**PATIENT LETTER FOR LEGISLATIVE HOME VISIT**

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient name)

As your home care agency, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (agency name) is actively involved with the NYS Association of Health Care Providers (HCP), a non-profit trade association serving the home care industry. HCP is our advocate in Albany to improve home care delivery in NYS. HCP is also YOUR advocate.

As a Licensed Home Care Services Agency, we must follow NYS health care rules and regulations, and as your provider, we may rely on state funding to provide your care. Home care has been underfunded for decades. It is only through advocacy that we can raise the voice of home care and show its value to those making budgetary decisions in Albany. We need legislative support for improved home care funding.

We want to make sure that your representatives in Albany are familiar with home care! As we discussed, are inviting NYS legislator, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (legislator’s name) to visit your home so they can see first-hand the important work we do to improve and maintain your health in your setting of choice.

We hope this visit will educate the legislator regarding the impact of home care, and the need for proper funding so that New Yorkers who want to stay in their homes and communities can access home care when they need it.

During this visit, we invite you to interact with your state Senator or Assembly Member! Perhaps talk about how home care helps you remain in your home, provides flexibility and support to your family, or provides a caring person who assists you with your basic needs. Your aide will be with you throughout this visit, and you do not have to discuss anything you don’t want to with the legislator.

The visitor/s (legislators and staff) have signed a privacy agreement, and we also require your permission to allow this visit. You will be given a copy of the privacy agreement and your signed authorization as required by law (45CFR Part 164.508).

**Authorization for Use and Disclosure of Protected Health Information to a Visiting Observer**

This form provides authorization to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the “Home Care Agency”)to use or disclose certain parts of your protected health information which is protected under federal law (45 C.F.R. Part 164), for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (date of birth: \_\_\_\_\_\_\_\_\_\_) authorize the Home Care Agencyto disclose to:

[Legislator Name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Legislator Office, and Address] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information: [**Initial** All the Protected Information to be Disclosed]

Observation of Assessments/Treatments/Personal Care/Home Care Services \_\_\_\_\_\_\_\_\_ (initial here)

Discussion of treatments/symptoms/diagnoses \_\_\_\_\_\_\_\_\_ (initial here)

Discussion of care history/experience \_\_\_\_\_\_\_\_\_ (initial here)

Purpose of Information to be Disclosed:To educate policymakers and aid the Home Care Agency and HCP in legislative advocacy and policy development to improve Home Care Services funding and regulations.

This authorization shall expire upon the earlier of (i) 365 days from the date of this request or; (iii) the occurrence of the following [Include the date, event, or condition upon which consent will expire]:

I am participating in this legislative visit voluntarily and of my own free will.

I understand the purpose of the legislative visit.

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to \_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Agency Compliance Officer] at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Agency Address], except to the extent that the visitor observation has already occurred.

I understand that the Home Care Agency may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization.

I understand that my protected health information cannot be re-disclosed for any other purposes without my written consent unless otherwise provided for by the regulations.

I hereby authorize the use or disclosure of my health information as described in this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient or Personal Representative Date

Relationship of Personal Representative to Patient: (Power of attorney, for example) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Witness Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Witness Name