UNIQUE HEALTH CARE LLC

SERVICE AGREMENT/PLAN

Unique Health Care LLC License: ☐ Comprehensive Home Care Provider ☐ Basic Home Care Provider

Resident Name_____Admission/date: _____

Address: _____City_____Zip_____

Phone Number_____Email_____

Previous Address: _____

Name of POA/Guardian_____Relationship_____

Address_____

City_____State_____Zip_____

Phone_____Cell_____

Email_____

☐ Power of Attorney ☐ Legally appointed Guardian

(must provide document of POA and/or Legal guardian)

Eligibility: Resident/client will be determined by Individual assessment prior to accepting resident/client.

UNIQUE HEALTH CARE LLC RESPONSIBILITIES

- **Provide qualified staff**
- **Notify resident and/or resident representative of any changes in schedule, services, or fees**
- **Available representative by phone 24 hours, 7 days a week**
- **Respond to resident/resident representative/family concerns**
- **Provide a safe environment, free of harassment or abuse, for Unique Health Care LLC personnel**
- **Coordinate care to assure appropriate and timely services provided**
- **Communicate changes in coverage and inform resident/resident representative of rights in obtaining supplies and services from other sources**

RESIDENT/RESIDENT REPRESENTATIVE RESPONSIBLITIES

- **Participate in development of Plan of Care**
- **Notify office if need to cancel or reschedule services/appointments and provide at least 2-hour notice**
- **Pay agreed upon fee for service provided or arrange for payment to be made**
- **Accept responsibility for actions if I choose not to follow physician orders**
- **Contact the office immediately if I have concerns or problems**
- **Inform Unique Health Care LLC of supply and equipment needs**

CONSENT OF CARE

The services to be provided to me by *Unique Health Care LLC* staff have been explained to me. I hereby consent to the staff of *Unique Health Care LLC* to provide the agreed upon services in my home or facility as defined in the scheduled services. I understand that the plan of care may change and that such changes will be discussed and agreed upon by the resident or the resident representative prior to the changes. Instructions for my care will be explained to me and will become my responsibility in the absence of a home care staff member in my home.

ASSIGNMENT OF BENEFITS

I request payment of any authorized health insurance benefits and hereby assign benefits payable on my behalf directly to *Unique Health Care LLC* . I understand that should payment not be made to *Unique Health Care LLC* I will be responsible for services rendered to me. Payer sources will be billed only after resident has met their financial responsibility including, but not limited to the following.

I will be responsible for □ Co-Pay/Deductible □ Private Pay □ Spend down (if applicable) □ None. I understand that the charges for services reflect time for direct care, travel time, mileage reimbursement, time spent in contacting my physician(s), charting, written information to keep the doctor informed of my progress, coordination with other services, secretarial time for billing, maintenance of medical records, and or non-chargeable supplies and services. Services are billed monthly. I will be notified in writing at least 30 days in advance of any increases in charges.

RELEASE OF INFORMATION

I authorize information in my medical record to be released to authorized representative of Medicare, Medicaid, or another medical insurance carrier for use in determining home health care benefits payable to *Unique Health Care LLC* on my behalf. I authorize my hospital, nursing home, physician's office, or other health facility where I have been a resident, to discuss any part or all my medical record to *Unique Health Care LLC* **.** Also, authorize the vendors whose services may be required in conjunction with the services provided by *Unique Health Care LLC* . I representative of accreditation and regulatory bodies as appropriate.

Resident Financially Responsible for Bill □ Yes □ No

If no, identify who will be responsible:(name)_____

Billing Address_____

_____

Signature (Resident or Authorized Representative) Date

_____Date_____

Unique Health Care LLC Representative Signature

If you have a complaint about *Unique Health Care LLC* or person providing your home care services, you may call, write, or visit the office of Health Facility Complaints, MN Department of Health, you may also contact The Ombudsman for Long Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities.

Office of Health Facility Complaints
(651) 201-4201
1-800-369-7994
Fax: (651) 281-9796
Email: health.ofhc-complaints@state.mn.us

Mailing Address
Minnesota Department of Health
Office of Health Facility Complaints
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, Minnesota 55164-0970

Office of Ombudsman for Long-Term Care
(651) 431-2555
1-800-657-3591
Fax: (651) 431-7452
Email: mba.ooltc@state.mn.us

Mailing Address
Home Care Ombudsman
Ombudsman for Long-Term Care
P.O. Box 64971
St. Paul, MN 55164-0971

Office of Ombudsman for Mental Health and Developmental Disabilities
(651) 757-1800 1-800-657-3506 Fax: (651) 797-1950 or (651) 296-1021
Email: ombudsman.mhdd@state.mn.us
121 7th Place East
Suite 420 Metro Square Building
St. Paul, Minnesota 55101-2117

Resident/Resident Representative Signature **Date**

Statement of Home Care Services Comprehensive Home Care Provider

Comprehensive Home Care Provider Name: Unique Health Care LLC

Below is a list of all services that *may* be provided with a Comprehensive Home Care License. **Each service that is offered by this provider is indicated by a check in the box next to the service.**

☐ Advanced Practice Nurse Services
☐ Registered Nurse Services
☐ Licensed Practical Nurse Services
☐ Physical Therapy Services
☐ Occupational Therapy Services
☐ Speech Language Pathologist Services
☐ Respiratory Therapy Services
☐ Social Worker Services
☐ Services by a Dietitian or Nutritionist
☐ Medication Management Services
☐ Delegated tasks to unlicensed personnel
☐ Hands-on assistance with transfers and mobility
☐ Providing eating assistance for residents with complicating eating problems (i.e. difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube, parenteral or intravenous instruments)
☐ Housekeeping/Other household chores
☐ Meal preparation
☐ Shopping
☐ Complex or Specialty Healthcare Services

☐ Assistance with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing

☐ Providing standby assistance within arm's reach for safety while performing daily activities

☐ Providing verbal or visual reminders to take regularly scheduled medication (includes bringing residents previously set-up medication, medication in original containers, or liquid or food to accompany the medication)

☐ Providing verbal or visual reminders to the resident to perform regularly scheduled treatments and exercises

☐ Preparing modified diets ordered bylicensed health professional

☐ Laundry

I have received a copy of this Statement of Home Care Services

Resident Signature:_____
Date:_____

Unique Health Care LLC

List of Services to be Provided

PLEASE INDICATE HOURS OF SERVICES

- **Note *Unique Health Care LLC* may not be able to meet requested start time and may suggest alternative times depending on caregiver availability.**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

If client is requesting changes to schedule or services, client must notify the office 24 hours in advance and in writing or by email by client and/or client representative. **Email: Nwaforpc@yahoo.com**

Discipline: Aide	**Rate $_____/hour**	**Supervision: RN at least every 90 days**	
Services	**Frequency**	**Services**	**Frequency**
Bathing		Hearing Aides	
ADL's		Ambulation	
Laundry		Meal Prep	
Light Housekeeping		Social Activities	
Blood Sugars			
Med. Reminders			
Med Administration			
Transportation			
Discipline: Nursing RN/LPN		**Rate: $_____/Hr.**	
Services	**Frequency**	**Services**	**Frequency**
Med Mgt.			
Psychiatric Mgt.			
Diabetic Mgt.			
Treatment/Therapies	**Frequency**	**Services**	**Frequency**

Services to be provided:

Basic and Comprehensive levels of services depend on the resident assessment.

Basic services are standby assistive tasks provide by licensed or unlicensed personnel that included only assistance with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing, provide verbal or visual reminders only to the resident to take regular scheduled medication, which includes bringing the resident previously set-up medication, medication in original containers, or liquid or food to accompany the medication. The resident must be able to identify the medication and medication time, (to be considered as a reminder and not administrative). Providing verbal or visual reminders to the resident to perform regular scheduled treatments and/or exercises, preparing modified diets ordered by licensed health professional. Assist with laundry, housekeeping, meal preparation, shopping or other household chores and services.

Services will be performed by Home Health Aide, Certified Nursing Assistant, (CNA) home health aide, or Licensed Practical Nurse, and/or Registered Nurse.
Basic Services Supervision: Employee supervision will occur within 30 days of resident start date and as needed thereafter not to exceed 6 months. Ongoing resident monitoring and reviews will be conducted as needed. The monitoring will be conducted at the resident's residence. Basis care reviews will be done by skilled professional either in person, electronically or by phone as deemed appropriate.
Comprehensive services included all the basic care services and one or more of the following; hands-on assistance with transfer and mobility, assisting residents with eating when the residents have complicating eating problems, medication management services, including set-up and administration, and any other task delegated by a health professional.

Services will be performed by Home Health Aide, Certified Nursing Assistant, (CNA) home health aide, or Licensed Practical Nurse, and/or Registered Nurse.

Comprehensive Services Supervision will be within 30 days, of being assigned to a resident unless employee is performing delegated task the supervision will be within 5 days and thereafter as needed.
Comprehensive care supervision will be conducted by a RN or other licensed health care professional qualified to supervise employees performing delegated task.

New Resident; Resident assessment/evaluation will be completed within 5 days of admission, 14 days after to final resident evaluation and as needed but not to exceed 90 days from previous assessment.
Ongoing resident monitoring and reassessment will be conducted as needed but not to exceed 90 days from the last assessment. Reassessment will be either in person, electronically or by phone depending on the resident needs.
Comprehensive care Supervision will be done by Registered Nurse or other health professional.

Comprehensive/Complex Care: requires training of staff by the RN with the resident for each caregiver that will be performing delegated tasks as well as regular supervision by the Registered Nurse. Complex care is defined as delegated nursing task to unlicensed personnel. (Stroke, feeding tube, Parkinson, Dementia, Medication Administration, and any other task delegated by the registered nurse.)

Medication Reminders/Administration:

In accordance with the changes in Laws & Rules (144a.4792) effective July 1, 2014 set by the State of MN and managed by MN Department of Health for Comprehensive Home Care Providers. Reminders and/or Administration of medication by a Comprehensive Home Care Providers requires all medication be set up by a Licensed Professional (Physician, Registered Nurse, or a Pharmacist) Except in the case of a Hospice resident. Hospice will set up medication and *Unique Health Care LLC* caregiver will remind and/or administer under the supervision of the *Unique Health Care LLC* Registered Nurse. Caregivers providing personal cares to residents are Certified Nursing Assistant, Home Health Aides or have been trained by *Unique Health Care LLC* .

Medication Management:

Under the professional oversight of a Registered Nurse**,** *Unique Health Care LLC* will:

- Assess individual needs, including a comprehensive review of all current prescribed medications along with confirmation of frequency and dosage
- Consult with physician and/or pharmacists when needed
- Complete medication set-up and on-going management and oversight
- Provide education to the care recipient, family members, and caregivers regarding management of prescribed medications

Medication Set-Up R.N. Visit: Review physician's orders for changes to medications. Call in refills when necessary and/or notify resident/resident representative/family. Set-up medications for the days to be covered, take vital signs of the Care Recipient as ordered by physician. Contact physician when/if necessary. Maintain records in Care Recipients file. The frequency of the Medication Management Set-up visits will be determined per resident. Generally, every two weeks unless otherwise specified. All drugs including narcotics and/or street value drugs will be kept in a secure locked location.

Holiday Rate: Resident will be billed at one-and-one-half times their hourly rate. *Unique Health Care LLC* **seven (7) holidays include**: New Year's Day, Memorial Day, and Easter Sunday, July 4th, Labor Day, Thanksgiving Day, and Christmas Day.

Overtime Rate: The overtime rate is one-and-one half the hourly rate and is charged for any hours worked over 40 hours in a workweek. *Unique Health Care LLC* will not schedule any caregiver for more than forty (40) hours in a workweek without prior consent of the Resident or Resident's representative.

_____

Signature of Resident or Resident Representative **Date**

_____

Signature of Unique Health Care LLC Representative **Date**

ADVANCE DIRECTIVE	
Health Care Directive ☐ **Written information has been proved to resident** ☐ Resident DOES NOT have Advance Directive – Call 911 in emergency ☐ **Resident HAS an Advance Directive _____** Notes	
Code Status	☐ **Resident** does not comprehend the Advance Directive question ☐ DNR/DNI ☐ Full Resuscitation

Emergency medical services will be summoned unless there is a physician signed DNR/DNI order or directive on file.

I have been advised of my rights regarding Minnesota Health Care Directive. I have been provided with written information about the *Unique Health Care LLC* policies regarding Advance Directives and information about my right to formulate Advance Directives. I have been advised of my privacy rights and have received a copy of *Unique Health Care LLC* Notice of Privacy Rights.

Medical Emergency: *Unique Health Care LLC* is not an emergency care service. In the event of an emergency the caregiver will call 911 and then will contact the office. *Unique Health Care LLC* will contact the person(s) listed below.

Name: _____

Address_____

Phone #1_____Phone#2_____

Email_____

CONTINGENCY PLAN

If scheduled services are unable to be provided by the Unique Health Care LLC , we will provide temporary qualified emergency staffing.

Unique Health Care LLC **representatives are available 24 hours 7 days a week:**

Unique Health Care LLC **Phone Number: 651.206.4093** **Registered Nurse: 651.500.4050**

EMERGENCY CONTACT INFORMATION

1. **Contact**_____**Releationship**_____

   Address: _____**City**_____**Zip**_____

   Primary Phone_____**Other**_____

2. **Contact**_____**Releationship**_____

   Address: _____**City**_____**Zip**_____

   Primary Phone_____**Other**_____

3. **Contact**_____**Releationship**_____

   Address: _____**City**_____**Zip**_____

   Primary Phone_____**Other**_____

PRIMARY PHYSICIAN NAME:

1. **Physican**_____**Clinic**_____
   Address: _____**City**_____**Zip**_____

   Primary Phone_____**Other**_____
   Fax_____

2. **Physican**_____**Clinic**_____
   Address: _____**City**_____**Zip**_____

   Primary Phone_____**Other**_____
   Fax_____

HOSPITAL PREFERENCE_____
Address: _____**City**_____**Zip**_____

Primary Phone_____**Other**_____
Emergency #_____

Other Health Care Providers Names & Phone _____

If I _____cannot sign on my behalf the person(s) listed below are authorized by me to sign on my behalf.

Name of Person authorized to sign on resident behalf_____

_____
Signature (Resident or Authorized Representative) **Date**

_____
Unique Health Care LLC Representative Signature **Date**

CONTACT INFORMATION

`Representative/Title	Contact #	Email
Peter Anosike./Administrator	651.206.4093	Nwaforpc@yahoo.com
Onyinyechi Anosike/RN	651.500.4050	nwaforpc@yahoo.com

Facility Emergency Information
Unique Health Care LLC 7743 Riverdale Drive Brooklyn Park, MN 55444 651.206.4093

Termination of Services If *Unique Health Care LLC terminates* a service plan with the resident and the resident continues to need home care services, *Unique Health Care LLC* will provide the resident and the resident's representative, if any with a written notice of termination which includes the following; (1). Effective Date of Termination (2) The reason or termination (3) List of known licensed home care providers in the resident's immediate geographic areas. *Unique Health Care LLC* will participate in a coordinated transfer of care of the resident to another home care provider, health care provider, or caregiver as required by the Home Care Bill of Rights. *Unique Health Care LLC* will provide the resident with. Name and Contact information of a person employed by the Home Care provider whom the resident may discuss the notice of termination.

Resident complaints and Investigation. *Unique Health Care LLC* takes all complaints seriously; If you or your representative have a complaint about *Unique Health Care LLC* or it staff please contact the office immediately (651.206.4093) and report the complaint/concern to *Unique Health Care LLC* will investigate and attempt to resolve the complaint as quickly as possible. *Unique Health Care LLC* will contact the person making the complaint within 24 hours to gather details. *Unique Health Care LLC* will have a written response to the complaint within 10 days. *Unique Health Care LLC* will not discriminate or retaliate against the resident for expressing concerns or complaints.

Disaster Emergency Plan In the event there is an emergency warning such as severe weather the caregiver has been trained and instructed to listen to the TV, Radio, Computer for updates. Severe weather is defined as Tornado, High Winds, Thunder Storms, Hail, etc. Caregiver will take the resident to the lowest level of the home, and go to and inside wall, cover the resident with blankets, pillows etc. to protect the head and body from flying debris. If the resident is unable to be moved, the caregiver will cover the resident with blankets, mattress, and other items that protect the resident from flying debris**. Gas leaks** will be reported to 911 and the home will be evacuated, if the resident is unable to be moved, let the 911 dispatcher know the situation**. Fire;** the resident, and caregiver will leave the home and call 911, if the resident is unable to be moved, let the 911 dispatcher know the situation and where the resident is in the home. Loss of Heat**,** Call Gas or electric company and report the loss of heat. Inform the dispatcher that you have a vulnerable adult in the home. Terrorist or other attacks**:** Listen to the TV, Radio, and or computer for updates and follow the instructions of the Emergency services. In all situations, the caregiver will contact the office and inform them of the status of the situation. (For complete Emergency Plan ask for a copy of Emergency Disaster Plan for facility)

Request for discontinuation of Life Sustaining Treatment; The caregiver will take no action to discontinue the treatment and promptly inform *Unique Health Care LLC* supervisor of the resident request. *Unique Health Care LLC ,* (RN) will contact the physician of the residents' request and work with the resident and the resident's physician to comply with the provisions of the Health Care Directive Act. This does not required *Unique Health Care LLC* to discontinue treatment, except as may be required by court order.

Securing Property: Resident shall secure all cash and valuables in a secure place (such as a safe) or remove them from Resident's premises. *Unique Health Care LLC* shall be bonded, and Resident shall file a police report if any cash or valuable is found to be missing from Resident's premises. In addition, Resident shall maintain insurance coverage for the theft or loss of

cash or valuables.

Release of Liability: Resident here by releases *Unique Health Care LLC* from liability for any act or omission of an *Unique Health Care LLC* employees that may be harmful to resident and that arises from the provision of services to resident pursuant to this agreement, including those acts or omissions that arise from an employee's negligence.

Jurisdiction & Venue: If necessary to litigate a dispute arising out of or relating to this agreement, resident agrees to jurisdiction in the State of Minnesota and venue in the County the Unique Health Care LLC resides

Entire Agreement & Severability. This agreement contains the entire understanding of the parties regarding the subject matter of this agreement, and supersedes all prior and contemporaneous negotiations and agreements, whether written or oral, between the parties with respect to the subject matter of this agreement. If a provision of this agreement is determined to be unenforceable in any respect, the enforceability of the provision in any other respect and of the remaining provisions of this agreement will not be impaired.

AGREED AND ACCEPTED

_____

Signature of Resident or Legal Representative Date

_____

Unique Health Care LLC Representative Signature Date

Unique Health Care LLC

ACCESS TO HEALTH RECORDS NOTICE OF RIGHTS

This notice explains the rights you have to access your health record, and when certain information in your health record can be released without your consent. This notice does not change any protections you have under the law.

YOUR RIGHT TO ACCESS AND PROTECT YOUR HEALTH RECORD

You have the following rights relating to your health record under the law:

- A health care provider, or a person who gets health records from a provider, must have your signed and dated consent to release your health record, except for specific reasons in the law.
- You can see your health record for information about any diagnosis, treatment, and prognosis.
- You can ask, in writing, for a copy or summary of your health record, which must be given to you promptly.
- You must be given a copy or a summary of your health record unless it would be detrimental to your physical or mental health, or cause you to harm to another.
- You cannot be charged if you request a copy of your health record to review your current care.
- If you request a copy of your health record and it does not include your current care, you can only be charged the maximum amount set by Minnesota law for copying your record.

RELEASE OF YOUR HEALTH RECORD WITHOUT YOUR CONSENT

There are specific times that the law allows some health record information held by your provider to be released without your written consent. Some, but not all, of the reasons for release under federal law are:

- For specific public health activities
- When health information about victims of abuse, neglect, or domestic violence must be released to a government authority
- For health oversight activities
- For judicial and administrative proceedings
- For specific law enforcement purposes
- For certain organ donation purposes
- The Departments of Health, Human Services, Public Safety, Commerce, Minnesota Management & Budget, Labor & Industry, Corrections, and Education
- Insurers and employers in workers' compensation cases
- Ombudsman for Mental Health and Developmental Disabilities
- Health professional licensing boards/agencies
- Victims of serious threats of physical violence
- The State Fire Marshal
- Local welfare agencies
- Medical examiners or coroners
- Schools, childcare facilities, and Community Action Agencies to transfer immunization records
- Medical or scientific researchers
- Parent/legal guardian who did not consent for a minor's treatment, when failure to release health information could cause serious health problems
- Law enforcement agencies
- Insurance companies and other payors paying
- When health information about decedents is required for specific individuals to carry out their duties under the law
- For research purposes approved by a privacy board
- To stop a serious threat to health or safety
- For specialized government functions related to national security
- For workers' compensation purpose

for an independent medical examination

If you would like additional information or links to specific laws, visit www.health.state.mn.us and search for "access to health records" or call the Minnesota Department of Health at (651) 201-5178.

Minnesota Statutes, section 144.292, subdivision 4 This notice may be photocopied.

Client Signature:_____

Date:_____

Unique Health Care LLC

AUTHORIZATION TO SHARE INFORMATION

Resident Name: _____Date_____

Indicate below the people with whom *Unique Health Care LLC* may or may not share your protected personal health information.

Note: *Unique Health Care LLC* will share information as stated in the Notice of Use Disclosure Practices.

Unique Health Care LLC may share my _____protected health information with the following (initial all that pertain and the names of the individuals by category.

____Spouse Name: _____

____Parents Name(s)_____

____Children Names: _____

____Aunts/Uncles Names: _____

____Step Children Names: _____

____Siblings Names: _____

_____Grandparents Names: _____

____Other family members Names: _____

____Other Names: _____

____ I **do not** want my protected personal health information shared with anyone

____ I **do not** want my protected personal health information shared with the following specific people:

_____

_____

Comments:_____

_____

_____

_____

Resident/Responsible Party Signature **Date**

_____

Relationship of Responsible Party

Witness:

_____

Unique Health Care LLC

Admission Consent, Release & Authorization Service Plan

*I **authorize** Unique Health Care LLC to render assisted living home care services by their personnel, (RN, LPN, CNA, HHA) which may include routine diagnostic procedures, advice and education with respect to my condition, and other nursing related cares as may be prescribed or indicated, all upon the direction of the attending physician.*

*I **authorize** Unique Health Care LLC to release all information acquired to assure continuation and coordination of my health care plan. You have the right to refuse or limit the release of your health care information. Unless otherwise specified, Unique Health Care LLC has my permission to release my health care information and billing information to coordinate and facility services such as Billing, Physician, Pharmacy and medical provider, case worker, guarding, financial team, etc.*

*I **authorize** Unique Health Care LLC to obtain prior health records, if necessary, to assure the continuation of my health care plan, This includes, but not limited to, any medication, nursing, therapy, or lab reports.*

*I **certify** the following information given by me in applying for payment for these services is correct. I authorized payment of benefits to be made on my behalf directly to Unique Health Care LLC .*

*I **understand** that I am financially responsible to the Unique Health Care LLC for any charges not covered by health care benefits.*

*I **acknowledge** that I have receive an explanation of and have received copies of the Bill of Rights, Advanced Directives, Maltreatment, Reporting of Vulnerable Adults, Privacy Information, services suspension and termination, grievance handout, and use of manual restraints.*

Unique Health Care LLC admission criteria, services, employee assignments are made regardless of race, religion, national origin, color, veteran or disabled status, sex, or age.

I have been given a copy of Unique Health Care LLC complaint procedure.

I have been given a copy of the Uniform Consumer Information Guide for Unique Health Care LLC . This form has been reviewed by me and/or my representative and my questions have been answered.

***Office of Ombudsman for Long Term Care** ●651.431.2555 or 1.800.657.3591 **Fax:** 651.431.7452*
Website: http://tinyurl.com/ombudsman-LTC ***Email:*** ombudsoman.mdhd@state.mn.us
***Mailing Address**: Home Care Ombudsman●Ombudsman for Long-Term Care● P.O. BOX 64971 St Paul, MN 55164*

Office for Mental Health & Developmental Disabilities** ●651.757.1800 or 1.800.797.1950 or 651.296.1021 **Website: http://mn.gov/omhdd/ombudsman.mhdd@state.mn.us
Email: ombudsoman.mhdd@state.mn.us
***Mailing Address**: 121 7th Place E. Ste 240 ● St Paul, MN 55101-2117*

Client Signature:_____Date:_____
Guardian Signature:_____Date:_____
RN Signature:_____Date:_____

Unique Health Care LLC
Grievance Policy/Reporting

Residents of *Unique Health Care LLC* are entitled to all the rights defined in the Home Care Bill of Rights and in the Health Insurance Portability and Accountability Act, (HIPAA) including the right to quality home care services and to protection of personal health information.

Residents have the right to complain about home care services and the privacy of protected health information without retaliation. *Unique Health Care LLC* is committed to providing a quality of service that meets and exceeds residents' needs and expectations

1. If a concern is reported to an employee of *Unique Health Care LLC* the employee shall the following steps to resolve.
   - The employee taking the complaint/information will attempt to resolve the complaint and meet the needs of the resident
   - If the complaint remains unresolved, the employee will turn the documentation over to his or her immediate supervisor within 3 business days
   - The supervisor or administrator notifies the person making the complainant of receipt of the grievance within 7 business days.
   - The supervisor will develop a resolution and notify the resident either in writing or electronically of the results within 14 days,
   - Employee counseling and/or training if appropriate will be done by the supervisor and recorded in the employee record
   - Expectations, develop plans and manage processes will be put in place to assess, improve, and maintain the quality of organization, management, quality of care and other activities

2. Residents of *Unique Health Care LLC* or their families or responsible parties may complain in writing, through E-mail, in person or by telephone to the following: a. Staff member providing home care
   b. Registered Nurse: Onyinyechi Anosike Phone: 651.500.4050
   c. Administrator: Peter Anosike.

Email: Nwaforpc@yahoo.com

Unique Health Care LLC
Resident Complaint Form

Our company takes complaints seriously. So, that we may properly investigate your concern, you are requested to fill out this form as completely as possible. Please use additional sheets of paper where needed. After a prompt and thorough investigation into your complaint, you will be notified of the company's intended action. Should you have any questions about the process, please call Peter Anosike./Administrator at 651.206.4093 or email: Nwaforpc@yahoo.com Thank you.

Date Incident	**Time of Incident**	**Person Reporting Incident**
Person Involved (Client)		
Client #		
Address where incident occurred		
Exact location of incident		
Employee Name Involved		**Phone #**

Note: Use back of form if more space is needed

1. Please describe in as much detail as possible the nature of your incident/complaint. Please provide or identify all known persons, documents, and witnesses to your concerns:

_____

_____

Type of Complaint ☐ **Service** ☐ **Theft** ☐ **Attendance** ☐ **Fall**

Other_____

Person investigating complaint: _____

Date Resident was Contacted by Company_____

Investigation Results_____

Date Investigation Completed_____

Date Resident Contacted to communicate resolution_____

Preferred Method of Contact:

☐ Phone ☐ Email ☐ Letter

Unique Health Care LLC Representative Signature_____

Unique Health Care LLC

VULNERABLE ADULT REPORTING

"Help protect people who are frail or vulnerable"

"Take Action Call and Report"

844.880.1574

Where to Report

- **You can report internally to Peter Anosike./Administrator at 651.206.4093 If the individual listed above is involved in the alleged or suspected maltreatment, you must report to MN. Adult Abuse Reporting Center (MAARC)** at **844.880.1574**
- **you can report to the Common Entry Point** as 800.880.1574 (MN Vulnerable Adult Protection**)**
- **you can report by phone; however, a written report must be completed and turned into /RN within 24 hours of the first call.**

Internal Report

- **When and internal report is receiving, is responsible for deciding if the report must be forwarded to the Common Entry Point. If that person is involved in the suspected maltreatment /RN at 651.500.4050 will assume responsibility for deciding if the report must be forwarded to the Common Entry Point. The report must be forwarded within 24 hours.**

- If you have reported internally, you will receive, within two working days, a notice that tells you the status of the investigation or whether your reports have been forwarded to the Common Entry Point. The notice will be given to you in a manner that protects your identity. It will inform you that, if you are not satisfied with the decision on whether to report externally, you may still make the external report to the Common Entry Point yourself. It will also inform you that you are protected against any retaliation if you decide to make a good faith report to the Common Entry Point.

Internal Review

When the Unique Health Care LLC has reason to know that an internal or external report of alleged or suspected maltreatment has been made, the Unique Health Care LLC must complete an internal review and take corrective action, if necessary, to protect the health and safety of the vulnerable adult(s). The internal review must include an evaluation or whether.

- Related policies and procedures were followed
- The policies and procedures were adequate
- There is a need for additional staff training
- The reported event is similarly to past events with the vulnerable adult(s) of the services involved and
- There is a need for corrective action by the license holder to protect the health and safety of vulnerable adults.

Primary & Secondary Person or Position to ensure Internal Reviews are Completed

Office Manager will complete the internal review or Common Entry Point.
If this individual is involved in the alleged or suspected maltreatment, Onyinyechi Anosike

Documentation of the Internal Review

The Unique Health Care LLC will document completion of the internal review and provide documentation of the review to the commissioner upon the commissioner's request.

For more information about the law, reporting maltreatment of a vulnerable adult, or Adult Protection Services, please call MN. Adult Abuse Reporting Center (MAARC) 844.880.1574

DEPARTMENT OF HEALTH

Statement of Rights

A client who receives home care services in the community has these rights:

1. Receive written information, in plain language, about rights before receiving services, including what to do if rights are violated.
2. Receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services.
3. Be told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and the potential consequences of refusing these services.
4. Be told in advance of any recommended changes by the provider in the service plan and to take an active part in any decisions about changes to the service plan.
5. Refuse services or treatment.
6. Know, before receiving services or during the initial visit, any limits to the services available from a home care provider.
7. Be told before services are initiated what the provider charges for the services; to what extent payment may be expected from health insurance, public programs, or other sources if known; and what charges the client may be responsible for paying.
8. Know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services.
9. Choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, other health programs or public programs.
10. Have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information.
11. Access the client's own records and written information from those records in accordance with Minnesota Health Records Act, Minnesota Statute, Sections 144.291 to 144.298.
12. Be served by people who are properly trained and competent to perform their duties.
13. Be treated with courtesy and respect, and to have the client's property treated with respect.
14. Be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act.
15. Reasonable, advance notice of changes in services or charges.
16. Know the provider's reason for termination of services.
17. At least ten calendar days' advance notice of the termination of a service by a home care provider. This clause does not apply in cases where:

- The client engages in conduct that significantly alters the terms of the service plan with the home care provider;
- The client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services; or
- An emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider.

18. A coordinated transfer when there will be a change in the provider of services.
19. Complain to staff and others of the client's choice about services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property, and the right to recommend changes in policies and services, free from retaliation, including the threat of termination of services.
20. Know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint.
21. Know the name and address of the state or county agency to contact for additional information or assistance.
22. Assert these rights personally, or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation.
23. Place an electronic monitoring device in the client's or resident's space in compliance with state requirements.

You may choose to discuss any concerns with your provider. As a reminder, providers are required to work to assure your rights and other requirements are followed. When providers violate the rights in this section, they are subject to the fines and license actions.

Providers must do all of the following:

- Encourage and assist in the fullest possible exercise of these rights.
- Provide the names and telephone numbers of individuals and organizations that provide advocacy and legal services for clients and residents seeking to assert their rights.
- Make every effort to assist clients or residents in obtaining information regarding whether Medicare, medical assistance, other health programs, or public programs will pay for services.
- Make reasonable accommodations for people who have communication disabilities, or those who speak a language other than English.
- Provide all information and notices in plain language and in terms the client or resident can understand.

No provider may require or request a client or resident to waive any of the rights listed in this section at any time or for any reasons, including as a condition of initiating services or entering into an assisted living contract.

Interpretation and Enforcement of Rights

These rights are established for the benefit of clients who receive home care services. All home care providers must comply with these rights. The commissioner shall enforce this. A home care provider may not request or require a client to surrender any of these rights as a condition of receiving services. This statement of rights does not replace or diminish other rights and liberties that may exist relative to clients receiving home care services, persons providing home care services, or licensed home care providers.

Resources

You may contact your licensed provider as indicated below:

Licensee Name: _____

Phone: _____

Email: _____

Address: _____

Name and title of person to whom problems or complaints may be directed: _____

_____

Report suspected abuse, neglect or financial exploitation of a vulnerable adult:

MINNESOTA ADULT ABUSE REPORTING CENTER (MAARC)
Phone: 1-844-880-1574 For more information:
Vulnerable adult protection and elder abuse (https://mn.gov/dhs/adult-protection/)

For all other complaints that are not suspected abuse, neglect or financial exploitation of a vulnerable adult, please contact the Office of Health Facility Complaints at the Minnesota Department of Health:

MINNESOTA DEPARTMENT OF HEALTH
OFFICE OF HEALTH FACILITY COMPLAINTS PO Box
64970
St. Paul, Minnesota 55164-0970
Phone: 651-201-4201 or 1-800-369-7994 Fax: 651-
281-9796 health.ohfc-complaints@state.mn.us
Office of Health Facility Complaints
(https://www.health.state.mn.us/facilities/regulation/ohfc/index.html)

To request advocacy services, please contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities:

OFFICE OF OMBUDSMAN FOR LONG-TERM CARE
PO Box 64971
St. Paul, MN 55164-0971
1-800-657-3591 or 651-431-2555 MBA.OOLTC@state.mn.us
Ombudsman for Long-Term Care (http://www.mnaging.org/Advocate/OLTC.aspx)

OFFICE OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES 121 7th Place East
Metro Square Building
St. Paul, MN 55101-2117
1-800-657-3506 or 651-757-1800 Ombudsman.mhdd@state.mn.us
Office of Ombudsman for Mental Health and Developmental Disabilities (https://mn.gov/omhdd/)

MID-MINNESOTA LEGAL AID/MINNESOTA DISABILITY LAW CENTER
(Protection and Advocacy Systems)
430 First Avenue North, Suite 300
Minneapolis, MN 55401-1780
1-800-292-4150 mndlc@mylegalaid.org
Legal Aid (http://mylegalaid.org/)

MINNESOTA DEPARTMENT OF HUMAN SERVICES
(Medicaid Fraud and Abuse-payment issues)
Surveillance and Integrity Review Services
PO Box 64982
St Paul, MN 55164-0982
1-800-657-3750 or 651-431-2650 DHS.SIRS@state.mn.us

SENIOR LINKAGE LINE
(Aging and Disability Resource Center/Agency on Aging)
Minnesota Board on Aging
PO Box 64976 St. Paul,
MN 55155 1-800-333-
2433
senior.linkage@state.mn.us
Senior LinkAge Line (www.SeniorLinkageLine.com)

For general inquiries, please contact:

Minnesota Department of Health
Health Regulation Division
85 E. 7th Place
PO Box 64970
St. Paul, MN 55164-0970 651-201-4101
health.fpc-web@health.state.mn.us
Minnesota Department of Health (www.health.state.mn.us)

To be used by licensed only home care providers per Minnesota Statute, Section 144Aa.44 Subdivision 1. These rights pertain to clients receiving home care services from licensed only home care providers.

The home care provider shall provide the client or the client's representative a written notice of the rights before the date that services are first provided to that client. The provider shall make all reasonable efforts

to provide notice of the rights to the client or the client's representative in a language the client or client's representative can understand.

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4101
health.fpc-licensing@state.mn.us

Revised November 2019

To obtain this information in a different format, call: 651-201-4101.

Licensee Name: Peter Anosike.
Phone: 651.206.4093 Email: Nwaforpc@yahoo.com
Address:7743 Riverdale Drive Brooklyn Park, MN 55444
Person to Whom Problems or Complaints May be directed:

Peter Anosike./Administrator

Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers

Statement of Rights

A client who receives home care services in an Assisted Living community has these rights:

1. Receive written information in plain language about rights before receiving services, including what to do if rights are violated.
2. Receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services.
3. Be told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and the potential consequences of refusing these services.
4. Be told in advance of any recommended changes by the provider in the service plan and to take an active part in any decisions about changes to the service plan.
5. Refuse services or treatment.
6. Know, before receiving services or during the initial visit, any limits to the services available from a home care provider.
7. Be told before services are initiated what the provider charges for the services; to what extent payment may be expected from health insurance, public programs, or other sources if known; and what charges the client may be responsible for paying.
8. Know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services.
9. Choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, other health programs or public programs.
10. Have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information.
11. Access the client's own records and written information from those records in accordance with Minnesota Health Records Act, Minnesota Statute, Sections 144.291 to 144.298.
12. Be served by people who are properly trained and competent to perform their duties.

13. Be treated with courtesy and respect, and to have the client's property treated with respect.

14. Be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act.

15. Reasonable, advance notice of changes in services or charges.

16. Know the provider's reason for termination of services.

17. At least 30 days' advance notice of the termination of a service by a provider, except in cases where:

    - The recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services;
    - An emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider; or
    - The provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided.

18. A coordinated transfer when there will be a change in the provider of services.

19. Complain to staff and others of the client's choice about services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property, and the right to recommend changes in policies and services, free from retaliation, including the threat of termination of services.

20. Know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint.

21. Know the name and address of the state or county agency to contact for additional information or assistance.

22. Assert these rights personally, or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation.

23. Place an electronic monitoring device in the client's or resident's space in compliance with state requirements.

You may choose to discuss any concerns with your provider. As a reminder, providers are required to work to assure your rights and other requirements are followed. When providers violate the rights in this section, they are subject to the fines and license actions.

Providers must do the following:

- Encourage and assist in the fullest possible exercise of these rights.
- Provide the names and telephone numbers of individuals and organizations that provide advocacy and legal services for clients and residents seeking to assert their rights.
- Make every effort to assist clients or residents in obtaining information regarding whether Medicare, medical assistance, other health programs, or public programs will pay for services.

- Make reasonable accommodations for people who have communication disabilities, or those who speak a language other than English.
- Provide all information and notices in plain language and in terms the client or resident can understand.

No provider may require or request a client or resident to waive any of the rights listed in this section at any time or for any reasons, including as a condition of initiating services or entering into an assisted living contract.

Provider Responsibility related to Content of Written Notice of Service Termination

If an arranged home care provider who is not also Medicare certified terminates a service agreement or service plan with an assisted living client, the home care provider shall provide the assisted living client and the legal or designated representatives of the client, if any, with a written notice of termination which includes the following information:

1. The effective date of termination;
2. The reason for termination;
3. Without extending the termination notice period, an affirmative offer to meet with the assisted living client or client representatives within no more than five business days of the date of the termination notice to discuss the termination;
4. Contact information for a reasonable number of other home care providers in the geographic area of the assisted living client;
5. A statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver;
6. The name and contact information of a representative of the home care provider with whom the client may discuss the notice of termination;
7. A copy of the home care bill of rights; and
8. A statement that the notice of termination of home care services by the home care provider does not constitute a notice of termination of the housing with services contract with a housing with services establishment.

Interpretation and Enforcement of Rights

These rights are established for the benefit of clients who receive home care services. All home care providers must comply with these rights. The commissioner shall enforce this. A home care provider may not request or require a client to surrender any of these rights as a condition of receiving services. This statement of rights does not replace or diminish other rights and liberties that may exist relative to clients receiving home care services, persons providing home care services, or licensed home care providers.

Resources

You may contact your licensed provider as indicated below:

Licensee Name: _____

Phone: _____

Email: _____

Address: _____

Name and title of person to whom problems or complaints may be directed: _____

_____ **Report suspected abuse, neglect or financial exploitation of a vulnerable adult:**

MINNESOTA ADULT ABUSE REPORTING CENTER (MAARC)
Phone: 1-844-880-1574 For more information:
Vulnerable adult protection and elder abuse (https://mn.gov/dhs/adult-protection/)

For all other complaints that are not suspected abuse, neglect or financial exploitation of a vulnerable adult, please contact the Office of Health Facility Complaints at the Minnesota Department of Health:

MINNESOTA DEPARTMENT OF HEALTH
OFFICE OF HEALTH FACILITY COMPLAINTS PO Box
64970
St. Paul, Minnesota 55164-0970
Phone: 651-201-4201 or 1-800-369-7994 Fax: 651-
281-9796 health.ohfc-complaints@state.mn.us
Office of Health Facility Complaints
(https://www.health.state.mn.us/facilities/regulation/ohfc/index.html)

To request advocacy services, please contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities:

OFFICE OF OMBUDSMAN FOR LONG-TERM CARE
PO Box 64971
St. Paul, MN 55164-0971
1-800-657-3591 or 651-431-2555 MBA.OOLTC@state.mn.us
Ombudsman for Long-Term Care (http://www.mnaging.org/Advocate/OLTC.aspx)

OFFICE OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES 121 7th Place East
Metro Square Building
St. Paul, MN 55101-2117
1-800-657-3506 or 651-757-1800 Ombudsman.mhdd@state.mn.us
Office of Ombudsman for Mental Health and Developmental Disabilities (https://mn.gov/omhdd/)

MID-MINNESOTA LEGAL AID/MINNESOTA DISABILITY LAW CENTER

(Protection and Advocacy Systems)
430 First Avenue North, Suite 300
Minneapolis, MN 55401-1780
1-800-292-4150 mndlc@mylegalaid.org
Legal Aid (http://mylegalaid.org/)

MINNESOTA DEPARTMENT OF HUMAN SERVICES
(Medicaid Fraud and Abuse-payment issues)
Surveillance and Integrity Review Services
PO Box 64982
St Paul, MN 55164-0982
1-800-657-3750 or 651-431-2650 DHS.SIRS@state.mn.us

SENIOR LINKAGE LINE
(Aging and Disability Resource Center/Agency on Aging) Minnesota Board on Aging
PO Box 64976 St. Paul,
MN 55155 1-800-333-
2433
senior.linkage@state.mn.us
Senior LinkAge Line (www.SeniorLinkageLine.com)

For general inquiries, please contact:

Minnesota Department of Health
Health Regulation Division
85 E. 7th Place PO
Box 64970
St. Paul, MN 55164-0970 651-201-4101
health.fpc-web@health.state.mn.us
Minnesota Department of Health (www.health.state.mn.us)

Per Minnesota Statutes, section 144A.44 Subdivision 1 and 144A.441. These rights pertain to consumers receiving home care services from licensed home care providers who provide care for assisted living clients as defined by 144G.

The home care provider shall provide the client or the client's representative a written notice of the rights before the date that services are first provided to that client. The provider shall make all reasonable efforts to provide notice of the rights to the client or the client's representative in a language the client or client's representative can understand.

P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4101
health.fpc-licensing@state.mn.us

Revised November 2019

To obtain this information in a different format, call: 651-201-4101.

Licensee Name: Peter Anosike.
Phone: 651.206.4093 Email: Nwaforpc@yahoo.com
Address:7743 Riverdale Drive Brooklyn Park, MN 55444
Person to Whom Problems or Complaints May be directed:
Peter Anosike./Administrator

For informational purposes only and is not required in the Home Care Bill of Rights text: MN Statute, section 144A.44 Subd. 2**. Interpretation and enforcement of rights.**

These rights are established for the benefit of clients who receive home care services. **All home care providers, including those exempted under section 144A.471, must comply with this section.** The commissioner shall enforce this section and the home care bill of rights requirement against home care providers exempt from licensure in the same manner as for licensees. A home care provider may not request or require a client to surrender any of these rights as a condition of receiving services. This statement of rights does not replace or diminish other rights and liberties that may exist relative to clients receiving home care services, persons providing home care services, or providers licensed under sections 144A.43 to 144A.482.

MN Statute, section 144A.442 **Assisted Living Clients; Service Termination.**

If an arranged home care provider, as defined in section 144D.01, subdivision 2a, who is not also Medicare certified terminates a service agreement or service plan with an assisted living client, as defined in section144G.01, subdivision 3, the home care provider shall provide the assisted living client and the legal or designated representatives of the client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client or client representatives within no more than five business days of the date of the termination notice to discuss the termination;

(4) contact information for a reasonable number of other home care providers in the geographic area of the assisted living client, as required by Minnesota Rules, part 4668.0050;

(5) a statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver, as required by section 144A.44, subdivision 1, clause (17);

(6) the name and contact information of a representative of the home care provider with whom the client may discuss the notice of termination;

(7) a copy of the home care bill of rights; and

(8) a statement that the notice of termination of home care services by the home care provider does not constitute notice of termination of the housing with services contract with a housing with services establishment.