1st American Choice Home Services LLC

Medicare Patient Choice Statement

(To be completed for all new patients/guardians)

I, _____ (patient name), the undersigned, patient/guardian understand that it is my right to select the home care provider of my choice.

I have selected _____ (further referred to as Agency) free of any undue pressure or solicitation by any officer, director, employee, agent or contractor of Agency. I have been advised by Agency that I may request information concerning its scope of practice, services available and telephone numbers. I was encouraged to ask specific questions concerning my individual needs to assess whether Agency is a good fit for me. I have been able to ask questions and express concerns, which have been satisfactorily responded to by Agency's staff. I further declare that my receipt of home care services from Agency is by choice. I have been advised by the admitting professional that if for any reason I wish to change services to another home care agency, it is my right to do so.
I have not selected a Medicare HMO provider. If I decide to select such a provider, I will notify this Agency immediately.

Beneficiary Elected Transfer Statement

(To be completed by all patients transferring from other agencies)

Discovery efforts:

❑ HIQH Query /Customer Service indicates patient under an established home health plan of care

I, _____, the undersigned patient/guardian choose to transfer to _____ (Agency), from _____ (Initial home health agency). Effective transfer date _____.

My reason(s) for this request is:

- ❑ I believe I will be better served by Agency
- ❑ I wish to be served by _____, a nurse/aide/therapist employed by Agency.
- ❑ Other (explain) _____.

I am making this request of my own free will and have not been coerced, solicited, or pressured to do so by any employee of Agency.
I understand if Medicare is the payer of services, the initial home health agency will no longer receive Medicare Payment on my behalf and will no longer provide Medicare covered services to me after the effective date of transfer. I request that my records be released to the receiving agency to ensure continuity of care.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Signature of Agency Representative Date

For Agency Use Only
Coordination of Transfer:
❑ Phone call to _____ (initial home health agency) for coordination of transfer on _____. Contact person:_____
❑ "Beneficiary Elected Transfer/Right of Choice" form sent /faxed to Initial agency on_____