LOYALTY ADULT FOSTER CARE

Loyalty AFC is a specialized program created to support caregivers who care for loved ones or close companions within the same home. As a trusted and approved provider, we are committed to delivering compassionate, high-quality care that enhances the lives of both caregivers and those they support.

BENEFITS OF THE LOYALTY AFC PROGRAM

- **24/7 Care & Support:** Caregivers provide continuous assistance to ensure members feel safe, comfortable and well cared for helping with bathing, mobility, meals and more.
- **Caregiver Compensation:** We recognize the dedication of caregivers through a monthly, tax-free stipend.
- **Clinical Oversight:** Registered nurses conduct regular visits to monitor care quality, maintain standards, and provide ongoing guidance.
- **Caregiver Empowerment:** No prior experience is required. Our free, comprehensive training equips caregivers with the skills needed to deliver exceptional care.
- **Home-Based Living:** Members receive support in the comfort of their own home, promoting dignity, independence, and familiarity.
- **Ongoing Education:** Personalized training and resources are provided to both caregivers and members, ensuring long-term success and confidence.

WHY FAMILIES TRUST LOYALTY AFC

- **Diverse Care Team:** Our team includes certified nurses and experienced case managers, delivering personalized care across the state.
- **Insurance Flexibility:** We partner with a wide range of insurance providers to ensure our services remain accessible.
- **Accredited Excellence:** Proudly certified and nationally recognized for delivering high-quality care.
- **Proven Expertise:** With years of experience supporting families, we provide dependable care tailored to individual needs.
- **Culturally Inclusive Care:** We embrace diversity through multilingual support including Kiswahili, Spanish, Portuguese, Somali & Arab, Sign Language and more. So every community feels understood and supported.

OUR SERVICE AREAS

- Loyalty AFC proudly serves communities across Massachusetts, from the city to the Cape. Ensuring every family has access to the support they deserve.

HOW TO GET STARTED WITH LOYALTY AFC

Interested in referring someone or learning more?

- **Call Us:** Speak with a service advisor at **774-420-2010**
- **Online Referral:** Submit a form at **www.loyaltyafc.com/referral**
- **Email or Paper Form:** Send your referral to **info@loyaltyafc.com**

LOYALTY
ADULT FOSTER CARE LLC
Compassionate care you can rely on
(774) 420-2010
324 Grove St., 2nd Floor Worcester, MA 01605

CONTACT: 774-420-2010
FAX: 508 - 304- 7461
EMAIL: info@loyaltyafc.com
LOCATION: 324 Grove St, 2nd Floor
Worcester, MA 01605
WEBSITE: www.loyaltyafc.com

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REFERRAL FORM

This form may be completed by the member or their authorized representative. The information provided will be used to determine eligibility for services. Our team will contact the member directly to discuss available service options. Please submit the completed form via fax or mail to the address listed above.

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

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:
LOYALTY ADULT FOSTER CARE LLC Attention: Medical Records **CONTACT:** 774-420-2010 www.loyaltyafc.com **LOCATION:** 324 Grove St, 2nd Floor Worcester, MA 01605	

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 Loyalty 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 **Loyalty Adult Foster Care LLC** (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.