HIPAA Release Authorization

I,_____, hereby authorize my physicians, nurses, home care agency, and all other health care providers and their staff (collectively, "health care providers") involved in my health care treatment, to release information regarding my location, medical condition, diagnosis and prognosis, as well as any other information about me, to include individually identifiable health information, and to freely converse and communicate, both orally and in writing, with the persons named below.

This document does not grant health care decision-making authority and does not in any way affect, inhibit, or otherwise limit the authorization granted in any existing health care power of attorney that I may have executed.

This document, executed by me pursuant to the Health Insurance Portability and Accountability Act of 1996, is effective immediately and is not to be affected by any subsequent incapacity.

I hereby release the disclosers of the above information from any liability for its release to the persons below. This authorization shall be in force and effect only for a period of one year from the date signed, below. The persons to whom my health care providers may disclose the above information, including individually identifiable health information, are:

The PA Foundation for Home Care and Hospice
and any of its employees or representatives
600 N. 12th Street, Suite 200, Lemoyne, PA 17043
Phone: 717-975-9448

AND

Name: _____ Phone:_____

Address: _____

AND

Name: _____ Phone:_____

Address: _____

_____ _____

Client/Representative Signature **Date**

_____ _____

Witness Signature **Witness Printed Name**

Financial Affidavit

Date: _____

County: _____

State: _____

Client/Affiant (Full Legal Name): _____

I, the undersigned,_____, who is a resident of

_____County, State of_____, makes this

his/her statement and General Affidavit upon oath and affirmation of belief and personal knowledge that the following matters, facts and things set forth are true and correct to the best of his/her knowledge: I certify that_____, the applicant for home health care services, has a total personal monthly income that does not exceed $5,000 (single) or $10,000 (dual income, including spouse/partner, excluding any child income*),in accordance with the guidelines and service criteria defined by the Pennsylvania Foundation for Home Care and Hospice's Home Care Grant program. Furthermore, I certify that the applicant for home health care services is not currently receiving similar services through a Pennsylvania Medicaid Waiver Program nor is the applicant a veteran receiving similar services through the VeteransAffairs'Aide and Assistance Program or similar program.

_____ _____

Client/POA Signature **Date**

_____ _____

Witness Signature **Witness Printed Name**

PENNSYLVANIA FOUNDATION FOR HOME CARE AND HOSPICE

Home Care Grant

Client Information and Care Plan

Client Demographics

Name_____ Phone_____ DOB_____

Address_____

Emergency Contact_____ Relationship_____

Email_____ Phone_____

PCP Name_____ Phone_____

Planned Frequency of In-Home Care Services

(subject to change by customer request)

Care to be delivered in increments of_____ hours per_____ *(i.e. 2 hrs/week)*

Type of Service/Care Requested

Personal Care

- ☐ Toileting
- ☐ Incontinence Care
- ☐ Bathing
- ☐ Grooming
- ☐ Lifting/Transfer Assistance
- ☐ Ambulation Assistance
- ☐ Medication Reminders

Other _____

Homemaker

- ☐ Meal Preparation
- ☐ Housekeeping
- ☐ Laundry
- ☐ Transportation

Skilled Care

- ☐ Skilled Assessment/Observation
- ☐ Medication Adherence/Management
- ☐ Disease Management
- ☐ Patient Education

Reason for Care Need

Check all that apply:

- ☐ Decline in Health Status
- ☐ Hospitalization within 30 days
- ☐ Discharge from LTCF within 30 days
- ☐ Other: _____
- ☐ Supplementing private pay services
- ☐ Waiting for funding approval or renewal through:

_____

Other Current In-Home Services

Check all that apply:

- ☐ Meals on Wheels
- ☐ Other funded skilled Home Health Care
- ☐ Other funded non-medical Home Care
- ☐ Personal Emergency Response System
- ☐ Telehealth
- ☐ Other:

Client, representative and agency must notify The Foundation immediately if another funding source for home care services becomes available while active with The Foundation's Home Care Grant.