Nevada Medicaid and Check Up

Personal Care Services Recipient Request for Provider Transfer

Purpose: Use this form to verify a recipient's request to transfer to another provider. All fields, signatures and initials must be completed and are required for processing of this transfer request. Provider is required to submit verification of release of information. Incomplete forms will not be acted upon.

DATE OF REQUEST: _____/_____/_____ **Fax to:** (855) 709-6846 **Questions? Call:** (800) 525-2395

SECTION I: RECIPIENT INFORMATION

The Recipient, Legally Responsible Individual (LRI) or Personal Care Representative (PCR) must complete Section I. Indicate the reason for the transfer, initial the items below to indicate an understanding of the changes that may occur due to the transfer and sign the form.

Last Name:	First Name:
Medicaid ID:	Date of Birth:

Reason for transfer of service to new provider: _____

_____

Recipient/LRI/PCR must initial, complete the following and sign below:

_____I/LRI/PCR understand that services will be terminated with my current personal care services agency: *(agency name)*_____and I have notified my current agency of my last date of service with them. I understand that I am authorized to receive service from only one agency at a time.

_____I/LRI/PCR understand that selecting a new agency may result in a new personal care assistant.

_____I/LRI/PCR understand that a request for transfer will not result in a change in my current personal care hours.

_____I/LRI/PCR have NOT been offered nor have I received financial incentives to authorize this transfer.

_____I/LRI/PCR for the Medicaid recipient identified above certify that I have completed this form and understand the actions that will take place upon my signature.

Recipient/LRI/PCR: *(print name)*_____

Relationship to Recipient:_____

Recipient/LRI/PCR Signature: **Date:**

SECTION II: NEW PROVIDER INFORMATION

The provider must complete Section II. Be sure to complete the effective dates and sign the form.

New Provider Name:	
New Provider Agency NPI:	New Provider Agency Phone Number:
Last Date with Current Provider:	
Start Date with New Requesting Provider (*the day after the last date with current provider*):	
Additional comments or contact information not specified above *(that would assist in the completion of this request):*	

The Individual Representative from the New Provider must initial the following and sign below:

_____I have met with the recipient and provided the recipient with a copy of our agency's policies and procedures.

_____No information has been provided to the recipient implying that a failure to transfer will result in consequences such as a decrease in PCS hours, loss of Medicaid eligibility or that the current/existing agency is now unable to provide services.

_____No financial incentives have been made or offered in relation to this transfer request.

_____No assurances regarding an increase in PCS hours have been made to the recipient.

Individual Representative from New Provider (*print name*):_____

Provider Signature: **Date:**

The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received. This referral/authorization is not a guarantee of payment.

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 your 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 your 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 _____