Community
Home Medical Equipment

Community Home Medical Equipment

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Fishers, IN 46037

Local: 317.6214800

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www.eCommunity.com/HME

Community Home Medical Equipment

We are honored that you and your family have entrusted us with your care. Our team works to develop a strong relationship with the individuals we serve, empowering them to become our partners. This book contains important information about your rights, your safety and your right to decide about your health care. If you have any questions, please speak with your caregiver or call the number listed below. Thank you for allowing Community Home Medical Equipment to provide care for you and your family.

Community Home Medical Equipment is a wholly owned subsidiary of
Community Health Network.

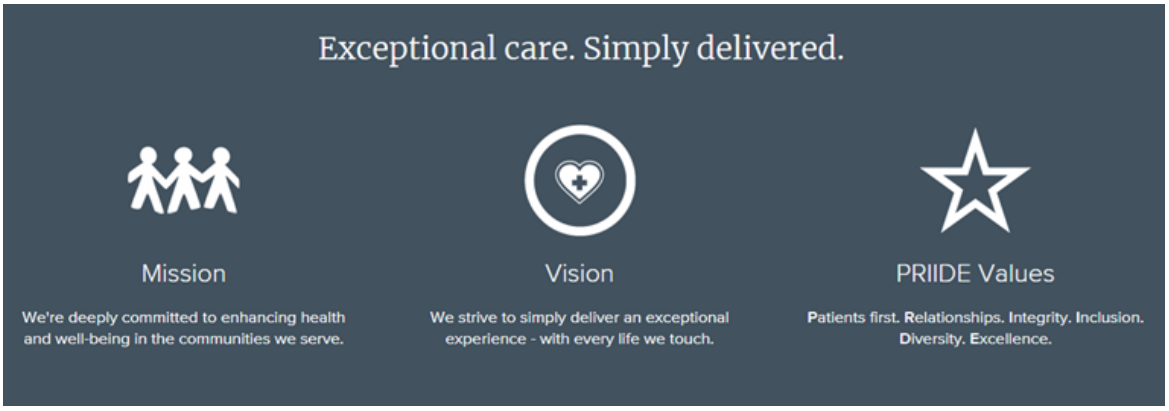
Patient and Family Partnership Philosophy

Our staff at CHME want to develop a partnership with those we serve, to empower them to help us provide the highest quality services.

Your Community Home Medical Equipment team is available 24/7. You may reach us by calling (317) 621-4800 or toll free at 1-800-404-4852.

Office hours are 8 a.m. to 5 p.m., Monday through Friday. Outside of these hours, and on holidays and weekends, our on-call staff will return your call as soon as possible.

Community Home Health Services, doing business as Community Home Medical Equipment, is a wholly owned subsidiary of Community Health Network. Community Health Network assigns care for all patients in a non-discriminatory manner and cannot guarantee that care preferences will be honored. You have the right to refuse treatment at any time and our staff will provide a list of other healthcare organizations where you may seek treatment.



Terms you may see in this booklet:

CMS	**Centers for Medicare/Medicaid Services**
DME	**Durable Medical Equipment**
HME	**Home Medical Equipment**
CHME	**Community Home Medical Equipment**
DMEPOS	**Durable Medical Equipment Prosthetic Orthotic Supplier**
DME MAC	**Durable Medical Equipment Medicare Approved Contractor**
Break-in need	**Change in medical condition that affects use of medical equipment**
Break-in service	**Break in monthly billing for medical equipment**
RUL	**Reasonable Useful Life (of a piece of medical equipment); generally 5 years**

Medicare payment for home medical equipment other than oxygen

"Capped Rental Services":

Medicare will pay a monthly fee for a period not to exceed 13 months, after which ownership of the equipment is transferred to the Medicare beneficiary.

After ownership of the equipment is transferred to the Medicare beneficiary, it is the beneficiary's responsibility to arrange for any required equipment service or repair.

Examples of this type of equipment may include: Hospital beds, wheelchairs, alternating pressure pads, nebulizers, suction pumps, CPAP devices , patient lifts, and trapeze bars.

"Inexpensive or Routinely Purchased Items":

Examples of this type of equipment may include: canes, crutches, commode chairs, low pressure and positioning equalization pads, home blood glucose monitors, seat lift mechanisms, pneumatic compressors, bed side rails and traction equipment.

HOME MEDICAL EQUIPMENT PATIENT BILL OF RIGHTS

Dignity and Respect

Patients have the right to:

- Have their property and person treated with respect
- Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property
- Have his or her personal values, beliefs and preferences respected.

Complaints

Patients have the right to file complaints with CHME:

- Regarding their treatment and/or care that is provided
- Regarding treatment and/or care that the agency fails to provide
- Regarding the lack of respect for property and/or person by anyone who is providing services on behalf of the home health agency.

Decision Making, Consent, and Services Provided

Patients have the right to:

- Participate in, and be informed about, and consent or refuse care in advance of and during treatment.
- Protection of rights during research, investigation and clinical trials
- When requested, CHME will make available a listing of all individuals or other legal entities who have an ownership or control of interest in CHME.

Privacy, and Access to Medical Records

- Patients have the right to a confidential clinical record.
- Patients have the right to access and to the release of patient information and clinical records.
- Patients have the rights to give or withhold informed consent to produce or use recordings, films, or other images of the patient for purposes other than his/her care.

Financial Information

Patients will be advised of:

- The extent to which payment for home medical equipment services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to CHME
- The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to CHME
- The charges the individual may have to pay before care is initiated
- Any changes in payment responsibility orally and in writing as soon as possible but no later than 30 calendar days from the date CHME becomes aware.

Home medical equipment services

CHME provides durable medical equipment such as:

- ◊ respiratory care equipment including oxygen, nebulizers, CPAP and Bi-level PAP, and suction machines
- ◊ orthopedic braces, splints
- ◊ wheelchairs, walkers, crutches, canes, and knee-walkers
- ◊ hospital beds, transfer and lift aids
- ◊ bath safety items such as bedside commodes, tub transfer benches, grab bars, elevated toilet seats
- ◊ pediatric equipment such as photo therapy (bili lights), apnea monitors and pulse oximeters.

Delivery

Normal delivery service is Monday through Friday from 8 a.m. to 5 p.m. but can be extended to after-hours and weekends for special needs.

Some equipment will be delivered to your home, while other products may be picked up or shipped. We will provide instructions regarding proper use, storage, and safety for your equipment. For in home deliveries, our staff will set up the equipment and make recommendations to prepare your home for safe operation and use, but cannot move furniture. Always follow instructions and use your equipment according to your doctor's orders and manufacturer's recommendations.

Maintenance, repair and warranty

Some rental equipment needs to have routine servicing. CHME will follow the manufacturer's recommended service schedule. You will not be charged for routine maintenance. **Never try to repair equipment yourself.** Contact our office to arrange a time to have your equipment serviced or replaced, if required. Manufacturer equipment warranty information is attached to all purchased equipment. Warranties only apply to the original purchaser.

Travel assistance

We will assist you in locating a provider to service your oxygen or medical equipment needs during travel. You are required to provide at least two weeks' notice for assistance in finding a provider and four weeks' notice if you need to reserve equipment to take with you.

Billing

Medicare, Medicaid, and most third party insurance carriers are accepted. If you have any questions regarding your bill, contact our billing staff directly at (317) 621-4800.

Discontinuing service

Please call (317) 621-4800 to coordinate the discontinuation of services. Do not return rental equipment to physician's offices or hospitals. We do not purchase, buy back or accept as a donation any patient-owned home equipment.

Resuscitation

Our delivery technicians are not trained to provide cardiopulmonary resuscitation (CPR), and will not attempt to resuscitate a patient in the event of cardiopulmonary arrest. We will call 911 in an emergency.

Medicare supplier standards

This is an abbreviated version of the Supplier Standards every Medicare DMEPOS supplier must meet in order to obtain and retain billing privileges. These standards are listed in their entirety in 42 C.F.R. pt 424, Sec 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment and of the purchase option for capped rental equipment
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine or cell phone is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000.00 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries with a few exceptions allowed. This standard prohibits suppliers from calling beneficiaries based on a physician's oral order unless an exception applies.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no cost or repair directly, or through a service contract with another company, Medicare covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or suitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare covered item.
17. A supplier must disclose to the government any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e. the supplier may not sell or allow another entity to use its Medicare Supplier Billing Number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by the CMS approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c).
27. A supplier must obtain oxygen from a state licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

Oxygen at home

Oxygen must be prescribed by your physician. An exact flow rate given in liters per minute will be ordered by your physician, and should never be changed unless your doctor tells you to do so. Too much or too little oxygen can cause complications. Oxygen concentrators require the same care, storage, cleaning and safety precautions, but they may look different.

Oxygen equipment

Reimbursement for the Initial 36 months

Reimbursement for oxygen equipment is limited to 36 monthly rental payments. Payment for accessories (e.g., cannula, tubing, etc.), delivery, back-up equipment, maintenance, and repairs is included in the rental allowance. Payment for oxygen contents (stationary and/or portable) is included in the allowance for stationary equipment (billing codes E0424, E0439, E1390, E1391).

Payment for stationary equipment is increased for beneficiaries requiring greater than 4 liters per minute (LPM) of oxygen flow and decreased for beneficiaries requiring less than 1 LPM. If a beneficiary qualifies for additional payment for greater than 4 LPM of oxygen and also meets the requirements for portable oxygen, payment will be made for the stationary system at the higher allowance, but not for the portable system. In this situation, if both a stationary system and a portable system are billed for the same rental month, the portable oxygen system will be denied as not separately payable.

The supplier who provides oxygen equipment for the first month must continue to provide any necessary oxygen equipment and all related items and services through the 36-month rental period, unless one of the following exceptions is met:

- Beneficiary relocates temporarily or permanently outside of the supplier's service area
- Beneficiary elects to obtain oxygen from a different supplier
- Individual case exceptions made by CMS or DME MAC
- Item becomes subject to competitive bidding

Providing different oxygen equipment/modalities (e.g., concentrator [stationary or portable], gaseous, liquid, transfilling equipment) is not permitted unless one of the following requirements is met:

- Supplier replaces the equipment with the same or equivalent item
- Physician orders different equipment
- Beneficiary chooses to receive an upgrade and signs an Advance Beneficiary Notice of Noncoverage (ABN)
- CMS or the DME MAC determines that a change in equipment is warranted
- A new 36-month rental period can begin only in the following situations:
- Specific incident of damage beyond repair (e.g., dropped and broken, fire, flood, etc.) or the item is stolen or lost
- Break-in-need for at least 60 days plus the days remaining in the month of discontinuation and new medical necessity is established.
- A new 36-month rental period does not start in the following situations:
    - Replacing equipment due to malfunction, wear and tear, routine maintenance, repair
    - Providing different equipment based on a physician order or beneficiary request for an upgrade
    - Break-in-need less than 60 days plus the days remaining in the month of discontinuation
    - Break-in-billing
    - Changing suppliers.

Months 37-60

There is no further payment for oxygen equipment during the 5-year reasonable useful lifetime (RUL) of the equipment after 36 rental payments have been made. If use of portable equipment (billing codes E0431, E0433, E0434, E1392, K0738) begins after the use of stationary equipment begins, payment for the portable equipment can continue after payment for the stationary equipment ends until 36 rental payments have been made for the portable equipment.

The supplier who provided the equipment during the 36th rental month is required to continue to provide the equipment, accessories, contents (if applicable), maintenance, and repair of the oxygen equipment during the 5 year reasonable useful lifetime of the equipment.

Rules for providing different equipment/modalities are the same in months 37-60 as they are in the initial 36 months (see above). A new 36-month rental period can begin only in the following situation:

There is a specific incident of damage beyond repair (e.g., dropped and broken, fire, flood, etc.) or the item is stolen or lost

A new 36-month rental period does not start in the following situations:

- Replacing equipment due to malfunction, wear and tear, routine maintenance, repair
- Providing different equipment based on a physician order or beneficiary request for an upgrade
- Break-in-need
- Break-in-billing
- Changing suppliers.

Months 61 and after

At any time after the end of the 5-year reasonable useful lifetime for oxygen equipment, the beneficiary may elect to receive new equipment, thus beginning a new 36-month rental period.

If the beneficiary elects not to receive new equipment after the end of the 5-year reasonable useful lifetime and if the supplier retains title to the equipment, all elements of the payment policy for months 37-60 remain in effect. There is no separate payment for accessories or repairs. If the beneficiary was using gaseous or liquid oxygen equipment during the 36th rental month, payment can continue to be made for oxygen contents.

If the beneficiary elects not to receive new equipment after the end of the 5-year reasonable useful lifetime and if the supplier transfers title of the equipment to the beneficiary, accessories, maintenance, and repairs are statutorily non-covered by Medicare. Contents are separately payable for beneficiary-owned gaseous or liquid systems.

If a beneficiary enters Medicare with beneficiary-owned equipment, then accessories, maintenance, and repairs are statutorily non-covered by Medicare. Contents are separately payable for beneficiary-owned gaseous or liquid systems.

Oxygen equipment replacement and cleaning recommendations

Nasal Cannula: Replace monthly or more frequently after having a cold or illness.

Extension tubing: Replace every 90 days and wipe with a damp cloth.

Humidifier: Add fresh, distilled water daily. Wash with warm, soapy water twice weekly.

Concentrator: Should have a clean filter weekly and should be rinsed under water and thoroughly dried before replacing. Wash the oxygen concentrator cabinet with clean, warm, soapy water. Rinse with a clean cloth, damp with clean clear water.

Safety/hazard rules for oxygen

Oxygen does not explode and will not burn by itself. Three elements are needed for a fire to ignite: flammable material (fuel), heat (such as a match, open flame or heat source), and an oxidizing agent (oxygen). When additional oxygen is present it can cause a small spark to ignite much more quickly and to burn hotter than usual.

Follow the rules below to prevent **fire-related injuries**.

DO NOT

- Do NOT permit the use of open flames where oxygen is being used or stored.
- Do NOT smoke near oxygen.
- Do NOT use any household electric equipment near oxygen (electric razors, heaters, blankets, etc.). Keep these items at least five feet away from your oxygen or your oxygen concentrator.
- Do NOT use oily lotions, face creams, oil or hair dressings.
- Do NOT use petroleum-based products (such as Vaseline) in your nose or near your oxygen.
- Do NOT use aerosol sprays around your oxygen equipment.
- Do NOT allow oxygen tubing to be covered by any objects.
- Do NOT leave oxygen on when equipment is not in use.
- Do NOT abuse or handle oxygen containers roughly.
- Do NOT store oxygen in a confined area (i.e., closet, under a bed with a bed skirt).

- Do NOT allow untrained persons to use or adjust equipment.

DO

- Keep all oxygen at least 15 feet away from any open flame, heat sources, hot surfaces, lubricants or flammable products.
- Secure oxygen in the back seat of a car.
- Open your window about one inch when you have oxygen equipment in your car.
- Secure oxygen cylinders in a stand, appropriate storage box, by a chain or cord. If unable to do so, lay cylinders flat on floor and contact CHHS for a storage device.
- Post NO SMOKING signs on your doors.
- Place a smoke detector/alarm on each floor of your home.
- Check the batteries in your smoke detectors monthly, or as recommended by the manufacturer.

- Develop a fire safety escape plan now. Choose a meeting place for everyone in your home. **Never** go back into a burning building.
- Have a fire extinguisher in your home in case of a fire.

Oxygen concentrator safety

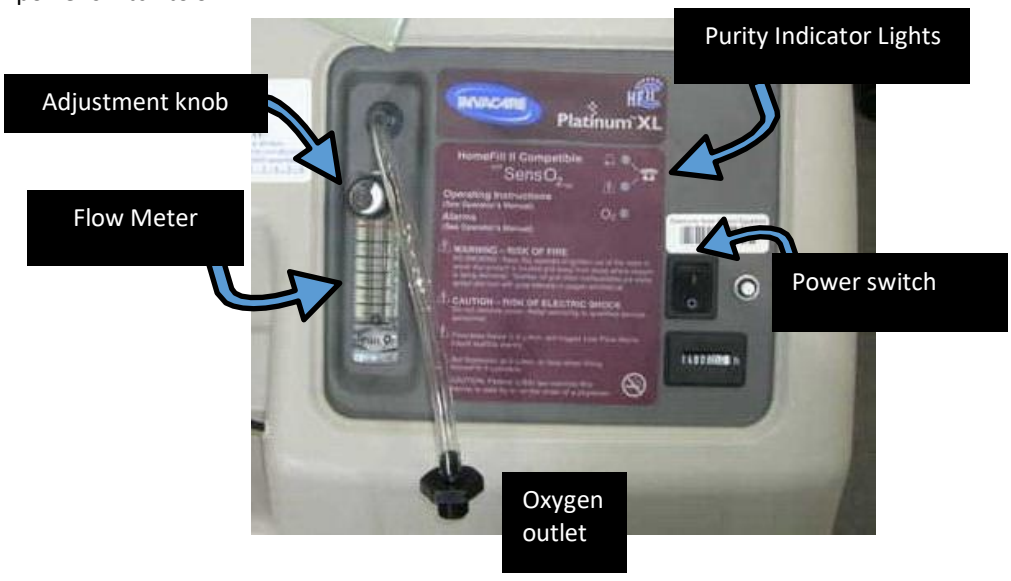
Your oxygen concentrator separates oxygen from room air. It provides a high concentration of oxygen directly to you through a nasal cannula. Your concentrator can be easily rolled from room to room in your home.

Take the following precautions:

- Never smoke within 15 feet of an oxygen concentrator and post **NO SMOKING** signs on your doors.
- Keep your concentrator and all related items away from open flame, heat sources, hot surfaces, lubricants or flammable products.
- Keep your concentrator three to six inches from any wall, furniture, draperies or similar surfaces.
- Never insert anything into an opening on your concentrator and do not block the air openings.
- Do not place the concentrator on a bed or near a couch where the soft surface could block an air opening.
- Avoid using the concentrator while you are bathing. If you must keep your oxygen in place while you bathe, place it at least seven feet away from the tub or shower.
- Never touch the concentrator while you are wet.
- Never use extension cords to plug your concentrator into an outlet.
- Never take the ground prong off the cord plug to make it usable.
- Use in a smoke free and soot free environment.
- Do not keep the concentrator in a confined space such as a closet.
- Do not put your concentrator near heat ducts, radiators, heaters, hot water heater, or hot air registers.

Using your concentrator

1. Plug concentrator power cord into house electrical outlet.
2. When you turn the concentrator on, all the panel lights and audible alarm will come on for one second, indicating that the unit is functioning properly.
3. After one second, the green system OK/power light will stay on.
4. Adjust the prescribed liter-per-minute (lpm) flow rate on the front of the concentrator. Locate the prescribed flow rate line on the flow meter.
5. Turn the flow knob until the ball rises to the line. DO NOT change the setting from the prescribed flow rate.
6. If the flow rate drops below 0.5L/min the alarm will sound.
7. To discontinue use, push or turn power switch to off.



Oxygen purity indicator lights

- **Yellow light**: Call CHME immediately. You may continue to use the concentrator unless instructed otherwise by your supplier. Be sure your backup oxygen supply is nearby.
- **Red light**: Total unit shutdown. Switch to your backup oxygen supply and call CHME immediately.
- **Green light with yellow light flashing**: Call CHME immediately. Oxygen sensor malfunctioning, but you may continue to use the concentrator.

Using the humidifier

1. Fill and maintain humidifier bottle (if prescribed) with sterile or distilled water to the full mark on the bottle and attach to the concentrator oxygen outlet fitting.
2. Attach supply tube, with cannula, to the humidifier bottle oxygen outlet fitting.
3. If humidifier is not prescribed, attach the oxygen outlet fitting directly to the concentrator fitting. Attach supply tubing to this fitting.

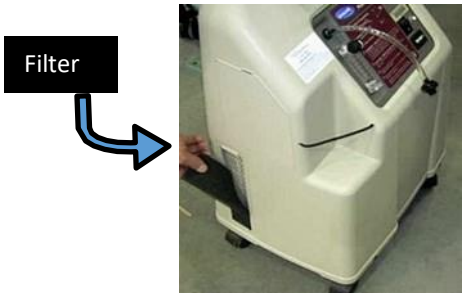
Cleaning the cabinet filters

There are two filters, one on each side of the cabinet.

Remove each filter to clean once each week with a vacuum

cleaner or wash them in warm, soapy water and rinse thoroughly.

Dry the filters before replacing in the concentrator.



Troubleshooting guide

Problem	You should
Concentrator is turned on but is not working and the alarm does not sound.	• Check wall electrical receptacle to make sure power cord is plugged in and try a different receptacle • Check household circuit breaker/fuse box • If equipped with battery-powered alarm, batteries may need replaced
Concentrator is turned on but the alarm does not stop beeping	• Call 317-621-4800
Concentrator not operating and the alarm is an intermittent short beep/long pause.	• Check wall electrical receptacle to make sure power cord is plugged in and try a different receptacle • Check household circuit breaker/fuse box • If concentrator equipped with battery-powered alarm, batteries may need replacing • If electricity to the house is out, turn the concentrator off and switch to back up cylinder until power is restored
Power switch is on and the fan is operating, but the compressor is not operating and the alarm is sounding	• There is not enough power in the plug you are using. Plug power cord into different wall receptacle • Check the oxygen liters per minute (LPM) setting • Remove tubing and humidifier bottle (if equipped) from unit. Replace with new humidifier bottle; make sure tubing is not kinked and nothing is sitting on it. Straighten old tubing or replace with new tubing by reattaching to concentrator or humidifier bottle
To check if concentrator is working, turn it on and place the end of the nasal cannula in a glass of water.	• Place the end of the nasal cannula in a glass or cup of water. • Water should bubble.

Managing your oxygen cylinders-Your oxygen cylinder (tank) is for use as a backup for your concentrator or as a portable oxygen supply.

E Cylinder 29 inches tall

D Cylinder 21 inches tall

M6 cylinder

How long will your oxygen tank last?

Full Oxygen Cylinders **Hours** of Oxygen Use

Liters per min	1	2	3	4	5
D Cylinder	5hrs	2.5hrs	1.75hrs	1.25hrs	1hr
E Cylinder	10hrs	5hrs	3.5hrs	2.5hrs	2hrs
M6 cylinder	2.5hrs	1.5hr	------	------	----

Oxygen cylinder safety

Store oxygen cylinders in an oxygen holder, an approved oxygen box, strapped in place or you can lay them flat on the floor.

Do not store oxygen cylinders near heat sources or enclosed areas such as closets.

You can store your oxygen cylinders under your bed as long as the air flow is not obstructed.

If you travel with oxygen cylinders in your vehicle you must make sure they are secured or tied down.

Keeping your oxygen cylinder in an approved holder is important for safety!

Placing a regulator (or "gauge") on your cylinder

1. Match up the two prongs on the gauge with the two holes in the top of the oxygen cylinder.

2. Slide the gauge over the top of the cylinder . Turn the "T" shaped handle until it is tight.

Adjust the liter flow

Oxygen outlet

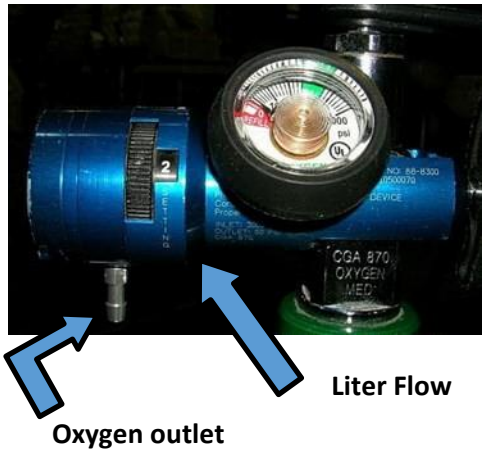
Using a conserving pulse regulator (or "gauge") with your oxygen cylinder

The conserving device for your oxygen cylinder is called a pulse regulator. It helps conserves your oxygen so your cylinder will last longer by only delivering oxygen when you take a breath. The amount of time you can expect your cylinder to last is listed in the table below, but will vary based on how fast you are breathing.

How long will your oxygen tank last?

Full Oxygen Cylinders **Hours** of Oxygen Use

LPM	1	2	3	4	6
D Cylinder	20hrs	13hrs	6.5hrs	5hrs	3hr
E Cylinder	34hrs	17hrs	11hrs	8hrs	5hrs
M6 cylinder	7hrs	3hrs	2hrs	----	----



Conserving pulse regulator

Place the regulator over the top of the cylinder and turn the black handle to tighten the regulator.

Attach your oxygen hose to the oxygen outlet and turn the wrench clockwise to turn on your oxygen. Set the liter flow as ordered by your doctor.

TROUBLESHOOTING: If your oxygen tank is not working be sure to check and make sure the main valve is open. Make sure the flow meter is turned on and that your oxygen tubing is secure on the outlet and is not crimped.

Managing Your Oxygen Cylinder Filling Station

- Your oxygen cylinder filling station should be placed at least 3 to 6 inches away from walls, curtains or furniture to ensure sufficient airflow.
- Avoid placing next to heaters, radiators or hot air registers.
- Keep it at least 5 feet away from hot objects or sources of flame.
- Never move it with a cylinder connected to it, or stored on it, to prevent injuries.
- Always inspect your cylinder for dents or dings and oil or grease before you place them on the self-filling system. If you have dents or other damage on your cylinder, you should call CHHS and ask to have your cylinder replaced.
- Never lubricate or grease any part of the oxygen equipment.
- **Never use ANY** kind of tools to connect or disconnect the cylinder and the oxygen station. **Severe injury or damage could occur.**
- Do not drop oxygen cylinders. Use two hands when handling oxygen cylinders to prevent injury.
- Infection control/ cleaning:
    1. Unplug the oxygen station and remove filters
    2. Clean filters with a vacuum cleaner or wash in warm soapy water and rinse thoroughly.
    3. Dry the filters thoroughly before you re-installation.
    4. Clean the exterior cabinet with a damp cloth or sponge and a mild household cleaner wipe it dry.

INDICATOR LIGHTS ON YOUR OXYGEN CYLINDER FILLING STATION AND WHAT THEY MEAN

Indicator Light Color	Oxygen Station Status	What it means
Service Red with audible alert	Internal failure	Contact CHHS
Standby Green	Cylinder is ready to being filling	Cylinder filling has not started
Filling green	Cylinder is filling	Cylinder is filling
Full green	Cylinder is full	You may remove cylinder
No light is on	Oxygen station unplugged	Not turned on. Check & make sure it is plugged in.

CONNECTING YOUR OXYGEN CYLINDER TO THE PERSONAL OXYGEN FILLING STATION

1. **Unplug your oxygen self-filling system from the wall outlet.**
2. Remove the oxygen fill cover.
3. Position the cylinder over the cradle while aligning the nipple connector on the oxygen cylinder with the fill connector.
4. Press down until the cylinder “clicks” into place.
5. Plug your oxygen fill station into the wall outlet.
6. Push the green start/stop button on the control panel.
7. The FILLING green light will illuminate.
8. Check the rotary Selector and turn it to “OFF”.

Oxygen Filling Station

Infection control

Unplug the oxygen station and remove filters

Clean filters with a vacuum cleaner or wash in warm soapy water and rinse thoroughly.

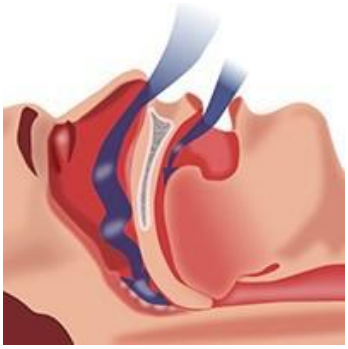
Dry the filters thoroughly before you re-installation.

Clean the exterior cabinet with a damp cloth or sponge and a mild household cleaner wipe it dry.

Trouble Shooting

Problem	**Solution**
No indicator light is on	• Make sure the unit is plugged in. Call CHME if it is plugged in a not working
Red Light is on	• Ensure the oxygen cylinder is connected correctly • Press the start/stop switch and if the red light remains on call CHME.
Excessive fill times or the green filling light stays on	Ensure the oxygen cylinder rotary selector is set to off Check and make sure the cylinder is connected properly. Press the start/stop switch to return to standby. Remove the cylinder and re-install. Press the start/stop button to begin filling the cylinder. If the light turns red again, call CHH
Hissing sound from the oxygen cylinder	• Turn rotary selector off If hissing sound continues call CHME.
Oxygen cylinder is on, but oxygen is not being delivered	• Refill the cylinder • Make sure the cannula is straight and is not pinched. • Call CHME if the problem persists.

CPAP/ AutoPAP / Bi-level PAP Equipment



Rental equipment

Most insurance providers require that CPAP/ Autopap/ Bi-level PAP are “capped” rental items. This means that the equipment rents for a certain rental period determined by the insurance provider. At the end of the rental period the equipment belongs to the patient. Depending on your insurance this rental can be up to 15 months. Be aware that if your insurance has a deductible you will have to meet your deductible again at the beginning of next year before the insurance makes any payment on your equipment.

Mask Returns and Exchanges

CHME cannot exchange masks that a patient receives from the sleep lab or any other provider. Masks sold to the patient by CHME may not be returned for a refund. **You may exchange a mask purchased from CHME, if you call within 14 days from date of purchase.** This program is offered through the mask manufacturers and has a strict time limit from the date of purchase. Most insurance providers allow a new mask only every 90 days. If you need a different mask after the exchange period has passed, you can choose to privately pay for a new mask or wait until you are eligible. **CHME cannot exchange masks that you have received from the sleep lab or another provider.**

Insurance Compliance Requirements for most insurance providers

Patients must demonstrate that they are using the equipment enough in order for the insurance company to continue to make payment on the equipment. When CHHS is required to obtain this data, we will retrieve it from a modem on your equipment, or send you an SD card. **Most insurances require that patients use the equipment for a minimum of 4 hours per night, 70% of the nights in a 30 day consecutive period (21 out of 30 consecutive days), within the 90 most recent day usage.**

Patients who are not compliant have the choice to return any equipment that is still under rental or pay privately until the time when the patient demonstrates compliance. Purchased equipment and supplies cannot be returned.

If at any time you find that you are not able to use your equipment for more than a few nights or are hospitalized or admitted to a skilled nursing facility, you must contact CHME to notify us. Insurance will not make payment for both outpatient equipment (from a home care provider) and inpatient care/ equipment (for example, a skilled nursing facility or hospital) at the same time.

Sleep Coaching - *you may opt out of these contacts at any time.*

Phone number for your Respironics machine sleep coach: 1-800-644-3324

We will attempt to reach you on a regular basis to ask a few questions about the use of your equipment and how you are doing, and will assist with any questions or troubleshooting needs you may have. Our goal is to ensure you are able to use your equipment and to assist you in becoming not only compliant with insurance usage requirements, but that you are comfortable with your equipment, answer any questions you may have, and ultimately to improve the quality of your sleep!

Our sleep coaches can assist you in troubleshooting and may enlist the help of a respiratory therapist as needed.

Supply reminder contacts- *you may opt out of these contacts at any time.*

Phone number for your supplies: (317) 218-7004

Many patients say it is hard to remember when they last ordered their supplies. Regular cleaning and replacement of supplies is important to prevent infection, to ensure the best mask seal and function of your machine. CHME will attempt to reach you on a regular basis to remind you that you when you are eligible for replacement supplies. You can choose to order all supplies that your insurance allows, you can choose which ones you need, or you may decline to receive any at that time.

If your insurance requires prior authorization, we may need to obtain data about your equipment usage before we can ship supplies. If you are not compliant with the usage guidelines, you may choose to pay privately.

Once CHME has everything we need for prior authorization, your order will be processed and should arrive in 5-7 business days. You will be responsible for any deductible or co-pay amounts that your insurance plan requires.

Once you receive your shipment, please open it immediately to ensure you have received the supplies requested, and contact us immediately for any issue resolution.

NOTES OR QUESTIONS:

How to use your machine

Before you go to bed

Wash the part of your mask that comes into contact with your face daily. Make sure your mask *and* face are clean and dry for the best seal.

Pull out your humidifier water chamber. Empty it if there is still water inside.

Put fresh **distilled water** into the water chamber and DO NOT fill past the MAX line.

Put water chamber back into machine.

Put your mask on.

Press the Start/Stop or On/Off button once to turn on your machine.

Lie down in your sleeping position and then make adjustments to your head gear to fix any leaks. Don't do this while sitting up or you will likely over-tighten your headgear.

If the pressure feels too strong, press the Ramp (triangle button) on the Respironics machine. If you have a ResMed machine, the Ramp will start automatically when turned on.

When you wake up

Turn off your machine by tapping the Start/ Stop or On/Off button once.

Take off your mask.

Remove the water chamber and empty out any remaining water.

Weekly

Wash your mask, headgear, water chamber, non-disposable filter (Respironics machines only) and tubing in mild dish detergent and warm water. Rinse in clear water and allow to air dry.

Infection Control/ Cleaning Guidelines

Wash your hands frequently when working with your equipment. All parts should be washed in a mild dish detergent and water. Rinse all parts well with clear water, and allow to air dry. Do not use chemicals such as bleach or alcohol, or place in a dish- washer, washing machine or dryer unless specified by the manufacturer that is it is safe to do so. These recommendations are minimum frequencies for cleaning your supplies. Clean more frequently, as needed.

Mask: wash the parts of the mask that come into contact with your face daily. Wash the entire mask at least once per week.

Tubing: wash weekly. Rinse well under running water, and hang up to drip dry.

Headgear: wash weekly.

Humidifier chamber: fill with fresh distilled water every night before using, and empty in the morning when you wake up. Wash once a week.

Re-usable filter: rinse in tap water (no soap) weekly.

Disposable filter: Never wash these filters. They are disposable and must be replaced when they look dirty. Allowing your filters to remain dirty can affect the performance of your machine, including reducing the pressure output.

"Cleaning machines" that you may have seen advertised are not covered by insurance, which means you would need to pay if you choose to purchase one. If you are interested in information, call Wellspring Medical at Home (317) 621-9358.

Replacing CPAP/ Bi-level PAP supplies and accessories

Most insurance companies follow the Medicare guidelines for replacement supplies, as follows:

Full face mask cushion	1 monthly
Nasal mask cushion	2 monthly
Nasal pillows	2 monthly
Disposable filters	2 monthly
Any style mask frame	1 every 3 months
Tubing	1 every 3 months
Headgear	1 every 6 months
Chinstrap	1 every 6 months
Water chamber	1 every 6 months
Non-disposable filter (reusable)	1 every 6 months

Phone number for supplies: (317) 218-7004

You must call in the first month to establish contact.

Our resupply program provides you with the option to receive email, phone, text messages or using an App for ordering, after your initial contact. You may change your choice at any time by simply asking to have it completed.

It is important to replace your supplies to prevent infection, mold and bacteria growth. Contact your insurance company to make sure how often you can order supplies. CHHS cannot guarantee insurance payment. Often, patients have deductibles that must be met before the insurance will pay anything, and you may have co-insurance or co-pays for each item as well.

Mask fitting

- Headgear straps need to be even. Uneven straps can cause your mask to put unequal pressure on your face and create air leaks.
- Your mask doesn't have to be completely tight to work properly. Your machine has the ability to compensate for small leaks. It's better to allow a small leak rather than cause pain. The only place a leak should be completely stopped is when it blows into your eyes.
- If the bridge of your nose is sore, then your mask is probably too tight. If you are using the nasal pillows and the skin between your nostrils is sore, then your headgear is probably too tight. You can try the next larger size pillows instead of making your headgear so tight.
- When adjusting your straps, make very small (tiny) adjustments to both sides at the same time and see if that corrects the problem. If not, make another tiny adjustment.
- Clean masks seal better. Make sure to clean off the part of your mask that contacts your face every day. Make sure your face is clean as well. Any natural facial oil, added lotions and/ or creams will prevent a good seal.
- Replace your mask cushion when you are allowed, which is generally every month. Seals do wear out with time. If you notice you must make your straps tighter in order to seal, then it may be time for a new cushion.

Pressure

- Ramp feature– this will decrease the pressure so that it's more comfortable when you are first going to sleep. Ramp will automatically build the pressure back up to the prescription setting that was ordered by your doctor while you sleep.
- If you cannot tolerate your prescription pressure even after using the ramp, please contact your doctor. **CHME is not able to change your pressure setting unless we have a prescription from your doctor.**

Humidity

The type of humidifiers that CHME provides have a sensor that detects the humidity and temperature of the room where you are sleeping and will only heat up when the machine senses the need to do so. Therefore, your humidifier may use different amounts of water from night to night, or may not feel warm to the touch. This doesn't mean your humidifier isn't working. Make adjustments based upon the following:

If your mouth or throat is dry:

- Turn up your humidifier setting by one number per night until the desired level of moisture is achieved.
- Make sure you are drinking an adequate amount of water during the day.
- If you are using a nasal mask or pillows and your mouth comes open, this will create a very dry mouth/throat. You may need a chinstrap to keep your jaw closed, or you may need a full face mask that covers both your mouth and nose.
- You can use a non-prescription saline spray. Spray several times in each nostril before and after using yourmachine.
- Do not place your machine too close to a heating or cooling vent.

If you feel like you are getting too much moisture in your mask or nose:

- Turn down the humidifier setting one number per night until you reach a comfortable humidity level.
- Make sure you do not have a buildup of water condensation in your tubing. Carefully detach the tubing from the machine, carry to a sink and empty any water out of the tubing, then reconnect to your machine.
- You can increase the tubing temperature setting to prevent condensation in the tubing.

If you feel that the temperature of the air is too warm or cold:

- Adjust the tubing temperature up or down until it is comfortable for you.

Tips for success with your CPAP or Bi-level PAP

Be positive: Have a positive attitude and realize this is a learning process. You have been sleeping with nothing on your face for years. Your brain will adjust if you keep using every night and make it a new, healthy habit. Also remember that this is a very simple, low-risk treatment in comparison to surgery or medication.

Be patient: Your body must adjust to sleeping with something new on your face. Practice wearing your mask while you are relaxing, watching TV or just resting.

Be persistent: Keep on trying and don't give up easily! Anything worth having is worth working for. Feeling better and being healthier is worth the work it may take up front. Don't skip any nights. You're developing a new sleeping habit, and skipped nights interfere with this process and your ability to establish compliance (required by many insurance providers).

Other important tips

Don't move, tilt, pack or relocate your machine with water inside the water chamber. Always remove the chamber and empty it first. This will prevent water from entering the electrical components of your CPAP/Bi-level PAP machine, causing equipment failure.

Don't send your CPAP/Bi-level PAP equipment to the baggage compartment of an airplane or public transportation system. Carry it on board with you to prevent damage.

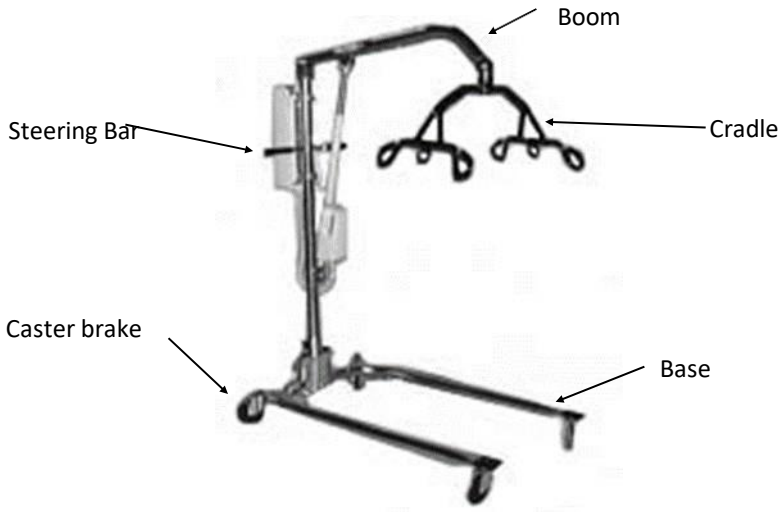
Schedule a follow up appointment with your doctor so they can evaluate and determine the effectiveness of your CPAP/Bi-level PAP treatment. Any necessary adjustments to your machine can be ordered at this time. Some insurance companies require that you have this face-to-face follow up visit with your doctor in order for continued payment for the equipment.

Patient Lifting Device

This lifting device is for transferring the patient, not for transporting the patient!

Before you try to lift anyone with this lifting device you should practice.

- Be sure you have the correct size sling before you try to use this lift device.
- Always explain the procedure to the patient before you begin.
- To raise the lifter you should pump the pumping handle.
- To lower the lifter open the pressure release knob by turning it counter clockwise, not more than one full turn.
- The knob is located near the pump handle.



Using the lifting device to get a patient from the bed to a chair

1. Roll the patient on his side and place the sling behind the back.
2. Roll the person onto his back.
3. Pull the leg loops forward and put them under each thigh, pulling the loops up between the legs, then cross the loops.
4. Roll the base of the lifting device as far under the bed as possible.
5. Make sure the cradle is over the patient you want to lift. Be Careful: Do not use the caster brake when you are lifting the patient.
6. Attach each side of the sling to the corresponding sides of the lifter cradle.
7. When both sides of the sling are attached you should lift the patient slowly until the buttocks are just above the mattress.
8. Grasp the patient's legs and swing them around slowly until they dangle off the side of the bed. DO NOT slide the patient away from the mattress until you are sure the sling is secure.
9. Grasp the steering handle and slowly move the lifter away from the bed.
10. Make sure the chair is secure before lowering the patient.

Using the lifting device to get a patient from the chair to the bed

1. Move the lifter base around the base of the chair and under the leg rests if the patient is in a wheelchair.
2. Be sure you lock the wheelchair brakes.
3. Attach the sling appropriately to the cradle on the lifting device and raise the patient above the seat.
4. Make sure the sling is secure before you move the patient.
5. Use the steering bar to move the patient to the bed.
6. Push the lifter base as far under the bed as possible.
7. Make sure the patient's buttocks are above the mattress.
8. Gently swing the patient's legs onto the mattress and lower the patient onto the bed.

Safety/hazard guide

- Patient lifts should be used only by order of the physician.
- If the patient is wearing slippery clothing it may cause them to slide out of the sling.
- Do not move the lifting device over shag or deep pile carpeting, thresholds, rough or surfaces or over other obstructions that can cause wheel stoppage and a tip over.
- Use care if a patient lift is used to lift a severely spastic or handicapped person.
- Base legs on lifter should be spread to widest position when lifting patient.
- Keep patient centered between the legs of base and facing toward the person who is operating the lift.
- Check position of sling to be sure seat is close to bend of knees.
- Adjust links of chains or slides on web straps to ensure the most comfortable position.
- Make sure wheels are locked when putting the patient into and out of the patient lift.
- Visually inspect the nut and bolt that attaches the boom to the top of the mast; verify that the nut and bolt are securely fastened.

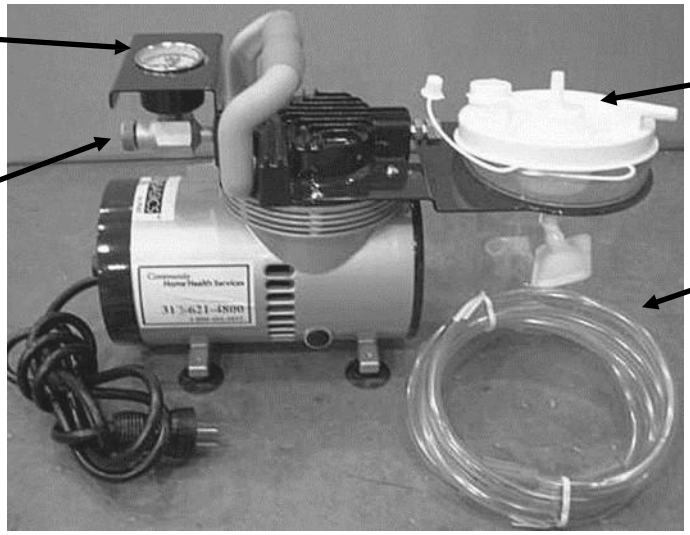
Troubleshooting

Call CHME if your lift is not working properly.

Cleaning and infection control

- Clean lift with warm soapy wash cloth or sponge; wipe with a damp non-soapy cloth.
- Soak the lifting sling in the one part vinegar to one part water, then hand wash with laundry soap and air dry.
- For infection control, the complete lift should be wiped with a clean cloth and a solution of one part vinegar to one part water.
- The entire lift can then be sprayed with disinfectant and allowed to air dry.

Suction unit instructions and care



Your particular unit may look different that this.

This equipment must be grounded. You must use a three prong plug. Never remove the prong to make this plug fit into a two prong socket. Improper grounding can result in electrical shock. **If you must use an extension cord make sure it is at least 18 gauge and no longer than 25 feet.**

Do not operate this suction equipment unless you have been properly trained. **Improper use of a suction unit can cause physical harm or tissue damage!**

Operating instructions

1. Read the instruction sheet and familiarize yourself with the unit.
2. Make sure the on/off switch is in the off position.
3. Attach the tubing to the suction outlet.
4. Turn the control knob counterclockwise as far as it will go.
5. Plug the unit into a properly grounded electrical outlet.
6. Turn the on/off switch to the on position.
7. Turn the control know clockwise, to adjust the amount of suction pressure. Typically, the range is a minimum of 80 mmHg and no greater than 120 mm Hg. Do not exceed 120 unless specifically instructed to do so by CHHS.
8. Your suction unit will operate on battery in case of a power failure, and it has an adapter to connect it to your car's adapter if needed. Keep the unit plugged in at all times, in order to ensure the best charge on the battery.

Changing the filter

If the unit loses suction you may need to replace the filter. **Never use a different type of filter in this suction unit.** Please call Community Home Health if you have questions.

- Remove the elbow connector end of the filter tubing from the top of the collection jar.
- Unthread the tubing assembly from the vacuum gauge and throw it away.
- Put the new filer assembly in place by threading it to the vacuum gauge and attaching the connector to the top of the collection jar.

Collection jar

The collection jar should be emptied and cleaned after every use.

- Turn the unit off and remove the elbow connector from the top of the collection jar.
- Lift the jar out of the bracket, remove the lid and empty the jar.

Infection control/cleaning the collection jar

The collection jar and lid is safe to put in the upper rack of a dishwasher. The water temperature maximum is 65 to 150 degrees.

- Wash the collection jar in soap and water or soak the jar for 20 minutes in a solution of 2% vinegar and water. (mix 4 teaspoons of white vinegar in 1 quart of water).
- Air dry the collection jar and lid on a towel or paper towel.

Infection Control for the Suction Unit:

You may wipe the outside of the unit with a clean dry cloth.

Troubleshooting

If the suction on your unit has decreased or stopped you should:

- Turn the unit off and unplug it from the electrical outlet
- Remove the collection jar and clean or replace, if needed.
- Resume the operation of the unit according to the instructions provided in the *"*Operation*"* section on the previous page.

If the suction continues to be decreased or stopped you should change the filter as instructed above. **If the suction still does not work properly call CHME at (317) 621-4800.**

Hospital bed

Hospital beds permit body positioning that is not easily performed in a regular home bed and allow for attachment of other pieces of equipment that cannot be used on a regular home bed.

Hospital beds may provide several other advantages such as:

- Making it easier and safer for the person to get in and out of the bed and to reach a standing position for ambulation with crutches, walker or cane.
- Making transfers to and from wheelchairs or bedside commodes easier and safer.
- Making care giving easier by placing the bed at a more convenient height when providing assistance with position changes, turning, bathing, eating or other care.

Operating instructions

Manual, multi-height bed models

When facing the foot of the beds:

The **left** crank raises and **lowers the head** section of the spring.

The **right** crank raises and **lowers the foot** section of the spring.

The **center** crank **raises and lowers the height** of the bed

Turning any of these three cranks **clockwise raises,** and **counter-clockwise lowers**.

Bed crank at the foot of the bed

Semi-electric bed models

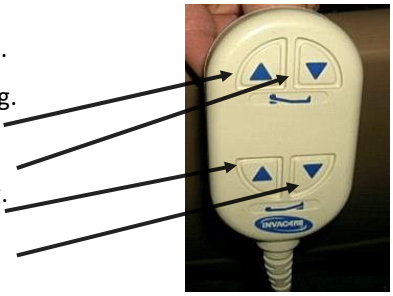
The pendant has four buttons:

Raises the head section of the spring.

Lowers the head section of the spring.

Raises the foot section of the spring.

Lowers the foot section of the spring.



Bed Control

The semi-electric models have a manual crank system to raise and lower bed **height**.

Full electric bed models

The control pendant has six buttons:

Four of the buttons are the same as those described above for the semi-electric models

The two additional buttons operate the bed height. One button raises the bed; the other lowers the bed. The function of each button is indicated on the control

On both electric models an emergency crank is furnished. This crank can be inserted into the appropriate sockets at the foot of the bed to allow manual adjustment of all bed functions. This provides emergency back-up operation in the event of power failure or the failure of one of the motors.

Troubleshooting

You and your caregivers should be familiar with all the basic operations of the bed in order to use it to meet your needs. Be alert to any unusual noise when you are using the bed or any changes such as cranks becoming stiffer or more difficult to turn. It could be a mechanical problem and you should call CHHS if this occurs.

Bed side rails

A side rail is a safety device to prevent the person from rolling out of the bed.

There will be a gap between the side rail & the mattress when the head is elevated. The mattress you received with your bed is the standard size mattress that is recommended by the manufacturer. **Do not** change mattresses because a smaller mattress would increase the gap between the mattress and side rail and a person could become trapped in the gap.

Bed rail safety

There have been reports of people being trapped between the mattress and side rails on hospital beds. Being trapped has caused injury and even death, making it important to take precautions when using side rails on any bed.

Some of the risks include: Strangling, suffocation or bodily injury, including death if you become caught between rails or between the rails and the mattress.

Serious injuries can occur from climbing over rails or skin cuts and scrapes. Most people are safe in bed without using rails.

To prevent injuries:

- Keep the bed locked and in the lowest position.
- Keep some of the bed rails down so you can get in and out of bed as needed.
- Use the proper size mattress to prevent being trapped between the mattress and the side rails.
- Reduce spaces between the mattress and side rails by using rolled blankets or pillows.
- If bed rails are used you should have your family members check on your frequently.
- If you are afraid of falling out of bed you could put padding on the floor near the bed.
- Make sure you have something to drink within easy reach of your bed.
- Make sure you use the bathroom prior to going to bed.

Operating instructions

- The rails are lowered by pulling out on the pull buttons or plungers. Be careful not to catch hands or feet in the rails as they are lowered. It is wise to hold the rail with one hand while releasing the pull button with the other.
- To raise the rail, slightly lift up in the center until the plungers snap into the holes in the rail. Look at the rails to check and make sure the plungers are in place
- On the universal telescoping rails, the head-end can be raised independently of the foot-end to provide a half-rail
- When assisting a person to turn onto their side, the rails should be in the up and locked position. The caregiver should stand on the side toward which the person is to be turned, then reach over the rail and pull to provide the needed assistance.

Wheelchairs, walkers and canes

Wheelchair (non-electric) safety

- Always lock both the left and right brakes before transferring in or out of the chair, or when stopped.
- Never use a wheelchair if the locks do not work.
- Position the wheelchair as close as possible to the place you are transferring.
- Lift and swing away, or remove the foot plates before you try to transfer to avoid tripping or injury.
- On wheelchairs equipped with removable arms, remove the arm between the patient and the item to be transferred to or from, prior to the transfer.
- If for any reason you feel the wheelchair is unsafe call CHHS.

Wheelchair Operation

- To fold the wheelchair grasp the underside of the front seat and back and lift up.
- When transporting a wheelchair grasp it only by the frame.
- When transporting a chair lying on its side, always lock the wheel on which the chair is laying.

Infection control and cleaning

- The frame, wheels, tires, seat and seat back may be cleaned with warm soapy water, and a clean cloth or sponge.
- Do not get water in wheel or caster bearings.
- For infection control wipe with 1 part vinegar to 1 part water.
- Discard cleaning solution after each use.
- Never use any cleaning solution or agent that might harm a person or damage a person's body or skin.

Troubleshooting

- If the front caster wheels will not roll freely, check for any hair or other foreign objects that might be between the caster bearing where the wheel attaches to the fork, and remove the object(s).
- If the caster wheel assembly will not rotate freely, check for any hair or other foreign objects that might be between the caster stem bearings, and remove the object(s).
- If the main wheels will not roll freely or propel the chair in a straight line, check tire pressure.
- Call CHME for assistance if needed.

Walking canes

- NEVER use a cane without a Cane Tip in place.
- Replace the tip or tips when they become worn out.
- The proper adjustment will have the cane handle in the area of the user's hip joint with a bend in the arm at the elbow.

Quad cane

- NEVER use a quad cane without Cane Tips in place.
- Replace the cane tips when they become worn.
- The proper adjustment will have the cane handle in the area of the users hip joint with a bend in the arm at the elbow.
- A small base should be used if your home has stairs.
- Be very careful when climbing stairs.

Walkers

- NEVER use a walker without walker leg tips
- Replace leg tips if they become worn.
- To properly adjust your walker: the walker hand grips should be in the area of your hip joints with the walker standing on a flat surface on its 4 legs.
- Your body should be bent slightly forward when walking with a walker.
- On folding walkers, MAKE SURE both the left and right sides of the walker are locked in place in the open position, before use.
- Steps should not be taken without using the walker.
- Placing the walker too far in front when walking can cause you to lose your balance when taking steps.

Bath/shower benches

- Replace leg tips that become worn.
- Some people who use these devices may need assistance when entering or exiting the bathtub and/or shower.
- These items are available in different configurations:
    - ◊ non-adjustable or adjustable legs
    - ◊ with or without seat backs
    - ◊ fit entirely in the tub
    - ◊ fit half in the tub and half out of the tub.

Infection control and cleaning

- Clean with warm soapy water and a clean cloth or sponge.
- For infection control wipe with one part vinegar to one part water.
- Discard cleaning solution after use.
- Never use any cleaning solution or agent that might harm or damage a person's body or skin.

Advocacy Resources

Patients will be advised of:

The state toll-free home health telephone hot line, its contact information, hours of operation, and its purpose.

- The hotline's purpose is to receive complaints or questions about local home medical equipment agencies.
- ISDH toll-free hotline number 1-800-227-6334, Monday through Friday, 8:00am to 4:30pm.
- Voicemails received after hours are responded to the next business day.

Free from Reprisal

Patients have the right to be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the HME agency or an outside entity.

Language Services and Auxiliary Aides

Patients have the right to be informed of the right to access auxiliary aids and language services and how to access these services.

The names, addresses, and telephone numbers of the area:

Agency on Aging

Center for Independent Living

Protection and Advocacy Agency

Aging and Disability Resource Center

Agency on Aging

Area 6 Lifestream Services, INC

1701 Pilgrim Boulevard

Yorktown, IN 47396-0308

765-759-1121 or 800-589-1121

TDD 800-801-6606

Area 8 CICOA Aging and In-Home Solutions

47755 Kingsway Drive, Suite 200

Indianapolis, IN 46205-1560

317-254-5465 or 800-432-2422

TDD 800-801-6606

Area 11 Thrive Alliance

1531 13th Street, Suite G900

Columbus, IN 47201

812-372-6918 or 866-644-6407

Center for Independent Living

AccessABILITY Center for Independent Living, Inc.

5032 East Washington Street

Indianapolis, IN 46219

317-926-1660 or 866-794-7245

Future Choices, Inc.

309 N. High Street

Muncie, IN 47305

765-741-8332 or 866-741-3444

Protection and Advocacy Agency

Indiana Protection and Advocacy Services – IPAS

4701 N. Keystone Avenue, Suite 222

Indianapolis, IN 46205

317-722-5555

Quality Improvement Organization (QIO)

Beneficiary and Family Centered Care QIO

KEPRO

5201 W. Kennedy Blvd, Suite 900

Tampa, FL 33609

855-408-8557

Quality Improvement Network QIO

911 E. 86th Street, Suite 202

Indianapolis, IN 46240

800-528-2655

INVESTIGATION OF COMPLAINTS

As a home medical equipment agency dedicated to providing quality care, Community Home Medical Equipment encourages patients to inform us when we fail to meet the patient's service's needs.

As a patient, you, your representative (if any), and your caregivers or family have the right and responsibility, without fear of reprisal, discrimination or retaliation, to express a complaint including but not limited to:

- Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately.
- Mistreatment, neglect, or verbal, mental, sexual, or physical abuse, including injuries of unknown source, and/or misappropriation of property by anyone furnishing services on behalf of Community Home Medical Equipment.

If you have a complaint, please call our office and ask to speak to a supervisor or the Director. If your concern is not resolved, please notify the administrator either by phone or in writing.

Kevin Stewart, RRT, Home Medical Equipment Director

Community Home Medical Equipment

9894 E. 121st Street

Fishers, IN 46037

317-621-4800 (800-404-4852 toll-free)

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The Joint Commission

Report a Patient Safety Concern

Do you have a patient safety concern about a health care organization?

What we do...

The Joint Commission helps accredited health care organizations improve patient safety and the quality of their services. Your report of a patient safety or quality of care concern will help us guide the organization to make the necessary improvements, which will reduce or preferably eliminate the likelihood of harm to patients in the future.

The Joint Commission's goal is to evaluate performance of the organization based on our established standards of care; therefore The Joint Commission does not evaluate the appropriateness of specific care of an individual patient; or address billing issues, payment/financial disputes, or legal matters/disputes.

If you prefer, you also have the option to contact and work directly with the health care organization to seek resolution of your patient safety concern and/or on matters beyond the scope of The Joint Commission's review, as listed above.

How to report a concern...

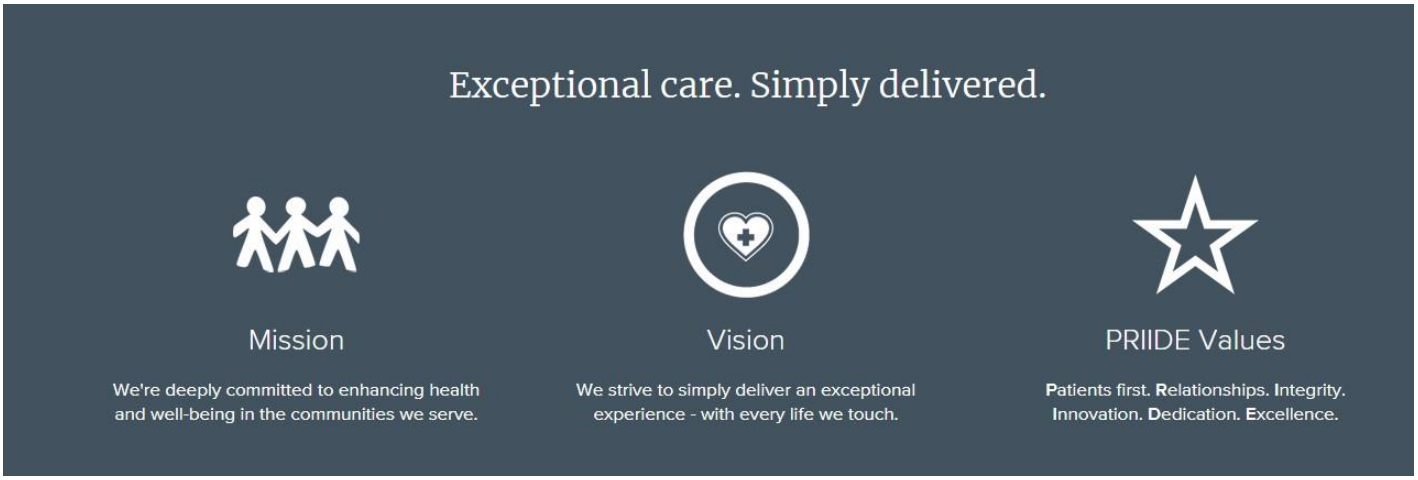
The preferred method for submitting a concern is through our **online submission form**. This is the quickest and most direct way to reach us. You also have the option to submit your safety concern or event anonymously.

Online: www.jointcommission.org; Click on tab at bottom of page to "Report a Safety Event."

Mail: Provide a brief (please limit to two pages) summary of your safety concern and the complete name and address for the location where care was received. Please be as specific as possible.

Office of Quality & Patient Safety
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181

In order to protect your Personal Health Information, The Joint Commission will not accept copies of medical records, photos, or billing invoices and other related personal information. Any such document received will be shredded upon receipt, per our policy.



PATIENT CONCERNS

If you have a concern about safety, care, billing or medical records provided by our organization, please contact Community Health Network, Office of Patient Experience:

www.eCommunity.com/contact or by phone at (317) 621-7000.

You may also call our HME director, Kevin Stewart, or complete this form and mail to the address listed below.

Thank you for helping us continue our commitment to our mission, vision and PRIIDE values.

****

Today's Date_____/____/_____ Your Name _____

Patient's Name (if different) _____

Date in which the concern became apparent_____/____/_____

Description of the concern:

_____

_____

_____

_____

_____

_____

_____

_____

****

Kevin Stewart, RRT

Director, Home Medical Equipment

Community Home Health Services

9894 East 121st St, Fishers, IN 46037

Phone (317) 621-4800 or 1-800-404-4852

Community Health Network

COMMUNITY HEALTH NETWORK, INC. NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("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.

This Notice describes privacy practices of Community Health Network, Inc., Community Hospital North, Community Hospital East, Community Hospital South, Community Heart and Vascular Hospital (a facility of Community Hospital East), Community Howard Regional Health, Community Hospital Anderson, Fairbanks Hospital, Community Physician Network, Community Home Health, Community Surgery Center North, Community Surgery Center East, Community Surgery Center South, Community Surgery Center Hamilton, Community Surgery Center Howard, Community Surgery Center Northwest, Community Surgery Center Plus, Community Endoscopy Center Indianapolis, Community Digestive Center Anderson, Figleaf Boutique, and their affiliates, including: any medical staff members, employees, volunteers, and health care professionals authorized to enter information into your health/medical records (hereinafter referred to as "Community Health Network" or the " Network").

Our Duty to Safeguard Your Protected Health Information:

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for your health care is considered Protected Health Information ("PHI"). We understand medical information about you and your health is personal and we are committed to protecting medical information about you. We are required by law to make sure your PHI is kept private and to give you this Notice about our legal duties and privacy practices. This Notice explains how, when and why we may use or disclose your PHI. In general, we must access, use or disclose only the minimum necessary PHI to accomplish the purpose of the access, use or disclosure. We use your health information (and allow others to have it) only as permitted by federal and state laws.

We must follow the privacy practices described in this Notice, though **we reserve the right to change the terms of this Notice at any time.** We reserve the right to make new Notice provisions effective for all PHI we currently maintain or receive in the future. If we change this Notice, we will post a new Notice in patient registration and/or patient waiting areas and post it on our website at www.eCommunity.com. Copies of the Notice currently in effect are available at the registration areas for the providers listed above.

How We May Use and Disclose Your Protected Health Information:

We access, use and disclose PHI for a variety of reasons. The following section offers more descriptions and examples of our potential access/uses/disclosures ("uses and disclosures") of your PHI. Other uses and disclosures not described in this Notice will be made only with your authorization.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations. Since we are an integrated system, we may share your PHI with designated caregivers within the Network and others outside our facilities, for treatment, payment or operations purposes. Generally, we may use or disclose your PHI:

- **For treatment:** Your PHI may be used or disclosed by the Network, our caregivers and others outside our facilities who are involved in your care and treatment for the purpose of providing or coordinating healthcare to you. For example, your PHI will be shared among members of your treatment team, referring providers, post-acute care facilities, pharmacies, etc. If you are an inpatient, your name may be posted outside the door of your room.

  The Network participates in certain Health Information Exchanges or Organizations ("HIEs" or "HIOs"). Specifically, the Network participates in the Indiana Health Information Exchange ("IHIE") and Indiana Network for Patient Care ("INPC"), which help make your PHI available to other healthcare providers who may need access to it in order to provide care or treatment to you.

- **To obtain payment:** We may use or disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to Medicare/Medicaid, a private insurer or group health plan to get paid for services that we delivered to you. We may release your PHI to the state Medicaid agency to determine your eligibility for publicly funded services.

- **For health care operations:** We may use or disclose your PHI in the course of our operations. For example, we may use your PHI or your answers to a patient satisfaction survey in evaluating the quality of services provided by our caregivers or disclose

your PHI to our auditors or attorneys for audit or legal purposes. We may also share PHI with health care provider licensing bodies like the Indiana State Department of Health. Further, we may allow other providers to use your PHI for some of their health care operations purposes, when you are also a patient of that provider. For example, we may share PHI with other providers for quality purposes.

We may use your PHI to tell you about appointments and other matters related to your care. We may contact you by mail, telephone or via MyChart, our patient portal. We may use the telephone number you provided to leave voice messages or send text messages.

- **Fundraising:** We or our Foundations may contact you to raise money for the Network and its operations, unless you tell us not to contact you for this purpose. You have the right to opt out of receiving fundraising communications from us and we will tell you how to opt out in every fundraising communication.

Uses and Disclosures Requiring Authorization: For other uses and disclosures not described in this Notice, we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. You may revoke an authorization by notifying us in writing. If you revoke your authorization, we will stop using or disclosing your PHI for the purposes covered by your written authorization as of the date we receive your revocation. Your revocation will not apply to information already released. We cannot refuse to treat you if you do not sign an authorization to release PHI, **unless** (a) services provided are solely to create health records for a third party, like physical exam and drug testing for an employer or insurance company; or (b) the treatment provided is research-related and authorization is required for the use of health information for research purposes. We will not sell or use your PHI for marketing purposes without your authorization. We will not disclose any psychotherapy notes (as defined by the Health Insurance Portability & Accountability Act (HIPAA)) without your authorization.

You may revoke an authorization to use or disclose your PHI by submitting your request in writing **except:** (1) to the extent action has been taken in reliance on the authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage and the insurer is questioning a claim under the policy. Your written revocation must include the date of the authorization, the name of the person or organization authorized to receive the PHI, your signature and the date you signed the revocation. Written revocation must be addressed to: Health Information Management, Release of Information, 1500 N. Ritter Avenue, Indianapolis, IN 46219. Such revocation will **not** be effective until received by the Network.

Uses and Disclosures Not Requiring Authorization: The law allows us to use or disclose your PHI without your authorization in certain situations, including but not limited to:

- **When required by law:** We may disclose PHI when a law requires or allows us to do so. For example, we may report information about suspected abuse and/or neglect, relating to suspected criminal activity, for FDA-regulated products or activities, or in response to a court order. We must also disclose PHI to authorities monitoring compliance with these privacy requirements.
- **For public health activities:** We may disclose PHI when we are required or allowed to collect information about disease or injury or to report vital statistics to the public health authority, such as reports of tuberculosis cases or births and deaths.
- **For health oversight activities:** We may disclose PHI to the Indiana State Department of Health or other agencies responsible for monitoring the Network for such purposes as reporting or investigating unusual incidents.
- **To a Business Associate:** Certain services are provided to us through contracts with third party entities known as "business associates" that require access to your health information in order to provide such services. Examples include transcription agencies, copying services and cloud service providers. We require these business associates to agree to protect your health information in compliance with all laws.
- **Relating to decedents:** We may disclose PHI relating to an individual's death to coroners, medical examiners, funeral directors, and organ procurement organizations.
- **For research purposes:** In certain circumstances, and under supervision of an Institutional Review Board, we may disclose PHI in order to assist medical research, such as comparing the health and recovery of all patients who received one medicine to those who received another.
- **To avert a threat to health or safety:** In order to avoid a serious and imminent threat to the health or safety of an individual or the public, we may disclose PHI to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **Law enforcement:** We may disclose PHI to a law enforcement official in circumstances such as: in response to a court order; to identify a suspect, witness or missing person; about crime victims; about a death that we may suspect is the result of a crime; or a crime that takes place at our facility.
- **For specific government functions:** We may disclose PHI of military personnel and veterans in certain situations; to correctional facilities in certain situations; and for national security and intelligence reasons, such as protection of the President.
- **Workers' Compensation:** We may disclose your PHI to your employer or your employer's insurance carrier for Workers'

Compensation or similar programs that provide benefits for work-related illness or injuries.

- **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Network may release your PHI in order for them to provide you with healthcare, to protect your health and safety or the health and safety of others, or to ensure the safety and security of the correctional institution.
- **De-Identified PHI:** We may de-identify your health information as permitted by law. We may use or disclose to others the de-identified information for any purpose, without your further authorization or consent, including but not limited to research studies, development of artificial intelligence tools, and health care/health operations improvement activities.

Uses and Disclosures Requiring You to Have an Opportunity to Object: In the following situations, we may use or disclose your PHI if we tell you about the use or disclosure in advance and you have the opportunity to agree to, prohibit, or restrict the use or disclosure, and you do not object. However, if there is an emergency situation and you cannot be given the opportunity to agree or object, we may use or disclose your PHI if it is consistent with any prior expressed wishes and the use or disclosure is determined to be in your best interests; provided that you must be informed and given an opportunity to object to further uses or disclosures for patient directory purposes as soon as you are able to do so.

- **Patient Directories:** If you are hospitalized, your name, location, general condition, and religious affiliation may be put into our patient directory for use by clergy or by callers or visitors who ask for you by name. If you ask to be a "No Information" patient, volunteers, caregivers and telephone operators will not tell anyone you are in the facility and flowers, mail, phone calls and visitors will be turned away and not accepted if your room number is not provided.
- **To families, friends or others involved in your care:** We may share with your family, your friends or others involved in your care information directly related to their involvement in your care or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or your death.
- **Disaster relief:** In the event of a disaster, we may release your PHI to a public or private relief agency, for purposes of notifying your family and friends of your location, condition or death.

Safeguards: We are required to have appropriate safeguards in place to protect the privacy of your PHI to limit incidental uses or disclosures. Oral communication often must occur freely and quickly in treatment settings as in physician offices, nurses' stations or emergency rooms. Overheard communications in these settings may be unavoidable and are considered incidental disclosures. Incidental disclosures are permitted when reasonable safeguards are in place.

Your Rights Regarding Your Protected Health Information: You have the following rights relating to your PHI:

- **To request restrictions on uses and disclosures:** You have the right to ask that we limit how we use or disclose your PHI. You must make your request in writing. If you have paid in full for a service and have requested we not share PHI related to that service with a health plan, we must agree to the request. For any other request to limit how we use or disclose your PHI, we will consider your request, but are not required to agree to the restriction. To the extent we agree to any restrictions, we will put the agreement in writing and abide by it except in emergency situations. If agreed upon, these restrictions will only apply to the Network affiliates listed in the beginning of this Notice. You understand restrictions will not apply to disclosures already made. We cannot agree to limit uses or disclosures required by law.

- **To request confidential communication:** You have the right to ask that we send you information at an alternative address or by an alternative means, such as contacting you only at work. You must make your request in writing. We must agree to your request as long as it is reasonably easy for us to do so.

- **To inspect and copy your PHI:** You have the right to inspect and obtain an electronic or paper copy of your PHI. You put your request in writing. If you want copies of your PHI, a reasonable, cost-based charge for copying may be imposed. If you request an electronic copy of your PHI that we maintain electronically, we will provide an electronic copy, and will do so in the electronic form or format you requested if the PHI is readily producible in that form or format. You have a right to choose what portions of your information you want copied and to have information on the cost of copying in advance. We will respond to your request within 30 days. In limited circumstances, we may deny your request. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed.

- **To request amendment of your PHI:** If you believe there is a mistake or missing information in your health record, you may request, in writing, that we correct or add to the record. Written requests must include a reason supporting your request and identify who needs to be informed of any changes. We will respond within sixty (60) days of receiving your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if we determine the PHI is: (1) correct and complete; (2) not created by us or not part of our records; or (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial reviewed. This information along with any written response you provide, will be added to your medical record. If we approve the request for amendment, we will inform you of the approval, change the PHI, and tell others who need to know

about the change.

- **To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released, except as listed below - this is called an accounting of disclosures. The list will **not** include any disclosures made: (a) more than six (6) years ago; (b) for treatment, payment or health care operations purposes; (c) that you authorized; (d) for national security purposes; (e) through a facility directory; or (f) to certain law enforcement officials or correctional facilities. Your request must be in writing. We will respond to your written request for such a list within sixty (60) days of receiving it. There will be no charge for the first list requested each year. There may be a charge for subsequent requests.

- **Right to Receive Notice of Breach:** We are required by law to maintain the privacy of your medical information, to provide you with notice of our legal duties and privacy practices with respect to your medical information and notify you following a breach of your unsecured medical information. We will give you written notice in the event we learn of any unauthorized use of your medical information that has not otherwise been properly secured as required by HIPAA. We will notify you without unreasonable delay but no later than sixty (60) days after the breach has been discovered.

- **To receive a paper copy of this Notice:** You have a right to receive a paper copy of this Notice and/or an electronic copy by e-mail upon request. To obtain a copy of this Notice, contact us at 317.621.7324 or at privacy@eCommunity.com.

Questions or Complaints About Our Privacy Practices:

If you have questions about this Notice, think we may have violated your privacy rights or disagree with a decision we made about access to your PHI, you may contact the VP Compliance, 317.621.7324 or at privacy@eCommunity.com. You may also submit an anonymous complaint by calling 1.800.638.5071. You may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. **You will not be penalized if you file a complaint.**

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

ATENCIÓN: Si usted habla Español, tenemos servicios de asistencia idiomática a su disposición, sin cargo. Por favor, comuníquele al personal que necesita un intérprete.

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。

AUTHORIZATION TO USE, RELEASE OR DISCLOSE PROTECTED HEALTH INFORMATION

Policy:

1. Terms used, but not defined in this policy and procedure, will have the meanings set forth in the HIPAA Privacy Rule (45 CFR §§ 160.103, 160.202, 164.304, 164.402 and 164.501).

2. Except as otherwise provided by the HIPAA Privacy Rule, CHNw may only use, release or disclose PHI without an authorization from the patient for purposes of treatment, payment, health care operations, or for public policy reasons set forth in 45 CFR §164.512 which include, but may not be limited to:

    a. required by law;
    b. public health activities;
    c. victims of abuse, neglect, or domestic violence;
    d. health oversight activities;
    e. judicial and administrative procedures;
    f. law enforcement activities;
    g. related to decedents;
    h. organ, eye or tissue donation;
    i. research;
    j. to avert a serious threat to health or safety;
    k. special government functions; or
    l. as authorized by and to the extent necessary to comply with workers' compensation and similar laws.

3. Examples of uses, releases or disclosures of PHI that require an authorization include, but are not limited to:

    a. birth announcements to newspapers;
    b. use of patient photograph in pamphlet;
    c. marketing activities;
    d. release of names and type of injuries of accident victims to media;
    e. drug screen results sent to employer;
    f. immunization records sent to a summer camp;
    g. PHI requested by a patient's lawyer;
    h. pre-employment physicals and drug screens sent directly to the prospective employer;
    i. completing and submitting application for handicapped parking for a patient;
    j. releasing name of patient by marketing department to media for news story or commercial;
    k. selling patient mailing list to diaper company, drug manufacturer or other vendor;
    l. work absence excuse or return to work statement containing PHI sent directly to an employer; and
    m. allowing vendors and other observers to observe a surgical procedure.

PREVENTING HEALTH CARE FRAUD AND ABUSE

Protection of our health care system from fraudulent, abusive and wasteful practices is the responsibility of all insurers, providers and consumers. Community Health Network is committed to adherence to the highest standards of practice that assures compliance with federal and state regulations while providing quality care to the patients and communities we serve.

Fraud can be defined as knowingly and willfully giving false information to obtain payment for a service not provided or not allowed. Some examples of fraud could be:

- Submitting bills for services or supplies not provided
- Altering claims or receipts to receive higher payment
- Falsifying patient or physician signatures or billing for non-covered services.

Abuse can be defined as practices, which unnecessarily drive up the costs of health care. Some examples of abuse could be:

- Providing services or supplies not medically necessary
- Overpricing services or supplies
- Providing poor quality services.

Some steps you can take to help prevent fraud and abuse are:

- Become familiar with your insurance coverage; remember Medicare and Medicaid are insurance policies
- Sign only documents, which you have read and understand
- Take an active part in planning your care
- Keep a record of services or supplies provided to you
- Ask for written information on services and supplies
- Check with your doctor if services or supplies are given that are not ordered by your doctor
- Review statements sent by insurance companies to verify that payments accurately reflect service and supplies that were provided.

If you suspect fraudulent or abusive practices to care being provided, please contact CHME at (317) 621-4800 or toll-free at 1-800-404-4852. The identity of all persons submitting concerns to CHME shall be kept confidential.

Indiana State Department of Health

2 N. Meridian Street, Indianapolis, IN 46204

(317) 233-1325

SAFETY AND EMERGENCY PREPAREDNESS

WEATHER RELATED EMERGENCIES

Thunderstorms

A Thunderstorm watch is issued when weather conditions are favorable for the developments of severe thunderstorms.

A Thunderstorm warning means that storms that are capable of providing large hail, high winds and other significant damage.

Stay inside a sturdy building or shelter to protect yourself.

Stay away from windows. Avoid electrical equipment and plumbing.

If you are caught outside, avoid metallic objects, standing water or bodies of water.

Tornados

A Tornado watch means tornados are possible. Be prepared to take shelter. If you live in a mobile home, you should move to a stronger structure.

A Tornado warning means a tornado has been sighted or detected on radar. Take shelter immediately. Turn on a battery operated radio and remain in your shelter until you hear the "All Clear" announcement.

A basement is generally the safest place during a tornado. If this is not available, go to an interior room or hallway on the lowest floor. Avoid areas with glass and doors.

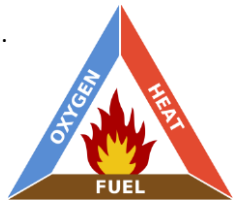
Stay away from the corners of rooms because they will attract debris. Try to get under a sturdy piece of furniture and use blankets and pillows to protect your head and neck.

If you or your loved one cannot be moved, cover him/her with pillows and blankets. Move heavy objects or furniture to pre-vent these from falling on him/her.

Fire Prevention

According to the American Red Cross, the most effective way to protect yourself and your home from fire is to identify and remove fire hazards. 60 percent of house fire deaths occur in homes with no working smoke alarms. During a home fire, working smoke alarms and a fire escape plan that has been practiced regularly can save lives.

Fire Safety Tips



- Install smoke alarms on every level of your home, inside bedrooms and outside sleeping areas.
- Test smoke alarms once a month. If they are not working, change the batteries.
- Talk with all household members about a fire escape plan and practice the plan twice a year.
- Carbon monoxide alarms should be installed in a central location on every level of your home.
- Keep a working fire extinguisher on each level of your home and in the kitchen.

Preparing and Preventing a Home Fire - Steps You Can Take Now

- Keep items that can catch on fire at least three feet away from anything that gets hot, such as space heaters or working stovetops.
- Never smoke in bed.
- Talk to children regularly about the dangers of fire, matches and lighters and keep them out of reach.
- Stay in the kitchen when frying, grilling or broiling food. If you leave the kitchen, turn off the stove.
- Do not overload extension cords or electrical outlets.
- Replace frayed or damaged cords.

Fall Prevention

Take these precautions to prevent falls:

- Make sure the temperature in your home is set above 65 degrees. If you are exposed to low temperatures for a long time it may lead to dizziness and falling.
- When you first wake, sit up for a few minutes before standing to make sure you are not dizzy.
- If you have a walker or cane, make sure it's within easy reach upon standing.
- Tell your doctors about all medications you take, including over-the-counter meds.
- Have your healthcare provider check your medications. Some medication combinations can cause dizziness and put you at risk for falls.
- Have your vision checked regularly.
- Do not sit in a chair that is very low or very high because it may be difficult to get up.
- Never sit in a chair with casters or wheels, unless the wheels are locked.
- When getting in or out of a wheelchair, be sure to set the brakes first.
- Rid yourself of clutter.
- Have furniture moved that is in your way.
- Remove throw rugs from the floor or tape down securely to avoid tripping accidents.
- Keep papers, books and magazines off the floor.
- Move cords and wires out of doorways and away from furniture.
- Be careful not to trip over oxygen tubing – consider colored tubing if needed.
- Use grabbers to pick items up from the floor or hard to reach places.
- Use a cordless phone.
- Avoid wet floors, or floors that appear slippery.

Prevention through vaccination

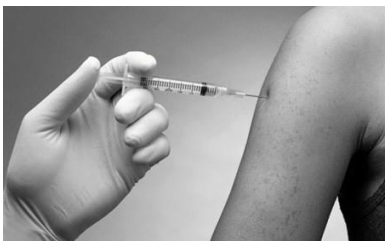
The single best way to prevent the flu is to get a flu vaccination each year. The "flu shot" – an inactivated vaccine (containing killed virus) that is given with a needle. The flu shot is approved for use in people 6 months of age and older, including healthy people and people with chronic medical conditions.

Who Should Get Vaccinated?

In general, anyone who wants to reduce their chances of getting the flu or pneumonia should get vaccinated. Ask your health care provider if the flu shot is right for you.

When to Get Vaccinated?

Early is best! October or November is preferred but the vaccine is still effective when given during later months of the flu season. Though it varies, the flu season can last as late as May.



How can you prevent the spread of infection?

- **Wash hands with soap & water frequently!**
- If no soap and water is available, use a disinfectant gel.
- Keep cold foods cold, and hot foods hot.

- Keep kitchen and bathroom areas clean.
- Cover your mouth when coughing or sneezing.
- If you are sick, stay home.

Ask friends and family who are sick to delay visiting until they are sure they are no longer contagious.

Indiana State Department of Health

2 North Meridian Street
Indianapolis, Indiana 46204

March 1999
Revised May 2004
Revised July 1, 2013
Revised November 1, 2018

ADVANCE DIRECTIVES

YOUR RIGHT TO DECIDE

The purpose of this brochure is to inform you of ways that you can direct your medical care and treatment in the event that you are unable to communicate for yourself. This brochure covers:

- What is an advance directive?
- Are advance directives required?
- What happens if you do not have an advance directive?
- What are the different types of advance directives?

THE IMPORTANCE OF ADVANCE DIRECTIVES

Each time you visit your physician, you make decisions regarding your personal health care. You tell your doctor (generally referred to as a "physician") about your medical problems. Your physician makes a diagnosis and informs you about available medical treatment. You then decide what treatment to accept. That process works until you are unable to decide what treatments to accept or become unable to communicate your decisions. Diseases common to aging such as dementia or Alzheimer's disease may take away your ability to decide and communicate your health care wishes. Even young people can have strokes or accidents that may keep them from making their own health care decisions. Advance directives are a way to manage your future health care when you cannot speak for yourself.

WHAT IS AN ADVANCE DIRECTIVE?

"Advance directive" is a term that refers to your spoken and written instructions about your future medical care and treatment. By stating your health care choices in an advance directive, you help your family and physician understand your wishes about your medical care. Indiana law pays special attention to advance directives.

Advance directives are normally one or more documents that list your health care instructions. An advance directive may name a person of your choice to make health care choices for you when you cannot make the choices for yourself. If you want, you may use an advance directive to prevent certain people from making health care decisions on your behalf.

Your advance directives will not take away your right to decide your current health care. As long as you are able to decide and express your own decisions, your advance directives will not be used. This is true even under the most serious medical conditions. Your advance directive will only be used when you are unable to communicate or when your physician decides that you no longer have the mental competence to make your own choices.

ARE ADVANCE DIRECTIVES REQUIRED?

Advance directives are not required. Your physician or hospital cannot require you to make an advance directive if you do not want one. No one may discriminate against you if you do not sign one. Physicians and hospitals often encourage patients to complete advance directive documents. The purpose of the advance directive is for your physician to gain information about your health care choices so that your wishes can be followed. While completing an advance directive provides guidance to your physician in the event that you are unable to communicate for yourself, you are not required to have an advance directive.

WHAT HAPPENS IF YOU DO NOT HAVE AN ADVANCE DIRECTIVE?

If you do not have an advance directive and are unable to choose medical care or treatment, Indiana law decides who can do this for you. Indiana Code § 16-36-1-5 establishes a priority list. If you cannot communicate and do not have an advance directive, your physician will try to contact a representative using the priority list. Your health care choices will be made by the representative that your physician is able to contact. The order of priority is:

1. A judicially appointed guardian of the person or a representative appointed by a probate court.
2. A spouse (unless legally separated or there is a pending petition for separation, dissolution, annulment, protective order or no contact order [Indiana Code § 16-36-1-9.5]).
3. An adult child
4. A parent
5. An adult sibling
6. A grandparent
7. An adult grandchild
8. An adult friend (special conditions apply)
9. The nearest other adult relative in the next degree of kinship not listed in 2 through 7

Note 1: If there are multiple individuals in any priority group and the group cannot achieve consensus, then a majority of the available individuals at the same priority level controls.

Note 2: You may disqualify one or more individuals. The disqualification must be in writing, designates those disqualified and signed by you [Indiana Code § 16-36-1-9].

WHAT TYPES OF ADVANCE DIRECTIVES ARE RECOGNIZED IN INDIANA?

- Talking directly to your physician and family
- Organ and tissue donation
- Health care representative
- Living Will Declaration or Life-Prolonging Procedures Declaration
- Psychiatric advance directives
- Out of Hospital Do Not Resuscitate Declaration and Order
- Physician Orders for Scope of Treatment (POST)
- Power of Attorney

TALKING TO YOUR PHYSICIAN AND FAMILY

One of the most important things to do is to talk about your health care wishes with your physician. Your physician can follow your wishes only if he or she knows what your wishes are. You do not have to write down your health care wishes in an advance directive. By discussing your wishes with your physician, your physician will record your choices in your medical chart so that there is a record available for future reference. Your physician will follow your verbal instructions even if you do not complete a written advance directive. Solely discussing your wishes with your physician, however, does not cover all situations. Your physician may not be available when choices need to be made. Other health care providers would not have a copy of the medical records maintained by your physician and therefore would not know about any verbal instructions given by you to your physician. In addition, spoken instructions provide no written evidence and carry less weight than written instructions if there is a disagreement over your care. Writing down your health care choices in an advance directive document makes your wishes clear and may be necessary to fulfill legal requirements.

If you have written advance directives, it is important that you give a copy to your physician. He or she

will keep it in your medical chart. If you are admitted to a hospital or health facility, your physician will write orders in your medical chart based on your written advance directives or your spoken instructions. For instance, if you have a fatal disease and do not want cardiopulmonary resuscitation (CPR), your physician will need to write a "do not resuscitate" (DNR) order in your chart. The order makes the hospital staff aware of your wishes. Because most people have several health care providers, you should discuss your wishes with all of your providers and give each provider a copy of your advance directives.

It is difficult to talk with family about dying or being unable to communicate. However, it is important to talk with your family about your wishes and ask them to follow your wishes. You do not always know when or where an illness or accident will occur. It is likely that your family would be the first ones called in an emergency. They are the best source of providing advance directives to a health care provider.

ORGAN AND TISSUE DONATION

Increasing the quality of life for another person is the ultimate gift. Donating your organs is a way to help others. Making your wishes concerning organ donation clear to your physician and family is an important first step. This lets them know that you wish to be an organ donor. Organ donation is controlled by the Indiana Uniform Anatomical Gift Act found at Indiana Code § 29-2-16.1. A person that wants to donate organs may include their choice in their will, living will, on a card, or other document. If you do not have a written document for organ donation, someone else will make the choice for you. A common method used to show that you are an organ donor is making the choice on your driver's license. When you get a new or renewed license, you can ask the license branch to mark your license showing you are an organ donor.

HEALTH CARE REPRESENTATIVE

A "health care representative" is a person you choose to receive health care information and make health care decisions for you when you cannot. To choose a health care representative, you must fill out an appointment of health care representative document that names the person you choose to act for you. Your health care representative may agree to or refuse medical care and treatments when you are unable to do so. Your representative will make these choices based on your advance directive. If you want, in certain cases and in consultation with your physician, your health care representative may decide if food, water, or respiration should be given artificially as part of your medical treatment.

Choosing a health care representative is part of the Indiana Health Care Consent Act, found at Indiana Code § 16 -36 -1. The advance directive naming a health care representative must be in writing, signed by you, and witnessed by another adult. Because these are serious decisions, your health care representative must make them in your best interest. Indiana courts have made it clear that decisions made for you by your health care representative should be honored.

LIVING WILL

A "living will" is a written document that puts into words your wishes in the event that you become terminally ill and unable to communicate. A living will is an advance directive that lists the specific care or treatment you want or do not want during a terminal illness. A living will often includes directions for CPR, artificial nutrition, maintenance on a respirator, and blood transfusions. The Indiana Living Will Act is found at Indiana Code § 16-36-4. This law allows you to write one of two

kinds of advance directive.

Living Will Declaration: This document is used to tell your physician and family that life - prolonging treatments should not be used so that you are allowed to die naturally. Your living will does not have to prohibit all life-prolonging treatments. Your living will should list your specific choices. For example, your living will may state that you do not want to be placed on a respirator but that you want a feeding tube for nutrition. You may even specify that someone else should make the decision for you.

Life-Prolonging Procedures Declaration: This document is the opposite of a living will. You can use this document if you want all life-prolonging medical treatments used to extend your life.

Both of these documents can be canceled orally, in writing, or by destroying the declaration yourself. The cancellation takes effect only when you tell your physician. For either of these documents to be used, there must be two adult witnesses and the document must be in writing and signed by you or someone that has permission to sign your name in your presence.

PSYCHIATRIC ADVANCE DIRECTIVE

Any person may make a psychiatric advance directive if he/she has legal capacity. This written document expresses your preferences and consent to treatment measures for a specific diagnosis. The directive sets forth the care and treatment of a mental illness during periods of incapacity. This directive requires certain items in order for the directive to be valid. Indiana Code § 16-36-1.7 provides the requirements for this type of advance directive.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

In a hospital, if you have a terminal condition and you do not want CPR, your physician will write a "do not resuscitate" order in your medical chart. If you are not in a hospital when an emergency occurs, the emergency medical personnel or the hospital where you are sent likely would not have a physician's order to implement your directives. For situations outside of a hospital, the *Out of Hospital Do Not Resuscitate Declaration and Order* is used to state your wishes. The *Out of Hospital Do Not Resuscitate Declaration and Order* is found at Indiana Code § 16-36-5.

The law allows a qualified person to say they do not want CPR given if the heart or lungs stop working in a location that is not a hospital. This declaration may override other advance directives. The declaration may be canceled by you at any time by a signed and dated writing, by destroying or canceling the document, or by communicating to health care providers at the scene your desire to cancel the order. Emergency Medical Services (EMS) may have procedures in place for marking your home so they know you have an order. You should contact your local EMS provider to find out their procedures.

PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

A "Physician Orders for Scope of Treatment" (also referred to as a POST form) is a direct physician order for a person with at least one of the following:

1. An advanced chronic progressive illness.
2. An advanced chronic progressive frailty.
3. A condition caused by injury, disease, or illness from which, to a reasonable degree of

medical certainty there can be no recovery and death will occur from the condition within a short period without the provision of life prolonging procedures.

4. A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

In consultation with you or your legal representative, your physician will write orders that reflect your wishes with regards to cardiopulmonary resuscitation (CPR), medical interventions (comfort measures, limited additional interventions, or full treatment), antibiotics and artificially administered nutrition. You additionally have the option on the POST form to designate a "Health Care Representative" [see the section "Health Care Representative" above for additional information]. Note that if you have previously designated a health care representative and you name a different person on your POST form, the person designated on the POST form replaces (revokes) the person named in the previous health care representative advance directive. The Indiana POST form is available on the Indiana State Department of Health website at www.in.gov/isdh/25880.htm.

The POST form must be signed and dated by you (or your legal representative) and your physician, physician's assistant, or advanced practice registered nurse to be valid. The original form is your personal property and you should keep it. Paper, facsimile (fax), or electronic copies of a valid POST form are as valid as the original. Your physician is required to keep a copy of your POST form in your medical record or; if the POST form is executed in a health facility, the facility must maintain a copy of the form in the medical record. The POST form may be used in any health care setting. The Physician Orders for Scope of Treatment statute is found at Indiana Code § 16-36-6.

Executed POST forms may be revoked at any time by any of the following:

1. A signed and dated writing by you or your legal representative.
2. Physical cancellation of destruction of the POST form by you or your legal representative.
3. Another individual at the direction of you or your legal representative.
4. An oral expression by you or your legal representative of intent to revoke the POST form.

The revocation is effective upon communication of the revocation to a health care provider.

POWER OF ATTORNEY

A "power of attorney" (also referred to as a "durable power of attorney") is another kind of advance directive. This document is used to grant another person say-so over your affairs. Your power of attorney document may cover financial matters, give health care authority, or both. By giving this power to another person, you give this person your power of attorney. The legal term for the person you choose is "attorney in fact." Your attorney in fact does not have to be an attorney. Your attorney in fact can be any adult you trust. Your attorney in fact is given the power to act for you only in the ways that you list in the document. The document must:

1. Name the person you want as your attorney in fact;
2. List the situations which give the attorney in fact the power to act;
3. List the powers you want to give; and
4. List the powers you do not want to give.

The person you name as your power of attorney is not required to accept the responsibility. Prior to executing a power of attorney document, you should talk with the person to ensure that he or she is willing to serve. A power of attorney document may be used to designate a health care representative.

Health care powers are granted in the power of attorney document by naming your attorney in fact as your health care representative under the Health Care Consent Act or by referring to the Living Will Act. When a power of attorney document is used to name a health care representative, this person is referred to as your health care power of attorney. A health care power of attorney generally serves the same role as a health care representative in a health care representative advance directive. Including health care powers could allow your attorney in fact to:

1. Make choices about your health care;
2. Sign health care contracts for you;
3. Admit or release you from hospitals or other health facilities;
4. Look at or get copies of your medical records; and
5. Do a number of other things in your name.

The Indiana Powers of Attorney Act is found at Indiana Code § 30-5. Your power of attorney document must be in writing and signed in the presence of a notary public. You can cancel a power of attorney at any time but only by signing a written cancellation and having the cancellation delivered to your attorney in fact.

WHICH ADVANCE DIRECTIVE OR DIRECTIVES SHOULD BE USED?

The choice of advance directives depends on what you are trying to do. The advance directives listed above may be used alone or together. Although an attorney is not required, you may want to talk with one before you sign an advance directive. The laws are complex and it is always wise to talk to an attorney about questions and your legal choices. An attorney is often helpful in advising you on complex family matters and making sure that your documents are correctly done under Indiana law. An attorney may be helpful if you live in more than one state during the year. An attorney can advise you whether advance directives completed in another state are recognized in Indiana.

CAN I CHANGE MY MIND AFTER I WRITE AN ADVANCE DIRECTIVE?

It is important to discuss your advance directives with your family and health care providers. Your health care wishes cannot be followed unless someone knows your wishes. You may change or cancel your advance directives at any time as long as you are of sound mind. If you change your mind, you need to tell your family, health care representative, power of attorney, and health care providers. You might have to cancel your decision in writing for it to become effective. Always be sure to talk directly with your physician and tell him or her your exact wishes.

ARE THERE FORMS TO HELP IN WRITING THESE DOCUMENTS?

Advance directive forms are available from many sources. Most physicians, hospitals, health facilities, or senior citizen groups can provide you with forms or refer you to a source. These groups often have the information on their web sites. You should be aware that forms may not do everything you want done. Forms may need to be changed to meet your needs. Although advance directives do not require an attorney, you may wish to consult with one before you try to write one of the more complex legal documents listed above.

Several of the forms are specified by statute. Those forms may be found on the Indiana State Department of Health (ISDH) Advance Directives Resource Center at www.in.gov/isdh/25880.htm. The following

forms are available on that web site:

- Living Will Declaration
- Life-Prolonging Procedures Declaration
- Out of Hospital Do Not Resuscitate Declaration and Order
- Physician Orders for Scope of Treatment (POST)

WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?

Make sure that your health care representative, immediate family members, physician, attorney, and other health care providers know that you have an advance directive. Be sure to tell them where it is located. You should ask your physician and other health care providers to make your advance directives part of your permanent medical chart. If you have a power of attorney, you should give a copy of your advance directives to your attorney in fact. You may wish to keep a small card in your purse or wallet that states that you have an advance directive, where it is located, and who to contact for your attorney in fact or health care representative, if you have named one.

ADDITIONAL INFORMATION

For additional information on advance directives, visit the Indiana State Department of Health Advanced Directives Resource Center located at www.in.gov/isdh/25880.htm. The site includes links to state forms, this brochure, links to Indiana statutes, and links to other web sites.

The ISDH Web site contains a wealth of information about public health. Visit the ISDH Home Page at www.in.gov/isdh.

SUMMARY OF ADVANCE DIRECTIVES

- You have the right to choose the medical care and treatment you receive. Advance directives help make sure you have a say in your future health care and treatment if you become unable to communicate.

- Even if you do not have written advance directives, it is important to make sure your physician and family are aware of your health care wishes.

- No one can discriminate against you for signing, or not signing, an advance directive. An advance directive is, however, your way to control your future medical treatment.

- This information was prepared by the Indiana State Department of Health as an overview of advance directives. The Indiana State Department of Health attorneys cannot give you legal advice concerning living wills or advance directives. You should talk with your personal lawyer or representative for advice and assistance in this matter.

Indiana State Department of Health
2 North Meridian Street
Indianapolis, Indiana 46204
http://www.in.gov/isdh

INDIANA LIVING WILL DECLARATION

State Form 55316 (6-13)
Indiana State Department of Health – IC 16-36-4

This declaration is effective on the date of execution and remains in effect until revocation or the death of the declarant. This declaration should be provided to your physician.

LIVING WILL DECLARATION

Declaration made this _____ day of _____ *(month, year)*. I, _____ , being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that:
(1) I have an incurable injury, disease, or illness;
(2) my death will occur within a short time; and
(3) the use of life prolonging procedures would serve only to artificially prolong the dying process,

I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. *(Indicate your choice by initialing or making your mark before signing this declaration.)*:

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

Signed _____

_____
City, County, and State of Residence

WITNESSES

The declarant has been personally known to me and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness _____ Date *(month, day, year)* _____

Witness _____ Date *(month, day, year)* _____

STATE OF INDIANA
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

State Form 49559 (R / 9-11)

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION

Declaration made this _____ day of _____, _____, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below.

I declare:
My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this Out of Hospital Do Not Resuscitate Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

I understand the full import of this declaration

Signature of declarant

Printed name of declarant

City and state of residence

The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Signature of witness	Printed name	Date *(month, day, year)*
Signature of witness	Printed name	Date *(month, day, year)*

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

I, _____, the attending physician of _____, have certified the declarant as a qualified person to make an Out Of Hospital Do Not Resuscitate Declaration, and I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out Of Hospital Do Not Resuscitate Declaration is revoked.

Signature of attending physician

Printed name of attending physician	Medical license number	Date *(month, day, year)*

INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

State Form 55317 (R3 / 5-18)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: This form is a physician's order for scope of treatment based on the patient's current medical condition and preferences. The POST should be reviewed whenever the patient's condition changes. A POST form is voluntary. A patient is not required to complete a POST form. A patient with capacity or their legal representative may void a POST form at any time by communicating that intent to the health care provider. Any section not completed does not invalidate the form and implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. The original form is personal property of the patient. A facsimile, paper, or electronic copy of this form is a valid form.

Patient Last Name	Patient First Name	Middle Initial
Birth Date *(mm/dd/yyyy)*	Medical Record Number	Date Prepared *(mm/dd/yyyy)*

DESIGNATION OF PATIENT'S PREFERENCES: The following sections (A through D) are the patient's current preferences for scope of treatment.

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse AND is not breathing.

☐ Attempt Resuscitation / CPR ☐ Do Not Attempt Resuscitation / DNR

When not in cardiopulmonary arrest, follow orders in **B, C** and **D.**

B *Check One*

MEDICAL INTERVENTIONS: If patient has pulse AND is breathing OR has pulse and is NOT breathing.

☐ Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

☐ Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

C *Check One*

ANTIBIOTICS:

☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.

☐ Use antibiotics consistent with treatment goals.

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible.

☐ No artificial nutrition.

☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)

☐ Long-term artificial nutrition.

OPTIONAL ADDITIONAL ORDERS:

SIGNATURE PAGE: This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.

Patient Name:_____ Date of Birth *(mm/dd/yyyy)*:_____

	SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE: In order for the POST form to be effective, the patient or legally appointed representative must sign and date the form below.
E	**SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE** My signature below indicates that my physician or physician's designee discussed with me the above orders and the selected orders correctly represent my wishes.

Signature ***(required by statute)***	Print Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*

F	**CONTACT INFORMATION FOR LEGALLY APPOINTED REPRESENTATIVE IN SECTION E *(IF APPLICABLE)*:** If the signature above is other than patient's, add contact information for the representative.

Relationship of representative identified in Section E if patient does not have capacity ***(required by statute)***	Address *(number and street, city, state, and ZIP code)*	Telephone Number

PHYSICIAN ORDER:

A POST form may be executed only by an individual's treating physician, advanced practice registered nurse, or physician assistant, and only if:

(1) the treating physician, advanced practice registered nurse, or physician assistant has determined that:
  (A) the individual is a qualified person; and
  (B) the medical orders contained in the individual's POST form are reasonable and medically appropriate for the individual; and
(2) the qualified person or representative has signed and dated the POST form

A qualified person is an individual who has at least one (1) of the following:

(1) An advanced chronic progressive illness.
(2) An advanced chronic progressive frailty.
(3) A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty:
  (A) there can be no recovery; and
  (B) death will occur from the condition within a short period without the provision of life prolonging procures.
(4) A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

G **DOCUMENTATION OF DISCUSSION: Orders discussed with *(check one)*:**

☐ Patient (patient has capacity) ☐ Health Care Representative ☐ Legal Guardian
☐ Parent of Minor ☐ Health Care Power of Attorney

H **SIGNATURE OF TREATING PHYSICIAN / ADVANCED PRACTICE REGISTERED NURSE / PHYSICIAN ASSISTANT**

My signature below indicates that I or my designee have discussed with the patient or patient's representative the patient's goals and treatment options available to the patient based on the patient's health. My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

Signature of Treating Physician / APRN / PA ***(required by statute)***	Print Treating Physician / APRN / PA Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*

Physician / APRN / PA office telephone number ***(required by statute)***	Physician / APRN / PA License Number ***(required by statute)***	Health Care Professional preparing form if other than the physician / APRN / PA

I **APPOINTMENT OF HEALTH CARE REPRESENTATIVE:** As patient you have the option to appoint an individual to serve as your health care representative pursuant to IC 16-36-1-7. You are not required to designate a health care representative for this POST form to be effective. You are encouraged to consult with your attorney or other qualified individual about advance directives that are available to you. Forms and additional information about advance directives may be found on the ISDH web site at http://www.in.gov/isdh/25880.htm.

Indiana Physician Orders for Scope of Treatment (POST)
Information for Patients about POST
November 2016

The Indiana Physician Orders for Scope of Treatment (POST) form is a physician's order determined by the patient's goals and the treatment options available to a patient based on the individual's current health. The POST is intended to record a patient's wishes for medical treatment. The following is intended to provide you with general information about the POST form:

The POST form:

- The POST form is always voluntary. A health care provider or facility cannot require you to complete a POST form.
- The original POST form is the personal property of the patient. You are encouraged to keep the original POST form; however, photocopies, electronic copies, and faxes are also legal and valid. Your treating physician should retain a copy in your medical record.
- The State periodically updates the POST form. Previous completed versions of the form are still valid.
- HIPAA permits disclosure of the POST to health care professionals as necessary for treatment.
- The POST form may be printed on white paper. There is no requirement that a POST form be printed on a particular color of paper.

Completing the POST:

- A family member of an adult patient is not authorized to complete and sign a POST unless the family member has been appointed in writing as the legal representative for the patient.

Provisions of the Physician Orders for Scope of Treatment (POST):

- The POST should reflect your current treatment preferences.
- Any section of the form not completed implies authorization for full treatment for provisions described in that section.
- The POST is a medical order and requires the signature of the treating physician to be legally valid.

Changing Physician Orders for Scope of Treatment (POST):

- Once initial medical treatment is begun and the risks and benefits of further treatment are clear, your treatment wishes may change. You may change the POST at any time to reflect your current treatment wishes.

Reviewing Physician Orders for Scope of Treatment (POST): Your POST form should be reviewed in the following circumstances:

- There is a substantial change in your health status.
- You are transferred from one care setting or care level to another.
- Your treating physician changes.
- Your treatment preferences change.

Revoking Physician Orders for Scope of Treatment (POST):

- A person with capacity, or the valid representative of a person without capacity, can revoke the POST at any time by any of the following: a signed and dated writing; physical cancellation or destruction; by another individual at the direction of the declarant or representative; or an oral expression of an intent to revoke. The revocation is effective upon communication to a health care provider.

Advance Directives:

- No form can address all the medical treatment decisions that may need to be made. There are numerous types of advance directives. You are encouraged to discuss advance directives with your attorney, physician, or other qualified individual. Your physician can provide you with information about POST and whether it is appropriate for you.
- An advance directive, including appointing someone to speak on your behalf if you cannot speak for yourself, is recommended. The ISDH has an Advance Directive Resource Center at www.in.gov/isdh/25880 that provides a brochure, forms, and information about advance directives.

INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

State Form 56184 (11-16)
Indiana State Department of Health – IC 16-36-1; IC 16-36-6

INSTRUCTIONS: See instructions on back.

Patient / Appointor Information		
Patient Last Name	Patient First Name	Patient Middle Initial
Patient Birthday *(mm/dd/yyyy)*	Medical Record Number of Healthcare Facility or Provider *(optional)*	Healthcare Facility or Provider *(optional)*

Appointment of Health Care Representative

I, being at least eighteen (18) years of age, of sound mind, and capable of consenting to my health care, hereby appoint the person(s) named below as my lawful health care representative in all matters affecting my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities, unless otherwise provided in this appointment. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation below supersedes (replaces) any prior named Health Care Representative(s).

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.

I specify the following terms and conditions *(if any)*:

Name of Representative Appointed	Address of Representative *(number and street, city, state, and ZIP code)*	Telephone Number of Representative
Signature of Patient / Appointor or Designee *(must be signed in the appointor's presence)*	Printed Name of Patient / Appointor or Designee	Date of Appointment *(mm/dd/yyyy)*
Signature of Witness	Printed Name of Witness	Date *(mm/dd/yyyy)*

INSTRUCTIONS FOR STATE FORM 56184, INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

1. There are numerous types of advance directives. The Indiana State Department of Health encourages individuals to consult with their attorney, health planner, and health care providers in completing any advance directive.

2. This state form is not required for an appointment of a health care representative. An individual may use a form designed by their attorney or other entity to specifically meet the individual's needs. To be valid, any form must comply with statutory requirements.

3. An individual is not required to complete a health care representative appointment form. An individual may always chose to not appoint a health care representative. If there is no appointed representative, state medical consent laws would determine who may consent to your healthcare.

4. The medical record number and health care facility or provider is not required for the appointment to be effective. It may be included as a means of assisting the health care provider in identifying the correct patient and locating the appointment in the correct medical record.

5. The patient / appointor may specify in the appointment appropriate terms and conditions, including an authorization to the representative to delegate the authority to consent to another.

6. The authority granted becomes effective according to the terms of the appointment.

7. The appointment does not commence until the appointor becomes incapable of consenting. The authority granted in the appointment is not effective if the patient / appointor regains the capacity to consent.

8. Unless the appointment provides otherwise, a representative appointed under this section who is reasonably available and willing to act has priority to act in all matters of health care for the patient / appointor, except when the patient / appointor is capable of consenting.

9. The appointment of a health care representative must be witnessed by an adult other than the health care representative.

10. In making all decisions regarding the patient's / appointor's health care, the health care representative shall act:
    a. In the best interest of the patient / appointor consistent with the purpose expressed in the appointment.
    b. In good faith.

11. A health care representative who resigns or is unwilling to comply with the written appointment may not exercise further power under the appointment and shall so inform the following:
    a. The patient / appointor.
    b. The patient's / appointor's legal representative if one is known.
    c. The health care provider if the representative knows there is one.

12. An individual who is capable of consenting to health care may revoke:
    a. The appointment at any time by notifying the representative orally or in writing; or
    b. The authority granted to the representative by notifying the health care provider orally or in writing.