

YOUR CARE BREVARD

*A Family Care Program
For Seniors*

Member Handbook



A Program of the
Brevard Alzheimer's Foundation, Inc.

4676 N. Wickham Road
Melbourne, FL 32935

321-757-6970

Important Information

YOURCARE
BREVARD Plan Member Identification Number: _____

Your Medicaid Number: _____

Your Medicare Number: _____

Your Primary Care Physician: _____

Primary Care Physician Phone: _____

Your Preferred Pharmacy: _____

Pharmacy Phone Number: _____

YOURCARE
BREVARD Plan Care Manager

Name: _____

Phone Number: _____

Toll Free Phone Line: 1-866-563-2582 (9:00 a.m. to 5:00 p.m.)

24 Hour Phone Line: 321-757-6970

Fax Line: 321-757-6971

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Welcome

Thank you for choosing ^{YOURCARE}_{BREVARD} to be your new Nursing Home Diversion Plan agency. ^{YOURCARE}_{BREVARD} is a program of the Brevard Alzheimer's Foundation. The Foundation has been supporting programs in Brevard since 1992.

This handbook describes the ^{YOURCARE}_{BREVARD} plan and should help you decide how to best get the help you need. Your care manager will explain the plan in detail during your first meeting. If you have questions, please call your care manager or our customer service line. The phone number is written on the inside cover of this handbook.

We look forward to helping you manage your care needs. Our goal is to make sure you get the help you need to live safely in your home for many years to come.

Best Wishes,

Chris Stagman
Executive Director

Your Plan

The State of Florida funds YOURCARE
BREVARD Nursing Home Diversion Plan. Two state agencies, the Department of Elder Affairs and the Agency for Health Care Administration, have set up the rules for us to follow as we provide you with service. Our goal is to see that you get the help you need to live safely in your home for a long time. Key plan benefits are:

Care Management:

This group helps you get other services. They check your needs. They plan with you to meet those needs. They manage the service you get through YOURCARE
BREVARD and any other help networks.

**All YOURCARE
BREVARD care plan members receive Care Management services.**

It starts with contacting you and goes on through the following:

- needs review
- service planning
- service delivery arrangement
- review and rechecking of your needs
- service plan changes as needed

These services are delivered by a “care manager.” His/her name and phone number are written on the inside cover of this book. Get to know your care manager. Talk with him/her about your needs. Ask questions. We want you to get the best care possible.

Please notify your care manager if you need special communication services.

Your care manager will call and set up a meeting within five days of your joining the **YOURCARE BREVARD** plan. This meeting should happen within two weeks of your joining the plan.

Member ID Card:

For medical emergencies: Call 911 or go to the nearest emergency room.
Member Services: 1-866-563-2582 (9 a.m. to 5 p.m.) or 321-757-6970 (24 hours)
The **YOURCARE BREVARD** program is a contracted Florida state plan for the Long-Term Nursing Home Diversion Pilot Program. This member is currently receiving care management services with **YOURCARE BREVARD**. This card does not prove membership or guarantee coverage.
YOURCARE BREVARD will be financially responsible for all AUTHORIZED Medicaid covered services secondary to Medicare (co-pays and co-insurance).
Claims Address: Medicare EOB must be submitted:
YOURCARE BREVARD
4676 N Wickham RD
Melbourne, FL 32935

When your care manager gives you this book, he or she will also give you a Member ID Card. Carry it with you at all times. Show it to any health care or home care provider at the time of service. Also tell your doctor and/or hospital that you are a **YOURCARE BREVARD** plan member. They

will then know that, with your okay, they should share your care needs with your care manager. Your Member ID Card looks something like this:

Member Name: JOHN DOE
Member ID #: 00000
Effective Date: 09/05/07
PCP Name: JOHN SMITH, MD
PCP Phone: 321-343-7787
PCP Address: 0000 Main ST, Melbourne FL 32907

YOURCARE BREVARD

ALL SERVICES REQUIRE PRIOR AUTHORIZATION: 321-757-6970

A PROGRAM OF THE BREVARD ALZHEIMER'S FOUNDATION, INC.

Your Card is for your use only. It may not be used by anyone else. Report lost or stolen cards at once by calling 321-757-6970.

Member ID Card looks like this: Member ID your use only. It used by anyone lost or stolen by calling 321-

Coordination of Care:

This is a main part of Care Management. It means that your care manager will help make sure you always get needed support. This is the case whether you are at home, in a hospital, in a rehab location, or in a nursing home. This may involve talks between the care manager, your primary care doctor, and/or other providers.

Access of Services:

As a ^{YOURCARE}_{BREVARD} plan member, you will receive care management from our staff. All other services may be supplied by us or by other agencies that are part of our network. No matter which provider you use, you will receive service in your home or somewhere nearby. If needed, we will take you to the service location.

Your care manager sets up services to meet your needs when the chosen providers can furnish it. We expect that you will get all services in a timely manner. This means that a service provider should come to your home or see you within 15 minutes of the planned meeting time. If there is a delay that can't be helped, we will let you know within this 15-minute time frame. We will then advise you when the service is likely to arrive.

Medical Services:

Another good thing about ^{YOURCARE}_{BREVARD} plan is the chance to keep what you have now with Medicare. This includes your primary care doctor and other specialists. It includes hospitals you use for inpatient, outpatient and emergency services. It also includes your medical test and X-ray providers. Medicare covers all of these.

^{YOURCARE}_{BREVARD} plan. Medical services covered under the ^{YOURCARE}_{BREVARD} plan include:

Home Health: Medically necessary service given at home if you are homebound. This includes home health visits from nurses or home health aides. It also includes therapy, medical supplies, and medical equipment such as hospital beds, walkers and wheelchairs.

Other Services:

Adult Companion Services: This includes non-medical care, supervision, and socialization. It may also include help with tasks like meal preparation, laundry, shopping, and some light housekeeping.

Adult Day Health Care: This is both social and health services in an outpatient setting. It includes therapeutic activities and nutritional meals. Physical, occupational, and speech therapy are also included. Nursing service includes periodic evaluations, medical screenings and supervision, and self-care service.

Chore Services: This is the performance of tasks, including such jobs as seasonal cleaning and window washing. It could include lifting and moving, and simple household repairs not requiring special tools or materials. This is for persons who cannot do these tasks for themselves.

Consumable Medical Supplies: These are disposable supplies used by you, your caregiver, or service staff that are needed for your care.

Environmental Accessibility Adaptation Services: These are physical changes to the home to ensure your health and safety. These changes improve your independence. They include any changes to structural design that have a direct medical or remedial benefit. They should help you to remain in your home.

Family Training Services: We will train and counsel your family members. Family is defined as those who live with or provide care to a person. It includes a parent, spouse, children, relatives, foster family, or in-laws. It does not include persons paid to care for you.

Home Delivered Meals: This is a hot or frozen, nutritionally balanced meal served in the home. It meets one-third of the recommended daily dietary allowances.

Homemaker Services: A trained homemaker performs specific duties, including light housekeeping, meal preparation, and laundry. It could include help with shopping.

Nutritional Assessment/Risk Reduction Services: This includes advice and guidance to persons at nutritional risk due to their nutritional history. It is also based on current dietary intake, medications, or chronic illness.

Personal Care Services: This is help with bathing, dressing, eating, ambulating, and other daily living activities. Service could include housekeeping, supervision, and emotional security. It does not include medical service.

Transportation: Transportation will be provided for medical appointments and to and from Adult Day Care Services. Transportation requests must be authorized by the Member's Care Manager. A three day notice of need for non-urgent appointments is required.

In-Home Respite Care: This is short-term care if you cannot care for yourself. We provide this care in the absence of the person(s) who normally provide your care. It provides relief for your caregiver. It is not a substitute for care usually provided by a registered nurse, a licensed practical nurse or a therapist.

Assisted Living Facilities: This may include personal care, homemaker or chore services. It may include attendant care, companion services, and medication management. It may include therapeutic, social and recreational programming in a home-like atmosphere. It does not include the cost of room and board furnished in conjunction with living in the facility.

Nursing Facility Services: These are for a member who lives – temporarily or permanently – in a health care facility. While living in a nursing facility, what you get with the YOURCARE
BREVARD plan. Medical services covered under the YOURCARE
BREVARD plan include: plan member receives the same or similar services they received at home or in a community setting.

Health Promotion:

As a member of the YOURCARE
BREVARD plan, you will be taught how to stay healthy and safe. In fact, your Care Plan made just for you will include a section on healthy living. Important health activities include:

- good eating habits
- regular exercise (up to your ability)
- regular visits to your primary care doctor
- regular screening for breast, cervical, prostate, colon, and skin cancers; diabetes; cardiovascular health; and osteoporosis
- medication management, including over-the-counter and prescribed medicines
- attention to mental health and changes your doctor should know about
- flu shots (if your primary doctor recommends this)
- regular dental exams
- regular eye exams

If you want more information on any of these, please call

321-757-6970

Out-of-Network Providers

In an Emergency:

In an emergency, you can go to any hospital or doctor, even if they are not part of the plan network.

YOURCARE
BREVARD

You may need emergency care in your home area or outside of your home area. If so, go to the closest emergency care center or emergency room. When you are able, please tell their staff that you are a member of the YOURCARE
BREVARD plan.

Whether you get the service within or outside the plan's network, the plan must also cover post-stabilization service without authorization. This is service that a treating doctor thinks is medically necessary after an emergency medical condition has become stable. It is not emergency service. It is non-emergency service that the plan normally does not cover out-of-plan, except in the circumstances described here.

Non-emergency use of Out-of-Network Providers:

You may want to use a provider outside of our network for one or more services. If you ask for and receive an okay from your care manager, the plan may pay for them. You are the one who must ask. You must also write down the authorization number if your request is approved. We will write to your chosen provider with

You are responsible for asking for the authorization and for writing down the authorization number if your request is approved.

the approval and the number. We will do this within one day of your request, if it is approved. Post-stabilization service without authorization is included if the service was pre-approved by the plan.

Your request to use a provider outside of the network for a non-emergency service may not be approved. If this is the case, you must pay all costs and fees billed for that service. However, post-stabilization service without authorization is included if the service was not pre-approved by the plan for the following reasons:

(1) The plan did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care.

(2) The plan could not be contacted for pre-approval.

These are not emergency services. They are non-emergency services that the plan chooses not to cover out-of-plan, except in the circumstances described here and in the previous section.

Member Rights

We want you to know all of your rights as a member of the YOURCARE
BREVARD plan. They are listed below. If you do not understand one or more of them, please ask your care manager to explain them. You can also call 321-757-6970.

You have the right to:

- receive proper and skilled care. This means that you should get the service you most need from well-trained people.
- choose the home care service providers you want from our Provider Network.
- get what you need to either:
 - give informed consent before a procedure or treatment, or
 - refuse part or all treatment within the law.

You have the right to understand the risks and possible problems resulting from either choice.

- be treated with dignity and respect by everyone from the YOURCARE
BREVARD plan. All providers within the Network must also treat you with respect. This is true no matter what kind of lifestyle, cultural and/or religious and spiritual beliefs you have.
- your own plan of care.
- take part in all aspects of your care. This includes forming your plan of care and choosing providers. It also includes a change to your plan of care or chosen providers. You have the right to be told about a change before it is made.

- you will be provided a summary copy of your care plan.
- you have the right to a second opinion concerning your care
- you will receive interpretive services in person where practical, but otherwise by telephone, for members whose primary language is a foreign language. Contact your Care Manager for assistance.
- tell us if you don't like something. You can suggest changes in service or staff without fear of being treated unfairly.
- look at your personal health information and correct it if you feel that it is wrong.
- have your personal health information kept private. Only people who are legally allowed, or who have a medical need to know, will see it.
- get a copy of a bill that lists all items and details of the charge.
- tell us your likes and dislikes about the plan. You can call 321-757-6970.
- call Florida's toll-free Agency for Health Care consumer Hotline if you have a problem or question about any home health agency. The number is 1-888-419-3456, ext. 1. Call between 8 a.m. and 5 p.m., Monday through Friday, except state and federal holidays.
- call the Florida Central Abuse Registry if you are being abused or neglected, or if you know someone who is. It is available 24 hours each day at:

1-800-96-Abuse (1-800-962-2873).

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- call the Florida Central Abuse Registry if you are being abused or neglected, or if you know someone who is. It is available 24 hours each day at:

1-800-96-Abuse (1-800-962-2873).

- You must tell us about any problems you have with the service provided by any agency or person within our network. You may do this by talking with your care manager or by calling Member Services.
- You must give us the right financial and insurance information.
- You must pay for your health care as soon as possible.
- When you are in any health care place within our network, you must behave according to their rules.

call us at 321-757-6970 ask for any of the following:

- ❖ a detailed description of our service authorization and referral process
- ❖ a detailed description of the process we use to see whether services are medically necessary
- ❖ a detailed description of our quality assurance program
- ❖ a detailed description of our approval process for other providers
- ❖ our policies and procedures about prescribed drugs
- ❖ our policies and procedures about keeping members' medical records private
- ❖ information on quality performance and member satisfaction data

Member Responsibilities

As a member of the YOURCARE
BREVARD plan, you must follow the rules listed below. If you do not understand one or more of them, please ask your care manager to explain them. You can also call 321-757-6970.

You must tell us as much as you know about your past and present medical history. You must tell us about a sudden change in your condition. You must tell us your knowledge of the service plan.

You must follow treatments and activities suggested by:

- your doctor
 - your care manager
 - any other health care person who helps create your plan of care add to the rules later on.
- If you do not use the treatment or do not follow your doctor's orders, you are responsible for what happens.
 - You must obey what the agency says and anything they add to the rules later on.
 - You must be respectful of our employees. Your caregiver, your legal agent, and other friends must also be respectful of our staff. This includes people you talk with on the phone. It includes people who provide service to you at home or in another setting.
 - You must tell your care manager, as soon as possible, if you cannot go to a planned visit. Except in an emergency, let us know at least 24 hours before the planned visit.

Complaints and Grievances

All Grievances and Appeals will be handled in accordance with the Alzheimer's Foundation Policy No: NHDP #19.0. You, your family or your representative have the right to ask questions about your care, services or benefits. You have the right to tell us your concerns. You can also help us fix them. You should call us as soon as you can when such questions or concerns come up. Besides helping you, this will help us to learn more about how to improve our services for all YOURCARE
BREVARD plan members.

What to do if you have a complaint:

Call, write, or tell us in person. Your complaint tells us that you are not happy with YOURCARE
BREVARD plan care or benefits.

If you have a concern about your care or benefits, please call your Care Manager. The number is 321-757-6970. He/She will try to decide what to do about your problem within five (5) working days.

What to do if you want to file a formal grievance:

This must be written and signed. Our Grievance Coordinator will help you write it. You may also fill out a formal form for this purpose. If you want to use a form, call our Grievance Coordinator and ask for one. We will send it within three (3) working days. Our Grievance Coordinator can also help you fill out the form if needed.

<p>IMPORTANT: Your initial grievance must be filed within one year after the date the grievance event occurred.</p>
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Please send all complaints and grievances to:

Brevard Alzheimer's Foundation
Attention: Grievance Coordinator
4676 N WICKHAM RD
MELBOURNE FL 32935

Phone: 321-757-6970 (between the hours of 9:00 a.m. and 4:00 p.m. Monday through Friday)

What happens after you file a formal grievance:

We will write to you within five (5) working days. We will tell you when the Grievance Coordinator plans to review it. We will also review information from other providers and other YOURCARE
BREVARD plan staff. You will have a chance to meet with the Coordinator at our offices, or at a place that is convenient for you. You will meet with he/she before a decision is made.

We will take care of your grievance within 60 days from the date we receive it. If we need to know more from another agency or provider, it may take longer. In that case, we will decide within no more than 90 days from the date we receive it. Within either 60 days or 90 days, as described above, we will write to you about our decision.

How to handle an unresolved grievance:

You may not be happy with the first decision. You then have the right to ask for an **Internal Review Committee**. It will be made up of people who did not take part in the first review. They will also be skilled in judging your problem. The Plan

may have someone internal review why the first decision can also meet with the members in person to concerns and

A request for review by an Internal Review Committee must be made within 30 days of the postmark date on the decision letter.

talk to the committee about was made. You committee discuss your problems.

IMPORTANT: This request must be made within 30 days of the date the Post Office stamped the decision letter.

The internal review committee will have the right to make YOURCARE BREVARD obey the final decision.

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Requesting a Medicaid Fair Hearing:

If Member is not happy with the final decision by our Internal Review Committee, you, or your representative may request a Medicaid Fair Hearing by writing the:

**Office of Public Assistance Appeals Hearings
1317 Winewood Boulevard, Bldg. 5, Room 203
Tallahassee, FL 32399-0700**

The Department of Children and Families decides your Medicaid acceptance. You can request a hearing if you think that their action, intended action or failure to act would keep you

(or your family) from receiving Financial Help, Medical Help, Social Services, or Food Stamp Program Benefits. You can also ask for a fair hearing if their action, intended action or failure to act causes an “unreasonable” delay in your getting such help or service. You may request a Medicaid Fair Hearing within 90 days of the date of the notice of action.

Our Grievance Coordinator will assist you in the process should you need assistance.

During this review benefits will continue if:

- (1) The appeal is filed in a timely manner
 - a. (within ten (10) days of the date on the notice of action (we will add five (5) days if the notice is sent via U.S. mail)
 - b. The effective date of the YOURCARE
BREVARD proposed action.
- (2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- (3) The services were ordered by an authorized contractor;
- (4) The authorization period has not expired; and
- (5) The enrollee requests extension of benefits.

If you need a faster grievance review:

You, your caregiver or your representative, with your written consent, may request a faster review. You might want this when you believe that putting it off could seriously threaten your life or health status. You may ask for this verbally or in writing. Make your request to the YOURCARE
BREVARD Grievance Coordinator.

Give us all information we need to make a decision as fast as possible. Also, ask your primary care doctor, or other providers involved in the request, to send us the needed information from their records. They can send it by phone, fax, or in some other quick way. We will help you get this if needed.

Requesting a Medicaid Fair Hearing:

If you are not happy with the DOEA final decision, you may request a Medicaid Fair Hearing by writing the:

**Office of Public Assistance Appeals Hearings
1317 Winewood Boulevard, Bldg., 5, Room 203
Tallahassee, FL 32399-0700**

The Department of Children and Families decides your Medicaid acceptance. You can request a hearing if you think that their action, intended action or failure to act would keep you (or your family) from receiving Financial Help, Medical Help, Social Services, or Food Stamp Program Benefits. You can also ask for a fair hearing if their action, intended action or failure to act causes an “unreasonable” delay in your getting such help or service. You may request a Medicaid Fair Hearing within 90 days of the date of the notice of action.

Disenrollment

You may end your membership in our ^{YOURCARE}_{BREVARD} plan at any time by filling out a form for this purpose. You can get one by calling or writing:

Brevard Alzheimer's Foundation, Inc./YourCare
4676 N WICKHAM RD
MELBOURNE, FL 32935

Phone: 321-757-6970

We will send you a form within 48 hours of your request. We will also help you complete it if needed. After we receive the completed form, we will give it to the proper agency to handle. We will also give a copy to the Department of Elder Affairs.

Your care manager or someone from Member Services will want to talk with you briefly about why you want to quit the ^{YOURCARE}_{BREVARD} plan. If you choose another plan for your health and long-term care services, we will work with them to ensure your services go on during the switch.

Your disenrollment from the ^{YOURCARE}_{BREVARD} plan becomes effective on the first day of the month after the date we receive your completed form.

Involuntary Disenrollment:

Sometimes the YOURCARE
BREVARD plan can disenroll you. This can happen even if you have not asked for it by sending us the proper form. We can only do this in the following situations:

- ❖ member death
- ❖ member loses Medicaid eligibility
- ❖ member becomes ineligible for the project
- ❖ member moves outside the project's service area
- ❖ Fraudulent use of the member's Medicaid ID card
- ❖ Incarceration
- ❖ non-cooperation subject to Department of Elder Affairs approval

YOURCARE
BREVARD may submit to the DOEA for approval an involuntary disenrollment form for a member whose behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her enrollment with the contractor seriously impairs the Plan's ability to furnish services to either the enrollee or other enrollees.

1. YOURCARE
BREVARD will provide at least one verbal and one written warning to the enrollee regarding the implications of his or her actions. A written explanation of the reason for disenrollment will be given to the enrollee prior to submitting the disenrollment request.
2. After providing at least one verbal and at least one written warning of the full implications of failure to follow a recommended plan of care, YOURCARE
BREVARD may submit an involuntary disenrollment request to the Department for an enrollee who continues not to comply. Enrollees must be given a reasonable opportunity to comply with

the plan of care subsequent to each verbal and written warning before disenrollment is made effective except in instances where the enrollee's actions threaten the health, safety, or well being of service providers or YOURCARE
BREVARD staff or representatives.

3. The Plan will maintain involuntary disenrollment documents in an identifiable enrollee record, and enrollees who are disenrolled through this action are not eligible for re-enrollment without the permission of YOURCARE
BREVARD.
4. The Plan will submit involuntary disenrollment form signed by the Plan's staff.

DOEA will respond in writing to involuntary disenrollment for failure to follow the plan of care or disruptive behavior. The Department may approve such requests provided YOURCARE
BREVARD has documented the actions described herein and the conditions for the involuntary request have been met. Involuntary disenrollments without the Department's consent will be considered an express or intentional violation of the contract. Repeated occurrences will be considered a cause for termination as specified in the contract.

Advance Directives

Who has the right to make your health care decisions?

You do, if you can make and communicate your health care decisions. This includes the right to have or not have medical or surgical treatment. It includes planning and directing the type of health care you get later on if you can no longer express your wishes. You can do this by making an Advance Directive.

What is an Advance Directive?

We cannot plan when or how we will die. However, we can make sure that our wishes are carried out at the end-of-life. You can do this with a written or verbal statement. This statement is witnessed before serious illness or injury. It explains how you want medical decisions to be made.

Two forms of this are:

Living Will: This generally states the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. Florida law provides a suggested form for this. You may use it or some other form.

Health Care Surrogate Designation: This is a signed, dated, and witnessed paper. It names another person who can make medical decisions for you if you become unable to make them for yourself. This may be a spouse, child, sibling or close friend. You can include instructions about any treatment you want or do not want. Florida law provides a suggested form for this. You may use it or some other form. Also, you may wish to name a second person in case your first choice is not available.

You want to be sure your wishes will be understood and followed. So you may wish to speak to a lawyer or doctor to make sure you have filled out the forms clearly.

What is a Durable Power of Attorney?

This is a document that can hand over the authority to make health, financial and/or legal decisions on your behalf. It goes into effect when you cannot speak for yourself.

This person may also serve as your health care surrogate designee. If this is your choice, the documents must spell out that health care decisions are included under their authority. This is generally called a durable power of attorney for health care.

What is the difference between a Living Will and a Health Care Surrogate Designation?

A living will goes into effect only when you are near death or in a vegetative state. You have no awareness of what is going on. It deals only with the use or non-use of things that will lengthen your life.

A health care surrogate designation also goes into effect when you can no longer make health care decisions. However, you do not have to be close to death or in a vegetative state. It allows another person to speak for you and make health care decisions that are not limited to artificial life support. The type of decisions this person can make depends upon how much authority you give when you fill out the form.

Should I have both?

It is best to have both. You may combine them into a single document. It would describe treatment choices in many situations. It would name someone to make decisions for you if you cannot make or express them yourself. If you have two separate documents, you should make sure they agree with each other. If they do not, a health care provider will follow the instructions of a health care surrogate, rather than instructions in the living will.

What if I change my mind?

You can cancel or replace either of these at any time. The different ways you can do this are explained on the forms you fill out when you make a living will or appoint a health care surrogate.

Does my health care provider have to follow my Advance Directives?

Some health care providers and doctors may have policies or beliefs that keep them from carrying out your wishes. It is important to discuss them with these people. This will also tell you if they will carry them out. If they will not, you may want to choose another health care provider.

For additional information concerning Advance Directives and Florida-specific guidelines and laws, call Florida's Home Health Agency Hotline. The number is (1-888-419-3456).

Preparing for Disaster

Many types of emergencies are especially disruptive and stressful for elders. Your care manager will discuss them with you. He or she will help you create emergency plans based on your personal situation and needs. If you want more information about this, call 321-757-6970.