NORTH CAROLINA

HOME CARE INDEPENDENCE PROGRAM

PARTICIPANT BILL OF RIGHTS AND RESPONSIBILITIES

As a Participant of the Home Care Independence program I have the RIGHT:

- To be safe.
- To be treated with courtesy, consideration and respect.
- To trust my instincts.
- To take and negotiate risks.
- To agree or disagree with others.
- To be informed of choices and consequences.
- To be free from mental, physical, financial and sexual abuse.
- To have communication appropriate to my communication needs.
- To be accepted for Home Care Independence services only if services can be provided in a safe and professional manner.
- To direct my own care or select a Representative who is willing and capable of assuming this responsibility.
- To be aware that I may request changes in services within the Home Care Independence Plan of Care from my Care Advisor.
- To know about all fees for the services I may receive and how my budgeted money may be spent.
- To tell my Care Advisor about any problems or concerns I may have without fear of being terminated from participating in the program or expressing those concerns. I may voice complaints verbally and/or in writing.
- To expect that all service providers that come into my home will respect my personal privacy and property.
- To expect that information I provide to Home Care Independence staff will be respected and held in confidence and that this information will be not be shared without my written consent.
- To request assistance from my Care Advisor and Fiscal Agent as needed.
- To be referred to other community agencies as appropriate.
- To be notified of any appeal rights I may have upon termination for cause from the Home Care Independence program.

As a Participant of the Home Care Independence program, I have the RESPONSIBILITY:

- To treat the people providing services to me with respect and courtesy.
- To notify the Fiscal Agent and my Care Advisor as soon as possible if there is:
    - Any change in my address

  - Any change in my phone service
  - Any change in my support system
  - Any change in my physician
  - Any admission to the hospital, nursing or rehabilitation facility or visit to the emergency room resulting in my not receiving service per normal
  - A change in the Personal Assistant who is providing my service
  - A need for changes in my Plan of Care determined with my Care Advisor or in the care plan followed by the Fiscal Agent
- To keep track of the balance of my monthly budget based upon the Plan of Care so that I do not overspend.
- To submit all required paperwork to the Fiscal Agent on time.
- To observe all tax and labor laws as explained to my by the Fiscal Agent.
- To have someone available to provide care for me in the absence of my Personal Assistant who may be out due to illness, emergency and/or holidays, in accordance with my back-up Plan of Care and to notify the Fiscal Agent when this occurs.
- To have a 24-hour a day supervision schedule in place, if it is required on my Home Care Independence Plan of Care, in order to maintain my health, safety, and well-being.
- To provide a safe working environment for those who will provide my care.
- To engage in a cooperative working relationship with my Personal Assistant, Care Advisor and Fiscal Agent.

The Consumer Bill of Rights and Responsibilities has been explained to me by my Care Advisor. I will be provided two copies of this document after I sign it. I will obtain the signature of the person I hire as my Personal Assistant and one copy will be provided this person.

(*Participant's Signature*) _____ (*Date*) _____

(*Care Advisor's Signature*) _____ (*Date*) _____

(Personal Assistant's Signature) _____ (Date) _____

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This form has been reviewed with my Personal Assistant and a copy has been provided this person. _____ (Participant's Initial) _____(Date)

Eff. 11/01/10