☐ UR Medicine Home Care – Certified Services, Inc.
2180 Empire Boulevard
Webster, NY 14580-2029
(585) 787-2233
(800) 253-4439

PATIENT BILL OF RIGHTS & RESPONSIBILITIES

UR Medicine Homecare Patients have the Right to:

1. Have property and person treated with respect.
2. Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect, and misappropriation of property.
3. Make complaints regarding treatment or care (see process outlined below).
4. Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, and with respect to:
    - Completion of the comprehensive assessment
    - Care furnished based on the comprehensive assessment
    - Establishing and revising the plan of care
    - The disciplines that will furnish the care
    - The frequency of visits
    - Expected outcomes of care, including goals, anticipated risk, and benefits
    - Any factors that could impact the effectiveness of treatment
    - Any changes in the care to be furnished
5. Receive all services outlined in the Plan of Care.
6. Privacy, including confidential treatment of patient records. Refer to the Notice of Privacy Practices for a description of how medical information about you may be used and disclosed.
7. Be advised of:
    - The extent which payment for home health services are expected from Medicare, Medicaid, and other federally funded or federal aid program known to UR Medicine Homecare.
    - The charges for services that may be covered by Medicare, Medicaid, and any other programs
    - The charges for services that may not be covered by Medicare, Medicaid, and any other programs
    - The charges the individual may have to pay before care is initiated; and any changes in the information
    - Any changes in the information above when they occur. The Agency must advise the patient and representative, if any, of these changes as soon as possible, in advance of the next home visit
8. Receive proper written notice, in advance of a specific service being furnished if UR Medicine Homecare believes that the service may be non-covered care, or in advance of UR Medicine Homecare reducing or terminating on-going care.
9. Be advised of the New York State Department of Health toll free hotline, it's contact information, hours of operation, and it's purpose to receive complaints or questions about local agencies including UR Medicine Homecare: referenced below
10. Be advised of the names, addresses, and telephone numbers of the following Federally funded and State funded entities that service the area where the patient resides such as; Agency on Aging; Center

for Independent Living; Protection & Advocacy Agency; Aging &Disability Resource Center; Quality Improvement Organization

11. Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievance to the Agency or any outside entity.
12. Be informed of the right to access auxiliary aids and language services and how to access those services.

Visual Impairment – www.urmhomecare.org

Please refer to Admission Packet for information regarding Discharge/Transfer Policies

Complaints and Suggestions:

1. Patients are encouraged to discuss problems or suggestions with their Case Manager and/or their Case Manger's immediate supervisor.
2. Patients may submit written complaints/ suggestions at any time through a letter addressed as follows:

Jane Shukitis, President & CEO
UR Medicine Home Care
2180 Empire Blvd.
Webster, NY 14580

3. Complaints or suggestions may also be made over the phone, Monday through Friday, 8:00am-4:30pm by calling **585-787-2233** or **toll free 1-800-253-4439** and asking for the President & CEO. When a problem, complaint, or suggestion is received, an immediate investigation is initiated. Follow-up with the person who initiated the complaint is done either by phone or mail to assure mutually acceptable resolution.

4. If the patient is unable to resolve their complaint with UR Medicine Homecare, the patient may file a complaint with the New York State Department of Health as Follows:

New York State Health Department- Regional Office
Triangle Building
335 E. Main St
Rochester, NY 14604

5. Home Health Compliance status may be obtained, and complaints may also be made by calling the New York **State Department of Health Hotline at 1-800-628-5972**, Monday through Friday, 10:00am through 4:00pm, except on State holidays.

6. If the patient is a Medicare beneficiary and there are concerns about the quality of medical services provided, the patient or representative may also request in writing a Medicare Peer review from Livanta. Livanta is a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). Requests for review can be made over the phone by calling **1 (877)588-1123** or in writing as follows:

Livanta LLC
BFCC-QIO
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105

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UR MEDICINE HOME CARE
PATIENT BILL OF RIGHTS AND RESPONSIBILITIES
PATIENT ACKNOWLEDGEMENT FORM

1. I hereby certify that I have received and understand the UR Medicine Home Care (URMHC) Bill of Rights and responsibilities, statement of services, charges, and billing procedures.

2. In addition, I certify that the information given to me is correct in applying for payments under Title XVIII of the Social Security Act (Medicare) or any other applicable payer.

3. I authorize release of all records required for URMHC to collect payment for services on my behalf from third party payers and/or to obtain additional/necessary services for my care.

4. I understand URMHC will use and exchange my health care information with my physician(s) in order to provide services.

5. I request that payment of authorized benefits be made to URMHC on my behalf.

6. I understand that I am responsible for charges not covered by my private insurance and I guarantee payment to URMHC for such charges.

7. I agree to accept treatment as ordered by my physician in conjunction with the URMHC's assessment.

8. I acknowledge that VNS will be releasing aggregate patient related data to Centers for Medicare and Medicaid Services (CMS) as required of all Certified Home Health Agencies, for the purpose of Patient Outcome Reporting.

9. I acknowledge that I have received copies of the New York State Department of Health Information on: Planning in Advance for your Medical Treatment Appointing your Health Care Agent- New York State's Proxy Law. I also acknowledge that I was asked whether or not I have an Advance Directive.

10. I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Print Patient Name ***Date***

_____ _____

Patient Signature/Legal Representative (if patient is unable to sign) ***Patient ID/Patient Number***

_____ _____

Legal Representative Relationship to Patient ***Episode/Admission Number***

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Legal Representative Relationship to Patient ***Episode/Admission Number***