ADULT PLACEMENT NETWORK

PO Box 1106
Lake Oswego, OR 97035

DHS Registry No. 1030
cindy@adultplacementnetwork.com

Office: 503.684.4455
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Long-Term Care Referral Agent Disclosure

General Information for Oregon Consumers

This advisory provides a list of disclosures that Long-Term Care Referral Agents must provide to clients.

Mandated Disclosures

Oregon law requires Adult Placement Network to make the following disclosures to a client:

1. **Description of the Referral** Adult Placement Network refers to the following:

- Independent Living Communities
- Room & Board
- Assisted Living Facilities
- Adult Care Homes
- Memory Care Communities
- Intermediate Care Facilities
- Continuing Care Retirement Communities
- Skilled Nursing Facilities
- Medicaid Contracted Communities
- Residential Care Facilities

These are collectively referred to as “Long-Term Care Communities”

2. **Limitations on Referrals** Most referrals from Adult Placement Network are to long-term care facilities that we have business-to-business contracts with.
3. **Referral Fees** Any fees paid to Adult Placement Network for referral services will be paid by the long-term care community.
4. **Expiration** This authorization will remain in effect until terminated by you. You have the right to revoke this authorization at any time by contacting Adult Placement Network in writing at the above address, email, or fax. The revocation may not be effective to the extent that anyone has already acted in reliance on this authorization.
5. **Privacy Policy** Adult Placement Network will have you or your legal representative sign a Release of Information prior to any written exchange of information. Adult Placement Network will not share your health or financial information with anyone other than those directly involved in the placement process.
6. **Long-Term Care Community Complaint History** The Department of Human Services (DHS) website listing complaints concerning long-term care communities is https://ltclicensing.oregon.gov/facilities (Independent Living and Room and Board facilities are not licensed and may not be listed on the above website).

Authorization to Share Information

I authorize Adult Placement Network to share my information with long-term care communities, health care providers, and case managers.

Client Name	Date	Signature

Referral Agent	Date	Signature

Additional Information

The following additional information beyond the mandatory disclosures is provided to assist the consumer in understanding Oregon laws regarding long-term care referrals.

A Long-Term Care Referral Agent Must:

1. Discontinue providing services to a client who notified the Long-Term Care Referral Agent in writing that the client no longer wishes to use the services of the Long-Term Care Referral Agent. If the Long-Term Care Referral Agent has received compensation from the long-term care community for a referral that has been made, the client may notify the Referral Agent in writing that they wish to use the services of another Long-Term Care Referral Agent in the future for referral to another long-term care community in a subsequent move. The client's written notice shall identify the name of the long-term care community and the move-in date of the original referral made by the Long-Term Care Referral Agent.
2. Provide the required disclosures to the client in writing in a conspicuous and clear manner. The disclosures may be made orally first if the Long-Term Care Referral Agent makes an audio recording with the consent of the client and thereafter provides the client a written disclosure.

A Long-Term Care Referral Agent May Not:

1. Provide a referral to a long-term care community for compensation unless registered with the Department of Human Services.
2. Refer a client to a long-term care community in which the Long-Term Care Referral Agent or an immediate family member has an ownership interest.
3. Contact a client or authorized representative who has requested in writing that the Long-Term Care Referral Agent stop contacting them.
4. Share a client's information with or sell a client's information to a community or marketing affiliate without obtaining affirmative consent from the client or their authorized representative for each instance of sharing or selling such information.

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Referral Service Agreement

Adult Placement Network (hereafter "APN") has been assisting Oregonians with their search for long-term care communities (hereafter "LTCC") since 1997. This referral service agreement outlines the scope of work provided by APN and our commitment to the clients we serve.

Services Provided to Client

- APN will consult with the client and, if applicable, the client's family, physicians, and current care providers to understand the client's functional care needs, resources, and preferences.
- Based on the information provided by the client and others, APN will research appropriate LTCC options for the client.
- APN will review two years of compliance history for each LTCC selected by the client. This can be found at **https://ltclicensing.oregon.gov**.
- APN will tour selected LTCCs with the client.
- APN will offer follow-up with the client after the client has moved to the LTCC.

APN will provide all services outlined in this agreement at no cost to the client.

Exclusive Agreement for Services

"I agree to work exclusively with APN for a period of 60 (sixty) calendar days from the date of this agreement. If APN is unable to find an LTCC that is suitable for the client within that time, I may cancel this agreement."

Initial here _____

"I understand that under this agreement, APN is the first point of contact to any LTCC. If I locate an LTCC on my own, I will bring it to the attention of APN, and allow APN to represent the client to that LTCC rather than initiating contact on my own."

Initial here _____

_____

Your Name | Date | Your Signature

_____

Name of Person Needing Care | Relationship to Person Needing Care

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Release of Information

I hereby authorize Adult Placement Network and its employees and contractors (collectively, "APN") to collect, use, and disclose protected health information concerning the person listed below (the "client"), for whom I have the legal authority to consent. I understand APN may redisclose the health information to long-term care communities (LTCC) for the limited purpose of locating long-term care options for the client.

Disclosed Information May Include

1. The medical information provided by myself, family members (including the client), medical staff, hospital staff, nursing home staff, medical records, an onsite evaluation by APN, notes, communication, correspondence and/or records provided to APN. APN may collect information through interviews, in writing, or by observation.

2. Basic financial information as it relates to care costs.

3. Social information as it relates to preferences and location.

If the information disclosed contains records or information as listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to any of the following types of protected health information:

_____ Mental health/Counseling

_____ Drug/Alcohol diagnoses

_____ Human Immunodeficiency Virus/AIDS

_____ Medical/Recreational marijuana use treatment, or referral

Redisclosure

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure, and once redisclosed may no longer be protected under federal law.

Provider Information

I understand that I do not need to sign this authorization. I understand that if I refuse to disclose this information to APN, APN may not be able to provide an adequate assessment of the client's needs for locating an LTCC.

Revocation

I understand that I may revoke this authorization in writing at any time. If I revoke this authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with my permission cannot be undone. To revoke this authorization, I will send a written statement of revocation to APN.

Your Name Date Your Signature

Name of Person Needing Care Relationship to Person Needing Care