DESTINY GIVERS ADULT FOSTER CARE

Destiny Givers AFC is a dedicated program designed to provide essential support to caregivers caring for loved ones or friends within the same household. We take pride in being a trusted and approved service provider, delivering compassionate care to improve the quality of life for both caregivers and recipients.

BENEFITS OF THE DESTINY GIVERS AFC PROGRAM

- **Round-the-Clock Assistance:** Caregivers offer continuous support to ensure members feel safe and cared for, with help in bathing, mobility, feeding, and more.
- **Financial Assistance:** We value caregivers' contributions with a monthly tax-free stipend of up to $1,600.
- **Professional Oversight:** Our registered nurses conduct regular visits to assess care quality, ensuring standards are met and caregivers receive ongoing guidance.
- **Empowering Caregivers:** No previous caregiving experience? No problem! We offer free, comprehensive training to equip caregivers with the skills they need to provide high-quality care.
- **Home-Centered Support:** Our program allows individuals requiring assistance with everyday tasks to stay comfortably at home with trusted caregivers, maintaining dignity and independence.
- **Comprehensive Training:** Both members and caregivers benefit from personalized education and resources, preparing them for success.

WHY FAMILIES TRUST DESTINY GIVERS AFC

- **Diverse Care Team:** Our clinical staff includes certified nurses and case managers, providing personalized care across the state.
- **Accepted Insurance:** We work with a variety of insurance providers, making our services accessible to many.
- **Accredited Excellence:** Proudly certified and nationally recognized for outstanding care.
- **Trusted Expertise:** With years of experience supporting families across communities, we offer dependable care that meets individual needs.
- **Cultural Understanding:** We embrace language diversity, including Kiswahili, Spanish, Portuguese, Sign Language, and more, ensuring our services meet the needs of every community we serve.

OUR SERVICE AREAS

- Destiny Givers AFC offers coverage throughout Massachusetts, from the city to the Cape, ensuring no family is left without the support they need.

HOW TO GET STARTED WITH DESTINY GIVERS AFC

Interested in referring someone or learning more?

- **Call Us:** Speak with one of our service advisors at **774 238 5751**
- **Online Referral:** Complete a referral form at **www.destinygiversafc.com/referral**
- **Email or Paper Form:** Submit your referral via email or fax it to us at **774-389-6299 / info@destinygiversafc.com**

CONTACT: 774-238-5751
FAX: 774-389-6299
EMAIL: referrals@destinygiversafc.com
LOCATION: 11 Foster St, Suite 206
Worcester MA 01608
WEBSITE: www.destinygiversafc.com

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REFERRAL FORM

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LOCATION: 11 Foster St, Suite 206
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This form is intended for completion by either the member or their designated representative. The information provided will be utilized to verify the member's eligibility for services. Direct communication with the member will follow to discuss our service offerings. Kindly transmit the completed form via fax or mail to the aforementioned address.

SECTION 1: MEMBER DETAILS

Last Name: ..... Last Name: ..... Middle Name: .....

DOB: ...../...../..... Gender: ..... Phone: .....

Address: ..... City: ..... State: ..... Zip: .....

Emergency Contact: ..... Relationship to Member: ..... Phone: .....

Address: ..... City: ..... State: ..... Zip: .....

Legal Guardian (if any): ..... Phone: .....

Address: ..... City: ..... State: ..... Zip: .....

Languages Spoken: .....English ..... Spanish .....Other (Specify) .....

Services Member is receiving: .....AFC ....._Adult Day Care Other (Specify) .....

Principal Caregiver:..... Relationship:..... Phone .....

SECTION 2: INSURANCE INFORMATION

Payer Name: ..... Member ID Number: .....

Other Payer Name: ..... Member ID Number: .....

SECTION 3: PHYSICIAN CONTACT DETAILS

Doctor's Name: .....

Phone: ..... Fax: .....

Address: ..... City: ..... State: ..... Zip: .....

Date of Last Physical: ..... Last Hospitalization: .....

Additional Comments: .....

SECTION 4: REFERRAL NAME AND CONTACT INFORMATION

Please specify the name and contact details of the person completing this form. If the member is signing, kindly ensure their signature is also included on this release of information form.

Completed By: ..... Title/Role: ..... Date: .....

Member Signature: ..... Date: .....

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

CONTACT: 774-238-5751
FAX: 774-389-6299
EMAIL: referrals@destinygiversafc.com
LOCATION: 11 Foster St, Suite 206
Worcester MA 01608
WEBSITE: www.destinygiversafc.com

I hereby authorize the release of information from the medical record of:

Patient Name: ..... DOB: .....

Patient Address: .....

Address: ..... City: ..... State: ..... Zip: .....

Release Information To:	Information Requested From:
DESTINY GIVERS ADULT FOSTER CARE LLC Attention: Medical Records **CONTACT:** 774 238 5751 www.destinygiversafc.com **LOCATION:** 11 Foster St, Suite 206 Worcester MA 01608	

Please Release the Following:

☐ Medical History Summary ☐ Current Medication List

☐ Discharge Paperwork ☐ Other:

.....

Purpose for Disclosure Needed:

☐ Start/Continued Patient Care ☐ Other: .....

I acknowledge that the information released is intended solely for the purposes specified above. Any unauthorized use of this information without the patient's written consent is strictly prohibited. I also understand that I have the right to revoke this consent in writing at any time, except where actions have already been taken in reliance on it. This consent will remain valid and effective for the duration of my receipt of services from Destiny Givers Adult Foster Care, expiring twelve (12) months after my last service date unless otherwise indicated.

Name of Patient or Legal Representative: .....

Signature of Patient or Legal Representative: ..... Date: .....

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

MassHealth Adult Foster Care Member Transfer Form

This form may be used by adult foster care (AFC) providers that are intaking a MassHealth member who wishes to transfer from a different AFC provider or service, or by AFC providers who are transitioning MassHealth members to a different AFC provider or service. The purpose of this form is to confirm the MassHealth member's consent to transfer their care.

Directions for the intaking AFC provider completing this form: the form must be completed with the MassHealth member and/or representative and submitted with your prior authorization (PA) request via the MassHealth LTSS Provider Portal (www.masshealthltss.com).

MassHealth recommends that when a member is seeking a transfer, they and/or the intaking AFC provider communicate to the previous AFC provider or other service provider their intention to end services.

I, _____ (Member Name), have chosen to transfer from _____ (Previous AFC Provider or Other Service Provider)

and I would like to begin adult foster care with DESTINY GIVERS AFC (Intaking AFC Provider).

I understand that this form will be submitted to MassHealth for review with my PA request. If my request is approved, I agree to end services from _____ (Previous AFC Provider or Other Service Provider) when the request is processed.

Member/Legal Guardian/Invoked Health Care Proxy
PRINTED NAME

Member/Legal Guardian/Invoked Health Care Proxy Signature Date

The form can either be signed by hand and then scanned, or it can be signed electronically using a digital signature tool, such as DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.