in a manner that is consistent with my needs, capacity, and interest in directing my own care. I understand that through AMCORD I will be able to choose the type of care provider I will require.

PARTICIPANT-DIRECTED MODELS OF SERVICE

In choosing the **EMPLOYER AUTHORITY**, I understand that I choose to be the legal employer of my service provider. As their employer, I have the right and responsibility to hire and direct my provider in the provision of my waiver services and perform and fulfill the duties of an employer, including recruiting, selecting, training, hiring, supervision, authorization and payment of wages, payment of taxes and required insurance, and dismissing the "employee," as needed. In choosing the participant/employer option, I understand that I can receive, at my request and as needed, assistance from contractor/coordinator and the Pennsylvania personal waiver program in performing these tasks. I also understand that I can choose to receive assistance from contractor/coordinator in fulfilling my payroll and fiscal duties and obligations as an employer by appointing contractor/coordinator as my payroll and fiscal agent, to act on my behalf, by signing the Internal Revenue Service (IRS) Form 2678 ("Employer Appointment of Agent") and the Pennsylvania Personal Waiver Program "Employer Appointment of Agent."

☐ ________ INITIALS **I CHOOSE THE EMPLOYER AUTHORITY OPTION AND CHOOSE TO EMPLOY THE ATTENDANTS WHO WILL PROVIDE MY WAIVER SERVICES.**

In choosing the **BUDGET AUTHORITY MODEL/SERVICES MY WAY**, similar to the Employer Authority, you are the employer of your direct care workers. Services my way, or budget authority allows you to design you your own budget to purchase goods and services based on your service plan. This can include goods and services that are not usually available through the aging or attendant care waivers. In services my way, or budget authority you get to choose how much to pay your workers based on your budget.

☐ ________ INITIALS **I CHOOSE THE BUDGET AUTHORITY/SERVICES MY WAY AND CHOOSE TO EMPLOY THE ATTENDANTS AND DESIGN MY OWN BUDGET.**

AGENCY MODEL OF SERVICE

In choosing the **AGENCY OPTION**, I choose not to employ my service provider. In choosing the agency option, I understand that I retain the right and responsibility to select and dismiss my care provider(s) from among candidates provided by contractor/coordinator or its designee, to supervise and direct provider employees and to authorize payment of employee wages. In choosing the agency option, I understand that I can also receive, at my request and as needed, assistance from contractor/coordinator and the Pennsylvania Personal Care Waiver Program in performing these tasks and in directing my waiver services.

☒ ES INITIALS **I CHOOSE THE AGENCY OPTION AND CHOOSE NOT TO EMPLOY MY PROVIDER OF WAIVER SERVICES.**

My signature indicates that I have been informed of my choices with regard to the control I want to exercise over the provision of my services under the personal care waiver and have freely chosen the provision of services I prefer.

Example Signature 11/24/2021

PARTICIPANT SIGNATURE DATE

11/24/2021

SERVICE COORDINATOR SIGNATURE DATE