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Patient Name: _____ **DOB:** _____ **MR#:** _____

General New Patient Packet

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Welcome to Aveanna Healthcare

Dear Valued Patient,

Welcome to Aveanna Healthcare Medical Solutions! We are pleased to offer you enteral and medical solutions in many markets across the country. I would like to take this opportunity to thank you for trusting us and selecting us for your home care needs.

It is our mission to provide you and your family with revolutionary care consisting of quality, integrity, accountability and compassion, in a compliant and trustful manner. We strive to provide services that cover the healthcare needs of every patient, and our employees encompass a variety of clinical roles including Nurses, Dieticians and Respiratory Therapists. All Aveanna clinical staff are appropriately licensed, certified, and committed to public and community service.

Because our clinicians serve as trusted liaisons between doctors and patients, every prospective employee undergoes a background check, reference checks, multiple interviews, and extensive training. Additionally, routine evaluation, on-site observations and supervision as well as skills competency exams ensure that each member of our team is prepared to provide the latest in patient care. We want you to know that we are committed to excellence at Aveanna Healthcare where performance improvement and education is a constant process.

Our organization prides itself on distinctive customer service, and our goal is that the services provided by Aveanna far exceed your expectations. Thank you for your trust, your confidence, and allowing us to serve your healthcare needs.

Sincerely,

Rachel Witt

Rachel Witt, RN
Chief Clinical Officer

For general inquiries, please contact our Aveanna Healthcare Medical Solutions department at: 866-883-1188.

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Welcome to Aveanna Healthcare Medical Solutions (AHMS)

On behalf of our team at Aveanna Healthcare Medical Solutions (AHMS), thank you for choosing us as your trusted medical supply provider. Our patients are at the heart of our organization, and we are honored to serve you and your family.

It is our mission to provide revolutionary care with **quality, integrity, accountability, and compassion** in a compliant and trustworthy manner. We strive to meet the healthcare needs of every patient with a team that includes licensed and certified professionals such as Nurses, Dieticians, and Respiratory Therapists.

To ensure a seamless transition into the AHMS family and provide you with exceptional care, we have outlined the steps for completing your paperwork, managing your orders and contacting us anytime.

Getting Started

Step 1: Review the Paperwork

Carefully read the Patient Rights and Responsibilities section. This outlines what you can expect from AHMS and what is expected of you as a patient or caregiver. When reviewing the forms, please read them thoroughly. Feel free to call us at (866) 883-1188 with any questions — we are here to support you!

Step 2: Complete the Forms

The forms may request information such as your name, address, phone number, and email address. Ensure accuracy to avoid delays. Be sure to sign and date all consent forms where indicated.

Step 3: Submit Paperwork

Please complete and return the forms as soon as possible. We cannot ship your first full order until we receive your completed paperwork, so prompt action is critical. Most patients and caregivers can conveniently complete their paperwork electronically at the time of set-up. This is the fastest way to get started with us, and we encourage you to use this option as your first choice. Alternatively, you may scan and e-mail the completed documents to **medical.records.shared@aveanna.com**. If submitting by fax, send the completed documents to (844) 754-1345. If submitting by mail, address the completed documents to:

Aveanna Healthcare Medical Solutions
2460 E. Germann Road
Suite 18
Chandler, AZ 85286

Contact Options

You can email us anytime at **Refills@aveanna.com** with questions or for assistance. You may also call AHMS toll-free at (866) 883-1188 during our normal business hours: Monday through Friday, 7:00 AM to 7:00 PM CST, or Saturday, 8:00 AM to 1:00 PM CST.

We are grateful for the opportunity to care for you and your family. We will be in contact with you throughout the entire process, however we encourage you to contact us if you need additional assistance.

Healthy Regards,
The Aveanna Healthcare Medical Solutions Team

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AHMS Patient Rights and Responsibilities

Patient Name: _____ **DOB:** _____ **MR#:** _____

As a patient, you have the following rights:

1. To be fully informed as evidenced by the patient's written acknowledgment, prior to or at the time of acceptance as a patient, of these rights and of all rules and regulations governing patient responsibilities, and can exercise rights at any time
2. To choose an alternative organization or service, and to be informed of the relationship between this agency and any organization or service to which you are referred by this agency
3. To receive services as outlined in the plan of care regardless of race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, disability, or any other basis prohibited by federal, state, or local law
4. To be informed of organizational ownership and control
5. Receive proper written notice, in advance of a specific service being furnished, if the organization believes that the service may be non-covered care or in advance of the organization reducing or terminating ongoing care or, during the initial evaluation visit before the initiation of care, of services available from the company and of related charges, including the extent to which payment may be expected from Medicare, Medicaid, or any other federally funded or aided programs known to the agency, and the charges that the individual is responsible for. The liability of payment must be given orally and in writing to the patient. Changes in any prior payment information should be given to the patient orally and in writing as soon as possible in advance of the next service provided
6. To receive clear and understandable information regarding diagnosis, prognosis, treatments, safety and emergency measures, and any responsibilities you will have in care
7. To be fully informed of one's own health condition to be afforded the opportunity to participate in the planning of care and services
8. To participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to: the mode of care-delivery including the use of telecommunications when applicable, the completion of all assessments, the care to be furnished based on assessments, the establishment and revision of the plan of care, the disciplines that will furnish care, the frequency of visits, the expected outcomes of care, including patient identified goals, risks, and benefits, any factors that could impact treatment effectiveness, and any changes in the care to be furnished
9. To have property and person treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and care for personal needs.
10. To be advised in advance of the disciplines that will be used to furnish care and services and the frequency of visits proposed to be furnished. To expect proper identification by name and title of all personnel providing service. To have personnel possess the necessary skills and knowledge required to do their job
11. To have a confidential clinical record, personal and medical records, and protected health information kept confidential to the extent provided by law, and to be able to access and restrict disclosure of protected health information to the extent provided by law. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information
12. To expect continuity of care and to be informed of impending discharge from services, transfer to another organization, or the need for alternative services. To be informed orally and in writing of any changes as soon as possible, but no later than 30 calendar days from the date the company becomes aware of the change
13. To make complaints to the agency regarding treatment or care that is furnished or fails to be furnished, as well as the lack of respect for property and/or person by anyone who is furnishing services on behalf of the company. To evaluate services, voice grievances, ask questions, or offer suggestions regarding care and services without restraint, coercions, discrimination, reprisals, or unreasonable interruption in services
14. To request and receive all health records pertaining to services and all regulatory licensure inspection reports.
15. To be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect, and misappropriation of property
16. Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the organization or an outside entity
17. To be informed of the right to access auxiliary aids and language services and of how to access these services

Patient Name: _____ **DOB:** _____ **MR#:** _____

18. To be advised, upon request, of the names, addresses, and telephone numbers of the following federally funded and state-funded entities that serve the area where the patient resides: Agency on Aging, Center for Independent Living, Protection and Advocacy Agency, Aging and Disability Resource Center, and Quality Improvement Organization
19. To be given the necessary information regarding treatment and choices concerning rental or purchase options for durable medical equipment so you will be able to give informed consent for your services prior to the start of any service.
20. To have an advance directive for medical care, such as a living will or the designation of a surrogate decision-maker, respected to the extent provided by law
21. To participate in the consideration of ethical issues that arise in your care

Patient/Family Responsibilities

It is expected that patients/families comply with the following responsibilities:

1. To give accurate medical information, to the best of your understanding
2. To keep the company aware of any changes in your condition, legal representative (if any), payer status, or place of residence
3. To let the company know if you have any questions about home-care services and treatment
4. To comply with treatment plans as ordered by the physician
5. To let the company know when you are unavailable for a visit, shift, or service
6. To provide a safe, acceptable atmosphere and location for staff to provide service
7. To inform the company of any problems you have with your home-care provider and/or services
8. To assume responsibility for financial obligations for care provided by the company
9. To provide the information necessary for the processing of bills and accepting responsibility for the payable amounts due that are not covered by Medicare/Medicaid or other such insurance plans
10. To maintain primary responsibility for your care
11. To treat company staff with dignity and respect
12. To contact your doctor whenever you notice any unusual feelings or sensations during your treatment.
13. To contact your doctor whenever your notice any change in your condition.
14. To contact Aveanna Healthcare Medical Solutions whenever you have received a change in your prescription.
15. To contact Aveanna Healthcare Medical Solutions whenever you are to be hospitalized.
16. To give information regarding concerns and problems you have to an Aveanna Healthcare Medical Solutions staff member.

Thank you for choosing the Aveanna family of companies! Your signature indicates that you have read (or had reviewed/read to you) and understand your rights, responsibilities, financial obligations, and grievance procedures.

For information about the company's accreditation or to file a complaint (check one or more of the following):

☐ **ACHC –** You can file a complaint with the Accreditation Commission for Health Care (ACHC) by calling the complaints department at 855-937-2242. Office Hours are M-F, 8:00am - 5:00pm EST. ACHC's office address is 139 Weston Oaks Ct., Cary, NC 27513. Local phone number: 919-785-1214.

☐ **This location follows all applicable state and regulatory guidelines.**

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Notice of Nondiscrimination

Patient Name: _____ **DOB:** _____ **MR#:** _____

Discrimination is against the law.

Aveanna Healthcare, LLC does not discriminate on the basis of race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, disability, or any other basis prohibited by federal, state, or local law.

Aveanna Healthcare, LLC provides the following:

- Free aids and services to people with disabilities to help them communicate effectively with us, such as
  - qualified sign language interpreters and
  - written information in other formats (large print, audio, accessible electronic formats, etc.).
- Free language services to people whose primary language is not English, such as
  - qualified interpreters and
  - information written in other languages.

If you need these services, contact Aveanna, at 1-888-255-8360 (TTY: 711). If you believe that Aveanna Healthcare, LLC has failed to provide these services or discriminated in another way on the basis of race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, or disability, you can file a grievance with Melissa Akali, Assistant Vice President of Compliance. Her contact information is as follows:

Melissa Akali, Assistant Vice President of Compliance
Aveanna Healthcare, LLC
400 Interstate North Pkwy, SE, Ste 1600
Atlanta, GA 30339
Phone: 1-800-408-4442
Email: compliance@aveanna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, Melissa is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone as follows:

U.S. Department of Health and Human Services
200 Independence Ave, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019
TTD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English
Phone number for hearing impaired or deaf at 1-888-255-8360 (TTY: 711)

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-888-255-8360 (TTY: 711).

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致
電 1-888-255-8360 (TTY: 711)。

Patient Name: _____ **DOB:** _____ **MR#:** _____

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-255-8360 (TTY: 711).

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele 1-888-255-8360 (TTY: 711).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-255-8360 (TTY: 711) 번으로 전화해 주십시오.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-255-8360 (телетайп: 711).

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-255-8360 (TTY: 711).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل:
مقرب: 1-888-255-8360
رقم هاتف الصم والبكم: 711

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1-888-255-8360 (TTY: 711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-255-8360 (ATS: 711).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-255-8360 (TTY: 711).

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero 1-888-255-8360 (TTY: 711).

ગુજરાતી (Gujarati)
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-255-8360 (TTY: 711).

اُردُو (Urdu)
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
1-888-255-8360
(TTY: 711).

Notice of Privacy Practices

Patient Name: _____ **DOB:** _____ **MR#:** _____

THIS 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.
Notice of Privacy Practices Effective 1/3/03 Revised 06/25/20

The agency uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of the agency.

How the Agency May Use or Disclose Your Health Information

For Treatment. The agency may use your health information to provide you with medical treatment or services. For example, information obtained by a healthcare provider, such as a physician, nurse, or other person providing health services to you, that is related to your treatment will be recorded in your record. This information is necessary for healthcare providers to determine what treatment you should receive. Healthcare providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment. The agency may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may he sent to you or a third-party payer such as an insurance company or health plan. The bill may contain information that identifies you, your diagnosis, and your treatment or the supplies used in the course of treatment.

For Healthcare Operations. The agency may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff or to risk or quality-improvement personnel and others to

- evaluate the performance of your staff,
- assess the quality of care and outcomes in your cases and similar cases,
- learn how to improve our facilities and services, and
- determine how to continually improve the quality and effectiveness of the healthcare we provide.

Appointments. The agency may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund Raising. The agency may use your information to contact you to raise funding for the agency, or a group health plan, health insurance issuer, or HMO with respect to a group health plan may disclose information to the sponsor of the plan. You have the right to opt out of such activities. If this is your desire, please contact the agency at the number listed below.

Required by Law. The agency may use and disclose information about you as required by law. For example. The agency may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority
- To report information related to victims of abuse, neglect, or domestic violence
- To assist law enforcement officials in their law enforcement duties

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities in preventing or controlling disease, injury, or disability, or for other health oversight activities.

Decedents. Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye, or tissue donation purposes.

Research. The agency may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Specialized government functions such as the protection of public officials or reporting to various branches of the armed services may require the use or disclosure of your health information.

Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to workers' compensation.

Patient Name: _____ **DOB:** _____ **MR#:** _____

Your Health Information Rights

Your have the following rights:

- You may request a restriction on certain uses; and disclosures of your information as provided by 45CFR§164.522. However, the agency is not required to agree to a requested restriction unless it is a request to restrict disclosure of your protected health information to your health plan and if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law; and if the protected health information pertains solely to a healthcare item or service for which you have paid in full.
- You have the right to see copies of their electronic health records if the agency uses electronic health records;
- You have the right to request and obtain a paper copy of the notice of information practices upon request.
- You have the right to obtain and/or inspect a copy of your health record as provided for in 45CFR§164.524.
- You have the right to amend your health record as provided in 45CFR§164.426.
- You have the rights to request that communications of your health information by alternative means or at alternative locations.
- You have the right to revoke your authorization to use or disclose health information except when i) action has already been taken or ii) if the authorization was obtained as a condition of obtaining insurance coverage or other laws that could provide the insurer with the right to contest a claim under their policy.
- You have the right to receive an accounting of where your protected health information was disclosed during the six years prior to the date of your request.

Use and Disclosures of your Health information that Require Authorization

- The use and disclosure of psychotherapy notes, except i) use by the originator of the psychotherapy notes for treatment; ii) use or disclosure for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or iii) use or disclosure to defend in a legal action or other proceeding brought by you.
- Uses and disclosures for marketing purposes. Face-to-face communication by us to you or a promotional gift of nominal value will not require your authorization.
- Disclosures that constitute a sale of protected health information.

Communication of Privacy Concerns

You may contact the agency and/or the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a concern. You may file a complaint with the agency by sending a written notice to the address below.

U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Ave, S.W.
Washington, D.C., 20201

You may also call 1-877-696-6775 or visit https://www.hhs.gov/hipaa/filing-a-complaint/index.html

Obligations of the Agency

The agency is required by law to:

- maintain the privacy of protected health information,
- provide you with this notice of its legal duties and privacy practices with respect to your protected health information,
- abide by the terms of this notice,
- notify you if we are unable to agree to a requested restriction on how your information is used or disclosed,
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations,
- obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law, and
- notify you following a breach of unsecured protected health information.

The agency reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by written notification.

If you have any questions or concerns, please contact the following:

Aveanna/The Agency/Compliance Officer
400 Interstate North Pkwy, SE, Ste 1600, Atlanta, GA 30339
1-800-408-4442

Patient Name: _____ **DOB:** _____ **MR#:** _____

MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain its billing privileges. These standards, in their entirety, are listed in 42 CFR § 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. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any state healthcare programs, or 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, as well as 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 and must maintain a visible sign with posted hours of operation. The location must be 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.
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, answering service, or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers 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 is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition, see 42 CFR § 424.57(c) (11).
12. A supplier is responsible for delivering Medicare-covered items, instructing beneficiaries on their use, and maintaining proof of such delivery and instruction.
13. A supplier must answer questions and respond to complaints from beneficiaries and maintain documentation of such contact.
14. A supplier must maintain and replace or repair at no charge, directly or through a service contract with another company, any 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 unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold items) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership of or financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number, that is, the supplier may not sell or allow another entity to use its Medicare 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 regulations.
22. All suppliers must be accredited by a 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 for those specific products and services (except for certain exempt pharmaceuticals).

Patient Name: _____ **DOB:** _____ **MR#:** _____

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. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57(d).
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. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except for physicians (as defined in section 1848(j) (3) of the Act), physical and occupational therapists, or a DMEPOS supplier working with custom-made orthotics and prosthetics.

DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

The products and/or services provided to you by (supplier legal business name or DBA) are subject to the supplier standards contained in the federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (for example, honoring warranties and hours of operation). The full text of these standards can be obtained at:
https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/downloads/dmepossupplierstandards.pdf.
Upon request we will furnish you a written copy of the standards.

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AHMS Patient Service Agreement

Patient Name: _____ **DOB:** _____ **MR#:** _____

Grievance Reporting Information:

Contact Aveanna Healthcare Medical Solutions at **866-883-1188** with any issues/concerns. Any Aveanna Healthcare Medical Solutions employee is capable of receiving a concern and will be responsible to resolve the issue and involve management as necessary. The client/patient shall be notified within 5 calendar days using either oral, telephone, e-mail, fax, or letter format of the investigation findings and resolution to the issue. For issues classified as high or critical, within 14 days, a member of the leadership team will provide written notification to the client/patient of the results of its investigation and response. A copy of the letter will be kept in the client/patient file.

The agency is accredited under the following:

ACHC – You can file a complaint with the Accreditation Commission for Health Care (ACHC) by calling the complaints department at 855-937-2242. Office Hours are M-F, 8:00am - 5:00pm EST. ACHC's office address is 139 Weston Oaks Ct., Cary, NC 27513. Local phone number: 919-785-1214.

Grievance Reporting

I acknowledge that I have been informed of the procedure to report a grievance should I become dissatisfied with any portion of my home care experience. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service.

I understand I can contact the agency 24 hours per day at **866-883-1188**. This is not an emergency line. In a true emergency I understand I am to call 911.

Aveanna Compliance

To report a concern or improper conduct, call the Compliance (Integrity Helpline) at 1-800-408-4442 or write to: Aveanna Compliance Department, 400 Interstate North Parkway, SE, Suite 1600, Atlanta, GA 30339

Abuse Reporting

To report abusive, neglectful, or exploitative practices by any employee associated with the agency, contact the following:

Adult/Elder Abuse: Eldercare Locator - (800) 677-1116

Child Abuse: Childhelp - (800) 422-4453

Unanticipated Service Interruption

I understand that the agency uses reasonable efforts to provide uninterrupted services by qualified staff, however, sometimes interruptions in service are unavoidable including but not limited to inclement weather or other natural disasters. During such unanticipated interruption of essential services, I agree to provide or arrange for backup care, or I agree that the agency may assist in arranging for transfer to an appropriate emergency facility, if determined necessary.

Termination of Service

Services may be terminated by either party upon written notice or such other notice required by applicable law and regulation.

AHMS Patient Service Agreement

Patient Name: _____ **DOB:** _____ **MR#:** _____

Authorization & Consent

I, _____, have been informed that the agency is my Durable Medical Equipment Provider and licensed to provide Durable Medical Equipment and supplies based upon the physician's referral and order. I consent to receiving medical equipment and/or supplies from the agency. It is the policy of the agency to protect all clinical records against loss, defacement, tampering and use by unauthorized persons. I authorize the agency to release medical information to the patient's physician, the facility of my choice, payer source or any accrediting/regulatory/consulting organizations as appropriate.

HIPAA - I have received the Notice of Privacy Practices and consent to the agency to use and/or disclose protected health information for payment, treatment, and any healthcare operations.

I have received a copy and an explanation of the Patient Rights and Responsibilities.

Education Materials

I have been informed verbally and in writing of what to do in an emergency/natural disaster. I have been informed about the Aveanna Community Emergency Guide and how to access it.

Signature

_____	_____	_____
Patient/Patient Representative Signature	Printed Name	Date

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Authorization for Alternate Communication

Patient Name: _____ **DOB:** _____ **MR#:** _____

Patient Representative Name: _____ Relationship: _____

Home Address: _____ Home Phone Number: _____

Cell/Alternate Phone Number: _____ Work Phone Number: _____

Please read before signing. This authorization is only acceptable to the communications with the agency regarding the above patient.

- Only the patient or patient representative may give permission for alternate communication.
- By signing below, I attest that I am the patient or patient representative.
- I agree that this authorization will last as long as the patient is receiving services.
- I can revoke or revise this authorization at any time by completing a new form.
- A copy or faxed copy shall be considered as valid as the original form.

I hereby give authorization for the above-named patient's information to be communicated in the following modes (check all that apply). This information may include, but is not limited to, the patient's name, services received from the agency, the date of scheduled appointments, and/or additional information specific to the patient's healthcare needs.

☐ Voicemail Messages (Enter Phone Number): _____

☐ Text Messages (Enter Phone Number): _____
Reply STOP to Aveanna messaging number in order to opt-out of text messaging at any time.

☐ Email Messages (Enter Email): _____

☐ Postcard Reminders

☐ Letters

☐ Messages via Alternate Caregiver(s)

Name 1: _____ Name 2: _____

Phone Number 1: _____ Phone Number 2: _____

Relation to the Patient 1: _____ Relation to the Patient 2: _____

☐ Other: _____

All indicated methods above may be used; however, the preferred method of communication is the following:

_____

_____ _____ _____

Patient/Patient Representative Signature | Printed Name | Date

Arbitration Agreement

Patient Name: _____ **DOB:** _____ **MR#:** _____

Voluntary Arbitration Agreement for:

_____ and Aveanna Healthcare.
(Insert Patient Name)

1. Parties. "Patient" shall include the above-identified Patient, the Patient's parents or Personal Representatives, and those signing with or for the Patient. A person signing who routinely makes decisions for the Patient will be considered a Personal Representative. The Patient will be considered a third-party beneficiary of this Voluntary Arbitration Agreement ("Agreement") and is intended to benefit directly from its execution in conjunction with the corresponding receipt of services. This executed Agreement becomes a part of the Patient's Treatment Agreement(s). "Provider" includes all of the following associated with the above-identified Provider: licensed operator, owners, officers, directors, employees, agents, subsidiaries, affiliates, parent companies, holding companies, managers, consultants, and administrative services providers. The Patient understands that (s)he can seek legal counsel prior to signing and is encouraged to ask questions.

BY SIGNING THIS AGREEMENT, THE PATIENT AND THE PROVIDER UNDERSTAND THAT THEY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR ANY DISPUTE, AND THAT THE DECISION OF THE ARBITRATOR BINDS BOTH PARTIES AND IS FINAL. IF THIS AGREEMENT IS NOT SIGNED, THE PATIENT WILL STILL BE ALLOWED TO RECEIVE SERVICES FROM THE PROVIDER.

2. Agreement to Submit Disputes to Binding Arbitration. All disputes between the Patient and the Provider where the amount in contention exceeds $25,000 shall be submitted to binding arbitration, including disputes arising out of or in any way relating to this Agreement (its enforceability), or any of the Patient's treatment by the Provider, whether existing or arising in the future, whether for statutory, compensatory, or punitive damages, and irrespective of the legal theories upon which the claim is asserted. This Agreement does not change, limit, or affect any duty of the Provider with regard to the Patient or limit the Provider's liability in any way. The Arbitrator shall apply the substantive law of the state where the Provider is located to the claims brought in arbitration, except that the parties expressly stipulate that the Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall exclusively govern this Agreement's enforcement. If any provision of this Agreement is held to be unenforceable by reason of law, the provision will be modified to reflect the parties' intention to arbitrate their claims, and all remaining provisions shall remain in full force and effect. In the event that a trial court does not enforce this Agreement, the parties agree to stay all proceedings in the lower court until the merits of any appeal are determined by the appellate court. If a court determines that the parties to this Agreement are not bound to arbitrate their claims, the parties agree that any dispute shall be resolved solely by a judge in a bench trial.

3. Demand for Arbitration and Selection of Arbitrator(s). The party wishing to sue ("Claimant") shall initiate arbitration by serving via certified mail, return receipt requested, on all other parties being sued ("Respondent"), a written demand ("Demand") specifying the matter to be submitted to arbitration and nominating an Arbitrator. The parties will then work together in good faith to choose one neutral, experienced, and disinterested Arbitrator. Within 20 days after receipt of the Demand, if the parties cannot agree on one Arbitrator, the Respondent may nominate a different person, and the two Arbitrators shall, within 10 days, select a third Arbitrator. The parties may agree to use only the third Arbitrator selected if they wish. Any Arbitrator nominated or selected must be a member in good standing of a nationally recognized arbitration association. (The arbitration shall not, however, be conducted by an arbitration association unless the parties expressly so agree.) It is the Claimant's duty to demand arbitration, and if any party overlooks this Agreement and participates in litigation in the court system, such party will not be deemed to have waived the right to compel arbitration.

Initials of All Signing Parties: _____

Voluntary Arbitration Agreement for:

_____ and Aveanna Healthcare.
(Insert Patient Name)

4. Arbitration Procedure. The arbitration shall be conducted in the city in which the Patient lives unless the parties agree otherwise. The parties may appear, present testimony, and make other examinations as justice shall require and as the Arbitrator(s) shall deem necessary. The arbitration proceedings shall be governed by the Rules of Civil Procedure and Evidence of the state in which the Provider is located. The parties intend for the arbitration process to be efficient and completed as quickly and inexpensively as possible while still preserving their right to a fair hearing. The parties intend that the Arbitrator limit discovery to only issues related directly to the Patient and that written discovery and depositions be limited to only the information necessary for a fair hearing. Additionally, it is the parties' intent that the claim be completely resolved within 180 days after selection of the Arbitrator, as long as both parties can still obtain a fair hearing. The Arbitrator shall issue a written decision within 10 days of the conclusion of the hearing. All discovery, proceedings, and the final award shall remain confidential, and no discovery in the case shall ever be used outside the case unless the parties agree otherwise in writing. The written decision of the Arbitrator shall include detailed findings of fact and conclusions of law, be marked "confidential," shall be signed by each Arbitrator presiding over the hearing, shall be unanimous, final, binding, and non-appealable, and may be enforced in any court of competent jurisdiction. The parties intend that this Agreement shall inure to the benefit of and bind the Provider, its affiliated entities, representatives, medical directors, employees, successors, assigns, and agents, and shall inure to the benefit of and bind the Patient, his/her successors, parents, assigns, agents, attorneys, third-party beneficiaries, insurers, heirs, trustees, and representatives, including the personal representative or executor of the estate and any person whose claim is derived through the Patient. This Agreement may be revoked within 15 days after signing it by written notice sent to the Provider. Any disputes arising prior to revocation will remain subject to this Agreement. If not canceled within 15 days, this Agreement shall be binding on the Patient for this and all treatment by the Provider without any need for further renewal. If the Patient cancels this Agreement, (s)he will be allowed to receive services at the Provider pursuant to the terms and conditions of the Admission Agreement.

5. PATIENT HAS READ THIS ARBITRATION AGREEMENT, OR HAD IT READ TO HIM/HER, AND HAS RECEIVED A COPY OF IT. PATIENT HAS HAD AN OPPORTUNITY TO ASK QUESTIONS. PATIENT UNDERSTANDS THAT BY SIGNING BELOW, (S)HE IS CONFIRMING THAT (S)HE UNDERSTANDS THIS AGREEMENT AND AGREES TO IT, INCLUDING THE WAIVER OF A JURY TRIAL.

_____	_____	_____
Patient/Guardian/Legal Representative Signature	Printed Name	Date

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Assignment of Benefits

Patient Name: _____ **DOB:** _____ **MR#:** _____

Patient Account:_____

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY: I authorize (a) direct payment to Aveanna Healthcare of any insurance or other healthcare benefits otherwise payable to me for equipment and supplies provided by Aveanna Healthcare, (b) my insurance company or companies and other payors to furnish to Aveanna Healthcare all information pertaining to my insurance benefits and status of claims submitted by Aveanna Healthcare for equipment and supplies provided, and (c) Aveanna Healthcare to release to my insurance company or companies, Centers for Medicare and Medicaid Services (CMS) and its agents, or any other payor any and all information pertaining to me for benefits determination. While insurance or other coverage may exist for the equipment and supplies provided by Aveanna Healthcare to me, I recognize that all equipment and supplies may not be covered, or that reimbursement may be less than 100% of charges billed, in accordance with my coverage. Therefore, I agree to be financially responsible for any balance owing on my account, including all copayments and deductibles. In addition, I agree, unless I am a Medicare recipient and Aveanna Healthcare has accepted assignment or I am a Medicaid/Arizona Health Care Cost Containment System (AHCCCS) recipient, to immediately pay the full amount due to Aveanna Healthcare if (a) no payment is received by Aveanna Healthcare within 90 days from the date Aveanna Healthcare submits a claim, or (b) my physician or I fail to provide Aveanna Healthcare with the information necessary to submit the claim. I agree to transfer immediately to Aveanna Healthcare any payments made directly to me for equipment or supplies provided by Aveanna Healthcare on an assigned basis. I agree that should Aveanna Healthcare decline to accept assignment of my benefits from Medicare, or any other payor, I will pay the full amount due to Aveanna Healthcare.

_____	_____	_____
Patient or Patient Representative Signature	Printed Name	Date

Please explain if someone other than patient signs:

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Warranty Letter

Patient Name: _____ **DOB:** _____ **MR#:** _____

Aveanna Healthcare honors all warranties expressed and implied under applicable State Law. Aveanna Healthcare will notify all Medicare beneficiaries regarding warranty coverage of any supplies sold or rented. Aveanna Healthcare will not charge the beneficiary or the Medicare program for the repair or replacement of Medicare covered items or services covered under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

Manuals are available at the following URL, or by scanning the QR Code:

https://www.aveannamedicalsolutions.com/manuals

I hereby acknowledge that I, _____ (patient name), received instruction and understand the warranty coverage on the product I received.

_____	_____	_____
Beneficiary Signature	Printed Name	Date

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Medicare Capped Rental and Inexpensive/Routinely Purchased Option Agreement

Patient Name: _____ **DOB:** _____ **MR#:** _____

This form is not required if no equipment is issued to the patient.

I received instructions and understand that Medicare defines the _____ that I received as being either a capped rental or an inexpensive or routinely purchased item.

For capped rental items:

- Medicare will pay a monthly rental 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 include: Hospital beds, alternating pressure pads, nebulizers, suction pumps, continuous airway pressure (CPAP) devices, feeding pumps and patient lifts.

For inexpensive or routinely purchased items:

- Items and Equipment in this category, that do not fall into the capped rental category, can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount.
- Examples of this type of equipment include: bed side rails.

I select the:

☐ Purchase Option ☐ Rental Option

_____	_____	_____
Beneficiary Signature	Printed Name	Date
_____	_____	_____
Agency Representative Signature	Printed Name	Date

DME Certification and Receipt Form

Certificación y Recibo de Equipo Medico Duradero (DME)

(Page 1 of 4 - Required)

Texas Only: DME Certification and Receipt Form must be submitted to TMHP for claims and appeals for DME that meet or exceed a billed amount of $2,500.00

This certification is required by section 32.024 of the Human Resources Code and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client.

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe llenar antes de poder rembolsar al proveedor del equipo médico duradero por cualquier equipo médico proporcionado al cliente de Medicaid.

Section A: Client Information

Name*:	Medicaid ID Number*:		
Address:	City:	State:	ZIP:
Telephone Number:	Alternate Telephone Number:		

Section B: Provider Information

Provider Name:	Prior Authorization Number (PAN):	
NPI/API:	Taxonomy:	Benefit Code:
Street Address:		
City:	State:	ZIP + 4:

Section C: Product Information

Date of Service:		
Procedure Code:	Description:	Serial No:
Procedure Code:	Description:	Serial No:
Procedure Code:	Description:	Serial No:
Procedure Code:	Description:	Serial No:
Procedure Code:	Description:	Serial No:

Section D: Certification

This is to certify that on (month/day/year) _____ the client received the _____ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client's needs.

The client, parent, the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment's proper use and maintenance.

_____ Printed name of DME supplier

_____ Printed name of client, parent, guardian, or primary caregiver

_____ Signature of DME supplier

_____ Signature of client, parent, guardian, or primary caregiver

DME Certification and Receipt Form
Certificación y Recibo de Equipo Medico Duradero (DME)

Section D: Certification

Certification (Spanish)

Esto certifica que el: (mes/día/año) _____ el cliente recibió [el] [la] [los] [las]

_____ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.

El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.

_____ _____

Nombre del proveedor del equipo médico duradero *Nombre del cliente, padre, tutor, o cuidador principal*

_____ _____

Firma del proveedor del equipo médico duradero *Firma del cliente, padre, tutor, o cuidador principal*

Section E: Qualified Rehabilitation Professional (QRP) Verification for Wheeled Mobility Systems

This is to certify that on (month/day/year) _____ the client received a wheeled mobility system or major modification to a wheeled mobility system as prescribed by the physician.

By signing this form, I verify all the following:

- I participated in the seating assessment for the wheeled mobility system or have obtained authorization to perform the fitting as the QRP, and
- The wheeled mobility system and/or major modification has been properly fitted to the client, and
- The wheeled mobility system and/or major modification meets the client's functional needs for seating, positioning, and mobility, and
- The client, parent, guardian of the client, and/or caregiver of the client has been trained and instructed regarding the wheeled mobility system's proper use and maintenance.

_____ _____

Printed name of QRP QRP NPI

_____ _____

Signature of QRP Date

This form must be submitted to TMHP for a single DME product with an allowed amount of $2500 or more, for multiple DME products submitted on the same date of service that meet or exceed a total billed amount of $2500, or for a wheeled mobility system or major modification of a wheeled mobility system. Section E must be completed for all wheeled mobility systems and major modifications to wheeled mobility systems. Submit this form with the appropriate claim form or fax this form to 512-506-6615. Information submitted in this form must match information in the claim form.

This form must be filled out completely; place none or N/A where applicable. Incomplete forms will be returned and will cause a delay in the verification and payment process. **Failure to submit this form will affect claim payment.**

Notice to clients: You may be contacted to verify receipt of the equipment provided.

Notificación al cliente: *Puede que usted sea contactado para verificar el recibo del equipo proporcionado.*

DME Certification and Receipt Form
Certificación y Recibo de Equipo Medico Duradero (DME)
(Page 3 of 4 - Required only for requests containing six or more items)

Client Information	
Medicaid ID Number*:	
Provider Information	
Provider Name*:	Prior Authorization Number (PAN):
NPI*/API:	

Product Information (Continuation)		
Date of Service:		
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
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Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:
Procedure Code:	Description:	Serial No.:

Certification

This is to certify that on (month/day/year) _____ the client received the _____ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client's needs.

The client, parent, the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment's' proper use and maintenance.

_____ Printed name of DME supplier

_____ Printed name of client, parent, guardian, or primary caregiver

_____ Signature of DME supplier

_____ Signature of client, parent, guardian, or primary caregiver

Certification (Spanish)

Esto certifica que el: (mes/día/año) _____ el cliente recibió [el] [la] [los] [las] _____ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.

El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.

_____ *Nombre del proveedor del equipo médico duradero*

_____ *Nombre del cliente, padre, tutor, o cuidador principal*

_____ *Firma del proveedor del equipo médico duradero*

_____ *Firma del cliente, padre, tutor, o cuidador principal*

DME Certification and Receipt Form
Certificación y Recibo de Equipo Medico Duradero (DME)

High Cost DME Call Verification

Your provider has sent you some medical equipment. We want to make sure that you got what you wanted and that it works well. We need to talk to you about the equipment before we can pay for it.

Call TMHP at 1-888-276-0702

Please call us toll-free at 1-888-276-0702 as soon as you can. We are open Monday through Friday from 7 a.m. to 7 p.m., Central Time. If you call us after hours, you can leave a message. Tell us your name, phone number, and the best time to call you back.

Required Information

Please have this information with you when you call:

- Name
- Medicaid number
- Birth date
- Address (street, city, state, ZIP)
- Provider's name
- Date you got the equipment
- Details about the equipment

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General New Patient Packet Signature Form

Patient Name: _____ **DOB:** _____ **MR#:** _____

I have read and understand the following forms/policies as described (initial each line below):
Aveanna Healthcare Medical Solutions Documentation Patient Packet

_____ 1. Welcome Letter
_____ 2. Getting Started
_____ 3. AHMS Patient Rights and Responsibilities
_____ 4. Notice of Nondiscrimination
_____ 5. Notice of Privacy Practices
_____ 6. Medicare DMEPOS Supplier Standards
_____ 7. AHMS Patient Service Agreement
_____ 8. Authorization of Alternative Communication
_____ 9. Arbitration Agreement
_____ 10. Assignment of Benefits
_____ 11. Warranty Letter

The following forms are if applicable:

_____ 12. *Medicare Capped Rental and Inexpensive/Routinely Purchased Option Agreement
_____ 13. DME Certification and Receipt Form (*Texas Only: See disclaimer on first page*)

* = *This form is not required if no equipment is issued to the patient*

Additional forms included as applicable:

_____ _____
_____ _____
_____ _____
_____ _____

The patient has the right to be advised, upon request, of the names, addresses, and telephone numbers of federally funded and state funded entities that serve the area where the patient resides.

By signing my name below, I certify that I have received and read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand I am responsible for all charges not paid by insurance. A photocopy of this document is as valid as the original. You may achieve a copy of this document upon request.

_____	_____	_____
Patient/Patient Representative Signature	Printed Name	Date

Enteral Nutrition, Respiratory, and Medical Supplies

Providing children and adults with quality home medical solutions

aveanna healthcare® | MEDICAL SOLUTIONS

A trusted leader in quality service and home medical supplies.

Welcome
to Aveanna Healthcare

Table of Contents

Hours of Operation

Monday — Friday | 7:00 a.m. — 7:00 p.m. CST
Saturday | 8:00 a.m. — 1:00 p.m. CST

Call us at
P: 866-883-1188 | F: 844-754-1345

Visit AveannaMedicalSolutions.com for current location-specific information.
English and Spanish speaking staff are available to assist you.

After-hours information

If you need to reach Aveanna after hours, please call us at the number above to be routed to our answering service. For all urgent situations (e.g., if you are out of formula or experience equipment failure), the answering service will quickly connect you with an on-call representative to provide further assistance. For non-urgent calls, the answering service will ensure your call is returned the following business day. *For medical emergencies, please call 9-1-1.*

About Aveanna Healthcare Medical Solutions

As part of the Aveanna family of companies, Aveanna Healthcare Medical Solutions brings together a 45-year tradition of excellence that extends from some of the most respected names in pediatric and adult care. Those names include Epic Medical Solutions, Medco Respiratory Instruments, and Option 1 Nutrition Solutions. Today, Aveanna serves as a true industry leader, dedicated to bringing superior service and products home to you.

Aveanna exists to deliver the highest quality home medical solutions with clinical expertise, compassion, and extraordinary service to achieve the best possible outcomes for our patients. In doing so, we elevate the quality of life experienced by those we serve and help create an environment of comfort, consistency, and normalcy for our patients and their families.

We consider it both a privilege and an honor when we are able to welcome a new patient into our Aveanna family. Our care is always delivered from a place of heartfelt compassion and empathy, and our clinical, customer service, and operations teams work together in unique synergy to deliver care that exceeds our patients' expectations.

Aveanna is fully dedicated to providing all the care that meets your family's needs. That's why we also offer private duty nursing, therapy, and more. Not all services are available in all locations, so please check your local branch or visit aveanna.com to learn more.

What To Expect With Your Order

When your request for medical supplies is received, a member of the Aveanna team will:

- Collect and verify the paperwork needed to complete your order
- Submit prescription forms to your doctor
- Work with your insurance company to get necessary authorizations
- Always treat you with respect and courtesy

Your Patient Responsibilities

Please help us process/ship your order accurately by fulfilling the following patient responsibilities:

1. Make sure we have your current address, phone number, and email address.
2. Call if there is any change in the supplies you need or have a new doctor.
3. Talk to your doctor about prescription renewal deadlines.
4. Respond to Aveanna calls, messages, or mail right away.
5. Review the full list of your Patient Responsibilities.

Important Information

- Aveanna will deliver supplies to your home.
- We will coordinate the needed paperwork between your doctor and insurance company.
- Aveanna always can provide bilingual services to you.
- Your privacy is important to us. We comply with all HIPAA (Health Insurance Portability and Accountability Act) guidelines.
- Questions or concerns? Call us and a live person will always answer your call during normal business hours (Monday through Friday, 7:00 a.m. - 7:00 p.m. CST, or Saturday 8:00 a.m. - 1:00 p.m. CST).

Prescription Management

- Your prescriptions for supplies are usually good for six months to one year, depending on your insurance. Please call us if you have questions about your coverage.
- One month before your prescription expires we will contact you to check that your supply needs are the same. A member of our team will verify paperwork then fax a renewal prescription to your doctor for completion and signature.
- Once we work with your doctor to get an authorized prescription, we will continue to ship your supplies.

Your Experience With Aveanna Is Important

We believe you deserve a high standard of service. If you feel that you have a concern or complaint, please call us immediately. Your dissatisfaction is taken seriously, and we will work to resolve your concerns.

Attention: Medicare and select other healthcare plans require that we make contact with you monthly and receive consent before shipping any supplies. If you are eligible with a health plan that requires this, our Patient Care team will notify you upon your initial contact. We will do our best to contact you (or the person you authorize us to contact) when you are scheduled for a delivery, but we encourage you to make contact with us each month that supplies are needed to avoid any interruption in your service.

Products

Product and service availability may vary based on location.

Many of our customers have multiple product needs. If you are currently using multiple kinds of products, please contact our customer service department to ask about how we can better meet your supply needs.

Enteral Nutrition (Tube Feeding)

Feeding supplies

- Portable feeding pumps
- Pump feeding bags
- Feeding tubes
  (G Tubes, NG Tubes, and G Buttons)
- Syringes, tape, and dressings
- Continuous extension sets
- Bolus extension sets
- IV poles

For our portable feeding pump patients, we supply corresponding manufacturer backpacks to hold their pump. Additionally, upon request, we offer a variety of themed, customized, and age-appropriate backpacks, as authorized by payer.

Nutritional formulas

We supply over 200 infant, pediatric, and adult formulas from Abbott, Nestle, Mead Johnson, Kate Farms, and Nutricia as well as natural and metabolic formulas.

Medical Supplies

Incontinence supplies

- Briefs/Pull-ups®
- Diapers
- Liners/inserts
- Wipes
- Underpads

Urological supplies

Available Coloplast & Bard products

- Intermittent, external, and foley catheters
- Closed system kits
- Leg bags/drain bags
- Irrigation and insertion trays

Respiratory Supplies

- Ventilator
- BiPAP/ST
- CPAP
- Oxygen
- Nebulizer
- Pulse oximeter
- Cough assist
- Tracheostomy supplies
- Suction machine and supplies
- 50 PSI compressor

Services

Product and service availability may vary based on location.

Aveanna offers the following benefits:

- Enteral nutrition (tube feeding), respiratory (where available), and medical supplies (incontinence and urological)
- Patient/caregiver education, both in-hospital and at-home by a Registered Nurse, Registered Dietitian, Respiratory Therapist, or Customer Service Technician *(bilingual staff available)*
- Nursing and technical support 24/7, 365 days a year
- Home and hospital setups
- Nutrition assessment, change order review, and formula selection expertise provided by a Registered Dietitian working in conjunction with a physician
- Patient and family follow up within 24 hours of discharge
- Verification of insurance eligibility and authorizations, as well as documentation coordination among providers, patients, and physicians
- The largest selection of enteral formulas, supplies, and pumps in the industry
- Over 45 years of experience providing high-quality home medical solutions
- Home delivery at no additional charge

Basic Hygiene and Infection Control Guidelines

Handwashing — Infection Control

Handwashing is the most basic method to control the spread of infections. Use an alcohol-based hand rub or antimicrobial soap and water. Antimicrobial wipes or hand foams may be considered as an alternative to hand washing, but are not as effective.

When to wash your hands

- Before direct contact with patients
- Before putting on sterile gloves
- After contact with a patient's skin
- After removing gloves
- Before eating
- After contact with bodily fluids or excretions, mucous membranes, non-intact skin, and wound dressings
- After contact with inanimate objects in the immediate vicinity of a patient
- After using a restroom

Centers for Disease Control handwashing tips

- When hands are visibly dirty or soiled with blood/bodily fluids, wash hands with soap and warm (not hot) water.
- First wet hands with water, then apply soap and rub hands together vigorously for at least 15 seconds, including fingers. (As a fun way to time, try singing "Happy Birthday" or the "ABC Song" twice!) Rinse hands with water and dry thoroughly with a disposable towel.
- Use towel to turn off the faucet.
- If hands are not visibly dirty, use an alcohol-based hand sanitizer.

NOTE: Multiple-use cloth towels are not recommended for use.

Keeping your equipment clean

The cleaning of equipment should be performed as needed and per manufacturer guidelines.

Always clean equipment using a damp cloth or sponge and thoroughly dry the equipment. As with any electrical powered device, care must be taken to prevent liquids from coming in contact with the electrical cord or entering the battery compartment area. CAUTION: Do not immerse equipment in water or other cleaning solutions.

If you have any questions, please contact us at **866-883-1188**

aveannamedicalsolutions.com

Aveanna Healthcare Medical Solutions

F: 844-754-1345

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-255-8360 (TTY: 711).

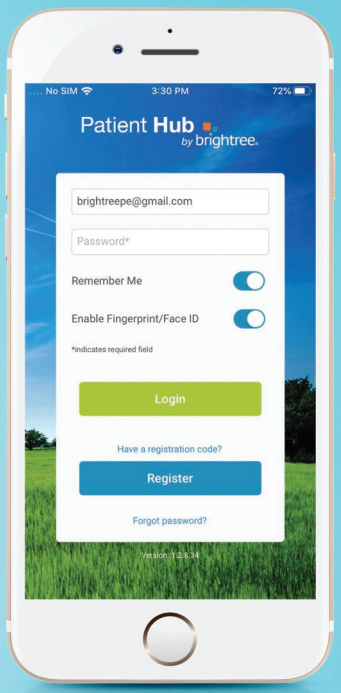
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-255-8360 (TTY: 711)。

Aveanna Healthcare, LLC does not discriminate on the basis of race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, disability, or any other basis prohibited by federal, state, or local law.

Download Our Mobile App!

Features of Patient Hub Application

- Send and receive secure messages
- Update your personal information
- Upload new insurance information
- Receive helpful notifications about shipments and order status



How to register with Aveanna Healthcare Medical Solutions

1. Contact Aveanna and ask us to send you an email invitation to register with Patient Hub.
   - Call 866-883-1188 or
   - Ask a representative when you confirm your monthly order
     - Be sure to include the patient's full name and Date of Birth (DOB)

2. After receiving the verification code go to the App or Play store and download Patient Hub by Brightree.

App Store

Play Store

3. Open the app, at the bottom tap Register.
   - Enter your email address and the verification code from the email invite
   - Verify your Date of Birth (DOB)
   - Confirm your information
   - Be sure to enable notifications

If you have any questions, please contact us at 866-883-1188.

AveannaMedicalSolutions.com

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