***Please fill out all highlighted areas. When completed, mail back to our office in the enclosed envelope. This packet must be mailed back to ExpertCare before ExpertCare staff can begin services. If you have any questions, please feel free to call our office 248-643-8900.**

Recipient Checklist

- ❑ Caregiver Request Form
  Please fill out with as much detail as possible. This information enables us to find a caregiver that meets the needs of you and your family. It also gives us an emergency plan to share with staff.

- ❑ Service Acknowledgement Form
  This form states that you will adhere to the Medicaid guidelines pertaining to restrictions as to who can be paid staff. This form also acknowledges your responsibility to notify ExpertCare of any changes in guardianship.

- ❑ Privacy Notification (HIPAA)
  This form is an acknowledgment that you and/or your family have reviewed the notice of privacy practices and have been given a copy of the notice.

- ❑ Recipient Rights Policies Acknowledgement
  This form is an acknowledgment that you and/or your family have reviewed ExpertCare's Recipient Rights Policies and have been given a copy of them.

- ❑ Allocated Authorized Hours
  This form states that you will only have the caregiver work the hours allocated by the core provider agency.

- ❑ Authorized Signature(s) for Digital Timesheets
  As part of our partnership, we rely on you and/or your family to verify the times that staff works. Anyone in your household who can verify hours must sign and fill out the information.

- ❑ Authorization to Disclose Protected Health Information
  This form is to disclose information to a person or organization not covered in our privacy practices.

ExpertCare Checklist (For Office Use Only)

- o Request Form
- o HIPAA Receipt
- o Recipient Rights Acknowledgement
- o Authorized Signatures
- o Authorized Hours
- o Service Acknowledgement Form
- o Authorization to Disclose PHI

STAFF REQUEST FORM

Recipient Name: _____

Contact Information:

Guardian or Legal Representative Name: _____

Address, City, State & Zip: _____

_____

Phone Number: (H) _____ (W) _____ (C)_____

E-Mail Address: _____

Emergency Plan:

1._____ _____ _____
Emergency Contact | Phone Number | Relationship to Recipient

2._____ _____ _____
Emergency Contact | Phone Number | Relationship to Recipient

Requested days and hours for care:

Special needs of Recipient: (i.e. allergies, communication method, behaviors, mental/physical challenges)

Service Acknowledgment Form

Recipient Name: _____

The Medicaid Provider Manual requires that payments for Community Living Supports (CLS) may not be made, directly or indirectly, to responsible relatives or guardian(s) of the beneficiary receiving Community Living Supports.

CLS services can **NOT** be provided by:

- Spouses of individuals receiving services
- Parents of minor children receiving services
- Guardians of persons receiving services, including co-guardians

The Medicaid Provider Manual states that respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care.

Respite care may **NOT** be provided by:

- Parents of a minor beneficiary receiving services
- Spouse of the beneficiary served
- Beneficiary's guardian
- Unpaid primary caregiver of the person receiving services

Any changes in guardianship must be disclosed in writing to ExpertCare Management Services.

I understand the above statement and attest that I will adhere to the aforementioned guidelines.

Guardian or Legal Representative Name: _____

Guardian or Legal Representative Signature: _____

If there is another Guardian or Legal Representative, please select "yes" from the dropdown to upload their signature.

Co- Guardian or Legal Representative Name: _____

Co- Guardian or Legal Representative Signature: _____

Privacy Notice Acknowledgement

ACKNOWLEDGEMENT OF REVIEW AND RECEIPT

Recipient Name: _____

Please review our Privacy Notice. Please sign below. Our Privacy Practices are for your protected health information.

I ACKNOWLEDGE THAT I HAVE REVIEWED THE EXPERTCARE MANAGEMENT SERVICES NOTICE OF PRIVACY PRACTICES AND HAVE BEEN GIVEN AN ELECTRONIC COPY OF THE NOTICE.

Guardian or Legal Representative Name: _____

_____

Guardian or Legal Representative Signature Date

Recipient Rights Policy Acknowledgement

ACKNOWLEDGEMENT OF REVIEW AND RECEIPT

Recipient Name: _____

Please review our Recipient Rights Policies and sign below.

I ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED THE EXPERTCARE MANAGEMENT SERVICES RECIPIENT RIGHTS POLICIES AND HAVE BEEN GIVEN AN ELECTRONIC COPY OF THEM.

Guardian or Legal Representative Name: _____

_____

Guardian or Legal Representative Signature Date

Allocated Authorized Hours

Recipient Name: _____

I shall not exceed the allocated/ authorized hours provided by the core provider agency. I understand that a caregiver cannot be directed to work in excess of the allocated hours and will not request work over and above those hours.

Guardian or Legal Representative Name: _____

_____

Guardian or Legal Representative Signature Date

Authorized Signature(s) For Digital Timesheets

Recipient Name: _____

Please fill out the box(es) with the Guardian(s) or Legal Representative's information and signature(s). Only Legal Guardian(s) or Legal Representative's information should be printed/signed in the box(es). Proof of guardianship documentation may be requested.

Guardian or Legal Representative Name: (Please Print)
Guardian or Legal Representative Phone Number:
Guardian or Legal Representative Signature:
Type of Guardianship:

Guardian or Legal Representative Name: (Please Print)
Guardian or Legal Representative Phone Number:
Guardian or Legal Representative Signature:
Type of Guardianship:

Please list all adults in the home, besides Guardian(s) or Legal Representative(s) above, who are authorized to verify digital timesheets. We must have their actual signature.

Authorized Signer's Name (Please Print): _____

Phone Number: _____ Relationship to Recipient: _____

Authorized Signer's Signature: _____

****

Authorized Signer's Name (Please Print): _____

Phone Number: _____ Relationship to Recipient: _____

Authorized Signer's Signature: _____

Authorization to Disclose Protected Health Information

Recipient Name	Recipient Date of Birth
Address	Phone

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Information about mental and behavioral health services and substance use, as applicable, may be disclosed to and used by the following person or organization:

Name of Person(s) authorized to receive the protected health information:

ExpertCare Management Services	**210 Town Center Drive Troy, MI 48084**	**(248) 643-8900**	**(248) 740-3505**
Organization Name	Address	Phone Number	Fax Number

Name of Person(s) authorized to receive the protected health information:

Name	Address	Phone Number	Fax Number

****Please Note: ExpertCare must have authorization prior to communicating with your Primary Care or referring physician regarding services. Please list your physician contact information here:**

Physician Name	Office Address	Phone Number	Fax Number

Health information exchanges or networks share information verbally and/or electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services. If I do not fill it out, I can still get treatment. But, without this form, my provider may not have all the information needed to treat me.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed Authorization.

I understand that if I give permission, I have the right to change my mind and revoke it. This must be in writing to ExpertCare. I also understand that any uses or disclosures already made with my permission cannot be taken back.

Unless otherwise revoked, this authorization will expire on the following date, event or condition. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date.

_____

Date, Event or Condition

I authorize ExpertCare to provide communication regarding services through the following:

✓ **Text Messages** ✓ **Voicemail Messages to my home and/or mobile phone** ✓ **Email Messages**

Guardian or Authorized Representative Printed Name:	**Guardian or Authorized Representative Signature:**	**Date**