McGregor

INTAKE/REFERRAL INFORMATION

Date: _____ Location: _____

Intake Coordinator: _____ MD: _____

SW: _____

Name: _____
First Last Middle (aka) Email Address

Address: _____
Street Apt # City Zip

Phone: _____ Date of First Visit: _____ Date of I/A: _____

Requested Enrollment Date: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: Male Female

Re-enrollment? _____ Previous Client # _____

LIVING SITUATION (circle one)

Home alone	01
Home w/ spouse/partner	02
Home w/ spouse & other relatives	03
Home w/ other relatives only	04
Home w/ non-relatives, not group home	05
Group Home	06
Independent Living Apt	07
Assisted Living Facility	08
Other	09

Do you own or rent your home? _____

Are utilities included? Yes _____ No _____

Payment Amount _____

ETHNICITY: _____

White, not Hispanic origin	1
Black, not Hispanic origin	2
Hispanic	3
Asian or Pacific Islander	4
American Indian or Alaskan Native	5
Other	6

EDUCATIONAL LEVEL _____

OF LIVING CHILDREN _____

OF CHILDREN INVOLVED IN CARE _____

MARTIAL STATUS

MARRIED/PARTNER 1

Please provide spouse/partner name:

_____

SS# _____ Birth Date: _____

WIDOWED 2

DIVORCED 3

SEPARATED 4

NEVER MARRIED 5

Place of Birth _____

Year Entered USA _____

Language: Primary _____

Other _____

English Fluency: None Little Fair Fluent

RELIGION: _____

FORMER OCCUPATION: _____

LIVING WITH: _____
Name Relationship

EMERGENCY CONTACT: _____
(must be completed) Name Address Email Address

_____
Phone Relationship

_____

INTAKE/REFERRAL INFORMATION

OTHER CONTACTS/SUPPORT SYSTEM:

____
Name Address Phone Relationship

____
Name Address Phone Relationship

DURABLE POWER OF ATTORNEY: YES / NO GUARDIAN: YES / NO

PERSON / HEATH CARE ______________________________
Name Phone

ESTATE / FINANCES ______________________________
Name Phone

Referral Source:

____
Name Agency Phone

MEDICAID # ____________________ MEDICARE # ____________________

HAVE YOU EVER APPLIED FOR MEDICAID: YES/NO
WHERE/WHEN: ____________________

ARE YOU RECEIVING ANY OTHER MEDICAID WAIVER PROGRAM?
YES/NO NAME OF PROGRAM ____________

OTHER INSURANCE: ______________________________
"Employer Group"

INCOME:	APPLICANT	SPOUSE
Social Security	________	________
Supplement Security Income (SSI/disability)	________	________
Pension/Annuity	________	________

FORMAL SERVICES CURRENT OR IN PAST YEAR

			WHO/WHERE
Adult Day Center	Yes	No	________
Senior Center	Yes	No	________
Home Care	Yes	No	________
Home Chores	Yes	No	________
Congregate/Meals on Wheels	Yes	No	________

Reasons for applying to PACE (Check all that apply):

- ☐ Socialization - attending PACE Adult Day Health Center
- ☐ Comprehensive coordinated care
- ☐ Supplemental services (audiology, dental, podiatry, vision)

INTAKE/REFERRAL INFORMATION

- ☐ Housing support –Group Home Placement
- ☐ Home-based care
- ☐ Rehabilitation services
- ☐ Team-based care
- ☐ Access to social services
- ☐ Transportation for health care
- ☐ Other _____

Primary Health Care System: ☐ CCF ☐ MH ☐ UH ☐ SVCH ☐ none

PRIMARY PHYSICIAN: _____
Name Address Phone

SPECIALTY PHYSICIAN: _____
Name Address Phone

SPECIALTY PHYSICIAN: _____
Name Address Phone

Within the last 2 YEARS, Number of:

Hospital Admissions	_____	Where	_____
Days spent in Hospital	_____		
Nursing Home Admission	_____	Where	_____
Days spent in Nursing Home	_____		
Visits to Physician/Clinic	_____		

MEDICAL PROBLEMS (Please note any active treatments or if surgery is planned in the next couple of months):

_____
_____
_____
_____
_____

SIGNIFICANT/UNUSUAL INFORMATION: (infestation with bed bugs – current or in the past)

_____
_____
_____

APS EVER HAD OPEN CASE? _____

Verify at 216-420-6700

INTAKE/REFERRAL INFORMATION

Intake Screening Questions for Level of Care

Applicant Name:		Date:	
Does the applicant require hands-on physical assistance with any of the activities of daily living below? If so who helps with these tasks currently?			
1.	Does the applicant need 24 hour supervision due to cognitive deficits? (wandering/elopement or unsafe cooking practices-cooking food on high or burning pots and pans due to leaving the stove unassisted related to forgetfulness.	Yes/ NO	Comment
2.	Who assists you with bathing? (getting in and out of the tub/shower or washing your back/feet?		
3.	Who assists you with getting dress daily? Describe how it is done if the person does it himself/herself.		
4.	a. Who assists you in the bathroom / toilet? b. Is there a bedside commode? Who empties it for you? c. Who assists you with your adult depends? Describe how it is done if you do it yourself?		
5.	Who assists you in and out of bed, a chair, car, etc.? If you do it yourself describe how you do it? (does he/she pull up on objects)		
6.	Who assists you with cooking food, eating, or preparing meals?		
7.	Who assists you with medications? (taking them, preparing to take them, picking them up from store)?		
8.	What things is the family prepared to do to keep applicant in the home? (move in, homecare, etc.)		

McGregor PACE

ENROLLMENT REQUEST & FINANCIAL AGREEMENT

I. DEMOGRAPHIC INFORMATION

A. NAME: _____

B. ADDRESS: _____

Street City State Zip code

C. DATE OF BIRTH: ____/____/_____ COUNTY: Cuyahoga SEX (circle) M / F

D. SOCIAL SECURITY #: _____-____-_____ MEDICARE/MBI #: _____-____-_____-____

E. MEDICAID #: _____ *Other Health Insurance #_____

II. I AM REQUESTING:

A. Initial enrollment with a date of: _____/____/____

B. Re-enrollment with a date of: ____/____/____

C. _____Should I not be eligible to receive Cuyahoga County ("Cuyahoga") Medicaid Benefits, I choose to not enroll at this time.

D. _____Should I not be eligible to receive Cuyahoga Medicaid Benefits, I agree to pay privately the set fee as described in Section III below.

III. Your Monthly Bill:

How much will you have to pay? Your payment each month will depend on your eligibility for Medicare and/or Medicaid and the eligibility is re-determined annually in accordance with Medicare/Medicaid guidelines.

A. If you are eligible for:

1. **Medicare and Medicaid or Medicaid only**- If you are eligible for both Medicare and Medicaid or 100% coverage with Medicaid only, your monthly share of cost payment to McGregor PACE will be determined by Medicaid and you will continue to receive all PACE services, including prescription drugs.

2. **Medicare only**- If you have Medicare and are not eligible for Medicaid, then you will pay a monthly premium to McGregor PACE in the amount of ***$3,671*** **($2,926+ $745 Medicare Part D premium)** starting on the first day of enrollment.

3. **Private Pay**- If you are not eligible for Medicare or Medicaid, you will pay a monthly premium to McGregor PACE in the amount of ***$5,506*** **($4,761+ $745 Medicare Part D premium)** starting on the first day of enrollment.

B. Instructions for making Payments to McGregor PACE - If you have to pay a monthly charge to McGregor PACE, you must pay the money by the first day of the month after you sign the Enrollment Agreement. The monthly charge then has to be paid on the first day of every month. Participants with a share of cost need to sign up for Automatic Electronic Payments (ACH). Payments can also be made by check or money order to the below address.

McGregor PACE

26310 Emery Road, Warrensville Heights, Ohio 44128

Attention: Accounts Receivable

IV. Participant/ Caregiver Understanding

A. I have received and understand the Enrollment Agreement and Participant Handbook.

B. I have been given an opportunity to ask questions.

C. I agree to participate in the McGregor PACE program and understand that my enrollment in McGregor PACE results in Disenrollment from any other Medicare and/or Medicaid prepayment plan or optional benefit.

D. My enrollment is voluntary and will be effective upon approval by the Ohio Department of Aging and I can disenroll from McGregor PACE if I want to for any reason.

E. I understand that electing enrollment in any other Medicare/Medicaid prepayment plan or optional benefit, including the Hospice benefit, after enrolling in McGregor PACE is considered a voluntary Disenrollment from McGregor PACE.

F. As a participant, I agree to receive all health and health-related services through McGregor PACE.

V. Consent

I hereby give McGregor PACE permission to disclose/exchange my personal information with CMS, its agents, State of Ohio and the Ohio Department of Aging for the purpose of determining eligibility for and/or enrollment in the PACE program.

_____ _____/____/_____

SIGNATURE OF PARTICIPANT DATE

_____ _____/____/_____

SIGNATURE OF DPOA / LEGAL GUARDIAN/ AUTHORIZED REPRESENTATIVE DATE

_____ _____/____/_____

SIGNATURE OF MCGREGOR PACE REPRESENTATIVE DATE

Ohio Department of Job and Family Services

Request for Medicaid Home and Community-Based Services (HCBS)

You must receive Medicaid to receive waiver services. If you have not applied for Medicaid or you have applied in the past but been denied, you must apply at this time.

Section I: To be completed by the individual or HCBS referring agency:

(Please Print)

Name (Last, First, MI)	Social Security Number
Address (Apartment #)	Date of Birth
City, State, and Zip Code	Phone Number
Name of authorized representative (Last, First, MI) MCGREGOR PACE	Phone Number (216) 791-3580
Address of authorized representative (Apartment #) 26310 Emery Road	
City, State, and Zip Code of authorized representative Warrensville Heights, Ohio 44128	

Indicate applicable waiver(s) below (check all that apply):

- ☐ Ohio Department of Job and Family Services
  - ☐ Ohio Home Care Waiver
  - ☐ Other
- ☐ Mental Retardation/Developmental Disabilities (specify waiver):
  - ☐ Individual Options Waiver
  - ☐ Residential Facility Waiver
  - ☐ Level I Waiver
  - ☐ Other
- ☐ Ohio Department of Aging (specify waiver):
  - ☐ PASSPORT Waiver
  - ☐ CHOICES Waiver
  - ☒ Other PACE
- ☐ Other (specify):

I authorize the County Department of Job and Family Services (CDJFS) and its designees to explore my eligibility for Medicaid coverage of HCBS waiver services.

Signature of Individual requesting medical assistance (or Authorized Representative)		Date
Name of Person who helped complete this form (please print):	Signature of Person who helped complete this form:	Date

Section II: To be completed by the CDJFS:

Name of CDJFS Case Worker (please print):	Is the individual currently on Medicaid or is an application for Medical Assistance pending? ☐ Yes ☐ No If yes: CRIS-E Number: Application Date:
Signature of CDJFS Case Worker	
Date Received By CDJFS:	

Ohio Department of Job and Family Services

Request for Medicaid Home and Community-Based Services (HCBS)

You must receive Medicaid to receive waiver services. If you have not applied for Medicaid or you have applied in the past but been denied, you must apply at this time.

Section I: To be completed by the individual or HCBS referring agency:

(Please Print)

Name (Last, First, MI)	Social Security Number
Address (Apartment #)	Date of Birth
City, State, and Zip Code	Phone Number
Name of authorized representative (Last, First, MI) MCGREGOR PACE	Phone Number (216) 791-3580
Address of authorized representative (Apartment #) 26310 Emery Road	
City, State, and Zip Code of authorized representative Warrensville Heights, Ohio 44128	

Indicate applicable waiver(s) below (check all that apply):

- ☐ Ohio Department of Job and Family Services
  - ☐ Ohio Home Care Waiver
  - ☐ Other
- ☐ Mental Retardation/Developmental Disabilities (specify waiver):
  - ☐ Individual Options Waiver
  - ☐ Residential Facility Waiver
  - ☐ Level I Waiver
  - ☐ Other
- ☐ Ohio Department of Aging (specify waiver):
  - ☐ PASSPORT Waiver
  - ☐ CHOICES Waiver
  - ☒ Other PACE
- ☐ Other (specify):

I authorize the County Department of Job and Family Services (CDJFS) and its designees to explore my eligibility for Medicaid coverage of HCBS waiver services.

Signature of Individual requesting medical assistance (or Authorized Representative)		Date
Name of Person who helped complete this form (please print):	Signature of Person who helped complete this form:	Date

Section II: To be completed by the CDJFS:

Name of CDJFS Case Worker (please print):	Is the individual currently on Medicaid or is an application for Medical Assistance pending? ☐ Yes ☐ No
Signature of CDJFS Case Worker	If yes: CRIS-E Number:
Date Received By CDJFS:	Application Date:

Ohio Department of Job and Family Services

DESIGNATION OF AUTHORIZED REPRESENTATIVE

First Name of Applicant/Recipient	MI	Last Name		Medicaid billing # or SSN
Street Address, including Apt. #		**City**	**Zip**	**County**
				CUYAHOGA

I hereby authorize the following person or company to act as my representative:

First Name	MI	Last Name	Home Phone	
Title	**Company**		**Work Phone**	
	MCGREGOR PACE		(216) 791-3580	
Mailing Address		**City**	**State**	**Zip**
26310 EMERY ROAD		WARRENSVILLE HTS	OHIO	44128

I authorize this person or company to represent me regarding:

☑ Food Assistance ☑ Cash Assistance ☑ Medicaid ☐ Child Care

This authority lasts until:

☐ My application has been approved
☑ I rescind this authority, or appoint a new representative
☐ Other (please specify a date or action) _____

I authorize this person or company to do the following on my behalf:

☑ Take any action that may be needed to ensure that I receive or continue to receive the benefits indicated above

OR only the specific actions selected below

☐ Present my application for benefits
☐ Provide verifications to the CDJFS on my behalf
☐ Receive and respond to copies of all correspondence regarding my application
☐ Represent me at a state hearing
☐ Collect my medical records
☐ Other (please specify) _____

While this authorization is in effect, all notices sent by the County Department of Job & Family Services or the Ohio Department of Job & Family Services will also be sent to your authorized representative.

Signatures. This form has no effect unless signed by the person granting authority and by the authorized representative or an employee of the company appointed to be the authorized representative.

Signature of Person Granting Authority		Date
Signature of Authorized Representative	**Title** *(if employee of authorized company)*	**Date**

McGregor PACE

FINANCIAL AUTHORIZATION TO RELEASE INFORMATION

I. DEMOGRAPHIC INFORMATION

A. NAME:_____

B. ADDRESS: _____

_____

CITY STATE ZIP CODE

C. PHONE #: ( )_____DATE OF BIRTH_____/_____/_____

D. SOCIAL SECURITY NUMBER: _____/_____/_____

II. CONSENT

I hereby give McGregor PACE permission to contact the following individuals or agencies who can assist and/or provide information relative to applying for the Cuyahoga County Medicaid Waiver in an effort to coordinate services and insure client health and safety:

a. Banking Institutions
b. Life Insurance Companies
c. Social Security Administration
d. Ohio Board of Elections
e. U.S. Railroad Retirement Board
f. PERS, SERS, CCDJFS, CMS
g. PSA 10A Agencies
h. Community Agencies
i. Family Members/Significant Others

_____ _____/_____/_____

SIGNATURE OF PARTICIPANT DATE

_____ _____/_____/_____

SIGNATURE OF DPOA/LEGAL GUARDIAN/ AUTHORIZED REPRESENTATIVE DATE

_____ _____/_____/_____

SIGNATURE OF MCGREGOR PACE REPRESENTATIVE DATE

McGregor PACE

☐ Dr. Cynthia Balina 4229 Pearl Road, Cleveland Ohio 44109 Phone: (216) 205-4000 Fax: (216) 205-4033

☐ Dr. Peter DeGolia 14800 Private Dr, East Cleveland, Ohio 4112 Phone: (216) 268-8600 Fax: (216) 268-8596

☐ Dr. Kristen Brockway 26310 Emery Road Warrensville Heights, Ohio 44128 Phone: (216) 791-3580 Fax: (216) 378-6238

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name _____ Last 4 digits of Social Security # _____

I request and authorize _____
to release healthcare information of the patient named above to

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Purpose for Disclosure _____

(Purpose for disclosure must be completed prior to processing .e.g. continuing care, personal use legal)

☐ Healthcare information relating to the following treatment, condition, or **dates**:

_____

(From)_____ _____ **(To)** _____

☐	Office Visit	☐	History and Physical	☐	Physical/Occupational Therapy Reports	☐ ☐	Diagnosis List Medication List
☐	Emergency Department Reports	☐	Cardiac Reports-	☐	Homecare Records	☐ ☐	Health Maintenance Report Immunization report
☐	Discharge Summary	☐	Laboratory Reports	☐	Radiology Oncology Records	☐	Colonoscopy
☐	Operative Reports	☐	Radiology Reports	☐	Last note from each specialty	☐	Other:

Select One:

	Paper		**Secure electronic delivery (If electronic provide recipient's email).**

☐ Yes ☐ No	I the undersigned, authorize the release of my health information as indicated/described above. I understand and acknowledge that the request may contain information regarding physical and mental illness. HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
☐ Yes ☐ No	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Signature of Patient/Patient personal Representative		Date Signed:	

Physician's Signature _____ Date Signed_____

THIS AUTHORIZATION EXPIRES WITHIN ONE YEAR AFTER IT IS SIGNED.

True Out Of Pocket ("TrOOP") Costs

Participant Name _____

True Out Of Pocket ("TrOOP") costs are prescription drug costs paid by participants or specified third parties on the participants behalf, that count toward the Part D annual out-of-pocket threshold that participants must meet before their catastrophic drug coverage begins. Sponsors are responsible for tracking and transferring participants TrOOP costs as participants change plans throughout the coverage year.

As part of the enrollment process for McGregor PACE, you will be required to provide McGregor PACE a letter from your prior Medicare Advantage Plan that states your TrOOP balance as of the date of enrollment in to the McGregor PACE program.

Please sign below regarding notification of TrOOP balances from your prior Medicare Advantage Plan. *This information is required by Medicare.*

_____ ___/___/___

SIGNATURE OF PARTICIPANT/ AUTHORIZED REPRESENTATIVE **DATE**

_____ ___/___/___

SIGNATURE OF MCGREGOR PACE REPRESENTATIVE **DATE**

McGregor PACE

AGREEMENT FOR CHANGE OF HEALTHCARE PROVIDER NOTIFICATION

My signature below certifies that I have been informed and fully understand that my enrollment into McGregor PACE allows the medical staff to serve as my primary healthcare provider. The doctor who completes my initial assessment will also serve as my primary care physician. All of my medical needs will be met by McGregor PACE which is affiliated with University Hospitals unless other arrangements are made by my primary doctor. Should I choose to seek medical attention from another healthcare provider I will be financially responsible for any medical expenses acquired at that time. Upon the approval of my enrollment I will be given a McGregor PACE health insurance card. Proper use of the insurance card will be discussed in the partnership meeting.

Participant/DPOA/Legal Guardian	Intake Staff
Date	Date

McGregor PACE

PARTNERSHIP AGREEMENT

TASK/ SERVICE	PARTICIPANT/ CAREGIVER	MCGREGOR PACE
Health Care	• Provide information on care needs and concerns to staff as needed • Only use PACE physician, and medical services, • (If not, Participant can be held liable for cost that are unauthorized by PACE.)	• PACE Physician is your Primary doctor • PACE is your insurance company • Nursing Care • Skill services as needed • Social work counseling • Day center • Spiritual care • Doctor on-call 24 hours
Communication	• Will call Center right away with changes in participant's health status and address, phone numbers, family contacts • Emergency Back-up Plan provided and kept updated	• Written Plan of Care updated at least semi-annually or upon request • Staff will contact participant/caregiver with concerns and information about services
Family Meetings	• Attend 2 care plan meetings a year.	• Educate family/participant on health care issues.
Medications	• Give participant medications when not at Center • Call the Clinic for refills • (if needed)	• Administer medications while at the Center and educate participant/family. • Provide filled medication box for home needs • PACE will mail medications to the home
Transportation	• Call Center in advance if canceling attendance • Family go on vacation • Participant is sick	• If no one is present when participant arrives home McGregor PACE calls the participant's family members. • Should attempts fail, participant may be taken to a contracted nursing facility at caregiver's expense. McGregor PACE will continue to attempt to reach caregivers if participant is taken to a nursing facility.
Medical Appointments Including Transportation	• Provide transportation to/from appointments • Attend appointments with participant	• Arrange transportation • Escort to appointments (Emergency coverage only) • PACE will schedule ALL appointments and send out letter to family/participant
Home Care And Personal Care	• Arrange for someone to stay with participant if participant is unable to be alone • General grooming and bathing as needed • Provide backup if home care aide can't show up	• Bathe at Center as needed • Arrange for specific home care services based on medical needs • Change schedule with Home Care Agency • Contact Home Care Agency with problems and concerns
Personal Care Items	• Purchase peri-wash, lotion, shampoo and other personal care	• Briefs provided • (distribution amount is determined upon

TASK/ SERVICE	PARTICIPANT/ CAREGIVER	MCGREGOR PACE
	items as needed • Family will provide extra supplies as needed	incontinence assessment) – • one case maximum per month
Overnight Relief For The Caregiver	• Request at least two weeks in advance, if possible	• Participant must be enrolled in the program 90 days prior to respite request. All requested are not guaranteed.
Care Of Medical Equipment	• Participant owned • Keep clean and maintained	• For McGregor PACE owned equipment - annual maintenance and periodic cleaning.
Laundry	• Label clothing to be worn to Center • Do regular laundry	• Clothing soiled at Center will be laundered • Laundry service by Home Health Aide per Care Plan
Meals	• Breakfast before coming to Center • Dinners • Weekend meals	• Light breakfast before 10 AM • Hot lunch • Home delivered meals (if applicable)
Money Management	• Participant or caregiver will provide • Do not bring large amounts to center. • (less than $5.00 suggested)	• Can arrange for Representative Payee Services for the participant. PACE will not hold any money for participant. • PACE is not responsible for lost money.
Participant Liability	• Pay liability each month. • If not paid, may cause involuntary disenrollment for participant.	• PACE will send an Invoice to participant/guardian each month.
Provide Clear Access To Home, Walkways Clear of Snow And Ice, Etc.	• Family to do if transportation is provided by McGregor PACE • Family is responsible for clearing walkways	• PACE will pick up and drop off participant as long as pathways have been cleared.
Stay With Participant If Participant Is Unable To Be Alone	• Ensure that someone will stay with participant if he/she is unable to be alone • Provide back-up to home care/transportation	• Quickly address problems with home care or transportation • Emergency placement for medical emergencies
Activities	• Provide opportunities for the participant to pursue activities at home and in community. • Request supplies for home activities when needed from activity department	• Plan and run activities of the Participant's interest when at the center. • Encourage and record participation in activities while at the center. • Send home workbooks of activities on the weekends for participants to work on with family. (as needed)

PARTICIPANT/CAREGIVER SIGNATURE: _____ DATE: _____

MCGREGOR PACE STAFF AT MEETING _____

DATE COPY GIVEN/SENT TO APPLICANT/CAREGIVER: _____

STAFF SIGNATURE: _____ DATE _____

NOTICE OF PRIVACY PRACTICES

Effective Date _____

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
(APPLICANT MUST BE GIVEN AN ORIGINAL COPY)

We are required by law to maintain the privacy of your health information; to provide you this detailed Notice of our legal duties and privacy practices relating to your health information; and to abide by the terms of the Notice that are currently in effect.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The following lists various ways in which we may use or disclose your health information for purposes of treatment, payment and health care operations.

For Treatment. We will use and disclose your health information in providing you with treatment and services and coordinating your care and may disclose information to other providers involved in your care. Your health information may be used by doctors involved in your care and by nurses and home health aides as well as by physical therapists, social workers, personal care attendants or other persons involved in your care. For example, members of the multidisciplinary team (which includes your primary care physician, a registered nurse, a social worker, physical and occupational therapists, and other care givers) will discuss your plan of care and contact any specialists regarding care provided to you.

For Payment. We may use and disclose your health information for billing and payment purposes. We may disclose your health information to your personal representative, or to an insurance or managed care company, Medicare, Medicaid or the state agency charged with administering McGregor PACE programs. For example, we may disclose health information to Medicare or the state administering agency in order to determine your continued eligibility for PACE program services. We will also require you to sign a release permitting the disclosure of personal information to Medicare, Medicaid, and the state administering agency for these purposes as a condition of your enrollment agreement.

For Health Care Operations. We may use and disclose your health information as necessary for health care operations, such as management, personnel evaluation, education and training and to monitor quality of care. For example, we will use data about your treatment in order to conduct quality assessment activities. We may disclose your health information to another entity with which you have or had a relationship if that entity requests your information for certain of its health care operations or health care fraud and abuse detection or compliance activities.

II. SPECIFIC USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following lists various ways in which we may use or disclose your health information.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose health information about you to a family member, close personal, friend or other person you identify, including clergy, who is involved in your care. We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying Rita Wright at the Emery Center.

Emergencies. We may use or disclose your health information as necessary in emergency treatment situations.

As Required By Law. We may use or disclose your health information when required by law to do so.

Business Associates. Our business associates are individuals and organizations that carry out functions or activities on our behalf that involve protected health information. We may disclose your protected health information to a contractor or business associate who needs the information to perform services for McGregor PACE. Our business associates are committed to preserving the confidentiality of this information.

Public Health Activities. We may disclose your health information for public health activities. These activities may include, for example, reporting to a public health

authority for preventing or controlling disease, injury or disability; reporting elderly abuse or neglect or reporting deaths.

Reporting Victims of Abuse, Neglect or Domestic Violence. If we believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your health information to notify a government authority, if authorized by law or if you agree to the report.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure actions or for activities involving government oversight of the health care system. As a condition of enrollment, we will require you to sign a release permitting the disclosure of personal information to Medicare, Medicaid, and the state administering agency for these purposes.

To Avert a Serious Threat to Health or Safety. When necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person, we may use or disclose health information, limiting disclosures to someone able to help lessen or prevent the threatened harm.

Judicial and Administrative Proceedings. We may disclose your health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request, or other lawful process; efforts must be made to contact you about the request or to obtain an order or agreement protecting the information.

Law Enforcement. We may disclose your health information for certain law enforcement purposes, including, for example, to comply with reporting requirements; to comply with a court order, warrant, or similar legal process; or to answer certain requests for information concerning crimes.

Research. We may use or disclose your health information for research purposes if the privacy aspects of the research have been reviewed and approved, if the researcher is collecting information in preparing a research proposal, if the research occurs after your death, or if you authorize the use or disclosure.

Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations. We may release your health information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

Disaster Relief. We may disclose health information about you to a disaster relief organization.

Military, Veterans and other Specific Government Functions. If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities. We may disclose health information for national security purposes or as needed to protect the President of the United States or certain other officials or to conduct certain special investigations.

Fundraising Activities. We may use certain limited information to contact you in an effort to raise funds for the PACE Program and its operations.

Appointment Reminders. We may use or disclose health information to remind you about appointments.

Treatment Alternatives and Health-Related Benefits and Services. We may use or disclose your health information to inform you about treatment alternatives and health related benefits and services that may be of interest to you.

III. USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Except as described in this Notice, we will use and disclose your health information only with your written Authorization. You may revoke an Authorization in writing at any time. If you revoke an Authorization, we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Listed below are your rights regarding your health information. Each of these rights is subject to certain requirements, limitations and exceptions. Exercise of these rights may require submitting a written request to McGregor PACE. At your request, McGregor PACE will supply you with the appropriate form to complete. You have the right to:

Request Restrictions. You have the right to request restrictions on our use or disclosure of your health information for treatment, payment, or health care operations. This includes the right to submit a written consent limiting the degree of information disclosed and the persons to whom information is disclosed. You also have the right to request restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction on how we use your health information within McGregor PACE. We will limit disclosures outside McGregor PACE (except for disclosures to CMS and the State Administering Agency) in accordance with your written consent. We will grant requests to restrict use of protected health information within McGregor PACE if they are reasonable and can be accommodated. If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment.

Access to Personal Health Information. You have the right to inspect and obtain a copy of your clinical or billing records or other written information that may be used to make decisions about your care, subject to some exceptions. Your request must be made in writing. In most cases we may charge a reasonable fee for our costs in copying and mailing your requested information.

Request Amendment. You have the right to request amendment of your health information maintained by McGregor PACE for as long as the information is kept by or for McGregor PACE. Your request must be made in writing and must state the reason for the requested amendment.

We may deny your request for amendment if the information (a) was not created by McGregor PACE, unless the originator of the information is no longer available to act on your request; (b) is not part of the health information maintained by or for McGregor PACE; (c) is not part of the information to which you have a right of access; or (d) is already accurate and complete, as determined by McGregor PACE.

If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

Request an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your health information. This is a listing of disclosures made by McGregor PACE or by others on our behalf, but does not include disclosures for treatment, payment and health care operations, disclosures made pursuant to your Authorization, and certain other exceptions.

To request an accounting of disclosures, you must submit a request in writing, stating a time period, beginning after April 13, 2003 that is within six years from the date of your request. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs.

Request a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice: You may request a copy of this Notice at any time.

Request Confidential Communications. You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests.

V. SPECIAL RULES REGARDING DISCLOSURE OF PSYCHIATRIC, SUBSTANCE ABUSE AND HIV-RELATED INFORMATION

[State laws may provide additional protections for information regarding psychiatric and substance abuse treatment and HIV-related information. Insert a discussion of these special requirements, if any, in this section].

VI. FOR FURTHER INFORMATION OR TO FILE A COMPLAINT

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact the Director of Community Services or designee at (216) 791-3580.

If you believe that your privacy rights have been violated, you may file a complaint in writing with McGregor PACE or with the Office of Civil Rights in the U.S. Department of

Health and Human Services. We will not retaliate against you if you file a complaint.

To file a complaint with McGregor PACE, contact the Director of Community Services at (216) 791-3580.

VII. CHANGES TO THIS NOTICE

We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all health information already received and maintained by McGregor PACE as well as for all health information we receive in the future. We will provide a copy of the revised Notice upon request.

Signature of Applicant:_____ **Date:**_____

Witness:_____ Date:_____

McGregor PACE

NOTICE OF PRIVACY PRACTICES

Effective Date _____

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
(APPLICANT MUST BE GIVEN AN ORIGINAL COPY)

We are required by law to maintain the privacy of your health information; to provide you this detailed Notice of our legal duties and privacy practices relating to your health information; and to abide by the terms of the Notice that are currently in effect.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The following lists various ways in which we may use or disclose your health information for purposes of treatment, payment and health care operations:

For Treatment. We will use and disclose your health information in providing you with treatment and services and coordinating your care and may disclose information to other providers involved in your care. Your health information may be used by doctors involved in your care and by nurses and home health aides as well as by physical therapists, social workers, personal care attendants or other persons involved in your care. For example, members of the multidisciplinary team (which includes your primary care physician, a registered nurse, a social worker, physical and occupational therapists, and other care givers) will discuss your plan of care and contact any specialists regarding care provided to you.

For Payment. We may use and disclose your health information for billing and payment purposes. We may disclose your health information to your personal representative, or to an insurance or managed care company, Medicare, Medicaid or the state agency charged with administering McGregor PACE programs. For example, we may disclose health information to Medicare or the state administering agency in order to determine your continued eligibility for PACE program services. We will also require you to sign a release permitting the disclosure of personal information to Medicare, Medicaid, and the state administering agency for these purposes as a condition of your enrollment agreement.

For Health Care Operations. We may use and disclose your health information as necessary for health care operations, such as management, personnel evaluation, education and training and to monitor quality of care. For example, we will use data about your treatment in order to conduct quality assessment activities. We may disclose your health information to another entity with which you have or had a relationship if that entity requests your information for certain of its health care operations or health care fraud and abuse detection or compliance activities.

II. SPECIFIC USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following lists various ways in which we may use or disclose your health information.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose health information about you to a family member, close personal, friend or other person you identify, including clergy, who is involved in your care. We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying Rita Wright at the Emery Center.

Emergencies. We may use or disclose your health information as necessary in emergency treatment situations.

As Required By Law. We may use or disclose your health information when required by law to do so.

Business Associates. Our business associates are individuals and organizations that carry out functions or activities on our behalf that involve protected health information. We may disclose your protected health information to a contractor or business associate who needs the information to perform services for McGregor PACE. Our business associates are committed to preserving the confidentiality of this information.

Public Health Activities. We may disclose your health information for public health activities. These activities may include, for example, reporting to a public health

authority for preventing or controlling disease, injury or disability; reporting elderly abuse or neglect or reporting deaths.

Reporting Victims of Abuse, Neglect or Domestic Violence. If we believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your health information to notify a government authority, if authorized by law or if you agree to the report.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure actions or for activities involving government oversight of the health care system. As a condition of enrollment, we will require you to sign a release permitting the disclosure of personal information to Medicare, Medicaid, and the state administering agency for these purposes.

To Avert a Serious Threat to Health or Safety. When necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person, we may use or disclose health information, limiting disclosures to someone able to help lessen or prevent the threatened harm.

Judicial and Administrative Proceedings. We may disclose your health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request, or other lawful process; efforts must be made to contact you about the request or to obtain an order or agreement protecting the information.

Law Enforcement. We may disclose your health information for certain law enforcement purposes, including, for example, to comply with reporting requirements; to comply with a court order, warrant, or similar legal process; or to answer certain requests for information concerning crimes.

Research. We may use or disclose your health information for research purposes if the privacy aspects of the research have been reviewed and approved, if the researcher is collecting information in preparing a research proposal, if the research occurs after your death, or if you authorize the use or disclosure.

Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations. We may release your health information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

Disaster Relief. We may disclose health information about you to a disaster relief organization.

Military, Veterans and other Specific Government Functions. If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities. We may disclose health information for national security purposes or as needed to protect the President of the United States or certain other officials or to conduct certain special investigations.

Fundraising Activities. We may use certain limited information to contact you in an effort to raise funds for the PACE Program and its operations.

Appointment Reminders. We may use or disclose health information to remind you about appointments.

Treatment Alternatives and Health-Related Benefits and Services. We may use or disclose your health information to inform you about treatment alternatives and health related benefits and services that may be of interest to you.

III. USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Except as described in this Notice, we will use and disclose your health information only with your written Authorization. You may revoke an Authorization in writing at any time. If you revoke an Authorization, we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Listed below are your rights regarding your health information. Each of these rights is subject to certain requirements, limitations and exceptions. Exercise of these rights may require submitting a written request to McGregor PACE. At your request, McGregor PACE will supply you with the appropriate form to complete. You have the right to:

Request Restrictions. You have the right to request restrictions on our use or disclosure of your health information for treatment, payment, or health care operations. This includes the right to submit a written consent limiting the degree of information disclosed and the persons to whom information is disclosed. You also have the right to request restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction on how we use your health information within McGregor PACE. We will limit disclosures outside McGregor PACE (except for disclosures to CMS and the State Administering Agency) in accordance with your written consent. We will grant requests to restrict use of protected health information within McGregor PACE if they are reasonable and can be accommodated. If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment.

Access to Personal Health Information. You have the right to inspect and obtain a copy of your clinical or billing records or other written information that may be used to make decisions about your care, subject to some exceptions. Your request must be made in writing. In most cases we may charge a reasonable fee for our costs in copying and mailing your requested information.

Request Amendment. You have the right to request amendment of your health information maintained by McGregor PACE for as long as the information is kept by or for McGregor PACE. Your request must be made in writing and must state the reason for the requested amendment.

We may deny your request for amendment if the information (a) was not created by McGregor PACE, unless the originator of the information is no longer available to act on your request; (b) is not part of the health information maintained by or for McGregor PACE; (c) is not part of the information to which you have a right of access; or (d) is already accurate and complete, as determined by McGregor PACE.

If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

Request an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your health information. This is a listing of disclosures made by McGregor PACE or by others on our behalf, but does not include disclosures for treatment, payment and health care operations, disclosures made pursuant to your Authorization, and certain other exceptions.

To request an accounting of disclosures, you must submit a request in writing, stating a time period, beginning after April 13, 2003 that is within six years from the date of your request. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs.

Request a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice: You may request a copy of this Notice at any time.

Request Confidential Communications. You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests.

V. SPECIAL RULES REGARDING DISCLOSURE OF PSYCHIATRIC, SUBSTANCE ABUSE AND HIV-RELATED INFORMATION

[State laws may provide additional protections for information regarding psychiatric and substance abuse treatment and HIV-related information. Insert a discussion of these special requirements, if any, in this section].

VI. FOR FURTHER INFORMATION OR TO FILE A COMPLAINT

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact the Director of Community Services or designee at (216) 791-3580.

If you believe that your privacy rights have been violated, you may file a complaint in writing with McGregor PACE or with the Office of Civil Rights in the U.S. Department of

Health and Human Services. We will not retaliate against you if you file a complaint.

To file a complaint with McGregor PACE, contact the Director of Community Services at (216) 791-3580.

VII. CHANGES TO THIS NOTICE

We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all health information already received and maintained by McGregor PACE as well as for all health information we receive in the future. We will provide a copy of the revised Notice upon request.

Signature of Applicant:_____ **Date:**_____

Witness:_____ Date:_____

McGregor PACE

INTAKE VERIFICATION REQUEST CHECK LIST

Applicant Name	Application Date	Department *Eligibility*

As discussed in your initial interview, there are eligibility factors, which must be verified before your **MEDICAID** can be determined. Checked below are the documents needed:

- ☐ **PROOF OF GUARDIANSHIP/DPOA FOR FINANCE - (If applicable to you):**
  - o Identification for Guardian/DPOA
- ☐ **Marriage/Divorce Certificate**
- ☐ **Social Security Card (self and spouse if applicable)**
- ☐ **Proof of Identity (self and spouse if applicable)**
  - o Drivers License
  - o State ID Card
  - o Voter's Registration Card
- ☐ **Proof of Citizenship (self and spouse if applicable)**
  - o Birth Certificate
  - o Alien Registration Card
  - o US Passport
- ☐ **Proof of Income (self and spouse if applicable)**
  - o Social Security Benefits Letter
  - o Disability Benefits & Deductions
  - o Pension Benefits & Deductions
  - o Pay Check Stubs – last 4
  - o Annuity Payments
  - o Rental Income
  - o Veteran's Benefit Letter
  - o Interest or Dividends
  - o ANY additional income
- ☐ **Proof of Living Expenses- (all of the following if applicable)**
  - o Rent or Mortgage Payment
  - o Homeowner's insurance and Property Taxes
  - o Utilities **(within last 30 days)**
    - ° Telephone
    - ° Gas
    - ° Electric
    - ° Water/Sewer/Trash
- ☐ **Proof of Health Insurance (self and spouse if applicable)**
  - o Medicare Card
  - o Health Insurance Card
  - o Health Insurance Premium
- ☐ **Proof of Assets (self and spouse if applicable)**
  - o Checking /Savings Account Statement (*4 months of statements; ALL PAGES*)
  - o Credit Union Accounts
  - o Stocks and Bonds
  - o IRA and Annuities
  - o Mutual or Trust Funds Agreement
  - o Term or Whole Life Insurance Policies with CASH, FACE VALUE AND LOAN AMOUNT
  - o Vehicles Registration with current Mileage
  - o Burial Contract and Cemetery Lots
  - o Any additional Assets

** All documents listed above needs to be provided by spouse if applicable**

It is necessary for the information to be provided by: _____

If you are unable to obtain any requested verifications, contact me immediately for assistance. Without this information, we will be unable to determine your Medicaid eligibility for the PACE program!

Medicaid Specialist	Date	Telephone Number

McGregor PACE

Your Next 6 STEPS to Join McGregor PACE

Step 1: The McGregor PACE nurse and Occupational Therapist will call you to set up visits at your home.

Step 2: The Western Reserve Nurse will call and set up a visit at your home.

Step 3: The McGregor PACE Intake Coordinator will call you and set up your visit for the DAY AT THE CENTER.

Step 4: A member of the Eligibility Team will contact to coordinate financial documentation pick up or submission preference. You may also email it to April.Gideon@mcgregorctr.org in advance, fax: 216-268-8599 or call 216-268-8509 for any questions.

Step 5: You will receive a WELCOME CALL, INSURANCE CARD, your schedule day and time to visit the center, and transportation arrangements.

Step 6: Enrollment starts on the 1st day of each Month.

Intake Coordinator:_____

Phone Number:_____