

**Master-Care****Enhanced Care Management, Community Supports and Care Coordination Program
Enrollment & Patient Consent Form****Introduction**

The Master-Care Enhanced Care Management, Community Supports and Care Coordination Program is intended to support you (the patient) identify needs and address them through an individualized plan of care. These services attempt to respond to the broad range of physical, emotional, environmental, and social needs individuals with complex care needs may encounter; the focus will be in assuring access to medical care and other critical services, including, in some cases; non-medical services.

Enhanced Care Management, Community Supports and Care Coordination promotes dignity and self-affirming choices of individuals through advocacy and support for personal, familial, environmental and community goals. Enhanced Care Management, Community Supports and Care Coordination can assist with gathering and coordinating the variety of medical, financial, social, and personal services required. You have (The patient has) been offered Enhanced Care Management, Community Supports and Care Coordination Program to assist in meeting service needs. You are (The patient is) eligible to participate because you (the patient) meet(s) the criteria needed for Enhanced Care Management, Community Supports and Care Coordination Program.

Data Privacy/Confidentiality

By consenting to participate in the Enhanced Care Management, Community Supports and Care Coordination Program, you (the patient) agree(s) to provide information at the time of enrollment and periodically thereafter which will assist in data collection, assessment, and the determination of an individualized plan of care. Your (The patient's) progress with meeting the goals identified in your plan of care will be through discussions with your (the patient's) assigned Care Navigator. Any information compiled about you (the patient) will be maintained in a confidential manner, with access limited to others who are involved in your (the patient's) care, and to others for whom you have (the patient has) provided consent for sharing information. Any identifiable information obtained in connection with your (the patient's) participation with the Enhanced Care Management, Community Supports and Care Coordination Program will be disclosed only with your (the patient's) consent and in adherence with HIPAA guidelines.

Description of Services

You (The patient) will be assigned a Care Navigator, and a Care Navigation Team that will assist you (and the patient) identify and meet service needs. There are requirements for meeting with and communicating with your Care Navigator, depending on the level or type of service you

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may need. At some time during participation in the Enhanced Care Management, Community Supports and Care Coordination Program the service level may be changed to best suit the patient's needs. Acceptance, refusal, or termination of Enhanced Care Management services does not affect participation or eligibility to benefits, treatments, or services otherwise covered.

Duration of Services

Enhanced Care Management, Community Supports and Care Coordination Program Services will end when:

- Patient's stated agreed-upon goals and needs have been met and services are no longer needed.
- Patient does not wish to participate in the program regardless of progress on stated goals.
- Patient rescinds consent to participate.
- Patient has moved to another region and an enhanced care management program hand-off and / or transition has been performed.
- Patient chooses to receive enhanced care management services through another company.
- When the consent between you and MasterCare has either ceased or has been determined by either party to be ineffective.
- Patient has been physically threatening or verbally abusive toward Enhanced Care Management and Care Coordination team members.
- Determination by the Care Navigation Team, Regional Manager or Chief Operating Officer that MasterCare is no longer able to perform or provide appropriate Enhanced Care Management and Care Coordination Program services (e.g., non-adherence of patient to plan of care)

Benefits/Compensation

The Enhanced Care Management, Community Supports and Care Coordination Program is provided as a benefit from your (the patient's) Managed Care Plan. You are (the patient is) not obligated to pay any co-payments or additional patient charges to participate in this Program and no form of compensation will be accepted from you (the patient.) Services provided by the Enhance Care Management, Community Supports and Care Coordination Program by MasterCare, Inc. are considered a beneficial and cost-effective means for individuals, like yourself (or patient) with complex care needs to access services and supports to better manage current and future medical, social, behavioral, and environmental challenges, as well as activities of daily living.

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Rights and Responsibilities

As a recipient of Enhanced Care Management, Community Supports & Care Coordination Program services you have (the patient has) the right to:

- Respectful treatment.
- Recognition of your (the patient's) dignity and right to privacy.
- Information about the program and the reason for your (the patient's) selection in it.
- Whenever possible, a consistent point-of-contact; your (the patient's) assigned Care Navigator to support, advocate for and assist you (the patient) over time.
- Confidential treatment of your (the patient's) personal health information (PHI).
- Upon request, an explanation of how the program may share your (the patient's) PHI with other entities.
- Access to your (the patient's) medical record according to applicable federal and state laws.
- Input to decisions about your (the patient's) enhanced care management plan. This includes candid discussions of appropriate and medically necessary treatment options, regardless of cost or benefit coverage.
- Reasonable access to medical services.
- Health care services performed without discrimination based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, sexual orientation, or national origin.
- Means to voice complaints and appeals about the health decisions or health care provider.
- A timely response to questions or complaints.
- To refuse Enhanced Care Management, Community Supports and Care Coordination Program services and to be told the implications of such refusal.
- To obtain notification and a rationale when Enhanced Care Management, Community Supports and Care Coordination Program services are terminated, upon request.

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As a patient of the Master•Care, Inc's Enhanced Care Management, Community Supports & Care Coordination Program it is important to:

- Notify your (the patient's) Care Navigator of any changes in address and / or telephone number to achieve regular and effective communication.
- Give your (the patient's) Care Navigator as much information as possible to help them care for you (the patient).
- Participate in setting appropriate goals with your (the patient's) Care Navigation Team and health care providers
- Follow the plans and instructions for care that you (the patient) agree(s) to with all your (the patient's) practitioners.
- Review all service materials carefully and consider possible consequences of not complying with recommended treatment.
- Ask questions to be sure you (the patient) understand practitioner's explanations and instructions.
- Treat others with the same respect and courtesy expected.
- Keep appointments or give adequate notice if you must delay or cancel them.
- Notify your (the patient's) Care Navigator, Care Navigation Team or Master•Care, Inc., if you choose to not participate in the Enhanced Care Management, Community Supports and Care Coordination Program.

Questions about Enhanced Care Management

You are (The patient is) free to ask whatever questions you have (the patient has) at any time. You (The patient) may contact your assigned Care Navigator, or the Care Navigation Team with any questions regarding Enhanced Care Management, Community Supports and Care Coordination Program.

Grievance Procedure

If, at any time during the course of your (the patient's) involvement with the Enhanced Care Management, Community Supports and Care Coordination Program, you (the patient) experience(s) concerns that warrant formal attention, you are (the patient is) encouraged to resolve the concern with your (the patient's) assigned Care Navigator. If this process proves unsatisfactory, and you (the patient) determine(s) that continuing would jeopardize your (the patient's) relationship with this provider, or if there are concerns for personal safety, you are (the patient is) encouraged to contact the Chief Operating Officer of Master•Care, Inc. at (916) 398-4999.

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**Enrollment & Consent/Acceptance of
Enhanced Care Management, Community Supports & Care Coordination Program**

Initial: _____ By signing below, I acknowledge that I have read and understand the above information and agree to receive Enhanced Care Management, Community Supports and Care Coordination Program services.

Initial: _____ I further authorize the authorized Care Navigator, and my Care Navigator Team to communicate with me in writing, electronically, or by telephone, as may be necessary for the purpose of my healthcare coordination and management.

Initial: _____ I may, without consequence, withdraw my participation from the program at any time after signing this document.

Initial: _____ By signing below, I authorize photos to be taken of my home, medications, and environment for purposes of assessment only. I understand that these photos will only be used for assessing my care and will only be shared with my Care Navigation Team or providers.

Initial: _____ I acknowledge that I have received copies of this consent form and release of information document.

Initial: _____ I may request and receive a copy of this signed consent form at any time. Any and all copies of this document are to be considered as binding as the original.

Self, Sponsor or Guardian (Signature)	Date/Time
Self, Sponsor or Guardian (Print)	
Care Navigator (Signature)	Date/Time
Care Navigator (Print)	



HIPAA Authorization for Use or Disclosure of Health Information

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____ Date of Birth: _____

I. My Authorization: I authorize the following using or disclosing party: **MasterCare, Inc.**

To use or disclose the following health information: (check one)

All of my health information

My health information relating to the following treatment or condition:

My health information covering the period from _____ (date) to _____ (date)

Other: _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization: _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

Or,

☐ Any Health Care or Non-Medical Provider who **MasterCare, Inc.** deems essential to their provision of Enhanced Care Management, Community Supports or Care Coordination.

The purpose of this authorization is: (check all that apply)

☐ At my request

☐ Other: _____

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This authorization ends: (check one)

☐ On (date) _____

☐ When the following event occurs: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a unable to sign, please complete the following:

☐ Patient is unable to sign because: _____

Print Name of Authorized Representative: _____

Signature of Authorized Representative: _____

Date: _____

Authority of representative to sign on behalf of the patient:

☐ Legal Guardian ☐ Court Order ☐ Other: _____

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