AMANI HEALTH CARE SERVICES LLC
1705 Southcross Drive West, Suite 105, Burnsville, MN 55306
Phone Number: **952-683-1628** Fax Number: **952-683-1629**

ADMISSION AGREEMENT

NAME OF CLIENT: _____

CONSENT FOR CARE

The services to be provided to me by Amani Home Health Care, LLC staff have been explained to me. I hereby consent to the staff of said program to visit my home periodically to render PCA Services.

RELEASE OF INFORMATION

I authorize information in my medical record to be released to authorized representatives of Medicaid, or another medical insurance carrier for use in determining home health care benefits payable to the Agency on my behalf. I authorize any hospital, nursing home, physician's office or other health care facility where I have been a client to disclose any part or all of my medical record to Amani Home Health Care, LLC. Also, I authorize the release of medical and other related information to appropriate agency staff and social/health care agencies and medical equipment/supply vendors whose services may be required in conjunction with the services provided by the Agency.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

I have received the notice of privacy rights and had it reviewed with me. I have had the opportunity to ask questions, and have been given the names of contact persons for future questions.

REQUEST FOR PAYMENT

I request payment of authorized Medicaid or other health insurance benefits and hereby assign benefits payable on my behalf directly to Amani Home Health Care, LLC. I understand that should payment not be made to the Agency, I will be responsible for service rendered to me, and that this payment is contingent upon written notice from Amani Home Health Care, LLC that services rendered are not authorized benefits under Medicaid or other health insurance. I understand that I am responsible for any insurance deductible, co-pay and coinsurance.

HOME CARE BILL OF RIGHTS

I acknowledge that I have been provided with a copy of the Minnesota Home Care Bill of Rights, I have read the Bill of Rights or explained to me. I have been instructed on how to contact the agency and informed of the complaint procedure.

Signature: _____

CERTIFICATION

I certify that I have read the above agreement, received a copy thereof, agree with the above conditions, and am the client, or am duly authorized by the client as the client's general agent to execute the above and accept its terms. I understand that this agreement can be revoked any time.

_____ _____

Signature of client or representative (state relationship) Date signed

_____ _____

Witness (signature by mark or representative must be witnessed) Date signed

If client unable to sign, give reason

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