



BestHomeCareSM

YOU ARE FAMILY HERE

2562 7th Avenue Suite 201 ~ North Saint Paul MN 55109 ~ P:651.330.2550 F:763.592.8262

Website: www.besthomecaremn.com Email: info@besthomecaremn.com

Thank you for choosing
Best Home Care!

Please complete, sign and
return the attached documents.

**Best Home Care's Client manual can be found
at: besthomecaremn.com, click on client**

Please call if you have any questions.
651-330-2550

We look forward to working with you!

Thank you!

Best Home Care Office Staff

Amanda: Office Manager

Brittany, Maureen, Adam: Administrative Assistants



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TO: PROSPECTIVE OR EXISTING CLIENTS
RE: INFORMATION ABOUT YOUR PCA ASSESSMENT OR REASSESSMENT

This letter is intended to provide general information about the pca assessment process and what you will need to demonstrate to qualify for services. In order to qualify for services you need to be “dependent” in at least 1 Activity of Daily Living (ADL). If you need assistance with several ADLs you will get more help accordingly.

Activities of Daily Living (ADLs) Include:

1. Dressing;
2. Grooming
3. Bathing;
4. Eating;
5. Transferring
6. Mobility
7. Positioning;
8. Toileting.

Being “dependent” in one of the above activities means either:

1. You need “hands-on assistance”; or
2. “Constant supervision or cueing”.
3. Every time you complete the activity.

You do not need to do the activity every day, but if every time you do the activity you need hands on assistance or constant supervision and/or cueing you have a “dependency” in that ADL.

For example:

1. You do not need to bathe every day, but if you require assistance **every time** you bathe, you **do** have a dependency in bathing.
2. Alternatively, if you need help getting out of the bath **sometimes** but other times you do not need help bathing, then you do **not** have a dependency in bathing.

During your assessment or reassessment, the Public Health Nurse (PHN) will ask you several questions and observe you to determine your eligibility. In order to qualify for services, your answers need to show that you have a “dependency” in at least one ADL activity listed above. It is very important that you make sure you understand the questions asked of you and take your time in answering.

If you don’t understand a question, let the PHN know. If you need an interpreter, let the PHN know. If you would like someone to help you answer the PHN’s questions, arrange for someone (friend or family member) to be there during the assessment. If you would like that person to be your responsible party, to make your PCA treatment decisions, let the PHN know. The person you choose as your responsible party will need to be there at the assessment.

If you have any questions or need more information please contact us!

Best Home Care
651-330-2550

You are family here. SM

14. PCA PROVIDER WRITTEN AGREEMENT (PCA CHOICE OR TRADITIONAL PCA)

Agreement between _____ (hereinafter “Consumer”);
Best Home Care, an enrolled PCA provider with the State of Minnesota

Consumer Roles and Responsibilities

As a consumer using Best Home Care, I, or my responsible party, agree to the following responsibilities:

1. Accept responsibility for my health and safety, and I will find staff or supports that ensure my health and safety needs are met.
2. Ensure that I meet the conditions to use or continue to use a PCA Provider. These include, but are not necessarily limited to:
 - a. I must be able to direct my own care, or my responsible party must be readily available to direct the care provided by the personal care assistant(s).
 - b. I or my responsible party must be knowledgeable of my health care needs and be able to effectively communicate those needs.
 - c. I must ensure that my health insurance coverage is active at all times and I must notify the agency immediately if there is any lapse in coverage. If fail to do so I am responsible for paying the PCA for the hours worked during the period where there was no coverage or for reimbursing the agency for payment made for those hours.
 - d. A face-to-face assessment must be conducted by the local county public health nurse at least annually, or when there is a significant change in the consumer’s condition or change in the need for personal assistant services.
 - e. I must be certain that time sheets submitted by PCAs accurately document the times of service and tasks performed.
 - f. I must notify the Agency when there are changes to my address or telephone number.
3. Abide by all of the consumer responsibilities as set forth in this written agreement.
4. Abide by all of the policies for the PCA program.
5. If PCA Choice, develop and revise a care plan that details my health, safety and care needs and schedule based on the public health nurse assessment.
6. If PCA Choice, recruit, interview and hire my own personal care assistant (PCA) staff. I understand even if I am using the PCA Traditional model I have the right to a PCA of my choice.
7. If PCA Choice, ensure that I have adequate backup staff or support in case a regularly scheduled PCA is unable to fulfill their duties as scheduled.
8. If PCA Choice, schedule my PCA staff. I understand that even if using the PCA Traditional option I have the right to schedule my own staff.
9. Manage the use of my PCA allocated hours/units to ensure I do not use more than the allocated hours/units in my service plan.
10. Ensure that no PCA shall work overtime without the express approval of BHC management in writing.
11. Monitor, ensure accuracy and verify time worked by my PCAs. Sign verified time cards for my PCA staff.
12. Coordinate with Best Home Care to notify the county public health nurse, waiver service coordinator or otherwise appropriate individual when it is time for a reassessment of my need for PCA services or if there is a change in condition or change in the level of services that I need. I will inform them of my intent to use Best Home Care.
13. Notify Best Home Care of my hospitalization dates throughout our service agreement, and ensure no time sheets for PCA services are submitted for the hospitalization dates.
14. Acknowledge a PCA Provider Written Agreement shall be provided to me annually by the Agency by mailing copy to me at my address on file with the Agency.
15. If I continue to use the services after the Agency has sent me an annual PCA Provider Written Agreement, my continued use of services shall constitute my acceptance and agreement without my signature.
16. I may also communicate my acceptance of any future annual PCA Provider Written Agreement by signing it and returning it to the Agency.

17. I may request a copy of my currently effective PCA Provider Written Agreement from the Agency at any time.

Provider Roles and Responsibilities

As your PCA provider, Best Home Care agrees to perform the following responsibilities:

1. Enroll and meet all standards as a PCA provider with the Minnesota Department of Human Services, including passing a criminal background check and follow all rules, regulations, and policies described by DHS for the PCA program.
2. Abide by all of the responsibilities set forth in this written agreement.
3. Bill the Minnesota Department of Human Services or appropriate health care plan for personal care assistant and Qualified Professional services rendered.
4. Withhold and remit all applicable state and federal taxes from personal care assistants' and Qualified Professional's paychecks.
5. Arrange for and pay the employer's share of payroll taxes, unemployment insurance, workers' compensation insurance, liability insurance, and bonds.
6. Keep records of the hours worked by PCAs and Qualified Professionals.

Qualified Professional Roles and Responsibilities

The Qualified Professional shall:

1. Hold the appropriate credentials to serve as a Qualified Professional by being a Registered Nurse, Licensed Social Worker, Mental Health Professional, or Qualified Developmental Disabilities Professional.
2. Assist the consumer in developing and revising a care plan to meet the consumer's needs, as assessed by the public health nurse.
3. Assist the consumer in the orientation, training, supervision and/or evaluation of their PCA staff.
4. Accurately document time worked and services provided for consumer by promptly completing and signing time sheets.
5. Report any suspected abuse, neglect, or financial exploitation of the consumer to the appropriate authorities.

Personal Care Assistant Roles and Responsibilities

The PCA(s) shall:

1. Complete all required forms and provide necessary information to Best Home Care, including criminal background check verification, prior to providing services to the consumer.
2. Pass a criminal background check, a requirement of eligibility to be a personal care assistant.
3. Obtain training from the consumer and Qualified Professional to ensure I can satisfactorily perform all responsibilities in the consumer's plan of care.
4. Work at scheduled times as determined by the consumer, notifying the consumer of changes as early as possible to arrange for backup assistance.
5. Provide and document personal care services for the consumer as specified in their plan of care, following written and oral directions from the consumer.
6. Assist with activities of daily living (ADLs) as directed.
7. Inform the consumer about all visible bodily changes that may need medical attention.
8. Keep consumer's personal life confidential and adhere to data privacy.
9. Observe and stay alert to ongoing instructions by the consumer.
10. Respect the privacy of the consumer's personal property.
11. While working within the consumer's home maintain respect as a professional and focus on job-related activities. Perform duties in an ethical matter, preserving and respecting the rights and dignity of the consumer.
12. Be present when working with the consumer in their service environment, and leave only when the shift is completed.
13. Communicate respectfully and directly to the consumer regarding services.
14. When assisting with the transportation of the consumer, request that seat restraints are used properly and consistently.
15. Follow safety procedures and work to identify my safety needs and those of the consumer.
16. Support the consumer when they participate in community activities, relationships and involvement with others.

17. Comply with policies, procedures and training provided by the consumer and/or Best Home Care.
18. Notify the consumer and agency of anticipated absences.
19. Accurately document time worked for consumer and cares given by promptly completing and signing time sheets.

Consumer Pricing Schedule (PCA Choice Recipients Only)

These rates remain in effect until further notice and supersede any previously published rates.

Hourly Rates for PCAs and QPs

Maximum Hourly Rate allowed for Personal Care Assistants _____

Maximum Hourly Rate allowed for Qualified Professionals _____

Benefit Rates for PCAs and QPs

Benefits notice in employee policies and procedures is incorporated by reference.

Administrative Fees

Best Home Care currently retains a maximum of 27.5% of its reimbursement rate as an administrative fee. This fee covers fiscal intermediary and enhanced program services including:

1. Background checks.
2. One time PCA/QP set-up costs.
3. Regulatory compliance monitoring.
4. Payroll processing.
5. Record maintenance and retention.
6. Program compliance assistance.
7. General liability insurance; professional liability insurance and fidelity bond.
8. Employer responsibility taxes and insurance, including Workers' Compensation and unemployment insurance.
9. Program development, outreach and recruitment activities.

Regulatory Compliance

Both parties are responsible for complying with all rules and regulations related to PCA. This includes, but is not limited to state Vulnerable Adults Act, Data Privacy, PCA regulations and the Nurse Practices Act, including assistance with medication administration, and Department of Labor laws governing overtime.

Grievance Procedures

Best Home Care, believes it is in the best interest of employees and management to have an environment where concerns are openly discussed. For this reason, PCAs are encouraged to bring all work-related issues to their manager, the consumer. Consumers are encouraged to address issues directly with their PCA. If the PCA and consumer are unable to resolve the issue, they may bring the issue to Best Home Care. Best Home Care is committed to providing a timely response to concerns brought forward.

Termination of Employment or Services

Employees may resign their employment with the consumer and Best Home Care at any time for any reason or no reason, and the consumer and Best Home Care reserve the same right regarding the discontinuation of an individual's employment.

Either the consumer or Best Home Care may terminate services at any time and for any reason or no reason. Best Home Care shall provide reasonable advance notice of termination of service in accordance with the Minnesota Home Care Bill of Rights and Minnesota Statute.

Consumer Date _____

Responsible Party Date _____

Best Home Care Date _____

15. MEDICAL RELEASE

Consumer's name: _____	Date of Birth: _____
Address: _____	
City/State/Zip Code: _____	
Subscriber #: _____	Consumer's phone #: () _____

I, the above-identified consumer, do hereby authorize the release of my medical records/information to:

<u>Best Home Care #A111107800</u> Name of Provider or Facility
<u>2562 7th Avenue Suite 201</u> Address
<u>North Saint Paul, MN 55109</u> City, State, Zip Code
<u>P: (651) 330-2550 F: (763) 592-8262 or (651) 964-3801</u> Phone # / Fax #

PURPOSE FOR THIS REQUEST: The purpose of this request related my receiving PCA services through Best Home Care, now or in the future.

TYPE OF RECORDS REQUESTED: I hereby request the release of any and all medical records/information that may reasonably pertain to my future or existing need or receipt of PCA services.

AUTHORIZATION VALID FOR: This authorization is valid for this request and any future services of the kind described herein until I revoke this authorization in writing. This authorization is only valid for Best Home Care.

I understand that I may revoke this authorization by written request at any time by contacting the facility listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that my treatment will not be conditioned on my signing of this authorization. A photocopy of this authorization will be treated in the same manner as the original.

Consumer

Date _____

Responsible Party

Date _____

17. ACKNOWLEDGEMENT OF RECEIPT MATERIALS

I acknowledge that I received a copy of the following:

1. Home care bill of rights;
2. Advance directive notice;
3. Service recipient rights;
4. Maltreatment of adults;
5. Maltreatment of minors;
6. Spend-down notice and policy;
7. Grievance policy;
8. Temporary service suspension;
9. Transportation policy;
10. Health information privacy notice and practices;
11. Notice regarding changes in insurance coverage;
12. Service verification policy and procedure;
13. Notice and consent to electronic delivery;
14. Written agreement;
15. Authorization for release of medical information; and
16. Acknowledgement of receipt of materials.

I understand the above materials shall be updated annually, and I will receive notice where to view the updated materials. I understand my continued receipt of services after receiving said notice shall be considered as my acknowledgement of having reviewed the materials annually and my acceptance of their terms.

Consumer

Date _____

Responsible Party

Date _____