ArchCare Senior Life

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

archcare
Senior Life

Revised Date: November 5, 2024
Original Effective Date: April 14, 2003

NOTICE OF PRIVACY PRACTICES

- ArchCare at Carmel Richmond Healthcare and Rehabilitation Center
- ArchCare at Ferncliff Nursing Home
- ArchCare at Mary Manning Walsh Home
- ArchCare at Providence Rest Nursing Home
- ArchCare at San Vicente de Paúl Skilled Nursing and Rehabilitation Center
- ArchCare at Terence Cardinal Cooke Health Care Center
- ArchCare Senior Life
- ArchCare at Home
- Family Home Health Care

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The Continuing Care Community
of the Archdiocese of New York

NOTICE OF PRIVACY PRACTICE

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.

About this Notice:

This Notice tells you about the ways we may use and disclose health information that identifies you (Health Information) It also describes your rights and the obligations we have regarding the use and disclosure of Health Information. We are required by law to maintain the privacy of your Health Information. We are also required to give you this Notice of our legal duties and privacy practices with respect to your Health Information and follow the terms of our Notice currently in effect. This Notice governs ArchCare and its affiliated nursing homes, their medical staffs, and other affiliated health care providers who jointly provide health care services with the nursing homes, and its affiliated managed care organizations. Together, ArchCare-sponsored Entities are designated as an affiliated covered entity.

How we may use and disclose health information about you:

With your permission, or the permission of someone authorized to act on your behalf, we will provide Health Information to anyone you choose. **Even without your permission**, we have the right to use and disclose your Health Information in the following situations:

I. TREATMENT, PAYMENT, & BUSINESS OPERATIONS

For Treatment:

We may use Health Information or share it with others who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. For example, a doctor at one of our nursing homes may share Health Information with another doctor inside the nursing home, or with a doctor at a hospital where you will receive treatment.

For Payment:

We may use Health Information or share it with others so that we may bill or pay for the medical treatment and the other services we provide or cover. For example, our nursing homes will share information about you with your health insurance company in order to obtain reimbursement.

For Business Operations:

We may use Health Information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you.

Fundraising Activities:

We may use certain information about you to contact you in an effort to raise money to expand and improve the services and programs we provide the community. Any fundraising letter you receive from us will provide you with instructions on how to opt out of any future fundraising letters. You are free to opt out of fundraising solicitations and your decision will have no impact on your treatment or payment for services.

Business Associates:

We may disclose Health Information to our business associates that perform functions on our behalf or provide us with service. For example, we may share Health Information with a billing company that helps us to obtain payment from your insurance company. If we do disclose Health Information to a business associate, we will require them to protect the privacy of your Health Information in the same way that we do. These business associates are also mandated under law to protect the privacy of your Health Information.

II. RESIDENT DIRECTORY & INDIVIDUALS INVOLVED IN YOUR CARE

Individuals Involved in Your Care or Payment for Your Care:

Unless you object, we may release Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend. We may also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Resident Directory:

If you are in one of our nursing homes, we will include your name in a Resident Directory, if we have one. If you are unable to express your wishes when you first arrive at the nursing home, we will discuss your preferences with you as soon as you regain capacity.

III. PUBLIC NEED As Required by Law:

We will disclose Health Information when required to do so by law.

Public Health Activities:

We may disclose Health Information for public health activities. These activities generally include, but are not limited to, disclosures to: report product defects or problems; prevent or control disease, injury or disability; report births or deaths; report reactions to medications or problems with products.

Victims of Abuse, Neglect, or Domestic Violence:

We may release Health Information to the appropriate government authority if we believe that you have been a victim of abuse, neglect or domestic violence.

To Avert a Serious Threat to Health or Safety:

We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, will be to someone who may be able to assist in preventing the threat.

Health Oversight Activities:

We may release Health Information to a health oversight agency for audits or other activities a government undertakes to monitor the health care system and government programs.

Lawsuits and Disputes:

If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We may also disclose Health Information in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement:

We may release Health Information to law enforcement officials for the following reasons: in response to a court order, or similar process; to identify a suspect, fugitive, material witness, or missing person; about the victim of a crime, if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities or Protective Services:

We may release Health Information to federal officials conducting national security intelligence activities or providing protective services to the President or other important officials.

Armed Forces Members:
If you are a member of the Armed Forces, we may release Health Information as required by military command authorities. We may also release Health Information to an appropriate foreign military authority if you are a member of a foreign military.

Inmates:
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement if necessary to provide you with health care, to maintain safety and security of others, or safety and security of the correctional institution.

Workers' Compensation:
We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners and Funeral Directors
We may disclose Health Information to a coroner, medical examiner or funeral director so that they can carry out their duties.

Organ and Tissue Donation:
If you are an organ or tissue donor, we may release Health Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

Research:
Under certain circumstances, we may use and disclose Health Information for research purposes. If we do so, however, the research project will go through a special approval process balancing the benefits of research with the need for privacy of Health Information. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for similar purposes, so long as they do not remove or take a copy of any Health Information.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information:
Special privacy protections apply to HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. You may contact the Privacy Officer for more information about these protections.

Incidental Uses and Disclosures:
When we share or disclose Health Information in the situations described above, we may share or disclose Health Information incidental to that circumstance. For example, a physician may instruct a staff member to bill Medicare for a particular procedure and may be overheard by another resident. We make efforts to minimize these incidental disclosures.

Other Uses of Health Information:
Other uses and disclosures of Health Information not covered by this Notice or the laws that apply to us will be made only with your written permission. For example, we usually need your written permission to use or disclose Health Information contained in psychotherapy notes. We also need your written permission to use or disclose Health Information for marketing or to disclose Health Information in a manner that constitutes a sale of that Information. You may revoke your permission at any time by submitting a written request to our Privacy Officer, except to the extent that we already acted in reliance on your permission.

Underwriting:
Our health plans are prohibited from using or disclosing your genetic information about you for underwriting purposes.

YOUR RIGHTS REGARDING HEALTH INFORMATION

You have the following rights, within certain limits, regarding Health Information we maintain about you. If you have any questions about any of these rights, please contact the appropriate Privacy Officer at the end of this notice.

Right to be Notified of Breach:
You have a right to receive notifications of breaches of unsecured Health Information if the breach compromises the security and privacy of your Health Information

Right to Inspect and Copy:
You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Request Amendments:
If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. If you do so, you must tell us the reason for your request.

Right to an Accounting of Disclosures:
You have the right to request an "accounting of disclosures" of Health Information. This is a list of persons or organizations to whom we have disclosed your Health Information.

Right to Opt Out of Fundraising Communications:
You have the right to opt out of being contacted for any fundraising purpose.

Right to Pay Out-of-Pocket Privately:
You may pay privately for care without a bill being submitted to insurance, if you so request and pay for the services out of pocket in full.

Right to Request Restrictions:
You have the right to request a restriction or limitation on Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are required to agree to your request not to disclose your Health Information to a health plan for payment or health care operations if the Health Information pertains solely to a health care item or service for which we have been paid in full. For other restrictions requests, we are not required to agree to your request. But if we do, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications:
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact your personal representative at home instead of at work. We will accommodate reasonable requests.

Right to a Paper Copy of this Notice:
You have the right to a paper copy of this Notice. Contact the appropriate Privacy Officer at the end of this Notice.

How to Exercise Your Rights:
To exercise any the rights described in this Notice contact our Privacy Officer at the address listed at the end of this Notice.

Changes to this Notice:
We reserve the right to change our practices regarding Health Information and this Notice. The revised notice will apply to all of your health information. The effective date of the revised Notice will be noted on the top right corner of the first page and at the end of this Notice.

How to File a Complaint:
If you believe your privacy rights have been violated, you may file a complaint with us. Please contact the Compliance and Corporate Ethics hotline at 1-800-443-0463 or visit www.archcare.ethicspoint.com or mail us at ArchCare Compliance and Corporate Ethics Department 205 Lexington Ave., New York, NY 10016. You may also file a complaint with the Secretary of the Department of Health and Human Services. No one will retaliate or take action against you for filing a complaint.

Revised Date: 11/05/2024

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Enrollment Agreement

I have received the Enrollment Agreement from ArchCare Senior Life PACE and a copy of the provider network and have had the opportunity to ask questions about the program.

Name: _____
(First) (Middle) (Last)

Address: _____
(City) (State) (Zip Code)

Date of Birth: _____ Social Security #: _____

Telephone Number: _____ Sex: □ Female □ Male

Medicaid # _____ Medicare # _____

Other Insurance Information: _____
Insurance Company's Name Policy #

Responsible Party: _____
(First) (Middle) (Last)

Address: _____
(City) (State) (Zip Code)

Relationship to Participant: _____ Telephone Number: (H) _____

Other Phone Numbers: (W) _____ Mobile Number: _____

Enrollment Options:

□ I have been informed of the Direct Enrollment Process and NYIA process, I choose:
- □ Direct Enrollment Process
- □ NYIA Process

□ By signing this Enrollment Agreement, I am confirming that I have received, read and understand this Enrollment Agreement with ArchCare Senior Life PACE contained in the booklet. The services covered and my Rights and Responsibilities, as described in the Enrollment Agreement and this Enrollment Agreement Acknowledgement, have been explained to me. I have been given the opportunity to ask questions. All my questions have been answered to my satisfaction. I agree to participate in ArchCare Senior Life PACE according to the terms and conditions in the Enrollment Agreement. As a participant, I agree to receive all health services and health related services from ArchCare Senior Life PACE.

□ I acknowledge that ArchCare Senior Life PACE is my sole provider of services as of the effective date of enrollment.

Payment:

□ I agree to promptly pay or the Responsible Party agrees to use my income and assets to promptly pay my monthly amount due to ArchCare Senior Life PACE as outlined prior to my enrollment. I agree to maintain Medicare Part A and Part B insurance by continuing to pay the applicable premiums, or if I do not maintain it, I agree to become responsible to pay a corresponding private pay premium. If receiving Medicaid and share of cost is determined, I agree to pay my share of the cost to ArchCare Senior Life PACE. I understand failure to pay could result in an involuntary disenrollment from the ArchCare Senior Life PACE program.

Participant's Authorization to Release Information and Payment Request:

□ I authorize ArchCare Senior Life PACE to release and receive any medical and/or financial information regarding this admission for use in providing services and in determining and receiving payment. I request that payment be made on my behalf to ArchCare Senior Life PACE.

□ I am responsible for informing the billing department when there is any change in my insurance coverage carrier.

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I have received the Enrollment Agreement from ArchCare Senior Life PACE and a copy of the provider network and have had the opportunity to ask questions about the program.

Name: _____
(First) (Middle) (Last)

Address: _____
(City) (State) (Zip Code)

Date of Birth: _____ Social Security #: _____

Telephone Number: _____ Sex: □ Female □ Male

Medicaid # _____ Medicare # _____

Other Insurance Information: _____
Insurance Company's Name Policy #

Responsible Party: _____
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Address: _____
(City) (State) (Zip Code)

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Enrollment Options:

□ I have been informed of the Direct Enrollment Process and NYIA process, I choose:
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□ I am responsible for informing the billing department when there is any change in my insurance coverage carrier.

PACE Organization Representatives - Access to and Release of Information:

- ☐ I authorize the Centers for Medicare and Medicaid Services (CMS), the Social Security Administration (SSA), New York State Department of Health (NYS DOH), and New York City Human Resource Administration (NYC HRA) to provide ArchCare Senior Life PACE with access to copies of information about my Medicaid eligibility status; and files including Medicaid applications, recertification information notices and request for information, and required documentation.
- ☐ My Responsible Party and I also agree to provide ArchCare Senior Life PACE with a copy of all notices about my Medicare or Medicaid eligibility within three days of receipt of such notice.
- ☐ My Responsible Party and I agree to provide complete and accurate financial information to ArchCare Senior Life PACE in a timely fashion.
- ☐ I authorize ArchCare Senior Life PACE to release medical and financial information about me that is necessary for ArchCare Senior Life PACE to obtain payment for the services provided to me and to disclose and exchange personal information between CMS, and its agents, and the NYS DOH.
- ☐ I agree to the current plan of care as outlined and explained to me. I understand that I will be advised in advance of any change in this plan of care before the change is made.

Advance Directives / Health Care Wishes:

- ☐ I have been informed of my right to appoint a health care agent and to document any advance directives regarding my health care. I understand that ArchCare Senior Life PACE staff will assist me in this area if I need help. I will provide ArchCare Senior Life PACE with copies of any advance directives and all documents authorizing an agent on my behalf including power of attorney, guardianship orders, and health care proxy.

Bill of Rights:

- ☐ My signature below indicates that I have received the ArchCare Senior Life PACE Participant Rights and have had a chance to review it and ask any question I might have about it.

Emergency Preparedness:

- ☐ My signature below indicates that I have received the ArchCare Senior Life PACE Emergency Preparedness packet.

Important Notice:

The benefits under this contract are made possible through a special agreement that ArchCare Senior Life PACE has with Medicare (CMS), and Medicaid (NYS DOH). When you sign this Agreement, you are signing to accept benefits exclusively from ArchCare Senior Life PACE in place of the usual Medicare and Medicaid benefits. By signing this agreement, you acknowledge that ArchCare Senior Life PACE is your sole service provider as of the effective date. If you choose to disenroll from ArchCare Senior Life PACE after your enrollment date, you must notify ArchCare Senior Life PACE of your intent to disenroll, as detailed in your Enrollment Agreement. You cannot enroll or disenroll from ArchCare Senior Life PACE at a Social Security Office.

I understand that my ArchCare Senior Life PACE effective enrollment date is: _____

Participant Name	Participant Signature	Date
Family, POA, Guardian Name	Family, POA, Guardian Signature	Date
Responsible Party (*If different from above*)	Responsible Party Signature	Date
Witness	Staff Member Signature	Date
Staff Member Name	Staff Member Signature	Date

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Family, POA, Guardian Name	Family, POA, Guardian Signature	Date
Responsible Party (*If different from above*)	Responsible Party Signature	Date
Witness	Staff Member Signature	Date
Staff Member Name	Staff Member Signature	Date

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PROJECTED SERVICE PLAN FOR PARTICIPANT

Name: _____ **Assessment Date**: _____

Projected Services:

❑ Nursing ❑ Physician ❑ Social Services

❑ PCA/HHA Recommended days & hours: _____

Name of Vendor LHCSA: _____

❑ Housekeeping

❑ Physical Therapy Evaluation

❑ Occupational Therapy Evaluation

❑ Speech Therapy Evaluation

❑ Nutrition Evaluation

❑ PACE Day Center # of days: _____

Medication: Part D Provider: _____

❑ PERS ❑ Safe Return Bracelet ❑ Medical ID Bracelet

❑ Transportation (medical appointments) ❑ Audiology ❑ Dental ❑ Podiatry ❑ Optometry

❑ Medical Equipment Needed: _____

❑ Medical Supplies Needed: _____

❑ Heavy Duty Housecleaning ❑ Home Repairs

Other: _____

Your finalized Service plan will be provided by the Care Team at your start of enrollment. The plan care will be revised based on your continuing care needs.
This proposed Service Plan was explained to participant/representative and I accept this plan as stated at this time.

Participant/representative Signature: _____ Date: _____

Assessment Nurse Signature: _____ Date: _____

Rev: May 2023

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PROJECTED SERVICE PLAN FOR PARTICIPANT

Name: _____ **Assessment Date**: _____

Projected Services:

❑ Nursing ❑ Physician ❑ Social Services

❑ PCA/HHA Recommended days & hours: _____

Name of Vendor LHCSA: _____

❑ Housekeeping

❑ Physical Therapy Evaluation

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Your finalized Service plan will be provided by the Care Team at your start of enrollment. The plan care will be revised based on your continuing care needs.
This proposed Service Plan was explained to participant/representative and I accept this plan as stated at this time.

Participant/representative Signature: _____ Date: _____

Assessment Nurse Signature: _____ Date: _____

Rev: May 2023

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HOME EVALUATION FOR PARTICIPANT

Participant Name: _____ ArchCare ID: _____

Address: _____ Phone: _____

_____

_____ Cross Street: _____

_____ _____

Special Instructions to Access Home: _____

Type of Housing:

_____ Apartment House

_____ Private House

_____ NYCHA

_____ Senior Building

_____ Rooming House

_____ Adult Home

Rent: _____

Subsidy:

_____ Sect. 8

_____ HUD 202

_____ SCRIE

Paid up to Date: _____

Utilities Included: _____

Number of Rooms: _____

Participant has own Bedroom: _____ Bathroom in Apartment: _____

Living Area on One Level: _____

# of Stairs Inside: _____ # Stairs Outside: _____ Ramp: _____ Problems: _____

Elevator: _____ Reliable Elevator Service: _____

Functional Smoke Detectors: _____

Cooking Facilities: _____

Functional Telephone: _____

Adequate Lighting for Safe Ambulation and ADLs: _____ Adequate Heat and Ventilation: _____

Wheelchair Accessible: _____

Participant's Own Home: _____ Lives in Someone Else's Home: _____

Other Residents in Home:

Name	Relationship	Age

Pets in Home: _____ Type: _____ Number: _____

Pet's Name _____

Overall Condition of the Home: _____

Adequately Maintained and Furnished: _____

In Need of Heavy Cleaning: _____

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SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (SPMSQ)

Name: _____ **Date**: _____

1. What is the date today? _____ Score: _____
2. What day of the week is it? _____ Score: _____
3. What is the name of this place? _____ Score: _____
4. What is your telephone number? _____ Score: _____
   (If no telephone, what is your street address)
5. How old are you? _____ Score: _____
6. When were you born? _____ Score: _____
7. Who is the President of the United States? _____ Score: _____
8. Who was the President just before him? _____ Score: _____
9. What was your mother's maiden name? _____ Score: _____
   (accept any surname other than sample person's)
10. Subtract 3 from 20 and keep subtracting 3 from each new number you get, all the way down.
    (Correct answer: 17, 14, 11, 8, 5, 2) _____ Score: _____

Total number of Incorrect or Not answered: _____

Notes (optional): _____

_____

_____

Scoring:
0-2 Incorrect or Not Answered: Normal mental functioning 3-4
Incorrect or Not Answered: Mild cognitive impairment
5-7 Incorrect or Not Answered: Moderate cognitive impairment 8-10
Incorrect or Not Answered: Severe cognitive impairment

*One or more incorrect or not answered is allowed in the scoring if the participant has had a grade school education or less.

*One less incorrect or not answered is allowed if the participant has had education beyond the high school level.

RN Signature _____

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BACKUP AGREEMENT

Date: _____

Participant Name: _____

I, _____ agree to participate as the back up care provider.

I am available to:

_____ provide personal care and other services when the home care staff is not available.

_____ provide direction to the home care aide if the participant is unable to do so.

_____ organize, prepare or administer medications if necessary.

_____ manage finances (insure rent, utilities and other bills are paid in a timely manner)

_____ other (please specify):

_____

_____
Name of Back-up provider

_____
Signature of Back-up provider

_____
Relationship

Print Name: _____

Address: _____

Telephone: _____

Witness: _____ Date: _____

1432 Fifth Avenue, New York, NY 10035
T 646 289 7700 F 646 289 7791
www.archcare.org

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Senior Life

BACKUP AGREEMENT

Date: _____

Participant Name: _____

I, _____ agree to participate as the back up care provider.

I am available to:

_____ provide personal care and other services when the home care staff is not available.

_____ provide direction to the home care aide if the participant is unable to do so.

_____ organize, prepare or administer medications if necessary.

_____ manage finances (insure rent, utilities and other bills are paid in a timely manner)

_____ other (please specify):

_____

_____
Name of Back-up provider

_____
Signature of Back-up provider

_____
Relationship

Print Name: _____

Address: _____

Telephone: _____

Witness: _____ Date: _____

1432 Fifth Avenue, New York, NY 10035
T 646 289 7700 F 646 289 7791
www.archcare.org

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PARTICIPANT CONSENT TO CONTACT

I, _____, hereby give permission to the staff of

ArchCare Senior Life to communicate with the following individual/s:

Contact 1

Name: _____

Phone: _____

Address: _____

_____

Contact 2

Name: _____

Phone: _____

Address: _____

_____

This communication will pertain solely to my membership in the PACE program and will involve any and all related information regarding my care through ArchCare Senior Life, PACE.

_____ _____

Participant Signature **Date**

_____ _____

Staff/Witness Signature **Date**

1432 Fifth Avenue New York, N.Y. 10035
T 646.289.7700 F 646-289-7791
www.archcare.org

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PARTICIPANT CONSENT TO CONTACT

I, _____, hereby give permission to the staff of

ArchCare Senior Life to communicate with the following individual/s:

Contact 1

Name: _____

Phone: _____

Address: _____

_____

Contact 2

Name: _____

Phone: _____

Address: _____

_____

This communication will pertain solely to my membership in the PACE program and will involve any and all related information regarding my care through ArchCare Senior Life, PACE.

_____ _____

Participant Signature **Date**

_____ _____

Staff/Witness Signature **Date**

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T 646.289.7700 F 646-289-7791
www.archcare.org

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AUTHORIZATION FOR TREATMENT

Participant Name:_____ Participant ID#:_____

_____ I give permission for approved personnel from ArchCare Senior Life and other ArchCare providers to perform all necessary procedures ordered by my physician for my health. I know I may refuse.

_____ I give permission to ArchCare Senior Life to photograph me and my treatment as long as the photos are used as part of my medical record or for teaching purposes.

My signature, or that of my representative, is proof that I have received a copy of my rights, responsibilities and obligations as a patient of ArchCare Senior Life.

_____ _____
Participant/Representative Signature Relationship to Participant

_____ _____
Signature of person completing form Date

archcare
Senior Life

AUTHORIZATION FOR TREATMENT

Participant Name:_____ Participant ID#:_____

_____ I give permission for approved personnel from ArchCare Senior Life and other ArchCare providers to perform all necessary procedures ordered by my physician for my health. I know I may refuse.

_____ I give permission to ArchCare Senior Life to photograph me and my treatment as long as the photos are used as part of my medical record or for teaching purposes.

My signature, or that of my representative, is proof that I have received a copy of my rights, responsibilities and obligations as a patient of ArchCare Senior Life.

_____ _____
Participant/Representative Signature Relationship to Participant

_____ _____
Signature of person completing form Date

YOUR RIGHTS IN THE PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

When you join a PACE program, you have certain rights and protections. ArchCare Senior Life, as your PACE program, must fully explain and provide your rights to you or someone acting on your behalf in a way you can understand at the time you join.

At ArchCare Senior Life we are dedicated to providing you with quality health care services so that you may remain as independent as possible. This includes providing all Medicaid and Medicare-covered items and services, and other services determined to be necessary by the interdisciplinary team across all care settings, 24 hours a day,7 days a week.

Our staff and contractors seek to affirm the dignity and worth of each participant by assuring the following rights:

You have the right to treatment.

You have the right to treatment that is both appropriate for your health conditions and provided in a timely manner. You have the right:

- To receive all the care and services you need to improve or maintain your overall health condition, and to achieve the best possible physical, emotional, and social well-being.
- To get emergency services when and where you need them without the PACE program's approval. A medical emergency is when you think your health is in serious danger— when every second counts. You may have a bad injury, sudden illness or an illness quickly getting much worse. You can get emergency care anywhere in the United States and you do not need to get permission from ArchCare Senior Life prior to seeking emergency services.

You have the right to be treated with respect.

You have the right to be treated with dignity and respect at all times, to have all of your care kept private and confidential, and to get compassionate, considerate care. You have the right:

- To get all of your health care in a safe, clean environment and in an accessible manner.
- To be free from harm. This includes excessive medication, physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, and any physical or chemical restraint that is used on you for discipline or convenience of staff and that you do not need to treat your medical symptoms.
- To be encouraged and helped to use your rights in the PACE program.
- To get help, if you need it, to use the Medicare and Medicaid complaint and appeal processes, and your civil and other legal rights.
- To be encouraged and helped in talking to PACE staff about changes in policy and services you think should be made.
- To use a telephone while at the PACE center.
- To not have to do work or services for the PACE program.

- To have all information about your choices for PACE services and treatment explained to you in a language you understand, and in a way that takes into account and respects your cultural beliefs, values, and customs.

You have a right to protection against discrimination.

Discrimination is against the law. Every company or agency that works with Medicare and Medicaid must obey the law. They cannot discriminate against you because of your:

- Race
- Ethnicity
- National Origin
- Religion
- Age
- Sex
- Mental or physical disability
- Sexual Orientation
- Sex characteristics, including intersex traits, pregnancy or related conditions, gender identity, and sex stereotypes
- Source of payment for your health care (For example, Medicare or Medicaid)

If you think you have been discriminated against for any of these reasons, contact a staff member at the PACE program to help you resolve your problem.

If you have any questions, you can call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

You have a right to information and assistance.

You have the right to get accurate, easy-to-understand information, to have this information shared with your designated representative, who is the person you choose to act on your behalf, and to have someone help you make informed health care decisions. You have the right:

- To have someone help you if you have a language or communication barrier so you can understand all information given to you.
- To have the PACE program interpret the information into your preferred language in a culturally competent manner, if your first language is not English and you can't speak English well enough to understand the information being given to you.
- To get marketing materials and PACE participant rights in English and in any other frequently used language in your community. You can also get these materials in Braille, if necessary.
- To have the enrollment agreement fully explained to you in a manner understood by you.
- To get a written copy of your rights from the PACE program. The PACE program must also post these rights in a public place in the PACE center where it is easy to see them.
- To be fully informed, in writing, of the services offered by the PACE program. This includes telling you which services are provided by contractors instead of the PACE staff. You must be given this information before you join, at the time you join, and when you need to make a choice about what services to receive.
- To be provided with a copy of individuals who provide care-related services not provided directly by ArchCare Senior Life upon request.

- To look at, or get help to look at, the results of the most recent review of your PACE program. Federal and State agencies review all PACE programs. You also have a right to review how the PACE program plans to correct any problems that are found at inspection.

Before ArchCare Senior Life starts providing palliative care, comfort care, and end-of-life care services, you have the right to have information about these services fully explained to you. This includes your right to be given, in writing, a complete description of these services and how they are different from the care you have been receiving, and whether these services are in addition to, or instead of, your current services. The information must also explain, in detail, how your current services will be affected if you choose to begin palliative care, comfort care, or end-of-life services. Specifically, it must explain any impact to:

- Physician services, including specialist services.
- Hospital services
- Long-term care services
- Nursing services
- Social services
- Dietary services
- Transportation
- Home care
- Therapy, including physical, occupational, and speech therapy
- Behavioral health
- Diagnostic testing, including imaging and laboratory services
- Medications
- Preventative healthcare services
- PACE center attendance

You have the right to change your mind and take back your consent to receive palliative care, comfort care, or end-of-life care services at any time and for any reason by letting ArchCare Senior Life know either verbally or in writing.

You have a right to a choice of providers.

You have the right to choose a health care provider, including your primary care provider and specialists, from within the PACE program's network, that is sufficient to ensure access to appropriate high quality health care. Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services.

You have the right to have reasonable and timely access to specialists as indicated by your health condition.

You also have the right to receive care across all care settings, up to and including placement in a long-term care facility when ArchCare Senior Life can no longer maintain you safely in the community.

You have a right to participate in treatment decisions.

You have the right to fully participate in all decisions related to your health care. If you cannot fully participate in your treatment decisions or you want to have someone you trust help you, you have the right to choose that person to act on your behalf as your designated representative.

You have the right:

- To be fully informed of your health status and how well you are doing, to make health care decisions, and to have all treatment options fully explained to you. This includes the right not to get treatment or take medications. If you choose not to get treatment, you must be told how this may affect your physical and mental health.
- To fully understand ArchCare Senior Life's palliative care, comfort care, and end-of-life care services. Before ArchCare Senior Life can start providing you with palliative care, comfort care, and end-of-life care services, the PACE program must explain all of your treatment options, give you written information about these options, and get written consent from you or your designated representative. Information will include how these services are different from the care you currently receive, if these services will be added to your current care or will replace your current care and will tell you how various types of current services will be impacted if you elect to receive palliative care, comfort care and end-of-life care. You have the right to revoke or withdraw your consent to receive palliative care, comfort care, and end-of-life care services.
- To have the PACE program help you create an advance directive, if you choose. An advance directive is a written document that says how you want medical decisions to be made in case you cannot speak for yourself. You should give it to the person who will carry out your instructions and make health care decisions for you.
- To participate in making and carrying out your plan of care. You can ask for your plan of care to be reviewed at any time.
- To be given advance notice, in writing, of any plan to move you to another treatment setting and the reason you are being moved.

You have a right to have your health information kept private.

- You have the right to talk with health care providers in private and to have your personal health care information kept private and confidential, including health data that is collected and kept electronically, as protected under State and Federal laws.
- You have the right to look at and receive copies of your medical records and request amendments.
- You have the right to be assured that your written consent will be obtained for the release of information to persons not otherwise authorized under law to receive it.
- You have the right to provide written consent that limits the degree of information and the persons to whom information may be given.

There is a patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used. If you have any questions about this privacy rule, call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800- 537- 7697.

You have a right to make a complaint.

You have a right to complain about the services you receive or that you need and don't receive, the quality of your care, or any other concerns or problems you have with your PACE program.
You have the right to a fair and timely process for resolving concerns with your PACE program.
You have the right:

- To a full explanation of the complaint process.

- To be encouraged and helped to freely explain your complaints to PACE staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns. This includes being punished, threatened, or discriminated against.
- **To contact 1-800-Medicare for information and assistance, including to make a complaint related to the quality of care or the delivery of a service.**

You have the right to request additional services or file an appeal.

You have the right to request services from ArchCare Senior Life, its employees, or contractors, that you believe are necessary. You have the right to a comprehensive and timely process for determining whether those services should be provided.

You also have the right to appeal any denial of a service or treatment decision by the PACE program, staff, or contractors.

You have a right to leave the program.

If, for any reason, you do not feel that the PACE program is what you want, you have the right to leave the program at any time and have such disenrollment be effective the first day of the month following the date ArchCare Senior Life receives your notice of voluntary disenrollment.

Additional Help:

If you have complaints about your PACE program, think your rights have been violated, or want to talk with someone outside your PACE program about your concerns, call 1-800-MEDICARE (1-800-633-4227) to get the name and phone number of someone in your State Administering Agency.

Signature	Relationship to Participant	Date
Witness Signature	Relationship to Participant	Date

BRONX LOCATION
ArchCare Senior Life at San Vicente de Paúl
Nursing Home and Rehabilitation Center
900 Intervale Avenue
Bronx, NY 10459
Main: 1-718-732-7171

MANHATTAN LOCATION
ArchCare Senior Life Harlem PACE Center
1432 Fifth Avenue
New York, NY 10035
Main: 1-646-289-7700

STATEN ISLAND LOCATION
ArchCare Senior Life at Carmel Richmond
Healthcare and Rehabilitation Center
88 Old Town Road
Staten Island, NY 10304
Main: 1-718-407-2916

WESTCHESTER LOCATION
ArchCare Senior Life Westchester PACE Center
115 Broadway
Dobbs Ferry, NY 10522
Main: 1-914-326-3199

- To be encouraged and helped to freely explain your complaints to PACE staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns. This includes being punished, threatened, or discriminated against.
- **To contact 1-800-Medicare for information and assistance, including to make a complaint related to the quality of care or the delivery of a service.**

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Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a required field).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

***I want this information released because:**

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date_____ to date_____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

***Address:** _____

Relationship (if not the subject of the record): _____ ***Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a required field).*

TO: Social Security Administration

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***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

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6. ☐ Medical records from my claims folder(s) from date_____ to date_____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
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***Signature:** _____ ***Date:** _____

***Address:** _____

Relationship (if not the subject of the record): _____ ***Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

OCA Official Form: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

(This form has been approved by the New York State Department of Health)

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York Slate law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL**.and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL, HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b)

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

❑ Medical Record from (insert date)_____to (insert date) _____

❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

❑ Other:_____

_____

Include: *(Indicate by Initialing)*

_____Alcohol/Drug Treatment

_____Mental Health Information

_____HIV-Related Information

Authorization to Discuss Health Information

(b) ❑ By initialing here_____I authorize_____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10.Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the Form

_____ Date:_____

Signature of patient or representative authorized by Law

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having my symptoms or infection and information regarding a person's contacts.

OCA Official Form: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

(This form has been approved by the New York State Department of Health)

Patient Name	Date of Birth	Social Security Number
Patient Address		

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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b)

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

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❑ Medical Record from (insert date)_____to (insert date) _____

❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

❑ Other:_____

_____

Include: *(Indicate by Initialing)*

_____Alcohol/Drug Treatment

_____Mental Health Information

_____HIV-Related Information

Authorization to Discuss Health Information

(b) ❑ By initialing here_____I authorize_____

Initials — Name of individual health care provider

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All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the Form

_____ Date:_____

Signature of patient or representative authorized by Law

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having my symptoms or infection and information regarding a person's contacts.

archcare

Authorization for Access to Patient Information through a Health Information Exchange Organization

New York State Department of Health

Patient Last Name	Patient First Name	Date of Birth
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow ArchCare Senior Life to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from the different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healhtix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice: ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.
☐ **1. I GIVE CONSENT** for ArchCare to to access all of my electronic health information through Healthix to provide health care.
☐ **2. I DENY CONSENT** for ArchCare to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and relatedservices.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.
2. **What Types of Information about You Are Included?** I If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - **Alcohol or drug use problems**
   - **Birth control and abortion (family planning)**
   - **Genetic (inherited) diseases or tests**
   - **HIV/AIDS**
   - **Mental health conditions**
   - **Sexually transmitted diseases**
3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.
4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.
5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.
6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call ArchCare at: 1-855-951-2273; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*..
7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.
8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.
9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.
10. **Copy of Form**. You are entitled to receive a copy of this Consent Form**.**

ArchCare Senior Life is a Coordinated Care plan with a Medicare contract. Enrollment in ArchCare Senior Life depends on contract renewal. This information is available for free in other languages. Please call our customer service number at 1-866-263-9083, TTY 711, Monday-Friday, 8:30 a.m.-5:00 p.m. Esta información está disponible gratis en otros idiomas. Por favor llame a nuestro número de servicio al cliente al 1-866-263-9083, TTY 711, de lunes a viernes, de 8:30 a.m.-5:00 p.m.

Discrimination is Against the Law

ArchCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ArchCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-263-9083 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-263-9083 (TTY: 711)。

archcare

Authorization for Access to Patient Information through a Health Information Exchange Organization

New York State Department of Health

Patient Last Name	Patient First Name	Date of Birth
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow ArchCare Senior Life to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from the different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healhtix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice: ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.
☐ **1. I GIVE CONSENT** for ArchCare to to access all of my electronic health information through Healthix to provide health care.
☐ **2. I DENY CONSENT** for ArchCare to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and relatedservices.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.
2. **What Types of Information about You Are Included?** I If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - **Alcohol or drug use problems**
   - **Birth control and abortion (family planning)**
   - **Genetic (inherited) diseases or tests**
   - **HIV/AIDS**
   - **Mental health conditions**
   - **Sexually transmitted diseases**
3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.
4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.
5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.
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ARCHCARE AND AFFILIATED ENTITIES

AUTHORIZATION FOR PATIENT PHOTOGRAPH, VIDEOTAPING, OR OTHER VISUAL/AUDIO IMAGE

To ArchCare and Affiliated Entities (aka Catholic Health Care System) Patients, Residents, and Participants:

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

I, the undersigned, hereby consent and authorize _____ ("Organization") to take, use, and disseminate photographs, films, videotapes, or other visual/audio images of me and to release associated identifying information, such as my name or the name of the facility where I live.

I understand that all such visual/audio images will be made and used for ArchCare and its member entities' purposes. Specifically, these images will be used in the following way:

(Specify how these images will be used: e.g., footage for television news or photos for ArchCare website.)

_____

_____

_____

I understand that in the course of making such photographs, videotapes, or other visual/audio images, my individually identifiable health information, such as my image, may be disclosed to the Organization and to other third parties.

By signing this authorization form, I understand:

- I am authorizing the use or disclosure of my protected health information only as described above. This information may be re-disclosed because the Organization is not required by law to protect the privacy of the information.

- I have a right to refuse to sign this authorization. My health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form.

- I have a right to see and copy the information described on this authorization form in accordance with ArchCare Facility or Program policies. I also have a right to receive a copy of this form after I have signed it.

ARCHCARE AND AFFILIATED ENTITIES

AUTHORIZATION FOR PATIENT PHOTOGRAPH, VIDEOTAPING, OR OTHER VISUAL/AUDIO IMAGE

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(Specify how these images will be used: e.g., footage for television news or photos for ArchCare website.)

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- I have the right to revoke this authorization at any time, except to the extent that the persons I have authorized to use and/or disclose my protected health information have already taken action based upon my authorization. To revoke this authorization, I should contact the ArchCare Facility or Program Privacy Officer.

I further understand that this authorization will expire:

when I am discharged from the ArchCare Facility where I reside or when I am no longer a participant of the ArchCAre Program in which I am enrolled.

other (please specify)_____

_____

_____

_____

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

_____ _____

Signature of Resident/Patient/Participant or Personal Representative Date

_____

Resident's Name (Printed)

If Personal Representative Signs on Behalf of Resident / Patient / Participant, Describe Basis of his or her Authority:

_____

_____

Note: The Resident or his or her Personal Representative must be provided with a copy of this form after it has been signed.

- I have the right to revoke this authorization at any time, except to the extent that the persons I have authorized to use and/or disclose my protected health information have already taken action based upon my authorization. To revoke this authorization, I should contact the ArchCare Facility or Program Privacy Officer.

I further understand that this authorization will expire:

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other (please specify)_____

_____

_____

_____

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_____ _____

Signature of Resident/Patient/Participant or Personal Representative Date

_____

Resident's Name (Printed)

If Personal Representative Signs on Behalf of Resident / Patient / Participant, Describe Basis of his or her Authority:

_____

_____

Note: The Resident or his or her Personal Representative must be provided with a copy of this form after it has been signed.

ARCHCARE AND AFFILIATED ENTITIES CONSENT TO BE PHOTOGRAPHED, FILMED, VIDEOTAPED OR INTERVIEWED

I, _____, hereby authorize ArchCare (aka Catholic Health Care
(Print Name)

System) to allow its agents or designees, or its member entities (ArchCare Facilities and Programs) and any of their agents or designees, to photograph, film, videotape and/or interview me or publish my writing or other mode of expression (such as, but not limited to, a drawing or painting) while a resident/patient of an ArchCare or an employee or visitor of an ArchCare Facility, whether such activities take place inside or outside of an ArchCare Facility.

I hereby release ArchCare, its administration, employees, staff members, trustees, and member entities from any liability which may arise from or in connection with such filming, photographing, recording, videotaping, interviewing, or publishing and grant ArchCare the unrestricted right to use and disseminate my image, interview, writing or mode of expression for the advertising, marketing of ArchCare or institutions of which ArchCare is the member, including the use of my image, interview, writing or mode of expression on a website, or for any other purpose which ArchCare in its sole discretion deems appropriate.

This is a legal consent form and a release from liability form. Please read it carefully.

Signature: _____ Date: _____

Status: patient, resident, or participant
employee
visitor
other _____

Witnessed by:
Print Name: _____

Signature: _____

Title: _____

ARCHCARE AND AFFILIATED ENTITIES CONSENT TO BE PHOTOGRAPHED, FILMED, VIDEOTAPED OR INTERVIEWED

I, _____, hereby authorize ArchCare (aka Catholic Health Care
(Print Name)

System) to allow its agents or designees, or its member entities (ArchCare Facilities and Programs) and any of their agents or designees, to photograph, film, videotape and/or interview me or publish my writing or other mode of expression (such as, but not limited to, a drawing or painting) while a resident/patient of an ArchCare or an employee or visitor of an ArchCare Facility, whether such activities take place inside or outside of an ArchCare Facility.

I hereby release ArchCare, its administration, employees, staff members, trustees, and member entities from any liability which may arise from or in connection with such filming, photographing, recording, videotaping, interviewing, or publishing and grant ArchCare the unrestricted right to use and disseminate my image, interview, writing or mode of expression for the advertising, marketing of ArchCare or institutions of which ArchCare is the member, including the use of my image, interview, writing or mode of expression on a website, or for any other purpose which ArchCare in its sole discretion deems appropriate.

This is a legal consent form and a release from liability form. Please read it carefully.

Signature: _____ Date: _____

Status: patient, resident, or participant
employee
visitor
other _____

Witnessed by:
Print Name: _____

Signature: _____

Title: _____

Participant Handbook

ARCHCARE SENIOR LIFE
PROGRAM OF ALL-INCLUSIVE CARE
FOR THE ELDERLY (PACE)

archcare
Senior Life

WELCOME TO ARCHCARE SENIOR LIFE

A PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

We are pleased to provide you with this Participant Handbook which includes a comprehensive description of benefits, services, and guidelines related to your enrollment and participation in our program. Our entire team looks forward to working together with you to maximize your health and independence.

ArchCare Senior Life
(866) 263-9083, TTY 711
Monday – Friday, 8:30 am – 5:00 pm

ArchCare Senior Life PACE Centers are in the following locations:

BRONX LOCATION:
ArchCare Senior Life Bronx
900 Intervale Avenue
Bronx, NY 10459
Main Number: **1-718-732-7171**

MANHATTAN LOCATION:
ArchCare Senior Life Harlem
1432 Fifth Avenue
New York, NY 10035
Main Number: **1-646-289-7700**

STATEN ISLAND LOCATION:
ArchCare Senior Life Staten Island
88 Old Town Road
Staten Island, NY 10304
Main Number: **1-718-407-2916**

WESTCHESTER LOCATION:
ArchCare Senior Life Westchester
115 Broadway
Dobbs Ferry, NY 10522
Main Number: **1-914-326-3199**

NOTICE OF NON-DISCRIMINATION

Discrimination is Against the Law

ArchCare Senior Life PACE complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **ArchCare Senior Life PACE** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ArchCare Senior Life PACE provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats such as Braille, large print, data CD, audio CD or qualified reader. Puede solicitar esta información de forma gratuita en otros formatos, tales como Braille, letra grande, en CD, CD de audio o un lector cualificado.
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages.

If you need these services, call **ArchCare Senior Life PACE** at 1-866-263-9083. For TTY/TDD services, call 711. If you believe that **ArchCare Senior Life PACE** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **ArchCare Senior Life PACE** by:

Mail:	1432 5th Avenue, New York, NY 10035
Phone:	1-866-263-9083 (for TTY/TDD services, call 711)
Fax:	1-646-304-7131
In person:	1432 5th Avenue, New York, NY 10035
Email:	aslqualityimprovement@archcare.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html
Phone:	1-855-467-9351 (TTY/TDD 711)

Participants may be fully and personally liable for the costs of unauthorized or out-of-PACE program agreement services. Learn more about our all-inclusive community care program at ArchCare Senior Life. Call 1-866-263-9083, Monday - Friday, 8:30 a.m. - 5 p.m., TTY/TDD: 711 or visit archcare.org.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-263-9083 (TTY:711).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-263-9083 (TTY:711).	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-263-9083 (TTY:711)。	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم TTY:711 رقم هاتف الصم والبكم 1-866-263-9083	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-263-9083 (TTY:711) 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-263-9083 (телетайп: TTY:711).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-263-9083 (TTY:711).	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-263-9083 (TTY:711).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-263-9083 (TTY:711).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון. אפצאל. רופט 1-866-263-9083 (TTY: 711)	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-263-9083 (TTY:711).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-263-9083 (TTY:711).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলেত পারেন, তাহেল নিঃখরচায় ভাষা সহায়তা [ে পরষবা উপলব্ধ আেছ। ফোন করুন ১-1-866-263-9083 (TTY: 711).	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-263-9083 (TTY: 711).	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-263-9083 (TTY:711).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-866-263-9083 TTY:711.	Urdu

ARCHCARE SENIOR LIFE TABLE OF CONTENTS

WHAT IS ARCHCARE SENIOR LIFE?

ArchCare Senior Life, a program of All-Inclusive Care for the Elderly (PACE), is approved by the New York State Department of Health and Centers for Medicaid and Medicare Services (CMS) for individuals who need long term care services and who are eligible for Medicaid and Medicare or eligible for Medicaid only or wish to private pay. ArchCare Senior Life provides long-term care and other health–related services to participants within Manhattan, The Bronx, Staten Island and Westchester. ArchCare Senior Life gives you the opportunity to receive all of your health care services covered by Medicaid and Medicare all under one Plan with a physician and care team guiding and coordinating your needs across all settings; home, hospital, nursing facility, outpatient departments or day centers.

Managed long-term care means that a coordinated Plan of Care and coordinated services are provided to individuals who choose to enroll in ArchCare Senior Life. Your assigned Primary Care Physician (PCP) along with your care team must order these services. Participants obtain these services through a network of ArchCare Senior Life participating health care providers. Once enrolled, you receive all your health care services from ArchCare Senior Life participating network of providers including medical specialists, home health care services, dental, podiatry and many more. A complete listing of covered services is described in this handbook. Your care team can choose or assist you in choosing the providers that meet your needs.

Participation in ArchCare Senior Life is voluntary. You can decide on your own, or with ArchCare Senior Life help, whether or not to enroll in ArchCare Senior Life, or to initiate disenrollment later for any reason.

ArchCare Senior Life makes every effort to be responsive to cultural diversity and communication needs in all of its operations. You have the right to obtain any information from ArchCare Senior Life translated into another language if you are not an English speaker. Written materials can also be provided in Spanish. As many participating providers speak languages other than English, please refer to our Provider Directory or call ArchCare Senior Life to obtain the most current provider information at (866) 263-9083. If you wish, ArchCare Senior Life can also provide specific staff to assist you.

"staff members are available to verbally translate materials for you on the telephone"

Program documents can be provided in alternate formats as well. Staff members are happy to read Program information to individuals who are visually impaired. Large type documents for materials such as this Participant Handbook can be provided. The Program can also arrange the services of a professional sign language interpreter on request for individuals who are hearing impaired.

WHO IS ELIGIBLE TO ENROLL IN ARCHCARE SENIOR LIFE?

To be eligible to enroll you must be:

- 55 years of age or older
- A resident of Manhattan, The Bronx, Staten Island, or Westchester
- Nursing facility level of care prior to enrollment.

We will gather this information by telephone before a visit is arranged. If you do not meet these three eligibility requirements, other ArchCare programs and plans may be discussed as well as alternative resources for you to consider.

You must also be:

- Capable of returning to or remaining in your home and community without jeopardy to your health and safety.
- In need of community based long term care services and care management from ArchCare Senior Life for more than 120 days from the date of enrollment. Long term care services include;
  - nursing services
  - therapies
  - home health or personal care aide services
  - adult day health center
  - private-duty nursing

- Consumer Directed Personal Assistance Services (CDPAS)
- Eligible for Medicaid or agree to pay a private pay premium for care as described in the private pay section of this handbook.

An Enrollment Nurse will arrange to visit you to discuss ArchCare Senior Life, to assist you with the details of applying for enrollment and to gather and assess information about your health and long-term care needs. During the visit, the Enrollment Nurse will complete a comprehensive clinical assessment using New York State (NYS) approved forms, and will discuss your service needs with you. The Enrollment Nurse will review your Medicaid and Medicare information, if applicable, and will discuss and provide information about Advanced Directives, how to access covered services, and your rights as an ArchCare Senior Life participant. The Enrollment Nurse will give you a copy of this Participant Handbook and will explain the forms you are required to sign for enrollment; an enrollment agreement/attestation form, an authorization for release of medical information, and a notice of HIPAA privacy practices.

Your enrollment agreement, once signed is submitted to New York Medicaid Choice/ Maximus. It will be reviewed and Medicaid eligibility will be confirmed. If New York Medicaid Choice/Maximus receives your enrollment agreement by the 20th of the month, enrollment will usually begin on the first day of the following month. For example, if New York Medicaid Choice/ Maximus receives the enrollment agreement after the 20th of the Month , for example on August 24th, enrollment will usually begin on October 1.

Once you are enrolled, you will be assigned to a Care Management Team. Members of this team will contact you upon notification of enrollment to arrange a home visit within the first 7 days of enrollment. During this visit you will have time to discuss the program services, your needs and any health concerns. A review of your overall Plan of Care will take place and how placement of services are arranged. If you are enrolled for the first day of the month, your services will begin according to your Plan of Care.

Applications for enrollment may be accepted for otherwise eligible inpatients or residents of hospital or residential facilities operated under the auspices of the State Office of Mental Health (OMH), State Office of Alcohol and Substance Abuse Services (OASAS), or State Office for People With Development Disabilities (OPWDD). Enrollment may only begin upon discharge from these programs or other home and community-based wavier programs to the applicant's home in the community.

An applicant who is enrolled in another managed care plan approved by Medicaid, a home and community-based wavier program, or an OPWDD day treatment program or who is receiving hospice services may be enrolled in ArchCare Senior Life only upon termination from the other program.

APPLICATION FOR ENROLLMENT PROCESS YOU MAY ENROLL THROUGH PACE DIRECT ELIGIBILITY OR THE NYIA PROCESS:

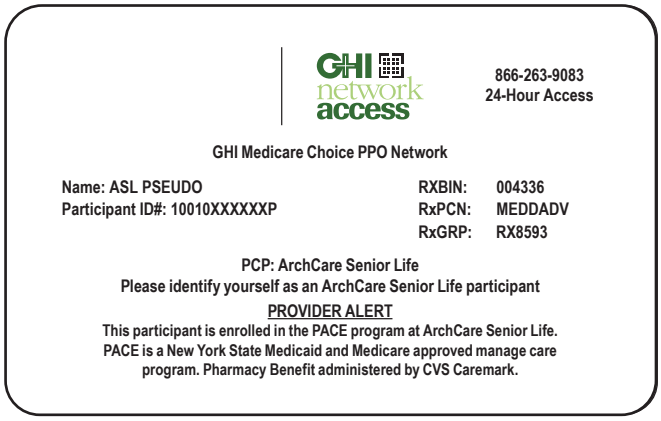
Direct Eligibility: You can have ArchCare Senior Life complete your assessment, which will determine if you are eligible to join our program. If you select Direct Eligibility our program will conduct your assessment. We will let you know if you are eligible for PACE. If you are found eligible, we can work with you to join our program. All Direct Eligibility assessments will be reviewed by the New York Independent Assessor (NYIA) to see if you can remain in the program. **You should note that our Direct Eligibility assessments only apply towards enrollment into ArchCare Senior Life.**

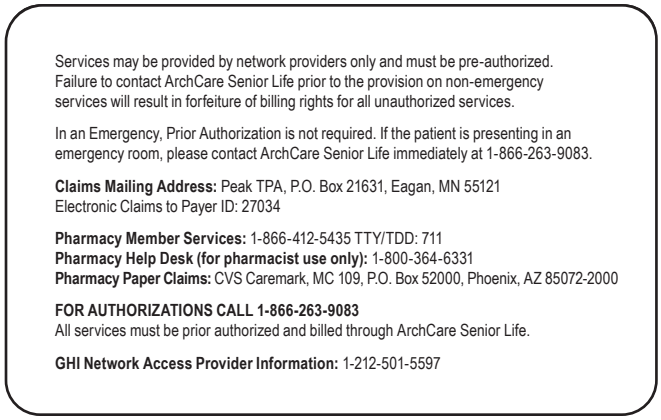
New York Independent Assessor (NYIA): You can contact NYIA to schedule an assessment. NYIA is the state-contracted independent assessor, that oversees and conducts assessments for individuals seeking personal care services, consumer directed personal assistance services, or Managed Long Term Care (MLTC), including PACE. If you choose to have a NYIA assessment and are found eligible for PACE enrollment, there will be no further review. If you are not eligible for PACE enrollment, the NYIA assessment can also be used to see if you are eligible for other MLTC programs.

PARTICIPANT IDENTIFICATION CARD

After you enroll, your ArchCare Senior Life identification card should arrive within 14 to 30 days. Remember to carry your ArchCare Senior Life identification card at all times, as well as your Medicare and Medicaid identification cards and any other health insurance card. The ArchCare Senior Life identification card is effective from the first day of your enrollment and will help your health care providers to bill correctly for covered services. Your identification card will also list a toll free number with any questions related to medications.

If you need care before you receive your card, or if you lose your identification card or need to change or correct information on your card, contact our participant service department at (866)263-9083.





ADVANCE DIRECTIVES

You have the right to let us and your family know how you would want to be taken care of if you became seriously ill or injured and could not communicate with your physician. Your instructions can be stated in a document called an Advance Directive. ArchCare Senior Life encourages you to think about this now before an extreme situation occurs. Please speak with us and get information about how to formulate your Advance Directive. Examples of such documents include a signed and witness statement with your instructions called a Living Will, a "Do Not Resuscitate" (DNR) order, or a form called a Health Care Proxy. New York State has a law that allows you to appoint a Proxy who is someone you trust, for example a family member or close friend, to decide about your treatment if you lose the ability to decide for yourself. Be sure to discuss your wishes with your agent(s) to make certain that he or she acts in accordance with your wishes. You may also use the NYS Health Care Proxy form to indicate your wishes regarding organ donation in the event of your death.

PROTECTION OF PARTICIPANT CONFIDENTIALITY

ArchCare Senior Life is committed to respecting your privacy. We keep your health records confidential, making them accessible only to appropriate health professionals, health care providers, and authorized personnel as necessary for your proper care as a participant of ArchCare Senior Life. All of ArchCare Senior Life's procedures are in compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA).

USEFUL TIP: Remember to carry your ArchCare Senior Life identification card at all times.

DO I HAVE TO PAY TO RECEIVE SERVICES

ArchCare Senior Life provides and coordinates services that are typically covered by Medicare and Medicaid. As a participant of ArchCare Senior Life, you will pay nothing. If you are eligible for Medicaid with a spend-down, you pay the monthly spend-down amount to ArchCare Senior Life.

If you choose to access services on your own that are not covered, not authorized or obtain services from a non-participating provider that are not authorized by ArchCare Senior Life, you may be responsible for payment of these services.

MONTHLY SPEND DOWN (SURPLUS)

If you are required to pay a monthly spend-down (Surplus) in order to receive Medicaid benefits, the Human Resource Administration (HRA) will determine the spend-down amount to be paid by you to ArchCare Senior Life in order for you to keep your Medicaid coverage active. If you have a spend-down (surplus) or a NAMI (Net Available Monthly Income), a bill will be sent to you each month requesting payment. If your bill is not paid on time; we will make an effort to collect payment by sending you another copy of the bill and making a follow-up call. If these efforts fail, you will receive a letter letting you know that you may no longer be able to continue enrollment in ArchCare Senior Life. Your spend-down payment, by check or money order, should be sent to the following address:

ArchCare Senior Life
Attn: Finance
205 Lexington Avenue, 2nd Floor
New York, NY 10016

If payment cannot be sent by mail, please contact us Monday through Friday, 8:30 am to 5:00 pm at (866) 263-9083 so that other arrangements can be made.

WITHDRAWAL OF ENROLLMENT APPLICATION

You may withdraw your application at any time during the enrollment process. You may elect to withdraw your enrollment application prior to enrollment by advising us orally or in writing, and we will confirm your withdrawal in writing.

DENIAL OF ENROLLMENT

Enrollment will be denied by New York Medicaid Choice/Maximus if, after assessment by ArchCare Senior Life , you do not meet these criteria:

1. Capable of returning to, or remaining in your home and community without jeopardizing your health and safety.

2. In need of community based long term care services and care management from ArchCare Senior Life for more than 120 days from the date of enrollment.

   If you do not meet the eligibility criteria for age, county of residence, and Medicaid eligibility , you many not be assessed for enrollment. If you choose to pursue enrollment even though you are not eligible, we will send this information to New York Medicaid Choice/Maximus for review and eligibility determination.

WHAT SERVICES ARE COVERED BY ARCHCARE SENIOR LIFE?

Below is the list of services covered by ArchCare Senior Life. Your care must be determined necessary by our PCP and your Care Management Team. This means that the services you get are determined necessary by the interdisciplinary team to improve and maintain your overall health status, taking into account your current medical, physical, emotional and social needs; and, current clinical practice guidelines and professional standards of care applicable to the particular service.

MEDICAID COVERED SERVICE	COVERAGE RULES
Care Management Your Care Team will assess your health care on an ongoing basis and will also be responsible for the coordination and delivery of planned services.	Every participant will be assigned to a Care Team, which may include the following: Primary Care Physician (PCP), Registered Nurse, Social Worker, Physical Therapist, Occupational Therapist, Recreation Therapist, Dietitian, PACE Center Manager, Home Care Coordinator, Personal Care Assistant, and Transportation Coordinator.
Non-Emergency Transportation Non-Emergency Transportation is transport by ambulance, ambulette, Taxi or livery service or public transportation at the appropriate level for the participant's condition to obtain necessary medical care and services reimbursed under the Medicaid or the Medicare programs.	You must receive Non-Emergency Transportation from the ArchCare Senior Life Provider Network, and you must obtain authorization from the Program.
Home Care Includes the following services, which are of a preventive, therapeutic rehabilitative, health guidance and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and speech/language pathology.	When a service is covered by either Medicare or Medicaid , you will have to use a provider that is in the ArchCare Senior Life Provider Network. and obtain authorization from the Program. Your ArchCare Senior Life PCP will provide the written orders needed to access services within the provider network.
Personal Care Personal Care is some or total assistance with activities of daily living such as personal hygiene, dressing and feeding, and nutritional and environmental support function task.	You must receive Personal Care from the ArchCare Senior Life Provider Network, and you must obtain authorization from Program.

MEDICAID COVERED SERVICE	COVERAGE RULES
Consumer Directed Personal Assistance Services (CDPAS) CDPAS is some or total assistance with personal care tasks, home health aide tasks and/or skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or designated representative. There is flexibility and freedom in choosing the consumer directed personal assistant or caregiver.	You must obtain authorization from the Program and you must work with a "fiscal intermediary" who is in contract with ArchCare Senior Life to administer the wage and benefit for your CDPAS service. Your ArchCare PCP may provide written orders for this service.
Physical Therapy, Occupational Therapy, Speech Pathology in setting outside the home Physical therapy (PT) is a rehabilitation service provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the participant to his or her best functional level. Occupational therapy (OT) is a rehabilitation service provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the participant to his or her best functional level. Speech/ Language pathology (SP) is a rehabilitation service for the purpose of maximum reduction of physical or mental disability and restoration of the participant to his or her best functional level.	You must receive Physical Therapy, Occupational Therapy and/or Speech Pathology from the ArchCare Senior Life Provider Network, and you must obtain authorization from Program. Your ArchCare Senior Life PCP will provide written orders needed to access services within the provider network. Therapy services may be provided at any of our PACE Centers or in your home.

MEDICAID COVERED SERVICE	COVERAGE RULES
Nursing Home Care Care provided in a Skilled Nursing Facility.	Short-term rehabilitative stays may be covered by Medicare. If your stay in a nursing home is covered by Medicare, you will have to choose a nursing home within the ArchCare Senior Life Provider Network. If your Medicare benefits expire, your stay would become Medicaid-covered. If that should happen, you will have to use an ArchCare in-network provider and obtain authorization from the Program. Long-term care placement is covered and your Care Team can help you apply for this. You must use an in-network provider and obtain authorization from the Program. Your PCP in ArchCare will provide written orders needed to access services within the provider network.
PACE Adult Day Center Health Care Day center health care provides care and services in a health care facility or approved extension site. Day health care centers are under the medical direction of a physician and are set up for those who are functionally impaired but who are not homebound. To be eligible, you must require certain preventive, diagnostic, therapeutic and rehabilitative or palliative items or services. Day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy and dental, pharmaceutical, and other ancillary services, as well as leisure time activities that are a planned program of diverse and meaningful activities.	You must receive Day Center Health Care at one of our PACE Center locations within each of our service areas.
PACE Social Day Care Social Day Care at PACE is a structured, comprehensive program that provides functionally impaired individuals with socialization, supervision and monitoring, personal care and nutrition in a protective setting during any part of the day, but for less than 24-hour period.	You must receive Social Day Care at one of our PACE Centers locations within each of our service areas.

MEDICAID COVERED SERVICE	COVERAGE RULES
Optometry/Eyeglasses Optometry includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low-vision aids.	You must receive Optometry services and eyeglasses from the ArchCare Senior Life Provider Network. Generally, an eye exam and a pair of eyeglasses are provided once every two years unless you have diabetes or unless services are medically needed more frequently. Your ArchCare Senior Life PCP will provide written orders needed to access services within the provider network.
Audiology/Hearing Aids Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hear aid prescription or recommendations, if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings and replacement parts.	Audiology exams are covered and you can receive the care from a provider that is in the ArchCare Provider Network. Your ArchCare Senior Life PCP will provide written orders needed to access services within the provider network.
Podiatry Podiatry means services by a podiatrist, which must include routine foot care when the participant's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as a necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections.	Podiatric exams are covered and you can recieve care from a provider that is in the ArchCare Senior Life Provider Network. When the service is covered by Medicaid, you will have to use an in-network provider. Your ArchCare Senior Life PCP will provide written orders needed to access services within the provider network.
Dentistry Preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.	Dental services is a covered service and you will receive the care from a provider that is in the ArchCare Senior Life Provider Network.
Home-Delivered or Congregate Meals	You must receive Home-Delivered or Congregate Meals from ArchCare Senior Life Provider Network, and you must obtain authorization from the Program.

MEDICAID COVERED SERVICE	COVERAGE RULES
Respiratory Therapy The performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gasses, humidity, aerosol, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.	You must receive Respiratory Therapy from the ArchCare Senior Life Provider Network, and you must obtain authorization from the Program. Your ArchCare Senior Life PCP will provide written orders needed to access services within the provider network.
Nutrition Services/Counseling The assessment of nutritional needs and food patterns, or the planning for the provision of foods and drinks appropriate for the individual's physical and medical needs and environment conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs.	You must receive Nutritional Services/Counseling from the ArchCare Senior Life Provider Network, and you must obtain authorization from the Program.
Medical and Surgical Supplies/ Enteral Feeding and Supplies/Parenteral Nutrition and Supplies Medical and surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliance and devices and durable medical equipment or orthopedic footwear that treat a specific medical condition, which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value.	These items are covered and you will receive the items from a provider that is in the ArchCare Senior Life Provider Network.

MEDICAID COVERED SERVICE	COVERAGE RULES
Durable Medical Equipment / Assistive Technology Durable medical equipment is made up of devices and equipment, including prosthetic, orthotic appliances and devices, which have been ordered by a practitioner in the treatment of specific medical condition and which have the following characteristics: • Can withstand repeated use for a protracted period of time • Are primarily and customarily used for medical purposes • Are generally not useful in the absence of injury • Are not usually fitted, designed or fashioned for a particular individual's use Where equipment is intended for use by only one patient, it may be either custom-made or customized.	These items are covered and you will receive the item from a provider that is in the ArchCare Senior Life Provider Network. Your PCP in ArchCare will provide written orders needed to access services within the provider network.

Social and Environmental Supports / Assistive Technology / Environmental Modifications
 	
Social and environmental supports are services and items that maintain the medical needs of the participant and include, the following:
• Home maintenance tasks
• Homemaker/chore services
• Housing improvement
• Respite care
• Examples of Environmental Modifications include, but are not limited to:
  • Ramps
  • Lifts that require modifications to the home: Hydraulic, manual or electric
  • Widened doorways
  • Roll-in showers and or accessible tubs
  • Cabinet and shelving adaptions
  • Installations of handrails, grab bards
  • Automatic or manual door openers and doorbells
  • Water faucet controls
  • Electrical and plumbing accommodations for new equipment
	You must receive social and environmental supports from the ArchCare Senior Life Provider Network, and you must obtain authorization from the Program.

MEDICARE COVERED SERVICES[3]	DEFINITION
Personal Emergency Response Systems (PERS) PERS is an electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center.	You must receive PERS from the Provider Network, and you must obtain authorization from the Plan.
In-patient Hospital care services	A hospital or other institutional bed for receiving care, including room, board and general nursing.
Out-patient hospital care services	Care received in a clinic, medical office or other site affiliated with a hospital but not occupying a regular hospital bed.
Physician Services	Preventive care, primary medical care and specialty services that fall within a physician's scope of practice.
Laboratory and Radioisotopes Services	Tests and procedures ordered by a qualified medical professional.
Emergency Transportation	Transportation by ambulance as a result of an emergency condition.
Chronic Renal Dialysis	Method used to treat advanced and permanent kidney failure, provided by a renal dialysis center.
Mental Health Services	Medical specialty concerned with the prevention, diagnosis, and treatment of mental illness.
Alcohol and Substance Abuse Services	Treatment to end the excessive use of a substance such as alcohol or drugs.
Prescription Drugs **Part D Medicare Coverage**	Medications prescribed by a healthcare provider. Prescriptions dispensed by a Pharmacist.

ArchCare Senior Life covers the traditional Medicare services listed above. The ArchCare Senior Life PCP will provide written orders for these services as required and will work with Medical Specialists to coordinate services. Benefits cannot be transferred from you to any other person or organization.

NURSING HOME CARE

During your enrollment with ArchCare Senior Life there may be times when your PCP, your care team, you and your family, decide that the best short or long-term care for you is within a nursing facility. This may be because your home is no longer the best place for you to be taken care of safely and comfortably. The ArchCare Senior Life care team will coordinate this transition for you. During this time, you will continue to receive your care through ArchCare Senior Life.

When nursing home care is required, a semi-private room will be provided in a network facility. Sometimes a private room is required due to medical necessity.

THE ARCHCARE SENIOR LIFE CARE TEAM

Upon your enrollment, you will be assigned a Primary Care Provider (PCP) and a Care Team. The team is comprised of a nurse, social worker, dietitian, rehabilitation therapist, transportation coordinator and center manager as well as other health care specialists. The staff is dedicated to you and is available to help you manage your chronic health problems. Your PCP, along with staff from your Care Team, will meet with you and your family to develop a Plan of Care that meets your needs. The Plan of Care is a written description of all the services you need. It is based on an assessment of your health care needs, the recommendation of your doctors and your personal preferences. You will be given a copy of the Plan of Care for your records, which will include a listing of how often and how long you will receive your authorized services.

Your Care Team will follow up with you on a regular basis to check on your health care status by meeting with you when you attend one of our PACE centers, scheduling visits in your home or calling you on the phone. Your Care Team in cooperation with your PCP will ensure that you are receiving all needed and ordered services. Below is a list of some other services you can expect from your care team:

- Authorize covered services for you based on your current medical, physical, emotional, and social needs in accordance with current clinical practice guidelines and professional standards applicable to the particular service necessity;
- Talk to you, your medical specialist, and your family member or representative about changes or updates to your Plan of Care;
- Be available to you, or provide coverage 24 hours a day to assist you with urgent care or other issues.

THE PACE CENTER

ArchCare Senior Life operates four PACE centers located within The Bronx, Manhattan, Staten Island, and Westchester. Each center is staffed with a Physician and/or a Nurse Practitioner to provide needed medical services. Our PACE centers contain health clinics staffed by doctors, nurses and other professionals who specialize in caring for seniors. Healthcare services can be provided on-site such as blood drawing, administration of medications and rehabilitation services provided by a Physical and or Occupational Therapist. If you have a need for services after a hospital or short-term nursing home stay, our team can coordinate care services at one of our centers or in your home. In addition, our PACE centers provide a place to engage in a variety of activities, enjoy a healthy lunch, socialize with friends or just relax.

PLAN OF CARE

You, your family, your ArchCare Senior Life PCP and your Care Team will work together to develop a Plan of Care that meets your needs. The Plan of Care is a written description, including the amounts, frequency, and duration of all the services you need. It is based on ArchCare Senior Life's assessment of your health and preferences, and the recommendations and medical orders of your

doctors and other caregivers. Your Care Team will work together and implement any changes to your Plan of Care. They will periodically evaluate it with you to ensure that the services you are receiving continue to meet your needs.

You are an important participant of the Care Team, so please discuss your needs with your ArchCare Senior Life PCP and Care Team if you have a need for any services you are not receiving or wish to change your Plan of Care in any way. For example, you may request to be seen by a Physical Therapist more often than was authorized originally, or you may be receiving services that you feel you no longer need. Also, please let your Care Team know if you are not taking your prescribed medications or have made any medication changes on your own.

PROVIDER NETWORK

When you need to access covered services, your Care Team will select or assist you in selecting providers from ArchCare Senior Life's Provider Directory and will make and/or assist you with the arrangements, including transportation, for you to receive the needed services. If you are dissatisfied with a specific provider, you may call your Care Team and request a change and he or she will help you select a new provider in time for your next scheduled or requested appointment. Access to participating providers for covered services is listed in the ArchCare Provider Directory, which is located on the ArchCare website. You can access covered services from a wide selection of in-network providers. ArchCare Senior Life covers all of your Medicare and Medicaid covered services and associated co-pays for covered services. Network providers will be paid in full directly by ArchCare Senior Life for each service authorized and provided to you with no co-pay or cost to you. Although there is no cost to you for individual services, you are required to pay the Medicaid Spend Down (Surplus), if you have one, to maintain your Medicaid benefit. See section in this handbook on Monthly Spend down for further information. Monthly Spend down does not apply to private pay participants.

If you receive a bill for covered services authorized by ArchCare Senior Life, please contact your Care Team. You may be responsible for payment of covered services that were not authorized by ArchCare Senior Life, or for covered services that are obtained by providers outside of the ArchCare Senior Life network.

If you have questions about the qualifications of any provider, you can ask your Care Team.

TRANSITIONAL CARE

If you have a life-threatening disease or condition or a degenerative or disabling condition on enrollment, you may continue an ongoing course of treatment with a non-network health care provider for up to 60 days after enrollment. The provider must accept payment at the ArchCare Senior Life rate, adhere to ArchCare Senior Life quality assurance and other polices and procedures, and provide ArchCare Senior Life with information so we may review these circumstances.

TRANSITIONAL CARE FROM NETWORK PROVIDERS

Should your ArchCare Senior Life network provider leave ArchCare Senior Life during an ongoing course of treatment, your Care Team can arrange payment for the continuation of medically necessary treatment from this provider for a transitional period of up to 90 days. We will ensure that you are kept updated on new service providers and their availability by issuing new listing or yearly updates, or more often as needed.

EMERGENCY CARE

An emergency is a sudden onset of a medical or behavioral condition that manifests itself by symptoms of sufficient severity including severe pain that a prudent layperson possessing an

average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of the person or others in serious jeopardy;
- Serious impairments to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person;
- Serious disfigurement of such person

Emergency services are services needed to evaluate or stabilize an emergency medical condition, and are NOT subject to prior authorization by ArchCare Senior Life.

If you have an emergency:

- Call 911; or
- Go to the nearest emergency facility, and show your ArchCare Senior Life identification card.

You or someone on your behalf should notify ArchCare Senior Life as soon as possible so that we and your ArchCare Senior Life PCP can provide or help you obtain any services you may need after your condition is stabilized.

OUT-OF-AREA CARE

If you plan to be away from home or outside the service area of the county that you live in, please notify your Care Team as soon as possible so that they can help arrange any appropriate services that you may need in the area you will be visiting. ArchCare Senior Life will work with you to plan your care and will continue to provide non-emergency covered services to the extent that they can be arranged with the area providers. You can use your Medicare or Medicaid identification card or any other health insurance card to access non-covered services in the services area and outside of the service area, if the health care provider accepts Medicare or New York State Medicaid.

If you are out of the area and have an emergency, go to the nearest emergency facility. You or someone on your behalf should notify ArchCare Senior Life as soon as possible.

If an urgent medical or behavioral condition happens unexpectedly, and you are outside the service area, please call your Care Team for guidance or seek care immediately and notify ArchCare Senior Life as soon as possible. This will enable your Care Team to change your Plan of Care if necessary, arrange follow-up care if needed, and coordinate services for you.

An urgent medical or behavioral condition happens unexpectedly, and usually care or services are needed within 24 to 28 hours.

SERVICES AUTHORIZATION

A member of the ArchCare Senior Life Care Team will authorize your covered services for specific amounts and period of time based on your needs and requests of your network providers.

A request from you or from your provider on your behalf for authorization for a new service in a new or existing authorization period, or a change of service in the Plan of Care in a new authorization period is called Prior Authorization. A Concurrent Review is a request by an ArchCare Senior Life participant or provider on the participant's behalf for additional services (more of the same services) that are currently authorized in the Plan of Care. You may also request that ArchCare Senior Life expedite the decision about a change in your Plan of Care.

ArchCare Senior Life must decide whether to make the request changes and must notify you by phone and in writing as fast as your condition requires, but in no more than the time frames below. If the provider indicates or we determine that a delay would seriously jeopardize your life, health or your ability to attain, maintain or regain maximum function, we will expedite the review. Should we deny the request from you to expedite our review,

we will notify you and will handle it as a standard review.

For Prior Authorization, we will decide and notify you as fast as your condition requires or within three business days after we receive the necessary information, but in no more than 14 days after we receive the request for services. If expedited, we will decide and notify you as fast as your condition requires or within three business days after we receive the request.

For Concurrent Reviews, we will decide and notify you as fast as your condition requires or within one business day after we receive the necessary information, but in no more than 14 days after we receive the request for services. If expedited, we will decide and notify you as fast as your condition requires or within one business day after we receive the necessary information, but in no more than three business days after we receive the request.

You or your provider may request an extension of up to 14 calendar days. ArchCare Senior Life may initiate an extension of up to 14 calendar days if the reason is in your interest and well documented and justified.

If your Care Team agrees with the request for a new service or change in service, we will change your Plan of Care. Should ArchCare Senior Life decline to authorize a service or intend to reduce, suspend, or terminate an authorized service, we will advise you in writing, and you or your provider may file an appeal of the denial. Any decision that denies any part of a service requested by you or your providers is a Notice of Action. You or your provider may appeal a Notice of Action. (See Filling an Appeal).

ELECTRONIC NOTICING

If you prefer, you can ask ArchCare Senior Life to send you certain notices electronically.

Notices that are available electronically are:

- Services you asked for
- Service you are getting
- Plan Appeals
- Complaints; and
- Complaint Appeals

Other communications about:

- Your member handbook
- Our provider directory
- Changes to your Medicaid managed long term care benefits

Who gets these notices?

You and your provider get these notices about your services and plan appeals. You can also choose someone to represent you, like a family member, friend, or lawyer. The person you choose will be able to file a complaint, plan appeal or fair hearing for you. We also send them a copy of your notices.

If you told us before that someone may represent you, we will send that person a letter. If you want someone new to represent you, you and that person must sign and date a statement saying this is what you want. The person you choose can get copies of your notices electronically if they ask. We will send their notices as required by law. If you have any questions about choosing someone to act for you, call us at: 1-866-263-9083. TTY users call 711.

What ways can these notices be sent?

ArchCare Senior Life and our vendors can send these notices to you by web portal.

The email notification option will send you an email that will include a link directing you to the web portal, where you can log in and see your correspondence. To utilize this option, you will need access to your email and a web browser with access to the internet, and your email.

If you have any questions or issues about your electronic notification options please reach out to our Member Services department at 1-866-263-9083 or visit https://www.archcare.org/health-plans/senior-life for more information.

How do I ask for electronic notices?
You can contact us by phone, email, online, fax, or mail:

Phone.....1-866-263-9083
Email.....PACEcom@archcare.org
Online.....https://mailingoptions.archcare.org
Fax.....1-646-762-7670
Mail..... PO Box 18023 Hauppauge, NY 11788

When you contact us, you must:

- Tell us how you want to get notices that are normally sent by mail,
- Tell us how you want to get notices that are normally made by phone call, and
- Give us your contact information (mobile phone number and email address).

To sign up by phone, please call 1-866-263-9083 and let us know that you would like to enroll in electronic notification. Our Member Services team can help guide you through the signup process. Once signed up, you can also add a designee to also receive electronic notifications about your correspondence. Our member services team can also help set up a designee even if you do not want to sign up for electronic notifications yourself.

To sign up via the web portal, visit https://mailingoptions.archcare.org and fill out the member registration page. You will need at least three of the following points of identification to register: full name, date of birth, member ID or CIN/Medicaid ID. Once the registration form is submitted, you will receive an email with a link to verify your registration. Once confirmed, you can choose your electronic notification preference as well as add a designee to also receive electronic notifications on your behalf.

To sign up by fax, please fill out the attached Electronic Notice Request Form and fax it to 1-646-762-7670. You can use the attached Electronic Notice Request Form, but it is not required. We will contact you at the email address you have provided to complete your registration. If you would like a designee to have access to your notifications without signing up yourself, you can also use this option.

To sign up by mail, please fill out the attached Electronic Notice Request Form and mail it to PO Box 18023 Hauppauge, NY 11788. You can use the attached Electronic Notice Request Form, but it is not required. We will contact you at the email address you have provided to complete your registration. If you would like a designee to have access to your notifications without signing up yourself, you can also use this option.

If your contact information changes, you must let us know. To change your information, please update your information on the portal, or contact us at the phone number, fax number, or mailing address listed above.

What happens once I ask for electronic noticing?
ArchCare Senior Life will let you know by mail that you have asked to get notices electronically.
If you ask to get your notices electronically:

- We will send you the notice in a way that lets you save and print the notice.
- You can still ask us to send any of your notices by mail.
    - We will send your notice by mail within **two (2) working days** from the day you asked if the notice is about services, plan appeals, complaints and complaint appeals.
    - We will send your notice by mail within **five (5) working days** from the date you asked if the notice is about other communications.
- You can still ask us to send any of your notices in an alternate format to accommodate a disability or language need.
    - We will send your notice within **five (5) working days** from the day you asked if the notice is about services, plan appeals, complaints and complaint

appeals. In some cases, it may take us up to **thirty (30) days** from the date of your request. In those cases, we will call you to help.
- We will send your notice within **fifteen (15) working days** from the day you asked if the notice is about other communications. In some cases, it may take us up to 60 days from the date of your request. In those cases, we will call you to help.

If you ask to get your notices electronically and we believe your electronic notice did not go through, we will then send it by mail and we may also call you by phone, as required by law.

Can I change the way I get these notices later?
You can change the way you get your notices at any time. To change the way you get notices, you can contact us at the phone number, email address, web portal, fax number, or mailing address listed in the *How do I ask for electronic notices* section above.

If you ask for a change by phone, email, web portal, or fax, we have **five (5) working days** from the date we got your request to make the change. If you ask for a change by mail, we have **ten (10) working days** from the date we got your letter to make the change.

What If I don't want electronic notices?
You will keep getting these notices by mail and we may also call you by phone. We will not send these notices electronically unless you ask.

You can still ask us to send these notices in a different way because of a disability or language need.

ArchCare Senior Life will not treat you differently if you do not want to get these notices electronically.

YOUR RIGHTS AND RESPONSIBILITIES AS AN ARCHCARE SENIOR LIFE PARTICIPANT

When you join a PACE program, you have certain rights and protections. ArchCare Senior Life, as your PACE program, must fully explain and provide your rights to you or someone acting on your behalf in a way you can understand at the time you join.

At ArchCare Senior Life we are dedicated to providing you with quality health care services so that you may remain as independent as possible. This includes providing all Medicaid and Medicare-covered items and services, and other services determined to be necessary by the interdisciplinary team across all care settings, 24 hours a day,7 days a week.

Our staff and contractors seek to affirm the dignity and worth of each participant by assuring the following rights:

You have the right to treatment.
You have the right to treatment that is both appropriate for your health conditions and provided in a timely manner. You have the right:
- To receive all the care and services you need to improve or maintain your overall health condition, and to achieve the best possible physical, emotional, and social well-being.
- To get emergency services when and where you need them without the PACE program's approval. A medical emergency is when you think your health is in serious danger— when every second counts. You may have a bad injury, sudden illness or an illness quickly getting much worse. You can get emergency care anywhere in the United States and you do not need to get permission from ArchCare Senior Life prior to seeking emergency services.

You have the right to be treated with respect.
You have the right to be treated with dignity and respect at all times, to have all of your care kept private and confidential, and to get compassionate, considerate care. You have the right:

- To get all of your health care in a safe, clean environment and in an accessible manner.
- To be free from harm. This includes excessive medication, physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, and any physical or chemical restraint that is used on you for discipline or convenience of staff and that you do not need to treat your medical symptoms.
- To be encouraged and helped to use your rights in the PACE program.
- To get help, if you need it, to use the Medicare and Medicaid complaint and appeal processes, and your civil and other legal rights.
- To be encouraged and helped in talking to PACE staff about changes in policy and services you think should be made.
- To use a telephone while at the PACE center.
- To not have to do work or services for the PACE program.
- To have all information about your choices for PACE services and treatment explained to you in a language you understand, and in a way that takes into account and respects your cultural beliefs, values, and customs.

You have a right to protection against discrimination.
Discrimination is against the law. Every company or agency that works with Medicare and Medicaid must obey the law. They cannot discriminate against you because of your:

- Race
- Ethnicity
- National Origin
- Religion
- Age
- Sex
- Mental or physical disability
- Sexual Orientation
- Sex characteristics, including intersex traits, pregnancy or related conditions, gender identity, and sex stereotypes
- Source of payment for your health care (For example, Medicare or Medicaid)

If you think you have been discriminated against for any of these reasons, contact a staff member at the PACE program to help you resolve your problem.

If you have any questions, you can call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

You have a right to information and assistance.
You have the right to get accurate, easy-to-understand information, to have this information shared with your designated representative, who is the person you choose to act on your behalf, and to have someone help you make informed health care decisions. You have the right:

- To have someone help you if you have a language or communication barrier so you can understand all information given to you.
- To have the PACE program interpret the information into your preferred language in a culturally competent manner, if your first language is not English and you can't speak English well enough to understand the information being given to you.
- To get marketing materials and PACE participant rights in English and in any other frequently used language in your community. You can also get these materials in Braille, if necessary.
- To have the enrollment agreement fully explained to you in a manner understood by you.
- To get a written copy of your rights from the PACE program. The PACE program must also post these rights in a public place in the PACE center where it is easy to see them.
- To be fully informed, in writing, of the services offered by the PACE program. This includes telling you which services are provided by contractors instead of the PACE staff. You must be given this information before you join, at the time you join, and when you need to make a choice about what services to receive.
- To be provided with a copy of individuals who provide care-related services not provided directly by ArchCare Senior Life upon request.

- To look at, or get help to look at, the results of the most recent review of your PACE program. Federal and State agencies review all PACE programs. You also have a right to review how the PACE program plans to correct any problems that are found at inspection.

Before ArchCare Senior Life starts providing palliative care, comfort care, and end-of-life care services, you have the right to have information about these services fully explained to you. This includes your right to be given, in writing, a complete description of these services and how they are different from the care you have been receiving, and whether these services are in addition to, or instead of, your current services. The information must also explain, in detail, how your current services will be affected if you choose to begin palliative care, comfort care, or end-of-life services. Specifically, it must explain any impact to:

- Physician services, including specialist services.
- Hospital services
- Long-term care services
- Nursing services
- Social services
- Dietary services
- Transportation
- Home care
- Therapy, including physical, occupational, and speech therapy
- Behavioral health
- Diagnostic testing, including imaging and laboratory services
- Medications
- Preventative healthcare services
- PACE center attendance

You have the right to change your mind and take back your consent to receive palliative care, comfort care, or end-of-life care services at any time and for any reason by letting ArchCare Senior Life know either verbally or in writing.

You have a right to a choice of providers.
You have the right to choose a health care provider, including your primary care provider and specialists, from within the PACE program's network, that is sufficient to ensure access to appropriate high quality health care. Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services.

You have the right to have reasonable and timely access to specialists as indicated by your health condition.

You also have the right to receive care across all care settings, up to and including placement in a long-term care facility when ArchCare Senior Life can no longer maintain you safely in the community.
You have a right to participate in treatment decisions.
You have the right to fully participate in all decisions related to your health care. If you cannot fully participate in your treatment decisions or you want to have someone you trust help you, you have the right to choose that person to act on your behalf as your designated representative.
You have the right:

- To be fully informed of your health status and how well you are doing, to make health care decisions, and to have all treatment options fully explained to you. This includes the right not to get treatment or take medications. If you choose not to get treatment, you must be told how this may affect your physical and mental health.
- To fully understand ArchCare Senior Life's palliative care, comfort care, and end-of-life care services. Before ArchCare Senior Life can start providing you with palliative care, comfort care, and end-of-life care services, the PACE program must explain all of your treatment options, give you written information about these options, and get written consent from you or your designated representative. Information will include how these services are different from the care you currently receive, if these services will be added to your current care or will replace your current care and will tell you how various types of current services will be impacted if you elect to receive palliative care, comfort care and end-of-life care. You have the right to revoke or withdraw your consent to receive palliative care, comfort care, and end-of-life

care services.
- To have the PACE program help you create an advance directive, if you choose. An advance directive is a written document that says how you want medical decisions to be made in case you cannot speak for yourself. You should give it to the person who will carry out your instructions and make health care decisions for you.
- To participate in making and carrying out your plan of care. You can ask for your plan of care to be reviewed at any time.
- To be given advance notice, in writing, of any plan to move you to another treatment setting and the reason you are being moved.

You have a right to have your health information kept private.

- You have the right to talk with health care providers in private and to have your personal health care information kept private and confidential, including health data that is collected and kept electronically, as protected under State and Federal laws.
- You have the right to look at and receive copies of your medical records and request amendments.
- You have the right to be assured that your written consent will be obtained for the release of information to persons not otherwise authorized under law to receive it.
- You have the right to provide written consent that limits the degree of information and the persons to whom information may be given.

There is a patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used. If you have any questions about this privacy rule, call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800- 537- 7697.

You have a right to make a complaint.

You have a right to complain about the services you receive or that you need and don't receive, the quality of your care, or any other concerns or problems you have with your PACE program. You have the right to a fair and timely process for resolving concerns with your PACE program. You have the right:

- To a full explanation of the complaint process.
- To be encouraged and helped to freely explain your complaints to PACE staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns. This includes being punished, threatened, or discriminated against.
- **To contact 1-800-Medicare for information and assistance, including to make a complaint related to the quality of care or the delivery of a service.**

You have the right to request additional services or file an appeal.

You have the right to request services from ArchCare Senior Life, its employees, or contractors, that you believe are necessary. You have the right to a comprehensive and timely process for determining whether those services should be provided.

You also have the right to appeal any denial of a service or treatment decision by the PACE program, staff, or contractors.

You have a right to leave the program.

If, for any reason, you do not feel that the PACE program is what you want, you have the right to leave the program at any time and have such disenrollment be effective the first day of the month following the date ArchCare Senior Life receives your notice of voluntary disenrollment.

Additional Help:

If you have complaints about your PACE program, think your rights have been violated, or want to talk with someone outside your PACE program about your concerns, call 1-800-MEDICARE (1-800-633-4227) to get the name and phone number of someone in your State Administering Agency.

Signature

Relationship to Participant

Date

Witness Signature

Relationship to Participant

Date

BRONX LOCATION
ArchCare Senior Life at San Vicente de Paúl
Nursing Home and Rehabilitation Center
900 Intervale Avenue
Bronx, NY 10459
Main: 1-718-732-7171

MANHATTAN LOCATION
ArchCare Senior Life Harlem PACE Center
1432 Fifth Avenue
New York, NY 10035
Main: 1-646-289-7700

STATEN ISLAND LOCATION
ArchCare Senior Life at Carmel Richmond
Healthcare and Rehabilitation Center
88 Old Town Road
Staten Island, NY 10304
Main: 1-718-407-2916

WESTCHESTER LOCATION
ArchCare Senior Life Westchester PACE Center
115 Broadway
Dobbs Ferry, NY 10522
Main: 1-914-326-3199

VOLUNTARY DISENROLLMENT

You may request to voluntarily leave ArchCare Senior Life at any time, for any reason by letting ArchCare Senior Life know verbally or in writing. This request starts the process to leave ArchCare Senior Life and arrange care through New York Medicaid Choice/ Maximus. Voluntary disenrollment requests are sent to New York Medicaid Choice/Maximus for processing.

You may contact our participant service line at (866) 263-9083 for any questions or to speak with a member of your care team for assistance in completing any necessary documents, arranging care for you, and obtaining New York Medicaid Choice/ Maximus approval.

INVOLUNTARY DISENROLLMENT

Involuntary Disenrollment means that ArchCare Senior Life has decided that you are no longer able to be a participant. There are circumstances under which ArchCare Senior Life must disenroll you, and other circumstances under which ArchCare Senior Life may disenroll you. ArchCare Senior Life will not discriminate based on health status, change in health status, or the need of or the cost of covered services.

ArchCare Senior Life ***Must*** Disenroll You If:

1. ArchCare Senior Life is aware that you no longer live in the ArchCare Senior Life service area;
2. You moved within ArchCare Senior Life service areas and you are denied continued enrollment by the receiving enrollment agency (New York Medicaid Choice/Maximus) evaluating our assessment of eligibility for continued enrollment;
3. You leave the ArchCare Senior Life service area for any reason for more than 30 consecutive days;
4. You lose your Medicaid eligibility and you do not want to pay the private pay premium;

5. You are hospitalized or enter an OMH, OPWDD, or OASAS residential program for more than 45 days;
6. You clinically require nursing home placement but do not qualify for institutional Medicaid.

ARCHCARE SENIOR LIFE MAY DISENROLL YOU IF:

1. You fail to pay or make arrangements with ArchCare Senior Life to pay any amount owed, for example, Private Pay, a Medicaid spend-down (Surplus), within 30 days after the amount first becomes due.
2. You or family/caregiver or others in your home engage in conduct or behavior that seriously impairs ArchCare Senior Life's ability to furnish services to you or to other enrollees, and we have made and documented reasonable efforts to resolve the situation (unless the conduct or behavior is related to an adverse change in your health status or service usage, diminished mental capacity, or result of your special needs.)
3. You knowingly fail to complete and submit any necessary consent or release which is reasonably requested by ArchCare Senior Life to obtain covered services.
4. You provide false information, deceive, or defraud ArchCare Senior Life.

Involuntary disenrollment requests are sent to New York Medicaid Choice/Maximus for review and approval.

WHEN DOES A DISENROLLMENT BECOME EFFECTIVE?

If you have Medicaid, the effective date of disenrollment from ArchCare Senior Life will be the first day of the month following the month in which the disenrollment request is received and is processed by New York Medicaid Choice/Maximus. Generally, a signed request form must be received by ArchCare Senior Life by the 15th of the month for disenrollment to become effective the next month. For example, if a form is received on May 3rd, you would be disenrolled June 1st. If a form is received May 20th, you would be disenrolled on July 1st. This applies to both voluntary and involuntary disenrollments.

ArchCare Senior Life will provide services until the effective disenrollment date. ArchCare Senior Life will also assist you by making referrals and helping you arrange for services through New York Medicaid Choice/Maximus.

RE-ENROLLMENT PROVISIONS

If you voluntarily disenroll from ArchCare Senior Life, you will be allowed to re-enroll in the program if you meet our eligibility criteria for enrollment. If you are involuntarily disenrolled, you may be considered for re-enrollment in the program if the circumstances that were the basis for disenrollment have been resolved.

PRIVATE PAY

You may be eligible to enroll in ArchCare Senior Life even if you are not eligible for Medicaid if you agree to pay the full premium for coverage to ArchCare Senior Life. The private pay participant premium is equal to the amount of the Medicaid and Medicare premium payment as approved for ArchCare Senior Life by the New York State Department of Financial Services. You must pay this amount on the first day of the first full month that services are provided by ArchCare Senior Life. You will have a one month grace period if your premium is overdue. ArchCare Senior Life will send you a letter advising you of the late payment and inform you that termination can and will result for non-payment of services. You will continue to receive benefits during this grace period. If your payment is not received, or alternative payment arrangements has not been

approved, your enrollment will be terminated, and you must pay for the services that you received during the grace period. A written notice of termination will be provided. Your premium cannot be pro-rated and is not refundable.
Monthly payment to ArchCare Senior Life remains the same even if you experience changes in your health. Premium payments may be made by check or money order to:

ArchCare Senior Life
205 Lexington Avenue, 2nd Floor
New York, NY 10016

Private pay premiums for Medicaid or Medicare portion of premium payments will be discussed with you. You will receive a monthly statement of amount owed. If you have Medicare, your Medicare coverage will be capiated with ArchCare Senior Life as well as your Part D prescription drug benefits.

The services and plan described in this handbook apply to private pay participants with certain exceptions as noted in this handbook including, but not limited to, the following:

- NYC Maximus concurrence for enrollment and disenrollment is not required,
- New York State Medicaid Fair Hearing cannot be requested
- New York State External Appeals process
- The ArchCare Senior Life Internal Grievance and Appeal process.

Private Pay enrollees must sign an enrollment attestation/agreement. Private pay participants may enroll and disenroll at any time during the month. Premium payments will be adjusted according to days of services received.

WHAT IS A GRIEVANCE?

A grievance is any complaint, either oral or written to us by you, a caregiver or a provider on your behalf expressing dissatisfaction with service delivery or the quality of care furnished through ArchCare Senior Life.

For example, if someone was rude to you or you do not like the quality of care or services you have received, you can file a grievance with us. You have the right to voice a grievance without discrimination or reprisal and without fear of the same. Rights under Medicare and grievance processing requirements.

THE GRIEVANCE PROCESS

You may file a grievance with us verbally or in writing. The person who receives your grievance will record it, and the appropriate staff will oversee the review of the grievance. If we are not able to immediately investigate and resolve the grievance the same day, the grievance will be acknowledged within five calendar days and resolved within 30 calendar days.

HOW TO FILE A GRIEVANCE?

There are several ways you can file a grievance. You may report a grievance with any member of the ArchCare Senior Life staff. You can call us toll free at (866) 263-9083 during regular business hours and after hours or weekends. You can write to us at;

ArchCare Senior Life
Attention: Quality Management
1432 5th Avenue
New York, NY 10035

If you are hearing impaired, you can contact ArchCare Senior Life by calling the New York Relay Service at 711 (TTY). They will help you file a complaint and will contact us at (866) 263-9083. There will be no change in your services or the way you are treated by ArchCare Senior Life staff or a health care provider because you file a grievance. We will maintain your privacy. We will give you any help you may need to file grievance. This includes providing you with interpreter services or help if

you have vision and/or hearing problems. You may choose someone, for example a relative, friend or provider, to act for you.

When you contact us, you will need to give us your name, address, telephone number and details of the problem.

HOW DO I REQUEST RECONSIDERATION, APPEAL OF A GRIEVANCE DECISION?

If you are not satisfied with the decision we made concerning your grievance, you may request a second review by filing a request for reconsideration. You must file this request within 60 calendar days of receipt of our initial decision about your grievance. Once we receive your reconsideration request, we will send you a written acknowledgment within 15 calendar days telling you the name, address and telephone number of the individual we have designated to respond to your reconsideration. All grievance reconsiderations will be conducted by appropriate professionals, including health care professionals for grievance involving clinical matters, who were not involved in the initial decision.

For standard grievance reconsiderations , we will make the reconsideration decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited grievance appeal process. For expedited grievance appeals, we will make our appeal decision within two business days of receipt of necessary information. For both standard and expedited grievance appeals, we will provide you with written notice of our decision. The notice will include the reason for our decision, and in cases involving clinical matters, the clinical rationale for our decision.

WHAT IS A NOTICE OF ACTION?

When ArchCare Senior Life does the following it is considered a Notice of Action:

- Denies or limits services requested by you or your provider;
- Denies a request for a referral; decides that a requested service is not a covered benefit;
- Reduces, suspends or terminates services that we already authorized;
- Denies payment for services; or
- Does not provide timely services; or does not make grievance or appeal determinations within the required timeframes.

A Notice of Action is subject to appeal. (See How Do I file an Appeal of Notice of Action on the next page for more information.)

TIMING OF NOTICE OF ACTION

If we decide to deny or limit services you requested or decide not to pay for all or part of covered services, we will send you a notice when we make our decision. If we are proposing to reduce, suspend, or terminate a service that is authorized, our letter will be sent more than 10 calendar days before we intend to change the service.

CONTENTS OF THE NOTICE OF ACTION

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us, including whether you may also have a right to the State's or Medicare appeal process;

- Describe how to file an internal appeal and the circumstance under which you can request that we speed up, or expedite, our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved concerned issues of medical necessity, or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any that must be provided by you and/ or your provider in order for us to render a decision on appeal.

If we are reducing, suspending or terminating an authorized service, the Notice of action will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we are reviewing your appeal.

HOW DO I FILE AN APPEAL OF AN ACTION?

If you do not agree with an action that we have taken, you may file an appeal. When you file an appeal, it means that we must review the reason for our action to decide if we were correct. You can file an appeal of an action with the plan verbally or in writing. When the program sends you a letter about an action its taking, such as denying or limiting services or not paying for services, you must file your appeal request within 60 calendar days of the date on the letter notifying you of the action. You may also send or submit supporting documentation to aid your appeal request of the decision letter. If you call us to file your request for an appeal, you must send a written request unless you ask for an expedited review.

HOW DO I CONTACT MY PLAN TO FILE AN APPEAL?

You can reach us by calling 866-263-9083 or by writing to:

ArchCare Senior Life
1432 5th Avenue
New York, NY 10035
Attn: Quality Management

If you are hearing impaired , you can contact ArchCare Senior Life by calling the New York Relay Service. You can reach them at (800) 421-1220 (voice) or (800) 662-1220 (TYY). They will help you file an appeal and will call us toll free at (866) 263-9083.

The person who receives your appeal will record it, and the appropriate staff will oversee the review of the appeal. We will send a letter within 15 calendar days of our receipt telling you that we received your appeal and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff members who were not involved in the plan's initial decision or action that you are appealing.

For some actions, you may request to continue service during the appeal Process. If you are appealing a reduction, suspension or termination of services you are currently authorized to receive these services while we are deciding your appeal. We must continue your service if you make your request to us no later than:

- 10 calendar days from our mailing of the notice to you about our intent to reduce, suspend or terminate your services
- The intended effective date of our action
- The expiration of the original period covered by the service authorization

Your services will continue until you withdraw the appeal, the original authorization period for your services has been met or until 10 calendar

days after we mail your notice about our appeal decision, unless you have requested a New York State Medicaid Fair Hearing with a continuation of services (See Fair Hearing Section) or Medicare external appeal process or both.

Although you may request a continuation of services while your appeal is under review, if your appeal is not decided in your favor, we may require you to pay for these services if they were provided, only because you asked to continue to receive them while your appeal was being reviewed.

HOW LONG WILL IT TAKE THE PLAN TO DECIDE MY APPEAL OF A NOTICE OF ACTION?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 calendar days from the day we receive an appeal. The review period can be increased up to 14 business days if you request an extension or we need more information and the delay is in your interest. During our review you will have an opportunity to present your case in person and in writing. You will also have the opportunity to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made regarding your appeal that will identify the decision made and the date reached.

If we reverse our decision to deny or limit requested services, or reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases you may request an "expedited" appeal. (See Expedited Appeal Process)

EXPEDITED APPEAL PROCESS

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within three business days after we receive all necessary information. In no event will the time for issuing our decision be more than three business days after we receive your appeal. The review period can be increased up to 14 business days if you request an extension or we need more information and the delay is in your interest.

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within two business days of receiving your request.

IF THE PLAN DENIES MY APPEAL, WHAT CAN I DO?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request an external appeal for a new and impartial review conducted by an organization that is independent of ArchCare Senior Life . You have several options depending upon the type of coverage you have; Medicaid, Medicare or both. If you are enrolled in both Medicare and Medicaid, we will help you choose which appeal process to follow, as you may not access both processes at the same time.

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

Private Pay participants may not request a Medicaid Fair Hearing.

MEDICAID APPEAL PROCESS: STATE FAIR HEARINGS

If you are a Medicaid recipient, and we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal. We will inform you of your New York State Fair Hearing rights, how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and in some cases, your right to receive services while the Hearing is pending. Please ask a member of your care team if you have questions about the external appeal and Fair Hearing process.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; or until the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

Private Pay participants cannot request a New York State Medicaid Fair Hearing.

STATE EXTERNAL APPEALS

If we deny your appeal because we determine the service is not deemed necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of deemed necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within 30 days from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to five business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide on an expedited appeal in three days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external State appeal. If you ask for a New York State Fair

Hearing and an external appeal, the decision of the New York State Fair Hearing officer will be the one that counts.

MEDICARE APPEAL PROCESS

If you are enrolled in Medicare only and have completed the ArchCare Senior Life internal appeal process, you may choose to appeal using Medicare's external appeal process. ArchCare Senior Life staff will provide you with the appeal forms and can assist you with an appeal to the Medicare Designated Review Agent. If you have both Medicaid and Medicare, ArchCare Senior Life staff will assist you in deciding which appeal process to use, and will assist you with the appeal, as you cannot pursue both the Medicare and Medicaid appeal process. Private pay participants may contact ArchCare Senior Life for assistance in accessing New York State Department of Health.

FILING COMPLAINTS WITH NEW YORK STATE DEPARTMENT OF HEALTH

If at any time you are dissatisfied with how ArchCare Senior Life has treated you or how we have handled your grievance or appeal, you many contact the Department of Health directly at:

The New York State Department of Health
Division of Long Term Care
Bureau of Managed Long Term Care
Corning Tower Room 1911
Empire State Plaza
Albany, NY 12237
1-866-712-7197

SURVEYS AND PARTICIPANT INPUT

We at ArchCare Senior Life are committed to providing the best possible service and care to our participants, and you input will help us in our efforts to continually develop and improve the program. We may ask for your participation in ArchCare Senior Life Board or Quality Management committee meetings. You will also periodically receive a written Participant Satisfaction Survey from ArchCare Senior Life requesting that you rate our performance and that you provide your comments and suggestions about ArchCare Senior Life. You can also call us at anytime with your comments.

TO SUPPORT THE ARCHCARE SENIOR LIFE PROGRAM

- To appropriately express opinions, concerns and suggestions in the following ways including, but not limited to, express your opinions or concerns to your Care Team, or through the ArchCare Senior Life Grievance and Appeals Process.
- To review the Participant Handbook and follow procedures to receive services.
- To respect the rights and safety of all those involved in your care and to assist ArchCare Senior Life in maintaining a safe home environment.
- To notify your Care Team at ArchCare Senior Life of any of the following;
    - o if you are leaving the service area
    - o if you have moved or have a new telephone number
    - o any changes in condition that may affect our ability to provide care ArchCare Senior Life corporate office is located at the address below. You can access our office by using our

ArchCare Senior Life, Inc.
205 Lexington Avenue, 2nd Floor
New York, NY 10016
Participant Service line at (866) 263-9083

Additional Information Available To Participants Upon Written Request:

The following information is available upon request by the participant:

- A list of names, business addresses and official positions of the members of ArchCare Senior Life' Board of Directors, officers, controlling persons, owners or partners of ArchCare Senior Life;
- Most recent yearly certified financial statement of ArchCare Senior Life, including balance sheet and summary of monies received and paid out;
- ArchCare Senior Life procedures for protecting the confidentiality of medical records and other participant information;
- Procedures ArchCare Senor Life uses to make decisions about experimental or investigational services, medical devices, or treatments in clinical trails;
- Written description of the organizational arrangements and ongoing procedures of the quality management and performance improvements programs;
- Written descriptions of the criteria relating to a particular condition or disease used to determine whether or not ArchCare Senior Life will authorize a service, and other clinical information which ArchCare Senior Life might consider in its authorization process; or
- Written application procedures and the qualifications which health care providers must present in order to be considered for participation in ArchCare Senior Life's Ethical and Religious Directives in accordance with which ArchCare Senior Life functions.

QUALITY IMPROVEMENT PROGRAM

Archcare Senior Life has a Quality Improvement Program to systematically monitor and evaluate the quality and appropriateness of care and service. This comprehensive quality management system must meet the New York State health and long-term care quality assurance standards.
Our Quality Improvement Program identifies opportunities for improving quality of service provided, availability and accessibility of services, as well as ongoing care management improvement practice. ArchCare Senior Life quality management plan includes a system for review of where improvement is needed identified by defined metrics or observation, a process for the continuous improvement of performance, a review of the credentials of all providers providing care or service, maintenance of health information records and review of service utilization.

NOTES

PLEASE USE FOR ALL CARBON COPY FORMS

archcare
Senior Life

1-866-263-9083 | TTY 711

archcareseniorlife.org