Client Intake Packet 1:

1. HC FORM – Client – 100. Clients Bill of Rights & Responsibilities
2. HC FORM – Client – 110. Client – Advanced Directives Notice
3. HC FORM – Client – 120. Service Interruption
4. HC FORM – Client – 140. Client Complaints & Grievances
5. HC FORM – Client – 141. Client Complaint & Grievances Form
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8. HC FORM – Client – 180. Notice of Privacy Practices

Administrative Policy and Procedure – Bill of Rights		
No. **HC FORM – Client – 100.**	Date Initiated: 07/17/2007	Date Revised/Reviewed: 08/19/2018
Title: **Client Bill of Rights Form**	WAC: 246-335-435	Date Approved: 09/01/2018

CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

As a client of First Choice In-Home Care (hereinafter referred to as First Choice) you and your family have certain rights and responsibilities that you are entitled to know before care is initiated. You have the right to have these responsibilities explained to you and to have assistance in understanding them so that you may properly exercise those rights and responsibilities.

As a client of First Choice you have the right to:

1. Receive quality services from the home care agency for services identified in the plan of care;
2. Be cared for by appropriately trained or credentialed personnel, contractors and volunteers with coordination of services;
3. A statement advising of the right to ongoing participation in the development of the plan of care;
4. A statement advising of the right to have access to the department's listing of licensed home care agencies and to select any licensee to provide care, subject to the individual's reimbursement mechanism or other relevant contractual obligations;
5. A listing of the total services offered by the home care agency and those being provided to the client;
6. Refuse specific services;
7. The name of the individual within the home care agency responsible for supervising the client's care and the manner in which that individual may be contacted;
8. Be treated with courtesy, respect, and privacy;
9. Be free from verbal, mental, sexual, and physical abuse, neglect, exploitation, and discrimination;
10. Have property treated with respect;
11. Privacy and confidentiality of personal information and health care related records;
12. Be informed of what the home care agency charges for services, to what extent payment may be expected from care insurance, public programs, or other sources, and what charges the client may be responsible for paying;
13. A fully itemized billing statement upon request, including the date of each service and the charge. Agencies providing services through a managed care plan are not required to provide itemized billing statements;

14. Be informed about advanced directives and POLST, and the agency's scope of responsibility;
15. Be informed of the agency's policies and procedures regarding the circumstances that may cause the agency to discharge a client;
16. Be informed of the agency's policies and procedures for providing back-up care when services cannot be provided as scheduled;
17. A description of the agency's process for clients and family to submit complaints to the home care agency about the services and care they are receiving and to have those complaints addressed without retaliation;
18. Be informed of the department's complaint hotline number to report complaints about the licensed agency or credentialed health care professionals; and
19. Be informed of the DSHS end harm hotline number to report suspected abuse of children or vulnerable adults.
20. The home care agency must ensure that the client rights are implemented and updated as appropriate.

First Choice In-Home Care Contact Information:

1. Telephone: 1-877-747-5090 (toll free)
2. Email: info@fcihc.com
3. Address King County: 15015 Main Street, Ste 209, Bellevue, WA 98007
4. Address Pierce County: 535 Dock Street, Ste 200, Tacoma, WA 98402

Complaint Hotlines:

1. Washington State's Complaint Department toll free Hotline telephone number (1-800-633-6828), the hours of operation (8:30am to 5:00pm Monday through Friday)

As a client of First Choice, I understand that in addition to my rights, I also have the following responsibilities:

1. To provide accurate and complete information about the type of care being requested and that all care provided is consistent with your agreed to Plan of Care.
2. To treat all First Choice employees with respect, courtesy, consideration and to accept all assigned employees regardless of their age, race, color, national origin, religion, sex, disability or any other category protected by law.
3. To maintain a safe environment for my care and to protect my valuables by storing them in an appropriate acceptable manner.
4. To arrange for all supplies, medicines and other services that First Choice does not provide but which are necessary to my care and safety.
5. To notify First Choice prior to any shift if I will not be available or wish to cancel services.

Administrative Policy and Procedure – Delivery of Services		
No. HC FORM – Client – 110.	Date Initiated: 01/07/2007	Date Reviewed/Revised: 08/26/2018
Title: Client-Advanced Directives	WAC: 246-335-420	Date Approved: 09/01/2018

Policy Statement:

The agency recognizes that all persons have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care. It is the policy of the agency to encourage individuals and their families, or client representatives to participate in decisions regarding care and treatment. Valid advance directives, such as Living Wills, Durable Powers of Attorney for Care and DNR (Do Not Resuscitate) orders will be followed to the extent permitted and required by law. In the absence of advance directives, the agency will provide appropriate palliative care and emergency procedures, including calling 911.
The agency will not condition the provision of care, or otherwise discriminate against an individual, based on whether or not the individual has executed an advance directive.

Definitions

Advance Directive: Instructions from a decisional capable individual regarding future medical treatment in the event that he or she becomes decisional incapable. An advance directive may specify medical treatment the individual consents to or refuses, designate a surrogate decision-maker, or both.

DNR: Do Not Resuscitate -- A medical order to refrain from cardiopulmonary resuscitation if a client's heart stops beating.

Palliative Care: Medical interventions intended to alleviate suffering, discomfort, and dysfunction (such as pain medication or treatment of an annoying infection), but not cure.

Surrogate Decision-Maker: A person appointed to make decisions for someone else, as in a durable power of attorney for care (also called an agent).

Procedure:

1. At the time of admission, the agency will ask the client and/or primary Home Care Aide if an advance directive has been executed by the client. If one exists, proper notation will be made in the clinical record.

2. No agency staff person is permitted to give either medical or legal advice regarding an advance directive.

3. Written information regarding the client’s rights under Washington State law to accept or refuse treatment, including the right to execute advance directives, will be made available

to clients, upon request, at the time of admission. The agency will provide updated information on changes in Washington State law concerning individual rights to make decisions about medical care within ninety (90) days from the effective date of any change in State law.

4. Each client is encouraged to participate in all aspects of decision making regarding care and treatment. Statements by a competent client of his or her desire to accept or refuse treatment will be documented in the client care record.

5. The client's Physician will be notified of any alteration in the advance directives, including both written and oral statements by the client.

6. If a client is determined to be incompetent to make decisions a surrogate decision-maker will be identified. The agency will inform the surrogate decision-maker of the plan of care and include them in decisions related to the client's care and treatment.

7. A Living Will or Durable Power of Attorney for Health Care may be revoked at any time by a client either orally or in writing. The client's Physician will be notified immediately of any revocation. Documentation will be placed in the client care record following a revocation.

8. If a client is transferred to another facility or provider, notification of an advance directive will be made to that facility or provider, and a copy of the directive will be forwarded, if available to the agency.

9. Actions to be taken when client has a signed POLTST form. Any section of the POLST form not completed implies full treatment for that section. Agency policy related to POLST form will include at minimum: **In the event of client medical emergency and agency staff present, provide emergency medical personnel with a client's signed POLST form.**

Administrative Policy and Procedure – Delivery of Services		
No. HC FORM – Client – 120.	Date Initiated: 01/07/2007	Date Reviewed/Revised: 08/27/2018
Title: Service Interruption	WAC: 246-335-420	Date Approved: 09/01/2018

POLICY:

First Choice In-Home Care staff will implement appropriate service interruption action when service interruption occurs due to circumstances that are unavoidable. Client case records must reflect service attempts, client contacts regarding absence of regularly scheduled home care aide, and notations when substitute home care aides serve the client.

PURPOSE:

1. To define the actions to be taken when a Home Care Aide is unable to make or complete a scheduled work shift.

PROCEDURE:

1. First Choice In-Home Care will include language within the Client Service Agreement to define Service Interruption. The Client Service Agreement must be signed by all clients of agency.
2. All clients will be informed that from time to time there may be an interruption of services due to circumstances that are unavoidable.
3. All clients will be informed that in the event of a service interruption, wherein, the Agency is not able to properly staff the scheduled work shift, the client and/or the parent, guardian and family members of the client agree to provide or arrange for back-up care.
4. In non-emergency situations First Choice In-Home Care will provide a Substitute Home Care Aide to the client and will be scheduled to arrive at the client's home within twenty-four (24) hours after the original Aide was scheduled, unless otherwise agreed to by the client.
    a. In the event First Choice In-Home Care is not able to properly schedule a Substitute Home Care Aide the Supervisor of Direct Care or the Home Care Manager will contact the client's DDA/AAA Case Manager to determine if other arrangements can be made to provide care to the client.

5. If the lack of immediate care would pose a serious threat to the health and welfare of the client (essential services), the Substitute Home Care Aide will be schedule by First Choice In-Home Care to begin providing personal care service to the client at the home of the client within four (4) hours after the original Aide was scheduled, unless otherwise agreed to by the client.
    a. In the event First Choice In-Home Care is not able to properly schedule a Substitute Home Care Aide the Direct Care Supervisor or the Home Care Manager will contact the client's DDA/AAA Case Manager to determine if other arrangements can be made to provide care to the client
6. All agency Home Care Aides will be instructed to contact the agency and the client to immediately and properly notify of a service interruption, wherein, the Aide is unable to attend or complete a scheduled work shift.
    A. Home Care Aides are to contact the Direct Care Supervisor or the Administrator to inform of the service interruption.
    b. Home Care Aides are to contact the client to inform of the service interruption.

NOTE: All clients will be instructed to immediately notify agency when a scheduled work shift cannot be worked by scheduled agency staff:

i. The client is to contact the agency via telephone to inform agency of the service interruption by calling the toll free telephone number at 1-877-747-5090.

ii. Once informed by the client the Direct Care Supervisor or the Home Care Manager will complete the necessary actions to assure the client's care needs are met. This is to include contacting the agency's On-Call Substitute Home Care Aides to arrange for shift coverage.

III. The Direct Care Supervisor or the Home Care Manager or Program Manager will contact client to inform the client if shift can be or cannot be properly staffed.

Administrative Policy and Procedure – Quality Improvement Program		
No. **HC FORM – Client – 140.**	Date Initiated: 07/17/2007	Date Revised/Reviewed: 08/19/2018
Title: **Client Complaints and Grievances**	WAC: 246-335-455	Date Approved: 09/01/2018

POLICY:

First Choice In-Home Care responds appropriately to all complaints by clients and their families and documents all actions taken to resolve the complaint using Form No. 141 – Client Complaint Investigation From.

PURPOSE:

1. To address individual client or family complaints and grievances.
2. To provide a means for early identification of problems.

PROCEDURE:

1. First Choice In-Home Care staff will:
   a) Listen attentively and courteously to complaints expressed by client and/or families.
   b) Seek to clarify and understand the nature of the complaint.
   c) Encourage clients and/or families to contact the agency Home Care Manager regarding complaints that cannot be resolved by agency staff.
   d) Report complaints directly to the Home Care Manager.
   e) Inform the client that they are welcome to contact the Washington State Complaints Hotline at 1-888-633-6828.
2. The Home Care Manager will:
   a) Review all client/family complaints as they are received.
   b) Clarify the complaints with appropriate staff.
   c) Discuss the complaint with the client or family to clarify their perceptions.
   d) Initiate a process to resolve the complaint.
   e) Evaluate and implement corrective actions as indicated.
   f) Report as needed to the Program Manager.
3. Problems will be reviewed within twenty-four (24) hours, or a process will be in place within forty-eight (48) hours to resolve the complaint. Program Manager may request that complaints filed by clients and/or family members be made in writing.
4. Client complaints will be documented and maintained in an administrative file.
5. Client complaints are incorporated as part of the quality assurance review process. All complaints will be placed on the complaint log.

6. Clients will be given the State complaint toll-free hotline number, when complaints and concerns cannot be resolved through the agency.
7. Clients will be informed of the agency's complaint and grievance policy and procedure at the time of admission for Home Care services.

Step	Action	Responsible Person	Approx. Time Frame
A.	Client calls in a complaint to FCIHC.	Receptionist routes to Home Care Manager or Supervisor	
B.	Supervisor or Home Care Manager calls the client within 48 hours to schedule an appointment or if the client prefers, completes complaint interview over the telephone	Home Care Manager or Supervisor	
C.	Meeting with Home Care and Supervisor scheduled, if necessary.	Home Care Manager	Scheduled for the next business day after the day complaint is called in.
D.	Meeting with client. Action to be taken at this meeting is: 1. Completion of client grievance form. 2. Written and detailed notes in the daily log sheet by Case Supervisor who is in attendance. 3. If complaint involves Home Care Aide, determine if the client wants the Home Care Aide replaced. 4. Discussion with client regarding possible plans of action.	Home Care Manager or Supervisor	During the scheduled in home visits.
E.	The Home Care Manager will develop a plan of action and communicate this plan to the Case Supervisor, Home Care Aide and client.	Home Care Manager	Within 4 business days following client visit.
F.	The Home Care Manager will send the client a copy of this plan of action.	Home Care Manager	Within 4 business days a copy is sent to client.
G.	The Home Care Manager will follow-up with the client to determine if resolution to complaint was successful.	Home Care Manager	Within 60 days.
H.	If the situation involves theft, accusations of theft, abuse, the Executive Director, AAA Case Management, Adult Protective Services, Police Dept. will be immediately informed and involved to assist.	Home Care Manager Program Manager	If this occurs, immediate actions will be taken.
I.	All formal complaints must be communicated to Executive Director.		

First Choice In-Home Care		
Administrative Policy and Procedure - FORMS		
No. HC FORM – Client - 141	Date Initiated: 01/17/2007	Date Revised/Reviewed: 08/27/2018
Title: Client Complaint Form	Per: WAC 246-335-455	Date Approved: 09/01/2018

Fax completed form to 425-562-2537 or mail to 15015 Main St. STE 209, Bellevue, WA 98007

Date of Complaint Time	AM PM	Date Reported	Reported by
Client Name		Age	Sex ☐ M ☐ F
Client Address			City/Zip
Is Complaint related to a Home Care Aide providing services to the Client? YES NO			
Is Complaint related to the Administrative Staff at First Choice? YES NO			

Name of person making Complaint:
Please Describe the Nature of your Complaint:

Date Compliant Investigated:
Name of Supervisor completing investigation:
Outcome of Investigation:

First Choice In-Home Care		
Administrative Policy and Procedure - FORMS		
No. HC FORM – Client - 141	Date Initiated: 01/17/2007	Date Revised/Reviewed: 08/27/2018
Title: Client Complaint Form	Per: WAC 246-335-455	Date Approved: 09/01/2018

Please identify all Corrective Actions taken:

Identify all monitoring of Corrective Actions required (if applicable):

Identify Agency evaluation of the Corrective Actions taken (if applicable):

Date Complaint Resolved:

Supervisor Name: _____ Date: _____

Supervisor Signature: _____

Administrative Policy and Procedure – Delivery of Services		
No. HC FORM – Client – 150.	Date Initiated: 01/07/2007	Date Reviewed/Revised: 08/27/2018
Title: Auto Release of Liability	WAC: Agency Policy	Date Approved: 09/01/2018

I understand that I may ask my caregiver to drive me/ and may ask that they use my car. I hereby give consent for my caregiver, an employee of First Choice In-Home Care to drive my car for services related to my care.

I understand and agree that First Choice In-Home Care and its affiliates are not responsible in the event there is an accident which involves my car, injury to its occupants, property damage or bodily injury to others. I also understand that any injuries I personally sustain during the use of my car will be covered by my insurance and not First Choice In-Home Care.

I Certify that the vehicle described below is properly licensed, registered, inspected and in safe and usable condition and that insurance is carried on it in accordance with applicable legal requirements of the State of Washington.

PLEASE ATTACH COPY OF YOUR CURRENT AUTO INSURANCE CARD

Year, Make and Model of Client's Automobile:	
License Plate No.	
Name of Auto Insurance Company:	
Auto Insurance Policy Number:	
Expiration Date of Auto Insurance:	
Name of Individual Insured:	
Please Identify Auto Insurance Policy Limits:	

CLIENT/PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

FOR OFFICE USE ONLY

VERIFIED BY:_____ TITLE: _____

DATE: _____

Administrative Policy and Procedure – Delivery of Services		
No. HC FORM – Client – 160.	Date Initiated: 01/07/2007	Date Reviewed/Revised: 08/27/2019
Title: Electronic Timekeeping Notice	WAC: Agency Policy	Date Approved: 09/01/2019

Electronic Timekeeping Notice:

First Choice In-Home Care utilizes an electronic timekeeping system which is required by Washington State's Department of Social and Health Services that is referred to as "electronic visit verification" or EVV. Our EVV system is HIPAA (*Health Insurance Portability and Accountability Act*) compliant, meaning that your personal information, including but not limited to, name, age, address, telephone and medical and non-medical data cannot be shared.

The EVV system accurately tracks the time that our assigned Homecare Aide spends with you during their schedule work shifts and allows for the recording of completed tasks and captures signature approvals from our Homecare Aide and the client or client's representative.

The use of this technology helps us provide you with a greater degree of customer service alerting us when your Homecare Aide is off schedule for any reason. Our Case Managers are then able to work directly with you to resolve any rescheduling needs immediately.

As required by Washington State Regulation, we wanted to make sure that you were aware of our required use of this technology.

First Choice In-Home Care		
Administrative Policy and Procedure - FORMS		
No. **HC FORM – Client – 180.**	Date Initiated: 07/17/2007	Date Revised/Reviewed: 08/25/2018
Title: **Notice of Privacy Practices**	Per: HIPA	Date Approved: 09/01/2018

Health Insurance Portability &
Accountability Act (HIPAA) Compliance Plan

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.

This Notice of Privacy Practices describes how First Choice In-Home Care (FCIHC) may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and comparable health care services.

First Choice In-Home Care (FCIHC) is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by: calling the office and requesting that a revised copy be sent to you in the mail; or asking for one at the time of your next appointment.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You will be asked to sign an acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your services will in no way depend on your signed acknowledgment. If you decline to sign an acknowledgment, we will continue to provide our services. We can and will also use and disclose your protected health information for provision, payment, and reporting of services, when necessary.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following are examples of permitted uses and disclosures of your protected health care information. These examples are not meant to be exhaustive.

Required Uses and Disclosures: By law, we must make disclosures to you unless it has been determined by a competent medical authority that it would be harmful to you. We

must also disclose health information when required by the Department of Social and Health Services in the State of Washington to investigate or determine our compliance with the requirements.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to an insurance company that pays for services provided to you. We will also disclose protected health information to other associates who may be involved in providing your services.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that FCIHC might undertake for health care services we provide for you such as: making a determination of eligibility or coverage; reviewing services provided to you for medical necessity; and undertaking utilization review activities. For example, your protected health information might be disclosed to a business associate to arrange payment for respite services.

Healthcare Operations: We may use or disclose, as-needed, your protected health information to support the daily activities related to healthcare. These activities include, but are not limited to: quality assessment activities; investigations; communications about a service; conducting or arranging for other healthcare related activities; and care coordination.

We will share your protected health information with third party business associates that perform various activities for FCIHC. The business associates will also be required to protect your health information.

We may use or disclose your protected health information, as necessary, to provide you with appointment reminders or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about our nonprofit organization and the services we offer.

Others Involved in Your Healthcare: We may disclose to a family member, caregiver, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person who is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. If there is a family member, other relative or close friend to whom you do not want

us to disclose your protected health information, please notify First Choice In-Home Care.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your protected health information to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. First Choice In-Home Care may disclose your protected health information, if authorized by law, to a person, who may have been exposed to a communicable disease, or may otherwise be at risk of contracting or spreading the disease or condition. In addition, we may disclose your protected health information, if we believe that you have been a victim of abuse, neglect or domestic violence, to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Health Oversight: First Choice In-Home Care may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies, seeking this information, include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and/or in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may disclose protected health information for law enforcement purposes. These law enforcement purposes include: (1) legal processes required by law; (2) information requests for identification and location purposes; (3) issues pertaining to victims of a crime; (4) suspicion that death has occurred as a result of criminal conduct; and (5) in the event, that a crime occurs on the premises of FCIHC.

Research: We may disclose your protected health information to researchers when their study has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to

prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, First Choice In-Home Care may use or disclose protected health information of individuals who are Armed Forces Personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

YOUR RIGHTS REGARDING YOUR

PROTECTED HEALTH INFORMATION

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in your client record for as long as we maintain the data. A client record contains medical, financial and service information and any other information necessary to provide services to you.

Under certain circumstances, such as protected health information that is subject to law prohibiting access, you may be denied access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your client record.

You have the right to request a restriction of your protected health information. This means you may ask First Choice In-Home Care not to use or disclose any part of your protected health information. We will consider all requests for restrictions carefully, but are not required to agree to any restrictions.

You must request a restriction in writing to the FCIHC Privacy Contact. In your request, you must tell us: (1) what information you want restricted; (2) whether you want us to restrict our use, disclosure, or both; (3) to whom you want the restriction to apply, for

example, disclosure to family members or friends who may be involved in your care; and (4) an expiration date.

If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If FCIHC does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You may revoke a previously agreed upon restriction, in writing, at any time.

You have the right to request confidential communications. We will accommodate reasonable requests. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have us amend your protected health information. If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 1, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this information electronically. To obtain a paper copy, send your written request to First Choice In-Home Care Administrator.

COMPLAINTS

You may complain to First Choice In-Home Care or to the Department of Social and Health Services or the Department of Health in the State of Washington if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Administrator of your complaint. We will not retaliate against you for filing a complaint.

CONTACT INFORMATION

You may contact First Choice In-Home Care Administrator for further information about the complaint process, or for further explanation of this document at:

First Choice In-Home Care
15015 Main Street, Suite 209
Bellevue, WA 98007
Phone: (425) 747-5000
Fax: (425) 562-2537

This notice was published and became effective on February 26, 2009.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by First Choice In-Home Care (FCIHC) for the purpose of making referrals on my behalf, carry out treatment to me, or obtaining payment for my health care bills. I understand that referrals or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to make referrals, carry out treatment, or payment. FCIHC is not required to agree to the restrictions that I may request. However, FCIHC agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that FCIHC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by FCIHC or another aging network provider. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review FCIHC's Notice of Privacy Practices prior to signing this document. First Choice In-Home Care's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of FCIHC. This Notice of Privacy Practices also describes my rights and FCIHC's duties with respect to my protected health information.

First Choice In-Home Care		
Administrative Policy and Procedure - FORMS		
No. **HC FORM – Client – 180.**	Date Initiated: 07/17/2007	Date Revised/Reviewed: 08/25/2018
Title: **Notice of Privacy Practices**	Per: HIPA	Date Approved: 09/01/2018

First Choice In-Home Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Contact Person: First Choice In-Home Care has a designated **Privacy Officer** as its contact person for all issues regarding patient privacy and your rights under Federal privacy standards.

If you have any questions regarding this notice, please contact:
Michael Howard, Executive Director, Privacy Officer
First Choice In-Home Care
15015 Main Street, Suite 209
Bellevue, WA 98007
Phone: 425-747-5000 Fax: 425-562-2537 Email: MHoward@fcihc.com