Volunteers of America®
Oregon

Office Use Only
Client/CG offered copy of intake packet:
Accepted: Declined:
Date:

Participant Contact Information

Center: Lambert House **Address**: 2600 SE 170th Ave, Portland OR 97236 **Phone**: (503) 760-2075
Fax: (503) 760-2192

Client Information

Name: **DOB:** **Age:** **Gender:** **Marital Status:**

Address: **City:** **State:** **Zip:**

Phone: **Email:** **Referral Source:**

Immigrant: ☐ Yes ☐ No **Veteran:** ☐ Yes ☐ No **Living Situation:**

Ethnicity: **Language(s):** **Religious Preference:**

Transportation

Caregiver: ☐ **Tri-Met Lift:** ☐ **Medical Transportation:** ☐ **Other:**

Visitors At The Center:

Is there anyone that should NOT visit the participant at the center? ☐ Yes ☐ No **If "Yes", please list and explain.**

Case Management Information

Case Manager: **Phone:**

Email: **Fax:**

Emergency Contact Information

Primary: **Phone:** **Cell:** **Email:**

Relation: **Address:** **City:** **State:** **Zip:**

Secondary: **Phone:** **Cell:** **Email:**

Relation: **Address:** **City:** **State:** **Zip:**

Physician Contact Information

Primary: **Phone:** **Fax:** **Email:**

Address: **City:** **State:** **Zip:**

Secondary: **Phone:** **Fax:** **Email:**

Address: **City:** **State:** **Zip:**

Participant's Health Insurance: **Participant's Hospital Preference:**

Billing Information

Billing Method(s): Private Pay: ☐ **Medicaid:** ☐ **VA:** ☐ **OPI:** ☐ Other: ☐

Responsible Billing Party: **Relationship:** **Phone:**

Address: **City:** **State:** **Zip:**

Prime or ID #: **VA#:** **Medicaid Branch #:**

Authorized # of Days:

Participant Health Information

Advanced Directives

Does the participant have a **POLST** (or other advanced planning document)? ☐ Yes ☐ No

Other Health Care Professionals

Physician: **Phone:** **Fax:** **Specialty:**

Address: **City:** **State:** **Zip:**

Physician: **Phone:** **Fax:** **Specialty:**

Address: **City:** **State:** **Zip:**

Physician: **Phone:** **Fax:** **Specialty:**

Address: **City:** **State:** **Zip:**

Diagnosis and Health Concerns

(Please mark with an "X" for diagnosis or "M" if medications are taken)

___ **Dementia**	___ **Diabetes**	___ **Dizziness**	___ **Cancer** _____
___ **Hypertension**	___ **Stroke**	___ **Thyroid Problem(s)**	___ **Mental Health** _____
___ **Arthritis**	___ **Heart Disease**	___ **Parkinson's**	___ **Allergies** (Please list any food, drug, animal, or other allergy below)
___ **Seizures**	___ **Osteoporosis**	___ **Alcohol/Drug Abuse**	_____
___ **COPD**	___ **Skin Problems**	___ **Respiratory Issues**	_____

___ **Other Concerns:**

Does Participant smoke? ☐ Yes ☐ No **Can they smoke safely and independently?** ☐ Yes ☐ No

Did they smoke in the past? ☐ Yes ☐ No **How Long?** **When did they quit?**

Sensory & Communication

Vision: ☐ Good ☐ Fair ☐ Poor ☐ Blind **Glasses:** ☐ Yes ☐ No

Concerns:

Hearing: ☐ Good ☐ Fair ☐ Poor ☐ Deaf **Hearing Aide:** ☐ Yes ☐ No

Concerns:

How well can the participant comprehend others?

Can they communicate their needs?

Dining Needs *(*Please note: family must provide food for special diets such as vegan, kosher, gluten-free, etc)*

Eats Independelty: ☐ Yes ☐ No **If "No", needs:** ☐ Cues ☐ Prompts ☐ 1 on 1

Diet (Check all that apply) ☐ Regular ☐ Diabetic ☐ Vegetarian ☐ Vegan* ☐ Kosher* ☐ Gluten-Free*

☐ Soft ☐ Puree ☐ Pre-cut ☐ Small Portion ☐ Other (Write below)

Ensure or other supplements? ☐ Yes (*Must be supplied by family*) ☐ No

If Yes, please specify:

Fluid Restrictions: ☐ Yes ☐ No **If "Yes", please explain:**

Needs Thick Liquids? ☐ Yes ☐ No **At Risk for Dehydration?** ☐ Yes ☐ No

Special Instructions, if any:

Participant Health Information

Mobility *(Please check all that apply)*

☐ Independent ☐ Stand-by assist ☐ W/C ☐ Walker ☐ Cane ☐ Quad cane ☐ Fall risk

Does participant have an exercise program? ☐ Yes ☐ No

Transfer Assistance *(Please check all that apply)*

☐ Independent ☐ Stand-by assist ☐ Needs cueing ☐ 1 person assist ☐ 2 person assist

Comments:

Sleep

Does participant need to nap at the center? ☐ Yes ☐ No **If "Yes", how long?**

Sleep pattern: ☐ Good ☐ Fair ☐ Poor **Describe any problems/concerns:**

Wandering/Confusion

Does participant try to leave regularly? ☐ Yes ☐ No

Redirection techniques you find helpful:

Are there any of the following behaviors related to confusion that we should know about?

☐ Anxiety ☐ Physical Outbursts ☐ Verbal Outbursts ☐ Hallucinations ☐ Delusions

If so, please explain:

Restrooming

Toileting: ☐ Independent ☐ Needs to be shown bathroom ☐ Wears pads
☐ has/needs toileting schedule ☐ Needs assistance in bathroom ☐ Needs Reminder

Bladder: ☐ Uncontrolled bladder incontinence ☐ Catheter ☐ Frequent UTIs

Bowel: ☐ Frequent bowel incontinence ☐ Constipation ☐ Colostomy (must be self-maintaining)
☐ Frequent diarrhea Known causes of diarrhea?:

Please describe the assistance needed or any concerns regarding toileting:

Additional Services *(Please select any services that you'd like the participant to receive)*

☐ Wander Tag
☐ Nail care
☐ Foot care*
☐ Shower (w/assistance)*
☐ Assistive Dining
☐ Blood sugar testing (if diabetic)
☐ Insulin injection
☐ Blood pressure monitoring
☐ Weight monitoring
☐ UTI Screening/Testing
☐ Nurse consultation
☐ Medication administration
☐ Functional maintenance therapy
☐ Caregiver support group

Fee for service

I have reviewed the information on this form, and to the best of my knowledge, it is accurate.

X

Participant/Caregiver signature Date

Volunteers of America Permissions

Authorization for Emergency Medical Treatment

Please read the Emergency Medical Treatment Policy before signing.

If the participant is found to be pulseless and not breathing:

☐ Day center staff has permission to perform CPR until EMS personnell arrive or the participant begins to breath on his/her own.

☐ The participant has/will submit a POLST or DNR that shows he/she does not want to be resuscitated. Staff should honor these orders.

Note: This form alone cannot act as a POLST or DNR order. The day center must have current POLST or DNR orders on file upon enrollment in order to honor the participant's wish to deny resuscitation. If the day center does not have these documents on file, staff WILL start CPR if the participant is found to be pulseless and not breathing until EMS personnel arrive or the participant begins breathing on his/her own.

Urine Dip Screening Permission

If the day center staff suspects that the participant may have a urinary tract infection, the day center RN or designee:

☐ has permission to collect urine fromhim/her and do a urine dip screening for a UTI.

☐ does **not** have permission to collect urine fromhim/her and do a urine dip screening for a UTI.

Media Release Permission

Occasionally, Volunteers of America Oregon may use photos and/or video footage of participants for advertising purposes. This includes, but is not limited to: TV/radio, internet ads, brochures, newsletters, and social media (Facebook, Twitter, etc). This authorization may be revoked at any time.

☐ I allow Volunteers of America to take photographs and/or video footage for the reasons state above.

☐ I **do not** allow Volunteers of America to take photographs and/or video footage for the reasons state above.

Outings Permission

Approximately once a month the day center will go on an outing. It can either be a scenic drive or a trip to a local attraction that may require getting off the bus. Every outing will be adequately staffed with day center staff and volunteers as needed to meet the needs of the clients attending. Participation in these trips is strictly voluntary. The day center also reserves the right to decline taking a client for reason including, but not limited to: medical needs, potential wandering, behavioral issues, excessive incontinence issues, limited space, etc.

_____

Participant name

☐ may participate in outings offered by the day center.

☐ may **not** participate in outings offered by the day center.

Policies and Procedures Review

Attached to this intake packet are the following VOA policies: "**Services, Eligibility, Payment, and Billing Agreement**", "**Participant Rights**", "**Emergency Medical Treatment Policy and Procedures**", and the "**Notice of Privacy Practices**". Please take a moment to review the policies and then sign below.

The day center has provided me copies of the policies listed above. I have read and understand the policies and procedures set forth by VOA and the day center.

_____ _____

Participant Name *Family/Care Giver Name*

_____ _____

Participant/Care Giver Signature *Date*

Volunteers of America Oregon
Adult Day Services
Authorization for Release of Information

Participant name: _____ DOB: _____

I hereby authorize _____
Name of physician, LPN, therapist, medical professional, etc

_____
Address City State Zip

_____ _____
Telephone Number Fax Number

To Disclose To and Receive From: Volunteers of America Oregon Adult Day Services Programs.

- ☐ Marie Smith Adult Day Center: 4616 N. Albina Street, Portland, OR 97217 fax: 503-335-0993
- ☐ Lambert House Adult Day Center: 2600 SE 170th, Portland, OR 97236 fax: 503-760-2192

The following information from my records (mark all sections below "yes" or "no"):

Yes	No		Yes	No	
☐	☐	Admission	☐	☐	Lab work
☐	☐	Insurance/billing	☐	☐	Discharge information
☐	☐	Nursing assessment	☐	☐	Care plan information
☐	☐	Medication list	☐	☐	Case management notes
☐	☐	Diagnosis	☐	☐	Other: _____

The purpose of the exchange or disclosure of information is to (mark all sections below):

Yes	No		Yes	No	
☐	☐	Plan treatment/services	☐	☐	Facilitate on-going treatment/services
☐	☐	Summarized treatment	☐	☐	Coordinate discharge

Other (specify)_____

Volunteers of America Oregon cannot condition treatment, enrollment or eligibility if the above named person refuses to sign this form.
I understand that this consent is subject to my revocation at any time except to the extent that action as already been taken as a result of my signed agreement. Unless I revoke my consent, this agreement will remain in effect for 90 days from the date of my discharge. Once we disclose the information it may no longer be protected by Federal HIPAA privacy laws.

_____ _____
Signature Date

_____ _____
VOAOR Adult Day Services Representative/Witness Date

Revocation: I do hereby revoke my agreement to release or exchange any and all of the aforementioned information signified on this document. Volunteers of America Oregon will not withhold treatment or services for refusal to sign this form.

_____ _____
Signature Date

_____ _____
VOAOR Adult Day Services Representative/Witness Date

Volunteers of America Oregon
Adult Day Services
SERVICES, ELIGIBILITY,
PAYMENT AND BILLING AGREEMENT

Updated 4/11/13

SERVICE AND ELIGIBILITY: The Volunteers of America Oregon Adult Day Service programs provide personal care support, restorative therapies, and recreational programming in a safe, professional, culturally sensitive and welcoming environment. Participants are admitted to the program without regard to race, color, religion, national origin, sources of income, ancestry, sexual orientation, gender, age, disability, marital or family status.

Our Adult Day Programs are group-based and provide a staffing ratio appropriate for the level of care required by our participants. In order to provide quality services at the Adult Day Programs, the following criteria are used for admitting and maintain participants in the programs:

1) Age 18 or older, with a focus on older adults with disabilities
2) Need on-going support services and daily supervision and/or activities to remain as independent as possible.
3) If incontinent of bowel or bladder, is managed with adult incontinence pads and toilet scheduling.
4) Safe wandering (not constantly exit seeking; respond to redirection).
5) Can feed themselves independently or with adaptive devices, cuing/prompts or needs minimal feeding assistance that can be managed within the Adult Day Center.
6) Not a danger to themselves or others.
7) Do not exhibit behavior that would be disruptive to the activities of the program.
8) Can bear weight and transfer with one-person transfer assistance or can bear some weight and needs two person transfer assistance. If the person cannot bear weight, an assessment (PT or OT) may need to be done (coordinated by the family) to determine if the person can be appropriately served at the Adult Day Center. The results of the assessment will be reviewed by the interdisciplinary care team at the Adult Day Center to determine eligibility for admission or for continuation of care at the Center.
9) The following list of medical therapies, including, but not limited to: colostomy, insulin injections etc, could limit or eliminate participation within the program. These situations will be reviewed by the interdisciplinary care team at the Adult Day Center to determine eligibility for admission or for continuation of care at the Center.
10) Use of an electric wheelchair while at the center only at Program Director and/or Program Supervisor/Case Manager's discretion.
11) Lambert House is a smoke free environment. Participants are not allowed to smoke during their visits to the center.

NEGOTIATED RISK: There are times when a client's special needs do not fall exactly into our programs' parameters or when a client may want to engage in activity that may be more than likely to cause harm to them than the alternative preferred by the program. In those circumstances, there may be special accommodations that can be made in the Adult Day Center that would allow the client to still receive the benefit of participating in the program. In those instances, the program's interdisciplinary team and the client and/or their designee may come to an understanding of what this special need is, will discuss the risks involved in having the person attend the program in spite of this risk and will discuss how this risk shall be managed within the context of the Adult Day Center.

REASONS FOR DISCHARGE FROM THE PROGRAM: A participant may be discontinued 1) if he or she no longer meets the above criteria, 2) if the individual's care can no longer be adequately met by the day program's staff. If it is determined by staff that a participant has declined below the eligibility criteria and can no longer be served by the program, a meeting will be offered with all concerned parties and the participant and/or the primary caregiver to plan for care. Ongoing communication will take place between the caregiver and the Adult Day staff regarding participant care. The staff will work with the caregiver and the participant to coordinate transition to another program or care setting whenever possible and every effort will be made to create a situation in which a participant can continue his/her participation in the adult day program until alternative care can be arranged. No advance notice is needed for families to discontinue services.

ILL OR INFECTIOUS PARTICIPANTS: Participants who are ill, infectious, vomiting, running a fever, have diarrhea or a urinary tract infection should not attend the Adult Day Center until they have been well for at least 24 hours. Participants who come to the center with any of the above ailments may be sent home at the discretion for the Adult Day Services RN and interdisciplinary team.

NOTICE OF CANCELLATION OF A SCHEDULED DAY: Caregivers are asked to call when the person they provide care for will not be attending a regularly scheduled day at the center. We encourage our participants to schedule make-up days within the month.

ENROLLMENT FEE: A one-time, non-refundable fee of $75 (for Private pay enrollees) is due on or before the intake/enrollment day.

LATE PICK-UPS: Please be on time to pick up the person you provide care for. Please contact staff if you will be picking up your loved one later than arranged. Caregivers picking up a participant *past closing time* will be charged $3.00 for every minute they arrive late past closing time, regardless of the cause of lateness. (5:30 pm Monday through Friday). Caregivers will NOT be charged for late Medical Transportation or Tri-Met Lift rides.

RESPONSIBILITY TO REPORT ABUSE: Adult Day Services staff are Mandatory Reporters and are obligated under Oregon law, as are all senior services providers, to report suspected or potential abuse to Adult Protective Services offices.

MEDICATIONS: If the person you provide care for will be taking medications while at the Adult Day Center we ask that you provide at least two weeks of medications in the following manner:

- Each medication in original prescription bottle or bubble pack.
- Over the counter medications or medications taken "as needed " (Tylenol, Imodium etc) must be in an original bottle marked with the participant's name.

If the above instructions are not followed, Med. Staff will not being able to administer medications at the center. Caregivers will be notified if medication cannot be administered due to insufficient information or improper packaging of the medication(s).

UPDATE OF INFORMATION: In order for us to provide quality care we must be informed of changes in the participant's contact information and health information. Please notify the Adult Day staff if there is a change in the participant's DNR/Advanced Directive status, medications, physician, emergency contact numbers, primary caregiver's contact information, diagnosis, health condition, diet, etc.

LOST OR STOLEN ITEMS: Because we serve a large number of participants that have memory loss and because we are a congregate program, Volunteers of America Oregon cannot take responsibility for lost or stolen items. We will make every effort to keep our participants' items safe and keep track of them, however please do not send the participant to the center with valuables, large amounts of money or irreplaceable items. Clothing, equipment, personal care supplies including but limited to wheelchairs, hearing aides, glasses, incontinence supplies, clothing, purses etc should be properly labeled.

Go on to the next page ➪

Services at the Adult Day Center

- Health Related Services
    - Nutritional services via our snacks and noon meal, which are USDA approved
    - Medical services via our RN on staff, CNA team and medication program
    - Education on health issues with support from our RN
    - Personal care as needed provided by our direct care team
- Therapeutic Activity Services
    - Exercise and/or yoga classes adapted to the needs and ability level of our participants
    - Monthly activity calendar developed with a variety of cognitive and physical activities to challenge, stimulate, enhance and encourage our participants.
    - Music Therapy, Art Therapy and Horticultural Therapy may be available based on contracts with professionals in these fields. See activity calendar for scheduling.
    - Relationships with a variety of community resources, volunteers, schools and social groups enhance our activity program to incorporate holiday celebrations, cultural celebrations, special events, outings, presentations and performances.
- Rehabilitation Services
    - We currently do not provide for, have contracts with or make referrals to providers of physical therapy, occupational therapy or speech-language pathology. Our RN is available to answer questions or help you as appropriate in these areas; however it is the responsibility of the family to make arrangements as needed for these therapies.
- Social Services
    - The Adult Day Center's Case Manager and RN will work with the participant and their family and assist them as needed and as appropriate with issues of stress, transition, decision making, community resources, grief and loss.
    - As funding is available we may offer support group services and education/training for family caregivers and access to a Licensed Clinical Social Worker. Please ask the Case Manager at the Adult Day Center for details about this program and if/when it is currently being offered.
- Transportation Services
    - The Adult Day Centers do not provide transportation to or from the centers. We do work with community transportation programs including Ride Connection, Medical Transportation, Tri-Met Lift and other agencies that provide transportation. The Case Manager of the Adult Day Center is a resource and will assist with setting up rides to and from the Adult Day Center. Family members or Caregivers are ultimately responsible for establishing transportation.

Volunteers of America Oregon
Adult Day Services

PARTICIPANT RIGHTS

1. The RIGHT to be treated as an individual with respect and dignity.

2. The RIGHT to participate in a program that promotes positive self-esteem and focuses on your strengths.

3. The RIGHT to participate in a program designed to encourage learning, growth, and development of one's talents, interests and capabilities.

4. The RIGHT to be encouraged and supported in maintaining one's independence to the extent that is safe and conditions and circumstances permit.

5. The RIGHT to self-determination within the day center setting, including the opportunity to:
   - Participate in developing your own plan of care
   - Decide whether or not to participate in any given activity
   - Be involved, to the extent possible, in programming and operation of the Adult Day Center

6. The RIGHT to privacy and confidentiality.
   - The Health Insurance Portability and Accountability Act (HIPAA) is a 1996 federal law to ensure the client's right to have health information kept private and confidential. This includes information about behavioral, medical and physical conditions. The HIPAA Privacy Rules governs who has access to an individual's health information, how that information is kept private and how individuals can access their own information.
   - The RIGHT to receive written notice regarding VOA's privacy practices.
   - The RIGHT to receive confidential communication in an alternate location.
   - The RIGHT to access one's own health record to inspect and copy.
   - The RIGHT to have all consents and authorizations and requests for records to be documented in chart notes.
   - The RIGHT to object to certain disclosures of information including generalized information.

7. The RIGHT to be cared for in an atmosphere of sincere interest and concern where needed support and services are provided.

8. The RIGHT that you will not be discriminated against because of race, color, national origin, sex, religion, age, sexual orientation, handicap, or marital status.

COMPLAINT PROCESS

If you or your caregiver feel any of the above-listed RIGHTS have been violated, please contact Volunteers of America Oregon's (VOA) Senior Services Division Director at (503) 235-8655. You will receive a response to your call within two working days. Your action of raising a complaint will not result in retaliation or barriers to services at our Adult Day Centers.

A VOA OR Representative will help problem solve and provide ongoing feedback to resolve the issue in a reasonable timeframe appropriate to the severity of the issue in a matter that is understandable to the complainant. You may request that an advocate be present while you problem solve with the VOA OR representative or are given feedback. If you need other assistance to work with the VOA OR representative, you may indicate that and the VOA OR representative will do his/her best to make accommodations or will let you know if the accommodation cannot be made.

A written response shall be provided to you regarding the actions that have been or that will be taken, if any, to address the complaint. This written response will be provided to you within 5 working days of problem solving with the VOA OR representative.

If you are not satisfied after contacting the Division Director, the problem solving process or with the outcome of the issue, you may contact Volunteers of America Oregon's Director of Finance/HR or CEO at (503) 235-8655.

If you are still concerned or have questions, please contact Aging and Disability Services at (503) 988-3646 or the Oregon Department of Education at (503) 378-3579.

If you feel that your records/chart/protected health information are not correct you may request that Volunteers of America Oregon Adult Day Services amend the records. (See "Request to Amend Records" form)

The Division Director of Senior Services and Program Director of the Adult Day Centers will conduct an annual review of any complaints or grievances in June. The review process will identify trends in the complaints and areas needing performance improvement.

Volunteers of America Oregon
Adult Day Services

Emergency Medical Treatment Policy and Procedures

Effective September 3, 2002

If a participant becomes ill, injured or loses consciousness at one of our Adult Day Center (ADC), the staff will provide care and comfort appropriate to the situation and seek assistance. If deemed necessary, the staff will call 911 for Emergency Medical Services (EMS) and will provide basic first aid and monitoring of pulse, respiration, and blood pressure until EMS personnel arrive. Participant's family, Attorney-in-Fact/Power of Attorney for Health Care (PAHC)/Durable Power of Attorney for Health Care (DPAHC), hereinafter referred to as *person responsible for care*, will be notified immediately. When EMS personnel arrive, staff will give the EMS personnel medical information from the participant's chart, including Physician Orders for Life-Sustaining Treatment (POLST) or Do Not Resuscitate (DNR) order, if available.

> **POLST** is an order written by a physician which was developed to document and communicate patient treatment preferences across treatment settings
> **DNR** is an order written by a physician stating that, in the event of cardiopulmonary arrest, cardiopulmonary resuscitation will not be administered. DNR orders apply only if the patient is pulseless and not breathing.

If a participant has no pulse and is not breathing, staff will call 911, alert other team members of the situation and take first aid measures appropriate to the situation. The participant's *person responsible for care* will be notified immediately.

- If the participant is identified by having a pink sticker on his/her name tag that there is a POLST or DNR on file at ADC that states they <u>do not</u> want to be resuscitated then staff **<u>will not</u>** start cardiopulmonary resuscitation (CPR) and will gather medical information and emergency contact information from the participant's chart/face sheet, including "Authorization for Emergency Medical Treatment" form and any POLST/DNR information available. TWO staff members will verify the participant's POLST/DNR document (one should be the RN or program coordinator/director, if possible). If the DNR status is verified the participant's wishes will be honored and CPR **<u>will not</u>** be started.

OR

- If the participant does not have a pink sticker on his/her name tag, then staff will start CPR and will gather medical information and emergency contact information from the participant's chart/face sheet, including "Authorization for Emergency Medical Treatment" form. Staff will verify that the participant **<u>does</u>** want CPR performed by checking the "Emergency Medical Treatment" form. CPR will continue until the participant begins breathing on his/her own or until EMS personnel arrive.

When EMS personnel arrive, they will be given all medical information from the participant's chart including available POLST/DNR information. EMS personnel will take over care for the participant according to their policies.

If there is any discrepancy between documentation of DNR status, staff will err on the side of caution and CPR will be started and continue until the participant begins breathing on his/her own or until EMS personnel arrive.

Definitions:

A. Do Not Resuscitate Order (DNR): An order written by a physician stating that in the event of cardiopulmonary arrest cardiopulmonary resuscitation will not be administered. DNR orders apply only if the patient is pulseless and not breathing.
B. Health Care Instruction: A document executed by a person to indicate the person's instructions regarding health care decisions.
C. Advance Directive: A document that contains a health care instruction or a power of attorney for health care. However, this term is best used to describe those documents drafted pursuant to ORS 127.505 to 127.660,as amended.
D. Directive to Physician: A written document executed before November 4, 1993, and still in effect, directing the withholding or withdrawal of life-sustaining procedures.
E. Living Will: A document that may confirm an *Advance Directive* or *Directive to Physician* informing her/him that if the patient has a terminal illness and death is imminent, the patient would not wish to be placed on artificial life support that will only prolong the process of dying. **In general, the traditional Living Will document alone is not helpful in the out-of-hospital setting because of its multiple restrictions and lack of clarity on when it should take effect**.
F. Attorney in Fact: An adult appointed to make health care decisions for a person.
G. Power of Attorney for Health Care (PAHC): Power of attorney document executed after November 1993 that authorizes an Attorney-in-Fact to make health care decisions for a person when the person is incapable.
H. Physician Orders for Life-Sustaining Treatment (POLST): The POLST is a voluntary form written by a physician, which was developed to document and communicate patient treatment preferences across treatment settings.

1. It includes a section for documentation of DNR orders and a section communicating patient preferences for EMS care.
2. While these forms are most often used to limit care, they may also indicate that the patient wants everything medically appropriate done.
3. Read the form carefully!
4. Must be signed by a physician (MD or DO).

I. Durable Power of Attorney for Health Care (DPAHC): A *Power of Attorney* executed prior to November 4,1993 and still in effect that authorizes an Attorney-In-Fact to make health care decisions for a person when the person is incapable. When an Attorney-In-Fact speaks, it is as if the patient is expressing wishes.

Updated 6/27/07

VOLUNTEERS OF AMERICA OREGON
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions about this Notice, please contact the Volunteers of America Oregon Privacy Officer at 503-235-8655 or speak with someone in your program.

Volunteers of America Oregon provides many types of services, including health and social services, to the clients we assist. We must collect information about you to provide these services. We also create a record of the care and services you receive from us. We need this information to provide you with quality care and to comply with certain legal requirements. Volunteers of America Oregon knows that the information we collect about you and your health is private. We are required by Federal and State law to protect this information, and we are committed to protecting your privacy.

This Notice of Privacy Practices will tell you how Volunteers of America Oregon may use or disclose information about you. This Notice also describes your rights to the information we keep about you and certain obligations we have regarding the use and disclosure of your information.

Acknowledgement of Receipt of this Notice. We are required by law to give you this Notice of Privacy Practices for the information we collect and keep about you and to follow the terms of the Notice that is currently in effect. We will request that you sign a separate form acknowledging that you have received a copy of this Notice. If you choose, or are not able to sign, a staff member will sign their name and date the form. This acknowledgement will be filed with your records, and you will be provided with a copy of the form.

Changes to this Notice. Volunteers of America Oregon reserves the right to change this Notice. Any changes will apply to health information we already have about you, as well as any information we receive in the future. A current copy of this Notice will be posted at each of our covered program sites and provided to you as required by law. You may also ask for a copy of the current Notice any time you visit one of our facilities.

Other Uses of Health Information. Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us with authorization to use or disclose health information about you, you make revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made pursuant to your authorization, and that we are required to retain our records of the care that we provided to you.

❖❖❖❖❖❖

FOR SUBSTANCE ABUSE TREATMENT CLIENTS

Please note that if you are receiving substance abuse treatment services from one of our outpatient or residential substance abuse treatment programs, you are further protected from disclosure by another Federal regulation, 42 CFR Part 2, *Confidentiality of Alcohol and Drug Abuse Patient Records*. While HIPAA may permit certain types of disclosure without your prior written consent, many of those disclosures are not permitted under 42 CFR Part 2. For additional information, please speak with a staff member in your program or contact the Privacy Officer at the address listed in this material.

❖❖❖❖❖❖

Effective Date: *April 14, 2003*
Revised: *May 1, 2006*

HOW WE MAY USE & DISCLOSE INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose your health information.

- **Treatment**. We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to health care providers involved in your care. They may work at our offices or at the office of another health care provider to whom we may refer you for other treatment purposes.
- **Payment.** We may use and disclose health information about you to get payment for the health care services you receive from us. For example, we may need to provide information about health care services that you received from us in order to bill your health plan for those services.
- **Health Care Operations.** We may use and disclose health information about you in order to manage operations of our programs and activities. For example, we may use health information to review the quality of the services you receive.
- **Health-Related Service & Treatment Alternatives.** We may use and disclose health information about you to tell you about health-related services or recommend possible treatment alternatives. Please let us know if you do not wish to receive this information, or if you wish to receive this information at a different address.
- **Fundraising.** Volunteers of America Oregon is a non-profit organization, and we may use limited information for the purpose of raising funds to support or expand our programs. If you would prefer that you are not contacted, you can "opt-out" by speaking with a staff member in your program.
- **To Avoid Harm**. We may use and disclose health information about you to law enforcement when necessary to prevent a serious threat to your health or safety or the health or safety of others.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Military & Veterans.** If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs.
- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose health information about you for public health activities, such as: (1) to prevent or control disease, injury or disability; (2) to report births and deaths; (3) to report child abuse or neglect; (4) to report reactions to medications or problems with products; (5) to notify people of recalls for products they may be using; (6) to notify a person or organization required to receive information on FDA-regulated products; (7) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) to notify the appropriate government authority when we believe a client has been the victim of abuse, neglect or domestic violence, including elder abuse or neglect. We will only make this disclosure if you agree, or if we are required or authorized by law.
- **Coroners, Health Examiners, and Funeral Directors.** We may release health information to a coroner or health examiner, for example, to identify a deceased person or determine the cause of death. We may also release health information to funeral directors, as necessary, so that they can carry out their duties.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or an administrative order. We may

also disclose health information about you in response to a subpoena or other lawful process by someone else involved in a dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **As Required by Law and for Law Enforcement.** We will disclose health information about you when required or permitted by federal, state, or local law. We may also release health information if asked to do so by a law enforcement official: (1) in reporting certain injuries, as required by law, such as gunshot wounds, burns, or injuries to perpetrators of crime; (2) in response to a court order, subpoena, warrant, summons or similar process; (3) to identify or locate a suspect, fugitive, material witness, or missing person; (4) about the victim of a crime if the victim agrees to disclosure or, under certain limited circumstances, we are unable to obtain the person's agreement; (5) about a death we believe may be the result of criminal conduct; (6) about criminal conduct at our facility or programs; and (7) in emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.
- **National Security and Intelligence Activities.** We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Disclosures to Family, Friends and Others.** We may disclose information to your family or other persons involved in your medical care. You have the right to object to the sharing of this information.
- **Facility Directory.** While you are staying at one of our program facilities (except substance abuse treatment programs), we may include your name, your location in the building, and your general condition in a facility directory. We may disclose this information to those who ask for you by name or to clergy. If you prefer not to have this information included in our facility directory or given out to anyone, simply let us know.

YOUR PRIVACY RIGHTS

You have the following rights regarding the health information we maintain about you:

- **Right to See and Receive Copies of Your Records**. In most cases, you have the right to look at and/or get copies of your health and billing records (this does not include psychotherapy notes). You must make your request in writing. If you request a copy of your information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request.

  In limited circumstances, we may deny your request to see or get copies of your records. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional (chosen by Volunteers of America Oregon) will review your request and the denial.
- **Right to Receive a Paper Copy of This Notice.** You have the right to ask for a paper copy of this Notice at any time. Current copies of the Notice will also be available at all times in the client common areas where brochures and other items are made available.
- **Right to Choose How We Communicate with You**. You have the right to ask that we share information with you in a certain way or at a certain place. For example, you may ask us to send information to your work address instead of your home address. You must make this request in writing. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

- **Right to Request a Correction or Update of Your Records.** If you think there is a mistake in your records, you may ask us to change or add missing information. All requests must be limited to one page of paper and legibly handwritten or typed in at least a 10-point font size. We may deny your request if it is not in writing or does not include a reason for the request. We may also deny your request if you ask us to change information that: (1) is accurate and complete; (2) is not part of the information you are permitted to inspect and copy; (3) was not created by us, unless the person or organization that created the information is no longer able to make the change; or (4) is not part of the health information kept by or for our programs. Any changes we make to your health information will be disclosed to those with whom we disclose information, as described above.
- **Right to Get a List of Disclosures.** You have the right to ask for a list of certain disclosures of your health information that we have made. Your request must be made in writing. We are not required to account for disclosures made before April 14, 2003, or for any period longer than 6 years. The first list you request within a 12-month period will be free. Fees will be charged for the cost of providing additional lists. We will mail you a list of disclosures in paper form within 30 days of your request or notify you if we are unable to supply the list within that time period.
- **Right to Request Limits on Uses or Disclosures of Health Information.** You have the right to ask that we limit how your information is used or disclosed. You also have the right to ask that we limit the health information we disclose about you to someone who is involved in your care, such as a family member or friend. For example, you may ask us not to disclose information to your spouse about treatment you receive in our care.

  You must make the request in writing. You must tell us what information you want to limit and to whom you want the limits to apply. We are not required to agree to the restriction. You can also request that any restrictions you put in place be terminated in writing or verbally.
- **Right to File a Complaint.** You have the right to file a complaint if you do not agree with how we have used or disclosed information about you or if you feel like your Privacy Rights have been violated.

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How to Contact Volunteers of America Oregon to Review, Correct, or Limit Your Health Care Information:

You may contact the Privacy Officer for Volunteers of America Oregon at the address listed below to:

- Ask to look at or copy your records;
- Ask to limit how information about you is used or disclosed;
- Ask to cancel your written authorization;
- Ask to correct or change your records; or
- Ask for a list of the times Volunteers of America Oregon disclosed information about you.

VOLUNTEERS OF AMERICA OREGON
Attn: Privacy Officer (ph) 503-235-8655
3910 SE Stark Street (fax) 503-239-6233
Portland, OR 97214

In certain cases, Volunteers of America Oregon may deny your request to look at, copy, or change your records. If we deny your request, we will send you a letter that tells you why your request was denied and how you can ask for review of the denial.

At that time, we will also provide you with information about how to file a complaint with either Volunteers of America Oregon or with the US Department of Health & Human Services, Office for Civil Rights.

For more information about this Notice of Privacy Practices, HIPAA, or how Volunteers of America Oregon will keep your information confidential, please contact a staff member in your program or the agency Privacy Officer.

How to File a Complaint or Report a Problem:

If you do not agree with how we have used or disclosed information about you, you may contact us at the address listed below to file a complaint or report a problem. You may also file a complaint with the US Department of Health and Human Services, Office for Civil Rights, at the address listed below. The services you receive from us will not be affected by any complaints you make. In fact, Volunteers of America Oregon cannot and will not retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

To file a complaint, contact:

VOLUNTEERS OF AMERICA OREGON
Attn: Privacy Officer
3910 SE Stark Street
Portland, OR 97214
(ph) 503-235-8655
(fax) 503-239-6233

AND/OR

OFFICE FOR CIVIL RIGHTS
Medical Privacy, Complaint Division
US Dept. of Health & Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Washington, DC 20201