PAS CONSENT **A Hug Away Healthcare Inc.**

CONSENT FOR SERVICE/RELEASE OF RECORDS

I, _____, has been informed that A Hug Away HealthCare Inc. referred to in this consent as Agency, is licensed to provide personal care services according to the Individualized Service Plan (ISP) established by the staff and the client/caregiver. I accept services from Agency. I can call the Agency 24 hours a day regarding my services at **832-437-1983** This is not an emergency line. I will call 911 in an emergency. It is the Agency's policy to protect all clinical records against loss, defacement, tampering and use by unauthorized persons. I authorize the Agency to release medical information to my physician, the facility of my choice, payor source, or accrediting/regulatory/consulting organizations, as appropriate. I authorize the release of the Plan of Treatment and Discharge Summary upon my transfer to another health care facility.

FINANCIAL AUTHORIZATION

Service Period payment of $_____Payment of_____ ☐ Per Hour ☐ Per day ☐ Week-end/relief/evening_____
Billing Information: Name:_____(i.e. Self, HMO/MCO)
Address/City_____
Phone: (____)_____HMO/MCO ID No:_____

- ☐ I agree to pay the co-pay of $_____
- ☐ I agree to pay for all supplies and/or equipment except the following:_____
- ☐ I authorize Agency to charge my credit card for services rendered and understand that I will be notified by invoice of the amount charged to my credit card. Card: ☐ MC ☐ Visa ☐ Other_____Exp date:_____
- ☐ I have received written and verbal instructions on Obligation of Client, Expense Reimbursement and Terms of Agreement

FREQUENCY/RIGHTS/HOTLINE/PROCEDURES

I understand that it is my right and responsibility to be involved in the plan of service. I have reviewed and approved the Individualized Service Plan and have received a copy for my record. Services Frequency:

☐ Caregiver/Attendant_____ ☐ Sitter_____ ☐ Homemaker_____
☐ Professional Cleaning_____ ☐ Live-In:_____

I understand that the plan for supervision is the following:

☐ Supervision of unlicensed person providing non-delegated tasks at least ☐ 6 months ☐ 60 days ☐ Other_____

I have received written and verbal instructions on what my caregiver/attendant can do for me.

I have received a copy and an explanation of the **Bill of Rights** and the **Rights of the Elderly**, as appropriate.

I have received the Obligation of Client form and agree to the terms set forth in the document.

I have been notified of my right to voice a complaint. I may direct a complaint to the Agency Administrator or designee at **832-437-1983** An investigation of the complaint will be initiated within 10 calendar days and resolved within 30 calendar days of receipt. I may also contact the Department of Aging and Disability Services, DADS' Consumer Rights and Services Division, PO Box 149030, Austin, TX 78714, at **800-458-9858**. The line is open 24 hours a day. This includes a complaint regarding advance directives. Complaints regarding Utilization Review or HMO services can be made directly to Texas Department of Insurance Consumer Protection, PO Box 149091, Austin, TX 78714 at **800-252-3439**.

I have received information and Agency policy on Advance Directives. I ☐ have ☐ not signed a ☐ Living Will/Directive to Physician ☐ Medical Power of Attorney ☐ Declaration of Mental Health ☐ Out of Hospital DNR.

I ☐ am ☐ am not providing a copy for my record.

Medical Power of Attorney Name:_____ Phone:_____

I understand that it is my right and responsibility to be involved in my care and that I will be informed as to the nature and purpose of my technical procedure.

I have been informed what to do in an **emergency/natural disaster** and have received education on completing an emergency preparedness plan for myself and my family. I understand the importance of completing this plan and know that Agency staff may assist in this process. I have been informed of how to register with 2-1-1.

I have been informed verbally and in writing regarding Agency policy on **abuse, neglect, and exploitation, Agency drug testing and hazardous waste disposal** in the home.

HIPAA – I have received Notice of Privacy Practices and consent to the Agency's use and/or disclosure of protected health information for payment, treatment and Agency's health care operations.

_____ _____
Client/Authorized Agent Signature (Relationship) If client is unable to sign, state reason why

_____ _____
Agency Representative Signature Date of Signatures

A HUG AWAY HEALTHCARE INC.

CLIENT COMPLAINTS/GRIEVANCES PROCEDURES

A Hug Away Healthcare Inc. strives consistently to ensure quality care for its patients in accordance with the Agency's philosophy. In order to assist our staff in meeting your needs, complaints or grievances may be logged by contacting the Agency administrator or Director of clinical services by telephone, mail, or in person at the following address:

A HUG AWAY HEALTHCARE INC.

1203 AVE D KATY TX 77493

P: 832-437-1983 F: 281605-1307

Your complaints or grievances will be investigated promptly and you will be informed of the outcome of the investigations by phone and/ or mail. If your complaint or grievance has not been resolved to your satisfaction you may lodge your complaint or grievance with the Texas Department of Health by writing.

ATTN:DIRECTOR
HEALTH FACILITY COMPLIANCE DIVISION
TEXAS DEPARTMENT OF HUMAN SERVICES
P.O BOX 149030
AUSTIN,TX 78714-9030

Complaints or grievances may also be lodged by calling Texas Department of Human Health services Hotline number
1-800-458-9858

Or

COMMUNITY HEALTH ACCREDITATION PROGRAM (CHAP)
1-800-656-9656

Regular hours of operation are Monday thru Friday 9AM to 5PM. Calls received after business hours or during the holidays will be answered by machine. You may leave a message and your call will be returned by the next business day. In addition to receiving complaints, the purpose of the hotline is also to receive questions about local home health agencies.

My signature signifies that I and or my authorized representative have been informed of the Agency's complaints/grievances procedures both orally and in writing, and a copy given to me for my record.

_____ _____
Client or Authorized Representative Date

_____ _____
Agency Supervisor Date

A HUG AWAY HEALCARE INC.

EMERGENCY PREPAREDNESS

If you are involved in a natural disaster, such as hurricane, tornado, flood, earthquake, or fire, please follow these instructions.

If you must leave your home, call **A HUG AWAY HEALTHCARE INC.** . and be ready to give the new address and phone numbers where you can be reached.

If you decided to stay home, let your Coordinator/Nurse know whether your home can be reached by a car. If not, **A HUG AWAY HEALTHCARE INC.** or your pharmacy will work with you to arrange for delivery of your supplies by other means or to another location.

If you need emergency medical care or medical supplies, go to the nearest hospital outside of the disaster area.

If you have no electricity, **A HUG AWAY HEALTHCARE INC.** or pharmacy may give you an emergency "gravity" method of infusion fluids if approved by your physician for your therapy. IV pumps generally have a battery backup which will last for a limited time.

If water is contaminated, you and/your caregiver should wash your hands with alcohol (rubbing alcohol or isotropy) or hydrogen peroxide prior to doing any sterile procedures. DO NOT EXPOSE YOUR CATHETER OR CATHETER SITE TO ANY DIRTY WATER.

Your pharmacy and **A HUG AWAY HEALTHCARE INC.** will try to contact you: however, calling into an area struck by a natural disaster can be difficult. Telephone lines are often jammed. Therefore, please call out and try to make contact with **A HUG AWAY HEALTHCARE INC.** so they can help you with specific emergency needs.

_____ SIGNATURE

_____ DATE

A HUG AWAY HEALTHCARE INC.

HOME SAFETY ASSESSMENT

Environmental:

_____ Safe and adequate food and water supplies
_____ Stove and means for refrigerator present
_____ Adequate heat and ventilation
_____ Free from infestation
_____ Pathways free of obstacles such as loose rugs, furniture, etc.
_____ Clean area exists in which to store medical supplies
_____ Is cautious with heating pads
_____ Has working smoke detector
_____ If uses Oxygen, appropriate signs posted

Fire /Electrical:

_____Fire exists available; warning devices installed
_____No overuse of extension cords/adequate electrical outlets installed
_____Turns off oven and stove burners
_____Emergency telephone numbers posted by phone
_____Turn pot handles to back of stove
_____Uses space heaters cautiously
_____Does not smoke in bed
_____Oxygen precaution used

_____ No throw rugs
_____ Safety bars present and in good condition
_____ Lighting is adequate
_____ Shower chair is study and in good working condition

Medication use:

_____ Keep all medications in original bottle or medication box
_____ Has a medication schedule

Home safety instruction Given: _____

_____

_____

NRN Signature:_____ Date:_____/_____/_____

A HUG AWAY HEALTHCARE INC.

HOME SAFETY MEASURES

Fire Prevention:

- Use smoke detector and change the batteries every 6 months
- Practice Fire Drills
- Be cautious with heating pads
- Unplug appliances after use
- Turn off oven and stove burners
- Store famous properly
- Avoid exposed wiring
- Do not use lighted matches or lighters around any suspected natural gas leaks
- Do not smoke in bed
- Be cautious around any open flame heater or fireplace

Poison Prevention:

- Label all poison
- Keep all substances in their original containers
- Have syrup of IPECAC on hand
- Store cleaning supplies away from food and medications
- Call the Poison Control center for any poison issued at (800)441-0040

Hot weather Precautions:

- Wear loose preferably light colored cotton clothing
- Drink water several times a day
- Adequate ventilation with air conditioning or if no AC, use fans
- Avoid direct exposure to the sun

Cold Weather precautions:

- Have enough blankets
- Wear warm housecoats and socks
- Have hot foods and drinks several times a day
- Avoid icy sideways, porch steps
- Cover head as 20% of body heat is lost through the scalp.

TEXAS
Health and Human Services

A HUG AWAY HHEALTCARE INC.

Rights and Responsibilities

(You have the right to have this explained aloud or in other appropriate manners.)

Section I – Your Rights

1. **Nondiscrimination –** If you believe you have been discriminated against because of race, color, national origin, age, sex, disability, political beliefs or religion, you may lodge a complaint with Texas Health and Human Services Commission (HHSC) management staff by contacting your case worker's supervisor, who will forward your claim to the Civil Rights Office and/or you may write directly to: Civil Rights Department, Texas Health and Human Services Commission, P.O. Box 149030, Austin, TX 78714-9030.

2. **Application –** You may file an application in person, by mail or you may have another person file the application for you. If you need help completing the application or with the application process, an HHSC volunteer or staff member will help you.

3. **Right to Receive Services –** If funds are available for the services you requested and you are determined eligible, you have the right to receive services. If funds are not available when you request services, you have a right to have your name placed on an interest list for that service.

   You have the right to receive services if you are determined eligible when funds become available and your name appears on the interest list as being the next to receive services. The person on the interest list with the earliest date of request for services goes through the eligibility process first.

4. **Confidentiality of Information –** Information collected to determine eligibility for services, whether collected by HHSC staff or provider agencies, is confidential under state and federal statutes and regulations. This information may be released following state and federal statutes and regulations.

5. **Right to Participate in Service Planning –** You have the right to participate in planning your services. The development of your service plan will include determining what services you need, how often you need the services, what time of day you need the services and which days of the week you need the services.

6. **Right to be Notified of Changes in Service Plan or Eligibility –** You have the right to be informed, in writing and orally, of your eligibility for specific services for which you have applied. You also have the right to receive, from HHSC, written and oral notice about increases or decreases in the number of hours or units of services you receive, loss of priority status or termination of your services. This notice is sent 12 days before the effective date of denial or termination unless:
   - you are no longer financially eligible for Community Attendant Services (CAS),
   - you are no longer Medicaid eligible,
   - you begin to receive services from another program,
   - your services are terminated because your behavior or the behavior of someone in your home threatens the health and safety of HHSC staff,
   - you sign a waiver requesting that your services be terminated immediately, or
   - required by state or federal state statutes and regulations.

   You have a right to receive the written notice in accessible formats, if desired. You also have the right to receive the oral notice in a medium of communication that you can understand.

7. **Right to Fair Hearing –** If you believe that an HHSC employee made a mistake and you did not get the correct services or were denied for services, you or someone acting for you may request, orally or in writing, a fair hearing. A fair hearing is held to review the provisions of your care plan, denial of services, reduction of services, change in the care plan, termination of services or failure of the department to act on requests for services in a reasonable amount of time. A fair hearing is held by an HHSC employee who has not been involved with the case. This HHSC employee reviews the case to determine if HHSC policies and procedures were followed correctly. When a notice is given to you 12 days before the change occurs and you request an appeal before the change is to occur, you may continue services at the same level until the hearing is held.

8. **Right to Complain or Voice Grievances –** You have the right to make a complaint, voice grievances or recommend changes in policy or service without restraint, interference, coercion, discrimination or reprisal. Your complaint, grievance or recommendation must be acknowledged within 14 days of the date it is received by the department and resolved within 60 days of that date. If you disagree with a decision the case worker makes and you want to talk it over with the office supervisor, you have the right to do so.

If you have any problems or questions regarding HHSC services that the case worker or office supervisor cannot solve or answer, you can talk it over with the case worker's program manager. Telephone numbers for the case worker, the office supervisor and the program manager are listed on the last page of this form.

Relay Texas Assistance - Relay services involve a relay operator who uses both a standard telephone and a TDD to type the voice message to the TDD user and read the TDD message to the standard telephone user. To access Relay Texas Assistance, dial 7-1-1.

If you have a problem or complaint, we encourage you to **first** discuss it with the person, program or office involved. Many times staff can explain a specific policy or correct the problem immediately. If the agency's normal complaint process cannot or does not satisfactorily resolve the issue, **there are four ways to send a question or file a complaint**:

1. **Call:** 1-877-787-8999 (Toll-Free). People who are deaf hard of hearing or speech impaired can call any HHSC office, by using the toll-free Texas Relay service at 7-1-1 or 1-800-735-2989.
2. **Online:** https://hhs.texas.gov/about-hhs/your-rights/office-ombudsman/
3. **Mail:** Texas Health and Human Services Commission
   Office of Ombudsman
   P.O. Box 13247, Mail Code H-700
   Austin, TX 78711-3247
4. **Fax:** 1-888-780-8099 (Toll-Free)

9. **Right to Privacy –** You have the right to privacy.

10. **Dignity and Respect –** You have the right to be treated with dignity and respect and to have your property treated with respect. If you believe someone from HHSC or a provider agency has not treated you with respect, you may make a complaint with the Consumer Rights and Services Office by calling 1-800-458-9858, sending an email to **CRSComplaints@hhsc.state.tx.us**, or you may write or fax directly to:

    Texas Health and Human Services Commission
    Consumer Rights and Services – Complaint Intake Unit
    Mail Code E-249
    P.O. Box 149030
    Austin, TX 78714-9030
    Fax: 512-438-2724 or 512-438-2722

    You have the right to advance notice of all visits the case worker has with you unless there is indication of abuse, neglect or fraud.

11. **Freedom from Physical or Mental Abuse or Exploitation –** You have the right to be free of abuse, neglect and exploitation. If you believe someone has abused, neglected or exploited you, contact the Texas Department of Family and Protective Services (DFPS) Abuse Hotline at: 1-800-252-5400 or **www.txabusehotline.org**. The hotline is toll-free and available 24 hours a day, seven days a week nationwide. The identity of the caller is confidential and the law requires DFPS to initiate a prompt and thorough investigation of any suspected need for protective services.

12. **Right to Register to Vote –** You have the right, to register to vote according to the National Voter Registration Act. HHSC will ask the following when you apply for services, HHSC completes an annual reassessment, or when you change residence:
    - Are you registered to vote?
    - Do you want to register today?

13. **Native Language –** You have the right to communicate in your native language (including American Sign Language) with other persons or employees to request services, apply for services and receive services.

14. **Service Delivery Option –** You have the right of choice based on your program between having certain services delivered through a provider agency, the Consumer Directed Services Option (CDS) or the Service Responsibility Option (SRO). Under the CDS option, you are responsible for recruiting, hiring, firing, training and managing your service providers. Under the SRO option, you are responsible for interviewing, selecting, supervising and setting schedules for your service providers.

15. **Home-Delivered Meal Contribution** – You may contribute a monetary donation to your home-delivered meals service provider if you choose. If you choose to make a contribution towards the cost of your home-delivered meals, you have the right to be given a receipt of your contribution.

Section II – Your Responsibilities

1. **Provision of Information –** It is important to coordinate with your case worker and provide all information necessary to establish eligibility and to develop service plans for purchased services. Falsifying information is illegal and may cause criminal charges to be brought against you.

2. **Service Plan Compliance –** You must comply with the service plan, including refraining from engaging in behaviors that endanger you, staff or provider agency employees. You must treat staff and provider agency employees with dignity and may not in any way harass or threaten staff or provider agency employees.

3. **Providing Changes** - You must report, within 10 days, any changes in income, living arrangements, family size, loss of assistance grants or Medicaid benefits or other changes that may affect your eligibility. If you willfully fail to report changes that affect your eligibility and receive services for which you are not eligible, you may be prosecuted for fraud and you must pay for the services.

Signature Page

Individual's Name	Individual's No.

Language Preference: I prefer to receive all written communication in ☐ English ☐ Spanish

Section III – Acknowledgment Statement

I certify that I have read the statements on this form and on any attachments checked below (or they have been explained to me) and I understand their content. I also certify that I have been given a copy of this form and any checked attachments, and been given an oral explanation of the form and attachments, if requested or required.

- ☐ **HIPAA Forms – Health and Human Services Agencies' Notice of Privacy Practices/Summary of the Protected Health**
- ☐ **Form 2307-A or Form 2307-AS – These are the rights and responsibilities specific to the Family Care, Community Attendant Services and Primary Home Care programs.**
- ☐ **Form 2307-B or Form 2307-BS – These are the rights and responsibilities specific to the Emergency Response Services program.**
- ☐ **Form 2307-F or Form 2307-FS – These are the rights and responsibilities specific to the Adult Foster Care program.**

I certify regarding the following attachments that:

- ☐ **The case worker gave me Appendix XXXV, Long Term Services and Supports, and gave me an oral explanation of other long term services.**
- ☐ **The case worker provided Form 1581/1581-S, Consumer Directed Services Option Overview, and gave an oral explanation of the rights and responsibilities relating to the Consumer Directed Services or Service Responsibility payment option. With assistance from the case worker, I have completed my service delivery choice on Form 1584/1584-S.**
- ☐ **I have been given the opportunity to register to vote and have declined to register to vote at this time.**
- ☐ **I have been given assistance in completing Form 0030, Application for Voter Registration.**

Signature – Individual or Responsible Party	Date
Signature – Family Member or Caregiver	Date
Signature – Witness	Date

☐ **Update**	Signature – Case Worker	Date Form Explained and Given or Mailed
☐ **Update**	Signature – Case Worker	Date Form Explained and Given or Mailed
☐ **Update**	Signature – Case Worker	Date Form Explained and Given or Mailed

Name of Case Worker	Case Worker's Area Code and Telephone No.
Name of Supervisor	Supervisor's Area Code and Telephone No.
Program Manager's Name	Program Manager's Area Code and Telephone No.

TEXAS Health and Human Services

A HUG AWAY HEALTHCARE INC

Family Care, Community Attendant Services and Primary Home Care Rights and Responsibilities

Case Manager or Provider Representative Name	Telephone No.

After you are determined eligible for ongoing services you may call your case manager at any time, even if you do not know if the service you need will be paid for by the department. You may call if you want to change your provider or if you need more hours of care.

I. Your Rights in Family Care (FC), Community Attendant Services (CAS) and Primary Home Care (PHC)

You have the right:

- to change the service plan you and your case manager agreed to and to determine, with your provider agency, what assistance you need, how often you need the assistance, and at what time of day and what days of the week you want help.
- to select, for any reason, another provider from which to receive services (except when you have been informed that your services may be terminated based on failure to comply with service delivery provisions).
- to refuse all or part of any services and to be informed of the likely consequences of such refusal.
- to receive education or training for yourself and for members of your family or household on the management of your services.
- to receive services even if they may not meet all of your needs.

Your Responsibilities

You must:

- sign the service plan that you agree to with the home and community support service agency.
- obtain approval from your case manager before receiving more hours of service per week.

Electronic Visit Verification

Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies service visits occur and documents the precise time service provision begins and ends.

The purpose of EVV is to verify that individuals are receiving the services authorized for their support and for which the state is being billed.

EVV is optional for individuals using Consumer Directed Services (CDS).

Your EVV Responsibilities

You must comply with EVV requirements for service delivered by an attendant by allowing:

- the attendant to use your home landline telephone to call a toll-free number when he or she starts and ends work; or
- an alternative device to be installed in your home for the attendant to report when he or she starts and ends work. This device must remain in the home at all times.

Services Available

The services which the department authorizes for you may not meet all of your needs. You must decide whether to continue in your present living arrangement using these services and the assistance available from your family and other sources. Your case manager will explain other options, such as: nursing facility care, adult day care, assisted living services and community services from other agencies.

Eligibility criteria for services appear on Page 2 of this form.

If you prefer to receive PHC or CAS before the department gives you a choice of providers, you may contact a provider of your choice to obtain services.

The tasks that the department pays for through FC and PHC/CAS are listed on Page 3.

(continued)

II. Eligibility Criteria for Primary Home Care (PHC), Community Attendant Services (CAS) and Family Care (FC)

The eligibility criteria for PHC/CAS and FC differ as shown below.

Eligibility requirements for PHC/CAS are met if:	Eligibility requirements for FC are met if:
• you receive Medicaid or have monthly income not more than $2,199 if single or $4,398 if married and resources not more than $2,000 (if single) or $3,000 (if married).	• same as PHC/CAS, except resource limit: $5,000 (if single) or $6,000 (if married).
• you have a practitioner's statement of medical need for PHC/CAS.	• no requirement for practitioner's statement.
• you have a functional impairment score of at least 24.	• same as PHC/CAS.
• you need at least one of these tasks -bathing, feeding, meal preparation, getting to or using the toilet, transferring in or out of bed or chair/on or off a toilet, reminders to take medications.	• no personal care task requirement.
• you need assistance with activities of daily living that you have difficulty with.	
• you need at least six hours of service per week, unless:	
• your functional impairment score is 30 or higher; **or**	• same as PHC/CAS.
• you live with someone who also receives CAS, FC or PHC; **or**	• same as PHC/CAS.
• you receive one or more of these services:	
○ Home-Delivered Meals or Congregate Meals	
○ assistance with activities of daily living from a home health aide	
○ Day Activities and Health Services	
○ Special Services to Persons with Disabilities	
○ Aid and Attendant Benefits from the Veterans Administration, or	
○ In-Home and Family Support Program.	

(continued)

III. PHC, CAS and FC Services Paid for by the Texas Health and Human Services Commission

Personal Care Tasks

Bathing

Feeding

Shaving

Brushing teeth

Washing, drying and brushing/combing hair

Washing hands/face

Applying makeup and non-prescription lotion

Dressing

Changing diapers

Assisting on/off bedpan

Help with use of urinal

Assisting with feminine hygiene needs

Assisting with clothing during toileting

Assisting with hygiene

Preparing toileting supplies and equipment

Emptying catheter bag or colostomy bag

Changing external catheter

Transferring you from one position to another on the bed or chair

Assisting you with putting on/removing leg braces and prostheses

Assisting with wheelchair

Reminding you to take your medicine

Preparing your meals

Housekeeping Tasks

Cleaning living area: dusting and vacuuming

Cleaning bathroom

Cleaning stove and counters

Defrosting and cleaning refrigerator inside and out

Carrying out trash

Washing and drying your clothes

Changing your bed linens and making bed

Washing your dishes

Preparing grocery or household item shopping list

Going to store to buy and pick up grocery items or medications

Putting food away

Escort: Accompanying you to the doctor's clinic or other destinations (**Note:** Additional time is not allotted for escort services for purposes other than to medical appointments. However, an individual may substitute escort services for time allotted to another task.)

(continued)

IV. Examples of Services NOT Paid for by the Department under PHC, CAS or FC

Services that are not usually done on a weekly basis to keep you or your house clean. For example:

- moving heavy furniture
- washing windows
- yard work
- supervision - sitting service
- accompanying you to department stores or social activities
- shopping for your clothes
- giving you a permanent

Services that must be provided by a person with professional or technical training, such as:

- changing a catheter
- changing a colostomy
- washing infected parts of the body
- tube feeding
- injections
- giving you medicine that is ordered by your doctor
- applying an ointment to your skin that is ordered by your doctor

Services that also help those you live with unless those persons also receive attendant services from the department. For example:

- cleaning floor and furniture in parts of your house you do not use
- cooking for everyone who lives with you
- buying groceries or household items that are not for your use
- washing and drying clothes and bed linens belonging to others who live with you

---

Signature- Individual

Date

A HUG AWAY HEALTHCARE INC.

RIGHTS OF THE ELDERLY

Sec. 102.001. DEFINITIONS:

(1) "Convalescent and nursing home" means an institution licensed by the Department of Aging and Disability Services under Chapter 242, Health and Safety Code.

(2) "Home health services" means the provision of health service for pay or other consideration in a patient's residence regulated under Chapter 142, Health and Safety Code.

(3) "Alternate care" means services provided within an elderly individual's own home, neighborhood, or community, including:

(A) Day care;

(B) Foster care;

(C) Alternative living plans, including personal care services; and

(D) Supportive living services, including attendant care, residential repair, or emergency response services.

(4) "Person providing services" means an individual, corporation, association, partnership, or other private or public entity providing convalescent and nursing home services, home health services, or alternate care services.

(5) "Elderly individual" means an individual 60 years of age or older.

Sec. 102.002. PROHIBITION.

(a) A person providing services to the elderly may not deny an elderly individual a right guaranteed by this chapter.

(b) Each agency that licenses, registers, or certifies a person providing services shall require the person to implement and enforce this chapter. A violation of this chapter is grounds for suspension or revocation of the license, registration, or certification of a person providing services.

Sec. 102.003. RIGHTS OF THE ELDERLY.

(a) An elderly individual has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. The elderly individual has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.

(b) An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the elderly individual:

(1) Has the right to make the individual's own choices regarding the individual's personal affairs, care, benefits, and services;

(2) Has the right to be free from abuse, neglect, and exploitation; and

(3) If protective measures are required, has the right to designate a guardian or representative to ensure the right to quality stewardship of the individual's affairs.

(c) An elderly individual has the right to be free from physical and mental abuse, including corporal punishment or physical or chemical restraints that are administered for the purpose of discipline or convenience and not required to treat the individual's medical symptoms. A person providing services may use physical or chemical restraints only if the use is authorized in writing by a physician or the use is necessary in an emergency to protect the elderly individual or others from injury. A physician's written authorization for the use of restraints must specify the circumstances under which the restraints may be used and the duration for which the restraints may be used. Except in an emergency, restraints may only be administered by qualified medical personnel.

(d) An elderly individual with an intellectual disability who has a court-appointed guardian of the person may participate in a behavior modification program involving use of restraints or adverse stimuli only with the informed consent of the guardian.

(e) An elderly individual may not be prohibited from communicating in the individual's native language with other individuals or employees for the purpose of acquiring or providing any type of treatment, care, or services.

(f) An elderly individual may complain about the individual's care or treatment. The complaint may be made anonymously or communicated by a person designated by the elderly individual. The person providing service shall promptly respond to resolve the complaint. The person providing services may not discriminate or take other punitive action against an elderly individual who makes a complaint.

(g) An elderly individual is entitled to privacy while attending to personal needs and a private place for receiving visitors or associating with other individuals unless providing privacy would infringe on the rights of other individuals. This right applies to medical treatment, written communications, telephone conversations, meeting with family, and access to resident councils. An elderly person may send and receive unopened mail, and the person providing services shall ensure that the individual's mail is sent and delivered promptly. If an elderly individual is married and the spouse is receiving similar services, the couple may share a room.

(h) An elderly individual may participate in activities of social, religious, or community groups unless the participation interferes with the rights of other persons.

(i) An elderly individual may manage the individual's personal financial affairs. The elderly individual may authorize in writing another person to manage the individual's financial affairs. The elderly individual may choose the manner of financial management, which may include management through or under a money management program, a representative payee program, a financial power of attorney, a trust, or a similar method, and the individual may choose the least restrictive of these methods. A person designated to manage an elderly individual's financial affairs shall do so in accordance with each applicable program policy, law, or rule. On request of the elderly individual or the individual's representative, the person designated to manage the elderly individual's financial affairs shall make

available the related financial records and provide an accounting relating to the financial management. An elderly individual's designation of another person to manage the individual's financial affairs does not affect the individual's ability to exercise another right described by this chapter. If an elderly individual is unable to designate another person to manage the individual's financial affairs and a guardian is designated by a court, the guardian shall manage the individual's financial affairs in accordance with the Estates Code and other applicable laws.

(j) An elderly individual is entitled to access to the individual's personal and clinical records. These records are confidential and may not be released without the elderly individual's consent, except the records may be released:

(1) To another person providing services at the time the elderly individual is transferred; or

(2) If the release is required by another law.

(k) A person providing services shall fully inform an elderly individual, in language that the individual can understand, of the individual's total medical condition and shall notify the individual whenever there is a significant change in the person's medical condition.

(l) An elderly individual may choose and retain a personal physician and is entitled to be fully informed in advance about treatment or care that may affect the individual's well-being.

(m) An elderly individual may participate in an individual plan of care that describes the individual's medical, nursing, and psychological needs and how the needs will be met.

(n) An elderly individual may refuse medical treatment after the elderly individual:

(1) is advised by the person providing services of the possible consequences of refusing treatment; and

(2) Acknowledges that the individual clearly understands the consequences of refusing treatment.

(o) An elderly individual may retain and use personal possessions, including clothing and furnishings, as space permits. The number of personal possessions may be limited for the health and safety of other individuals.

(p) An elderly individual may refuse to perform services for the person providing services.

(q) Not later than the 30th day after the date the elderly individual is admitted for service, a person providing services shall inform the individual:

(1) Whether the individual is entitled to benefits under Medicare or Medicaid; and

(2) Which items and services are covered by these benefits, including items or services for which the elderly individual may not be charged.

(r) A person providing services may not transfer or discharge an elderly individual unless:

(1) The transfer is for the elderly individual's welfare, and the individual's needs cannot be met by the person providing services;

(2) The elderly individual's health is improved sufficiently so that services are no longer needed;

(3) The elderly individual's health and safety or the health and safety of another individual would be endangered if the transfer or discharge was not made;

(4) the person providing services ceases to operate or to participate in the program that reimburses the person providing services for the elderly individual's treatment or care; or

(5) The elderly individual fails, after reasonable and appropriate notices, to pay for services.

(s) Except in an emergency, a person providing services may not transfer or discharge an elderly individual from a residential facility until the 30th day after the date the person providing services provides written notice to the elderly individual, the individual's legal representative, or a member of the individual's family stating:

(1) That the person providing services intends to transfer or to discharge the elderly individual;

(2) The reason for the transfer or discharge listed in Subsection (r);

(3) The effective date of the transfer or discharge;

(4) If the individual is to be transferred, the location to which the individual will be transferred; and

(5) The individual's right to appeal the action and the person to whom the appeal should be directed.

(t) An elderly individual may:

(1) Make a living will by executing a directive under Subchapter B, Chapter 166, Health and Safety Code;

(2) Execute a medical power of attorney under Subchapter D, Chapter 166, Health and Safety Code; or

(3) Designate a guardian in advance of need to make decisions regarding the individual's health care should the individual become incapacitated.

Sec. 102.004. LIST OF RIGHTS.

(a) A person providing services shall provide each elderly individual with a written list of the individual's rights and responsibilities, including each provision of Section 102.003, before providing services or as soon after providing services as possible, and shall post the list in a conspicuous location.

(b) A person providing services must inform an elderly individual of changes or revisions in the list.

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Sec. 102.005. RIGHTS CUMULATIVE.

The rights described in this chapter are cumulative of other rights or remedies to which an elderly individual may be entitled under law.

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| Name | Signature | Date |