AC PERSONAL CARE AGENCY

1735 N. NELLIS BLVD STE. A LAS VEGAS, NV 89115

PHONE: 725-204-4713 FAX: 725-204-4714

Client Package

Client's Last Name First Name Date

Street Address City State Zip Code

Primary Phone Number Alternate Phone Number

Client Disclosure

AC Personal Care Agency cannot manage the client's unstable/unpredictable medical and health conditions.

Attendant No-Show Disclosure

If your attendant no shows to your home, please call the office so that we may find a cover for the day. If the attendant is a no-show to the client's home without prior approval or contact to the office, the attendant will be terminated and the agency will do its best to find a cover attendant for the day and a permanent attendant for the authorization approval dates.

NON DISCRIMINATION POLICY

By federal law and regulations, ACPCS does not discriminate unlawfully against recipients based on race, color, national origin, sex, religion, age, disability, or handicap.

AC Personal Care Agency does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse, or harassment, based on actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender, identity or expression or HIV status.

ACPCS CLIENT PACKAGE

Privacy Policy and Procedures

In compliance with the Health Insurance Portability Act (HIPAA) 45 CPR Part 162, our confidential records are kept in a safe pla666ce under a locked cabinet. All folders are to be returned to the locked cabinet after each use. This is applied to both workers and clients.

A patient consent form is signed prior to discussing pertinent information that applies to the employee assigned to the recipient.

A summary of privacy practices is provided to the client. Initials: _____

I have received a copy of the summary of the Definitions, Licensing, Administration, and Provision of Services: _____

Dear Client,

HIPPA (Health Information Portability and Accountability Act of 1996) grants you, as a client, certain rights regarding medical record privacy. Enclosed you will find two documents that are required to be given to each client per HIPAA law.

1. Provider Notice of Privacy Practices – This document outlines how ACPCA will use and disclose your individually identifiable health information.

2. Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations- Authorizes AC PCA to use your protected health information to develop and implement a plan of care and to obtain payment from third-party payers.

AC Personal Care Agency

Notice of Privacy Practices (HIPAA)

This notice describes how AC Personal Care Agency uses your medical information. Your information may be used and disclosed and how you can get access to this information.

Please read it carefully.

Your health information is personal and private. The law says that we (AC Personal Care Agency) must protect this information. When you first asked for our services, you gave us information that helped us decide if you qualified. It became part of your file, which we keep in our offices. Also, in your file, is information that is given to us by hospitals, doctors and other people who treat you. A federal law says that we must give you this notice to help you understand what our legal duties are and how we will protect your health information.

When is it okay for us to share your health information?

If you sign a special form that tells us it is ok to share your health information with someone, then we will share it. You can cancel this at any time by notifying us in writing except if we have already shared the information. Your information can be shared without you're okay when we need to approve or pay for services. We can share it when we review our programs and try to make them better. Under the law, these uses are called treatment, payment and health care operations. The law says that there are some other situations when we may need to share information without you're okay. Here are some examples.

For your medical treatment and payment

- When you need emergency care
- To tell you about treatment choices
- To remind you about appointments
- To help our business partners do their work
- To help review program quality

For your personal reasons

- To tell your family and other who help with your care things they need to know
- To be listed in a patient directory
- For workers compensation
- To tell a funeral director of your health
- If you have signed organ donation papers, to make sure your organs are donated according to your wishes

For public health reasons

- To help researchers study health problems
- To help public health officials stop the spread of disease or prevent an injury
- To protect you or another person if we think that you are in danger

Other special uses

- To help the police, courts and other people who enforce the law
- To obey laws about reporting abuse and neglect
- To report information to the military
- To help government agencies review our work and investigate problems
- To obey court orders

What are your rights?

You can ask us not to share your information in some situations. However, the law says that we do not always have to agree with you. If you are reading this notice on the Internet or bulletin board, you can ask for a paper copy of your own. You can ask to look at your health information and get a copy of it. You may be charge a fee for the copies based on Division policy. However, you need to remember that we do not have a complete medical record for you. Our records mostly deal with payments to your doctors and other people who care for you. If you want a copy of your complete medical record, you should ask your doctor or provider of health care. If you think that something is missing from or wrong in your health record that we have, you can ask us to make changes. You can ask to have a copy of your health information provided in electronic format if it is available. You can ask us to give you a list of the times (after April 14, 2003) that we have shared your information for the

purposes of treatment, payment or health care operations. You may ask to restrict the release of your health information to a health plan when you have paid out of pocket in full for items or services. You can ask us to mail health information to an address that is different from your usual address or to deliver the information to you in another way.

What if you have a complaint?

If you think that we have not kept out promise to protect your health information, you may complain to us or to the U.S. Department of Health and Human Services. Nothing will happen to you if you complain.

What are our responsibilities?

Under the law, we must keep your health information private except in situations like the ones listed in this notice. We must give you this notice that explains out legal duties about privacy. We must follow what we have told you in this notice. We must agree when you make reasonable requests to send your health information to a different address or to deliver it in a way other that regular mail. We must notify you if there is a breach of your unsecured health information. We will only use or share the minimum amount of your health information necessary to perform out duties. We must tell you if we cannot agree when you ask us to limit how your information is shared.

Contact Information

If you have any questions or complaints about our privacy rules, please contact us at:

AC Personal Care Agency
1735 N. Nellis Blvd. # A
Las Vegas, NV 89115
Office: 725-204-4713
Fax: 725-204-4714

Or contact: Department of Health and Human Services
Office for Civil Rights
90 7th Street. Suite 1-100
San Francisco, CA 94103
Phone: (415)437-3810

I have been given this notice and understand its content. By signing this document I accept receipt pf the Privacy Policy issued by AC Personal Care Agency.

Recipient's Name (Please Print) _____ Recipient Signature _____ Date _____

AC Personal Care Agency _____ Date _____

AC PERSONAL CARE AGENCY

Health Insurance Portability and Accountability Act (HIPAA)

Summary of Notice of Privacy Practices

The following summary is provides to assist you in understanding our Notice of Privacy Practices and is a synopsis of our policies and procedures.

Use and Disclosures of Health Information: we will use and disclose your health information in order to care for you or to assist other health care providers in caring for you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing accreditation and training of staff.

Uses and Disclosures Based on Your Authorization: We will not use or disclose your health information without your written authorization, except as noted above or below.

Uses and Disclosures Not requiring Your Authorization: In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are directly involved in your case.
- For purpose of public health and safety.
- To government agencies for purpose of their adult, investigations or other oversight activities.
- To government authorities to prevent child abuse or domestic violence.
- To law enforcement authorities to protect public safety and assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights: as a client in our agency, you have the following rights:

- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosure we have made that contain your health information.
- To request restrictions as to how your health information is disclosed.
- To request that we communicate with you in confidence.

- To request that we amend your health information.
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding out privacy practices, please contact HIPAA Officer/Contact person. HIPAA Officer/Contact person is the Administrator at (702) 485-5029

I have been informed about HIPAA Privacy Rights and been given an opportunity to discuss and ask question and certify that I fully understood my Right and Responsibilities.

Patient Signature: _____ Date: _____

Family and/or Significant other

(If patient is unable to sign) _____ Date: _____

Witness: _____ Date: _____

MR# _____ Name: _____

PROVIDER 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.

Uses and disclosures of Health Information:

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the public area of the office. We will also mail a copy of the new notice to you. If needed, you can request a copy of our notice at any time. For more information about our privacy practices, contact any office staff member.

Individual Rights:

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you only normal photocopy fees. Records will be provides to you within 60 days. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes and other than when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. Our office can provide you with the appropriate address upon request.

Our Legal Duty:

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

If you have any questions or complaints, please contact:
Olive Ejiofor
At 1735 N Nellis Blvd Suite A Las Vegas NV 89115

Acknowledgement of receipt of Notice of Privacy Practices:

Please sign your name and date on this acknowledgement form. Then detach the form from this notice and return your signed acknowledgement to the client coordinator or to the address above.

_____

Signature of Client or Representative

_____

Relationship to Client

_____

Witness

_____

Date

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a. . .

- Basis for planning my care and treatment
- Means of communication among the many health care professionals who contribute to my care
- Source of information for applying my diagnosis and health care information to my bill
- Means by which a third-party payer can verify that services billed were actually provided
- Tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand that it is agency practice to maintain a client care plan notebook in my home which contains individually identifiable health information which will be reviewed by all TLC employees brought into my home.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

My signature below acknowledges acceptance of the *Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations.*

Signature: _____

Date: _____

AC PERSONAL CARE AGENCY

1735 N. NELLIS BLVD STE. A LAS VEGAS, NV 89115

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Client Package

Recipient's Responsibilities: Into _____

Recipient will inform and provide AC Personal Care Services of the following:

1. The changes in Medicaid eligibility within 3 days.
2. The changes in health status, service needs, address and location or changes of status of legally responsible adult(s).
3. Sign time slips to verity services were provided.
4. Current insurance and/or changes in insurance.
5. Accurate information about their health, treatment, and medications.
6. Recipient's will appointments.
7. Missed visits and/or late arrival of caregivers and/or additional visits if required.
8. Complaints regarding delivery of services, unusual occurrences when they occur or to request change in caregiver.
9. When scheduled visits cannot be kept or services are no longer needed at least two hours in advance.
10. Copy of advance directives.
11. Not to request caregiver to work for non-recipient family or household members, or to ask caregiver to work less or extra hours not covered by the approved service plan
12. Establish a backup plan in case ACPCS staff member is unable to work at a scheduled time.
13. Provide a safe environment for provision of personal care services in the home (liquid antibacterial soap, and paper towel).

Recipient's Rights

The Recipient will: in _____

- Inform ACPCS of changes in Medicaid services and other insurance information.
- Provide the copy of Advance Directive if applicable.
- Not to request the following to the PCA
    - → To work more than the hours in the Service Plan.
    - → To work or clean for non-recipient family or household members.
    - → To provide services not authorized in your service plan.
- Inform the services provider agency of complaints regarding delivery of services or to request a change in caregiver.
- Always sign each attendant visit from after completed to verity services were provided.
- Treat employees of ACPCS with respect and not discriminate on the basis of race, color, national origin, sex, religion, age disability or handicap.
- Inform the service provider agency when the services are no longer required or scheduled visits cannot be kept
- Inform the service provider agency of changes and service needs, address, medical status, and location.
- Inform the service provider agency of missed visits.

Client Bill of Rights: in _____

- You have the right to contact your Medicaid Case Manager in regards to the care that you receive by ACPCS.
- You will be informed when there is a change in your assigned PCA or when a back-up attendant must be utilized.
- You have the right to notify ACPCS of any complaints you may have regarding the services we provide.
- You have the right to receive a written schedule of approved services that we rendered.
- You will be assured that the privacy and confidentiality about your health, social, domestic and financial circumstances will be maintained pursuant to law.
- You shall receive considerate and respectable care in the home at all times, and your property will also be treated with respect.
- Expect that within the limit set by the Service Plan and within your criteria ACCPCS will respond in good faith to your reasonable request for assistance.
- You will not be discriminated upon by employees of ACPCS on the basis of race, color, national origin, sex, religion, age or disability.
- You will receive a copy of the Service Plan.

A Right to Choose Statement (for transfer only)

It is in your own free will that your decision to choose ACPCS as your personal care provider agency. And that; I,

_____, choose ACPCS for the following reasons:

1. A friend or family member referred me _____
2. From the provider list _____

Other reasons:

_____

_____

_____

_____

Client printed name: _____ Date: _____

Client Signature: _____ Date: _____

ACPCS Signature: _____ Date: _____

RECIPIENT ORIENTATION TO THE MEDICAID SERVICE PLAN OF CARE

Recipient Name: _____

Date of Service: _____

The Plan of Care developed by Medicaid or PT/OT Staff must be followed exactly and not deviated in any way. The Personal Care Assistant assigned to your case is oriented to your individual care plan and is aware that they are to follow the care plan exactly.

If at any time you feel your care plan is not being followed, please contact the office and speak to a supervisor to resolve any conflicts at:

During office hours: 725.204.4713

After office hours: 725. 769-1226

Client's Signature: _____ Date: _____

_____ Date: _____

Agency Representative's Signature

Client Package

Services provided: _____

ACTIVITIES OF DAILY LIVING (ADL'S)

- Assisting the client in bathing, showering, or bed bath
- To assist in dressing and undressing
- Helping the recipient in toileting needs such as to and from the bathroom, either bed pan using, sometimes a routine care of an incontinent recipient, includes use of diapers, protective sheets, which this services needs changing colostomy bag, also emptying and maintaining a urinary system
- Non-ambulatory recipients need assist transferring and positioning from one stationary position to another, includes adjusting and changing recipient position in a bed or chair
- Give assistance to ambulatory recipients in walking or to walk with support of a wheelchair, walker, cane, or assist in and out of bed or wheelchair
- Assist with grooming like combing, brushing of hair, shaving face, legs or underarms, oral hygiene such as care of dentures, fingernails application of "esthetics" (support of bracing weak or impaired joints or muscles)
- Assisting the client with simple physical activity like taking them for a walk or passive, no-prescribed range of motion exercises
- To assist with medication that's self-administered, verbal reminders, for client to take medications, bringing **medication to the client, and loosing cap of the medication container.**

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL'S)

- Meal preparation: planning of menu, storing, preparing and serving of food.
- Laundry services: only the clothes of the recipient need to be washed including drying, folding of personal laundry and linens (sheets and towels) (no need of ironing, not allowed)
- Light housekeeping: dusting, vacuuming the living room, changing bed linens, and washing the dishes.
- Essential shopping: PCA can buy prescribed medications, groceries, medical supplies, and other household items that the client needs to maintaining good health

PCA Services no permitted

The provider agency is responsible to ensure that all PCA's work within the scope of services and conduct themselves in a professional manner at all times. The following are some of the activities that are not with the scope of a personal care aide and are therefore not permitted.

Skilled Services

PCA Services must never be confused with services of a higher level that must be performed by persons with professional training and credentials. Services that are not appropriate as personal care include, but are not limited to the following:

- Insertion and sterile irrigation of catheters
- Irrigation of any body cavity. This includes both sterile and non-sterile procedures such as ear irrigation. Vaginal douches and enemas
- Application of dressing involving prescription medications and aseptic techniques, including treatment of moderate or severe skin problems
- Administration of injections of fluids into veins, muscles, or skin
- Administration of medication, including the insertion of rectal suppositories
  (As opposed to assisting with self-administered medication)
- Physical assessments
- Monitoring vital signs
- Specialized feeding techniques
- Rectal digital stimulation
- Massage
- Specialized range of motion
- Toe-nail cutting
- Medical case management, such as accompanying a recipient to a physician's for the purpose of providing or receiving medical information and
- Any task identified within the Nurse Practice Act as requiring skilled nursing including certified nursing assistant (CNA) services.
- Increasing and/or decreasing time authorized on the service plan
- Accepting or carrying keys to the recipient's home
- Buying alcoholic beverages for use by the recipient of the other in the home unless prescribed by the recipient's physician
- Making personal long distance call from the recipient's home
- Performing services not identified on the service plan
- Loaning, borrowing or accepting gifts of money or personal items from the recipient
- Accepting or retaining money or gratuities for any reason other than needed for purchase of groceries or medications for the recipient, and
- Maintenance of pats except in the case where the animals is a certified service animal
  These services must be absorbed in the recipient's current service plan. No additional hours will be authorized.

Client Print Name	Signature	Date

ACPCA Signature	Date

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Advance Directives

An Advance Directive is a document allowing a person to give directions about their future medical care or to designate another person to make medical decision if he or she should lose decision-making capacity. The purpose of an advance directive is to state in advance what kind of treatment you want or do not want under special and/or serious medical conditions. Advance Directives may include Living Wills, Durable Power of Attorney for health care or similar documents conveying the patient's preferences. It is very difficult to make decision in time of stress. Therefore, it is important for you to learn about the levels and types of medical care available and to discuss the kinds of treatment you would feel comfortable with before you and your family are called upon to make such decisions. (See Attachment).

Patient's Bill of Rights

As a client of AC Personal Care Services, you and your family or caregiver (when patient judged incompetent) have the right to be informed regarding services provided by this agency. You have the right:

1. To be informed, of all services to be provided, the frequency of these proposed visits and the charges prior to and/or admission.
2. To have your property treated with respect.
3. To voice grievances regarding care, or lack thereof, without threat of discrimination or reprisal.
4. To have grievances regarding care or lack thereof, be investigated by the agency.
5. To be informed of the availability of a Home Health Hotline for the State of Nevada for the purpose of receiving question or complaint.
6. To have records and reports regarding any grievances and its resolution maintained by the agency.
7. To be informed, in advance, of all the care to be furnished and of any changes in the plan of care.
8. To be informed, of any changes in the extent of payment or expected of an insurance company, federally funded program or yourself for care to be provided.
9. To refuse home care services; and, if so, must notify the agency prior to schedule visits.
10. To have all personnel caring for you to be current in skills and knowledge of their particular area of home care services to be current.

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11. To expect proper identification of all personnel providing home care services.
12. To participate in the development of the care plan, treatment and discharge planning. Make informed decisions regarding care/right to formulate Advanced Directives.
13. To be served without regard to race, color, religion, gender, age, national origin, or handicap.
14. To have your personal and clinical record maintained confidential.
15. To participate in the consideration of ethical issues that may arise in your case.
16. To be informed prior to services being provided, of any payment or co-payment required of an insurance company, federally funded program, or yourself for care to be provided.
17. To have your clinical record disclosed to another individual, agency or facility only upon written authorization from you or legal representatives.
18. To exercise your rights: a family member or guardian may exercise the patient's right when the patient is judged incompetent.

Client's backup plan for emergencies is as follows:

Name: _____

Phone#: _____

Address: _____

Relationship: _____

I have received written information regarding Advance Directives. I have read and understand the preceding pages concerning service provided, not provided, and my responsibility and rights as a client of ACPCS. I have or have not given a copy of my personal Advance Directives to ACPCS. I completely and fully understand my rights as they are stated.

Client Print Name: _____ Date: _____

Client Signature: _____

CCPCS Signature: _____ Date: _____

Client Package

AC PERSONAL CARE SERVICES

3-IN-1 Patient Consent Form

In April of 2003, new federal requirements took effect regarding privacy of information for health care patients. The Health Insurance Portability Act (HIPAA) requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe. AC PERSONAL CARE SERVICES requests that each patient sign this consent form which allows us to share protected health information (PHI) with other physician offices, your hospital and insurance company, including Medicaid. By signing this section of the form, you consent to our use and disclosure of PHI about you for care, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature: _____ Date: _____

Relationship to patient: _____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request protected health information or discuss their care. Under the requirements for the Health Insurance Portability Act (HIPAA), we are bit allowed to give this information to anyone without the patient's consent. If you wish us to be able to speak to family members regarding your care, you must list the person below and sign. Signing this section will give your consent for our agency to discuss your care with those you have identified.

1. _____ Relationship to Patient: _____ Date: _____

2. _____ Relationship to Patient: _____ Date: _____

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it may be necessary to leave a message regarding your care. The purposes of these messages may include, but not limited to, a reminder that a new staff member will be visiting, or chat a new or renewed request for service has been issued on your behalf. Signing this section will give out agency permission to leave messages with family members or on your answering machines.

_____

Patient Name

_____ Date: _____

Patient Signature

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Client Package

ACPCS may terminate services for the following reasons:

- → The recipient request for termination
- → The recipient does not meet PCA program eligibility criteria
- → The recipient is ineligible for Medicaid
- → The recipient or other persons in the household subjects the ACPCS staff to substantiated physical or verbal abuse, sexual harassment and/or exposure to the use of illegal substances or threatens physical harm.
- → No availability of attendant to provide services
- → The client refuses services in accordance with the Service Plan
- → The environment of the client is unsafe for the provision of personal care services
- → The recipient refuses services based solely or partly on the ACPCS staff member's race, religion, sex, marital status, color, age, disability, or national origin
- → The recipient request termination of services

Immediate Termination: INITIAL _____

ACPCS may terminate services immediately for the following reasons:

- → The recipient is ineligible for Medicaid. This applies for Medicaid recipient
- → The patient request termination of services
- → The environment of the recipients is unsafe for the provision of personal care services
- → The recipient or other persons in the household subject ACPCS staff to substantiated physical or verbal abuse, sexual harassment, and/or exposure to the use of illegal substances or threats of physical harm

Discontinuation of Provider Agreement: INITIAL _____

In the manner that ACPCS decides to discontinue the services, they will do the following:

- → Provide a copy of written notice thirty (30) days in advance to the DHCFP
- → Will continue the service through the notice period OR until the recipient selects a back-up person to do the services; whichever is applicable

Final Agreement: INITIAL _____

I authorized and agree that ACPCS will bill Medicaid, State of Nevada, for the services rendered during the length of person services that have been authorized by the State of Nevada Medicaid service plan.

Charges for private Services: INITIAL _____

Personal Services rate ----- $19.00/hr., $22.00 for less than 4 hours, $250/day for 24 hour services

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Recipient Contract

Service Provider Responsibilities: Into _____

Upon admission, the following are discussed with the recipient by ACPCS

- ACPCS policies and philosophy.
- Hiring policies, recipient assistance, and personal care assistant training.
- ACPCS Responsibilities.
- Grievance/complaint procedures and Advance Directives, and provide a written copy.
- ACPCS respond to complaint within 24 hours and maintain records that identify the complaint, the date received, and the response.
- ACPCS investigate and responds, in writing, to all written Complaints within 10 calendar days of receipt of written complaint. A written notification of the complaint and its outcome will be provided to the recipient and the Division.
- The recipient is required to exhaust the provider's dispute resolution process prior to requesting a hearing from the Division.
- ACPCS will provide Medicaid District Office (NMDO) Personal Care Attendant (PCA) case manager with written notification of serious occurrences and/or incidents that involve the recipient, PCA or that affect the ability to deliver services. The NMDO will be notified by telephone within one (1) working day and in writing within five (5) working days.

Serious occurrences involving the PCA, and/or recipient include but are not limited to the following:

- Suspected physical or verbal abuse; sexual harassment; injuries requiring medical intervention; neglect of the recipient; an unsafe working environment; any event which is reported to child and/or Elder Protective Services or law enforcement; and/or death during the provision of Personal Care Services. A summary of serious occurrences must be submitted in January and July of each year to the DHCFP Central Office.
- Loss of contact with the recipient for three (3) consecutive scheduled days.
- Will not release any information without written consent from the recipient or the recipient's legal representative, except when it is required by law.

- The Service Plan.
- The scheduled visits with the recipient.
- The procedures to be followed when ACPCS staff doesn't show up for a scheduled visit and/or when approved additional visit is required
- Signing of the time sheet for the services provided.
- Monthly verification of eligibility of the recipient.

ACPCS will notify the recipient ten (10) days in advance written notice when services are to be terminated except for IMMEDIATE TERMINATION. The DHCFP/NMDO PCA care manager will be notified by telephone within one (1) working day. ACPCS will submit written documentation within five (5) working days.

AC PERSONAL CARE AGENCY

1735 N. NELLIS BLVD STE. A LAS VEGAS, NV 89115

PHONE: 725-204-4713 FAX: 725-204-4714

Review Service Plan with the Recipient:

Before the initiation of service, the staff from the management or the supervisor will review and discuss the following steps with the recipient.

1. AC Personal Care Service Policies and Procedures
2. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
3. Advance Directives Information
4. Service Plan of Care
5. Recipient's schedule and authorized hours / missed / additional visits explained procedure
6. Recipient's/Client's Rights
7. Permitted/Covered and Not Permitted/Not Covered for Personal Care Assistants (PCA's)
8. Back-up plan (Reliever if PCA is absent or not available)
9. Recipient's Responsibilities
10. Grievances/Complaint procedure

(Copies of documentation provided by the agency provider)

_____ _____

Recipient Signature Date

_____ _____

PCA / Caregiver Signature Date

_____ _____

ACPCS Staff / Supervisor Date

AC Personal Care Agency

The patient Self-Determination Act
(Which includes Advance Directives)
Requires

_____
(Name of hospital)

To inform you of your rights as a patient and of our policies:

1. You have the right to make decisions concerning your medical care.

2. You have the right to accept or refuse medical or surgical treatment, including the right to formulate advance directives (declarations and/or durable powers of attorney for health care decisions).

3. You have the right to be given information concerning Advance Directives within 24 hours of your admission to this hospital.

4. Upon admission, you will be asked if you have an advance directive.

5. It will be documented in your medical record whether you have an advance directive.

6. If you have an advance directive you should furnish a copy to this hospital, so it can be place in and made part of your medical record/chart, so hospital personnel are made aware of your medical treatment desires.

7. If you have an advance directive it will be honored by the hospital.

8. The hospital will not condition the provision of care or otherwise discriminate against you based on whether you have formulated and advance directive.

9. For further information regarding advance directives, or to obtain advance directives forms, please contact _____ (name or department) at this hospital.

10. For further information in the community you may contact The Nevada Center for Ethics & Health Policy, (775)327-2309, http:/www.unr.edu/ncehp/ads.html

11. Complaints or grievances concerning hospital advance directives noncompliance may be addressed to:

State of Nevada Department of Health
State Health Division
Bureau of Health Care Quality and Compliance
Licensure and Certification Program
727 Fairview Drive
Carson City, NV 89701
(775) 684-1030

AC Personal Care Agency

ACKNOWLEDGEMENT OF PATIENT INFORMATION ON ADVANCE DIRECTIVES

Name: _____

Address: _____

Social Security #: _____ Date of Birth: _____

1. I have received written information on state law, and the hospital's written policy, advising me of my right to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment, and formulate advance directives (declaration and/or durable power of attorney for health care decisions).

   ☐ YES ☐ NO

2. I have formulated an advance directive:
   - Declaration ☐ YES ☐ NO
   - Durable Power of Attorney For Health Care Decisions ☐ YES ☐ NO

   If YES is marked, I have provided a copy of my advance directive to the hospital (if I haven't, I will provide a copy to the hospitals soon as possible)

   _____ check here if copy is provided

Comments: (hospital follow up efforts if the patient cannot receive the advance directives information upon admission or does not bring in a copy of the advance directive if he/she states he/she has one): _____

_____

_____

Although the patient is instructed to bring in a copy of his/her advance directive to be placed in the medical record, the substance/instructions of patient's advance directive states: _____

_____

_____

I understand I will not be discriminated against on my provision of care whether or not I have an advance directive.

_____

(Patient's Signature) *(Date)*

_____

(Family or Other (if patient is unable to sign) *(Date)*

_____

(Hospital Representative) *(Date)*

AC Personal Care Agency

The following is the form of a "Declaration" provided for under Nevada Statues:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment. I direct any attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of gastrointestinal tract after all other treatment is withheld pursuant to this declaration . . . . . [_____]

Signed this _____ day of _____, 20_____

Signature: _____

Address: _____

_____

_____

This declaration voluntarily signed this writing in my presence.

Witness: _____

Address: _____

Witness: _____

Address: _____

AC Personal Care Agency

The following is the form of a "Durable Power of Attorney for Health Decisions" provided for under Nevada Statute:

DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. It creates a Durable Power of Attorney for Health Care. Before executing the document you should know these important facts:

1. This document gives the person you designate as your Attorney-in-Fact the power to make health care decision for you. The power is subject to any limitations or statement of your desire that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any type of treatment or placements that you do not desire.

2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known, or, if your desires are unknown, to act in your best interest.

3. Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.

4. Unless you specify a shorter period in this document, this Power will exist indefinitely from the date you execute this document and if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health decisions for yourself.

5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.

6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.

7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.

8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

9. This document revokes any prior Durable Power of Attorney for Health Care.

10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

AC Personal Care Agency

- DESIGNATION OF HEALTHCARE AGENT

I, _____ (insert your name) do hereby designate and appoint:

Name: _____

Address: _____

Telephone Number: _____

As my attorney-in-fact to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: (1) your treating provider of health care; (2) an employee of your treating provider of health care; (3) an operator of a health care facility; or (4) an employee of an operator of a health care facility.)

- CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document, I intend to create a Durable Power of Attorney by appointing the person designated above to make health care decision for me. This power of attorney shall not be affected by my subsequent incapacity.

- GENERAL STATEMENT OF AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power, and authority to make health care decisions for me before, or after my death, including : consent, refusal of consent, or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose, or treat physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

- SPECIAL PROVISIONS AND LIMITATIONS

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on your attorney-in-fact authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of Attorney for Health Care, The authority of my attorney-in-fact is subject to the following special provisions and limitations:

_____

_____

PCA CLIENT REVIEW

(NAC 449 Section 18, 21 & 23)

NAME OF PCA AGENCY_____ DATE _____

Client Name: _____ Admit Date: _____

Phone number: _____ Address: _____

	YES	NO
Written disclosure of services provided to client	☐	☐
Signed by client or representative, copy of written disclosure in file	☐	☐
Disclosure includes description of personal care services offered	☐	☐
Statement that agency cannot manage unstable/unpredictable medical/health conditions	☐	☐
Qualifications and training requirements for attendants	☐	☐
Charges for services, rate increase policy, due dates for bills	☐	☐
Description of billing methods, payment system	☐	☐
Client informed he/she may request agency policies	☐	☐
Client informed of prohibited services	☐	☐
Client informed of procedure if PCA fails to provide service in accordance with service plan	☐	☐
Criteria/conditions for termination of services	☐	☐
Procedure for contacting administrator during the day and after hours	☐	☐
Grievance/complaint procedure reviewed with client	☐	☐
Initial client screening evaluation conducted by administrator or state agency (DAS)	☐	☐
Service plan provided, reviewed with client, including schedule, in file	☐	☐
Client informed he/she may make reasonable requests	☐	☐
Hiring and training policies reviewed with client	☐	☐
Responsibilities of agency reviewed with client	☐	☐
Attendant no-show policy reviewed with client	☐	☐
Client rights provided to client, signed by client, in file	☐	☐
Client informed he/she may speak with an advocate	☐	☐
BLC telephone number provided	☐	☐
Client informed Health Division may review records	☐	☐
Home visits or telephone call by administrator documented in client's chart?	☐	☐
Did the home visit/telephone call documentation include an evaluation of whether:		
Appropriate and safe techniques were being employed?	☐	☐
Service plan has been followed?	☐	☐
Service plan met the client's needs?	☐	☐
Attendant received sufficient training?	☐	☐
Follow-up conducted for any problems identified in the home visits or telephone calls?	☐	☐

If a client needs additional services he or she may contact the agency after hour emergency number (702) 769-1226

AC PERSONAL CARE AGENCY COMPLIES WITH THE PATIENT SELF-DETERMINATION ACT THROUGH IMPLEMENTATION OF THE FOLLOWING PROCEDURES:

Client Contact and Record Keeping

1. During the initial assessment visit, before services begin, adult clients (age 18 and older) are provided with an information packet that contains a copy of Nevada's 13-page description of state law concerning Advance Directives **OR** another description that includes:

   a. A thorough explanation of Advance Directives including the client's right to make health care decisions, accept or refuse medical or surgical treatment, and formulate and Advance Directive;
   b. References to Nevada Revised Statues 449.535 to 449.690 and 449.800 to 449.860; and
   c. Copies of the Declaration (Living Will) and Durable Power of Attorney for Health Care Decisions or, at minimum, information about where to obtain copies of these forms.

2. If the client is incapacitated, the information packet is provided to a personal representative or family member. When and if it becomes possible to communicate the information directly to the client, the information packet is also provides to the client.

3. At the time the information packet is provided to the client, personal representative or family member, the client is asked whether he/she has an Advance Directive.

4. The client, personal representative or family member is asked to sign an acknowledgement form verifying that the agency has provided the required Advance Directives information and indicating whether the client has an Advance Directive. The completed form is placed in the client's file.

5. If the client has an Advance Directive, a copy is requested. If one is provided, it is placed in the client's file.

6. If a client, personal representative or family member has questions about Advance Directives, he/she is directed to a **Client Care Coordinator** within the agency. If further information is needed he/she may be referred to one of the organizations on the attached sheet.

7. If a client, personal representative or family member has a complaint about the way this agency handles its responsibility regarding Advance Directives, the individual is directed to the Recipient Civil Rights Officer at the Division of Health Care Financing and Policy, 1000 E. William St., Suite 102, Carson City, NV 89701; (775) 687-8226.

Staff Training and Community Education

1. Within 30 days of initial employment, this agency will provide new staff members with training regarding its policies and procedures related to Advance Directives. At least once yearly, all staff will receive in-service training regarding policies and procedures related to Advance Directives. Training will be documented and maintained in the agency's files for potential review by oversight agencies.

2. At least once yearly, information about Advance Directives will be provided to the community. The method of outreach and the estimated number of people who receive the information will be documented and maintained in the agency's files for potential review by oversight agencies.

THE PATIENT SELF-DETERMINATION ACT, WHICH INCLUDES ADVANCE DIRECTIVES, REQUIRES **AC PERSONAL CARE** TO INFORM YOU OF YOUR RIGHTS AS A CLIENT AND OF OUR POLICIES:

1. You have the right to make decisions concerning your medical care.
2. You have the right to accept or refuse medical or surgical treatment including the right to formulate Advance Directives (Declarations and/or Durable Powers of Attorney for Health Care Decisions).
3. You have the right to be given information concerning Advance Directives before personal care aide services begin.
4. Also before services begin, you will be asked if you have an Advance Directive.
5. It will be documented in your record whether you have an Advance Directive.
6. If you have an Advance Directive you should furnish a copy to this personal care aide agency so it can be placed in and made a part of your record, and so that personal care aide personnel are made aware of your medical treatment desires.
7. If you have an Advance Directive it will be honored by this personal care aide agency. (If the personal care aide agency has a policy stating it cannot honor an Advance Directive on the basis of conscientious objection, the agency **must** include a clear and precise statement of limitation. At a minimum, an agency's statement of limitation must: a) clarify any differences between institution-wide conscientious objection and those that may be raised by individual physicians; b) identify the state legal authority permitting such objection which in Nevada is NRS 449.628; and c) describe the range, if any, of medical conditions or procedures affected by conscientious objection).
8. The personal care aide agency will not condition the provision of care or otherwise discriminate against you based on whether you have formulated an Advance Directive.
9. For further information regarding Advance Directives, or to obtain Advance Directives forms, please contact the **CLIENT CARE COORDINATOR** at this personal care aide agency.
10. For further information in the community you may contact one of the organizations listed on the attached sheet.
11. Complaints or grievances concerning the way this personal care aide agency handles its responsibility in the area of Advance Directives may be addressed to: Nevada Division of Health Care Financing and Policy, Recipient Civil Rights Office, 1000 E. William St., Suite 102, Carson City, NV 89701; (775) 687-8226.
12. Complaints or grievances concerning the way a licensed health care provider handles its responsibility in the area of Advance Directives may be addressed to:

North (includes rural Nevada)

Nevada State Health Division
Bureau of Licensing and Certification
1550 East College Parkway, Suite 158
Carson City, NV 89706
(775) 687-4475

South

Nevada State Health Division
Bureau of Licensing and Certification
4220 South Maryland Parkway
Las Vegas, NV 89119
(702) 486-6515

CLIENT INFORMATION ON STATE LAW CONCERNING ADVANCE DIRECTIVES

TODAY'S HEALTHCARE CHOICES

Years ago, we didn't have the choices in medical care that we have today. Seriously ill people, old and young, were more likely to die quickly of natural causes that they are today. Now, medical technology can extend the life of seriously ill people for longer periods of time. It can even keep permanently unconscious people alive for many years. This has created choices that just a few years ago wouldn't have seemed possible.

Sometimes, the new technology seems truly miraculous in its ability to restore health to someone who is seriously ill. At other times, it only seems to prolong suffering and the dying process.

MEDICAL TREATMENTS

There are three kinds of life-prolonging care to consider: cardiopulmonary resuscitation (CPR); artificial provision of nutrition and fluids (tube-feeding); and active treatment to fight disease.

1. CARDIOPULMONARY RESUSCITATION (CPR)

Cardiopulmonary resuscitation is the act of reviving someone whose heart and/or breathing has stopped. CPR (sometimes called a "code") can include basic and advanced measures.

The basic measures are:

- Cardiac compression (repeatedly pressing on the chest to squeeze the heart so that blood begins to circulate again);
- Mouth-to-mouth breathing, to push air into the lungs.

The advance measures are:

- Intubation (putting a tube through the mouth or nose into the windpipe) and attaching a machine or device to do artificial breathing;
- Defibrillation (powerful electrical shocks to the chest to start the heart beating again);
- Strong medications.

The success of CPR depends on the individual's previous health and on how soon the procedure is started. The best results occur in a generally healthy person whose heart stops unexpectedly, and when CPR is started promptly. The chance of restarting the heart is much less likely when it has stopped as the result of many chronic problems.

Prompt CPR can save a person's life and prevent damage to the body's tissue and organs. On the other hand, brain damage is likely if more than about four minutes have elapsed before the procedure is started. Other risks include injuries to the chest and liver as a result of the force applied during chest compression.

Modern hospitals and nursing homes automatically attempt CPR on anyone whose heart and/or breathing stops, unless there is a Do Not Resuscitate – or "DNR" order – on file for the patient. A DNR order (also called a "no code") can only be taken by the doctor with the permission of the patient, his or her health care agent or the family. (Note: A DNR order is not the thing as an advance directive. If you want to limit CPR, your doctor must write a separate DNR order.)

Non-Intensive Treatment

- Antibiotics (available in pill form or by injection) to treat infections.
- Blood transfusions.
- Chemotherapy (a drug treatment) and radiation (such as X-ray therapy) to fight cancer.

The following is a statement of Patient Rights with respect to Treatment and a Description of Advance Directives under Nevada State Law:

QUESTIONS & ANSWERS

DO I HAVE THE RIGHT TO MAKE DECISIONS ABOUT MY MEDICAL CARE?

YES. NRS 449.680 provides that a patient retains the right to make decisions regarding the use of life-sustaining treatment, so long as he/she is able to do so. NRS 449.720 provides that a patient has a right to refuse treatment to the extent permitted by law and to be informed of the consequences of that refusal.

DO I HAVE THE RIGHT TO REFUSE TREATMENT?

YES. NRS 449.720 provides that you have the right to refuse treatment if you are able to make that decision and to be informed of the consequences of that refusal. A qualified patient may also forego life-sustaining treatment if he/she is able to do so. Sometimes a patient is so ill that he/she cannot refuse treatment. Therefore, it is very important to have an advance directive if you wish to refuse life-sustaining treatment during a terminal illness.

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is a written statement, which you complete in advance of serious illness, about how you want medical decisions made. The two most common forms of advance directives are:

- A "Living Will," or "Declaration" and;
- A "Durable Power of Attorney for Health Care"

An advance directive allows you to state your choices for health care or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment. In short, an advance directive can enable you to make decisions about your future medical treatment. You can say "yes" to treatment you want or say "no" to treatment you don't want.

WHAT IS A LIVING WILL OR DECLARATION?

A Living Will or Declaration generally state that kind of medical care you want (or don't want) if you become unable to make your own decision. It is called a "living will" because it takes effect while you are still living. The Nevada Legislature has used the word "Declaration" as its preferred type of advance directive. Nevada's form of Declarations is found in NRS 449.535 et seq.

WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS?

A "Durable Power of Attorney for Health Care" is a signed, dated, and witnessed paper naming another person, such as a husband, wife, daughter, son, or close friend as your "agent" or "proxy" to make medical decisions for you if you should be unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid, such as surgery or artificial feeding. The statutes regarding a Durable Power of Attorney for Health Care are found in NRS 449.800 et seq.

SHOULD I DISCUSS MY PLAN TO EXECUTE OR NOT EXECUTE AN ADVANCE DIRECTIVE WITH MY LAWYER?

YES. Your lawyer can explain the function and advisability of having an Advance Directive to you.

SHOULD I DISCUSS MY ADVANCE DIRECTIVE WITH MY FAMILY OR LOVED ONES?

YES. It is advisable that those dear to you be aware of your wishes and where your original Advance Directive is so that your wishes can be carried out.

MUST AN INSTITUTIONAL WHERE I AM BEING CARED FOR ASCERTAIN WHETHER I HAVE EXECUTED AN ADVANCE DIRECTIVE?

YES. Federal law requires that the provider or organization must "document" in the individual's medical record whether or not the individual has executed an Advance Directive.

You should not wait until you are old or facing a serious illness to think about these issues. Thinking about them while you are in good health gives you and your loved ones the opportunity to prepare for the sort of medical crisis that could happen to anyone at any time.

The following is the form of a "Durable Power of Attorney for Health Care Decisions" provided for under Nevada Statutes:

DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. It creates a Durable Power of Attorney for Health Care. Before executing this document, you should know these important facts:

1. This document gives the person you designate as your Attorney-in-Fact the power to make health care decisions for you. This power is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.

2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in your best interest.

3. Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.

4. Unless you specify a shorter period in this document, this Power will exist indefinitely from the date you execute this document and if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.

5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection and health care necessary to keep you alive may not be stopped if you object.

6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.

7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.

8. The person designated on this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

9. This document revokes any prior Durable Power of Attorney for Health Care.

10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

DURATION

I understand that this power of attorney will exit indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this Power of Attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this Power of Attorney end on the following date: _____

STATEMENT OF DESIRES

(With respect to decisions to withhold or withdraw life sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interest; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decisions that is in your best interest. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statement in the space below.)

(If the statement reflects your desires, initial the box next to the statement)

1. I desire that my life be prolonged to the greatest extent possible, without regard to My condition, the chances I have for recovery or long-term survival, or the cost of Theprocedures..... [_____]

2. If I am in a coma which my doctors have reasonably concluded is irreversible, I Desire that life-sustaining or prolonging treatments not be used. (Also should Utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is Initialed..... [_____]

3. If I have an incurable or terminal condition or illness and no reasonable hope of Long-term recovery or survival, I desire that life-sustaining or prolonging treatments Not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, And sections 2 to 12, inclusive, if this subparagraph is initialed..... [_____]

4. Withholding or withdrawal of artificial nutrition and hydration may result in death by Starvation or dehydration. I want to receive or continue receiving artificial nutrition And hydration by way of the gastro-intestinal tract after all other treatment is Withheld.....
[_____]

5. I do not desire treatment to be provided and/or continue if the burdens of treatment Outweigh the expected benefits. My attorney-in-fact is to consider the relief of Suffering, the preservation or restoration of functioning, and the quality as well as The extent of the possible extension of my life.....
[_____]

(THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE, OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

(You may use acknowledgement before a notary public instead of statement of witnesses.)

State of Nevada)

: SS:

County of _____) _____

On this _____ day of _____, in the year _____, before me, _____ _____ (here insert name of notary public) personally appeared _____ _____ (here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

NOTARY SEAL

_____
(Signature of Notary Public)

I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Signature: _____

Names: _____ Address: _____

Printed Name: _____ _____

Date: _____ _____

COPIES: You should retain an executed copy of this document and five one to your attorney-in-fact. The power of Attorney should be available so a copy may be given to your providers of health care.

Under NRS 449.628, a health care provider is allowed to transfer care of a patient to another provider if The first provider objects on the basis of conscience to implementation of an advance directive.

The following is the form of a "Declaration," provided for under Nevada Statutes:

DELCARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct any attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:

Withholding or withdrawal of artificial nutrition and hydration may result in death by

Starvation or dehydration. Initial this box if you want to receive or continue receiving

Artificial nutrition and hydration by way of the gastro-intestinal tract after all other

Treatment is withheld pursuant to this declaration..... [_____]

Signed this _____ day of _____, 20_____.

Signature: _____

Address: _____

The declarant voluntarily signed this writing in my presence.

Witness: _____

Witness: _____

Witness: _____

Witness: _____