Admission Packet

[Insert Facility Name]
Address
City, State Zip Code
Phone Number

[Insert Facility Logo]

Date

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[Insert Facility Name]
Address
City, State Zip Code

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[Insert Facility Name]
Address
City, State Zip Code

Financial Admission Information

Patient Name: _____

Admission Type: Skilled / Basic

Primary Payer Upon Admission: _____

Person Responsible: _____

Financial Info for Skilled Stays

Days 1 - ___: $_____per day Day___ - 100: $_____per day

D/C Plan: _____

If D/C Plan is to Remain in LTC, Payer for Basic LTC: _____

Financial Info for Basic Stays

Private Pay Daily Room Rate: _____

Does patient have NH Medicaid?: YES / NO

If no, does patient qualify for NH Medicaid? Yes / NO

Monthly Income: _____

Assets: _____

If yes, estimated monthly patient liability: _____

Does patient have a long-term care policy: YES / NO

If yes, policy name: _____

LTC Policy payment method: Reimburse Member / Pay Facility Directly / NA

Business Office Contact Info:

[Insert Name]
[Insert Title]
Phone: ___-____-_____
Email:

Initial _____ Date _____

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[Insert Facility Name]
Address
City, State Zip Code

[Insert Facility Name]

Application for Medicaid Benefits

[Insert Facility Name] Business Office staff can now assist you to apply for Long Term Care Medicaid online. This will improve the application process.

Please call [Insert Name] at (____) ___-____ and make an appointment to bring in the required documents.

Documents Required to Apply Online for Long Term Care Medicaid

1. All pages of the last 4 months of bank statements for all accounts in applicant's name including all pages that are included in the month's statement. If applying for previous months, must provide a bank statement for each month that application will cover.
2. Social Security award letter with breakdown of amounts. If not available, call 1-800-772-1213 and they will mail the form to the last address that Social Security has on file.
3. Pension Information-name, address and telephone number of company. Requires breakdown of all deductions and year to date total. Must be on the company's letterhead or check stub.
4. Investment Account-need to know principal and interest breakdown.
5. Any property/warranty deeds or titles.
6. Copy of power of attorney if applicable.
7. Medicare and Supplemental Health Insurance Cards. Required to have notice of premium amount for insurance policies with company's name on it. Direct debit information on bank statement is not accepted by Medicaid.
8. Contract for prepaid burial arrangements stating paid amount.
9. Life Insurance Policies with name, address, phone number, policy number, cash and face value listed. Must be a recent copy.
10. Social Security Card and Driver's License
11. Tag Receipt for vehicle if applicable.

Business Office staff will assist in online application.

After finishing the online application, copies of the above documents will be faced to the state agency for processing.

Initial_____

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[Insert Facility Name]
Address
City, State Zip Code

Patient Paid Amount Calculation Sheet

Resident Name: _____ Facility: _____

The following is the calculations of the amount that the resident listed above is required to pay each month, starting on the first month of Medicaid eligibility. This is called the "Patient Paid Amount" or PPA. It may also be called "Applied Income."

The Applicant must pay this amount to the facility promptly every month to ensure that the income does not accumulate and possible jeopardize continued coverage and eligibility. This amount must be paid each month during the application process and must be paid every month thereafter once Medicaid is approved in order to continue Medicaid benefits. We ask that you please complete using the most recent income received.

Resident Income:	Social Security:	$978.00	**Short Term Allowance:**	**$1,074.00**
	Pension:	$0.00		
	VA Income:	$0.00		
	Annuity Income:	$0.00		
	Other Income:	$0.00		
	Total Income:	**$978.00**		
Allowances:	Personal Needs:	$72.80		
	Health Insurance:	$0.00		
	Spousal Allowance:	$0.00		
	Total Allowances:	**$72.80**		
Monthly Patient Paid Amount Due Facility		**$905.20**	**Long Term: $0.00**	**Short Term**

Please return within 7 business days to assure proper calculations and payments needed.

You can calculate the PPA by taking all the income and subtracting your Health Insurance premium (if applicable) and $78.80 for personal needs allowance (please note this is all the residents can keep from their income) and the difference is what you will pay the nursing home every month.

Responsible Party: _____ Date: _____

Facility Representative: _____ Date: _____

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[Insert Facility Name]
Address
City, State Zip Code

[Insert Facility Name]

Assignment of Benefits
Authorization to Bill

Resident Name _____ Medicare # _____

Facility: _____

Medicaid # _____ Date of Birth _____

Assignment of Benefits

I hereby transfer, assign and set over to the above-named [Insert Facility Name] any third party payments to which the undersigned may be or become entitled to from all insurance policies, including Medicare and Medicare supplement policies. The undersigned hereby authorizes and directs that said insurance benefit payments be made directly to the [Insert Facility Name], as may be applicable under the billing arrangement. Any insurance benefit payments received by the undersigned for services rendered by the [Insert Facility Name] shall be paid to the [Insert Facility Name].

Authorization to Bill

I hereby authorize the above-named [Insert Facility Name] to submit Medicare, Medicaid and insurance claims on my behalf for services or supplies furnished to me by the [Insert Facility Name].

Executed this _____ day of _____, 20_____.

_____ Date _____
Signature – Resident

_____
Print Name of Resident

Resident is unable to sign due to _____

Signed on the Resident's behalf by –

_____ Date _____
Signature – Resident Representative

_____
Print Name of Representative

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[Insert Facility Name]
Address
City, State Zip Code

[Insert Facility Name]

Resident's Personal Funds/Trust Fund Authorization

Resident name: _____ Acct #: _____

Our facility provides each resident with an opportunity to deposit his/her personal funds into an interest bearing Resident Fund Account.

Should you elect to deposit funds into the Resident Fund Account, it must be authorized in writing by you or your representative, and such authorization must be filed in your financial record.

- No service charge will be levied against you
- You will be provided with a quarterly report of all transactions made to your account
- Funds will be protected to according to the following policy:
    1. The facility shall furnish the Resident with a written receipt for all expenditures and deposits regarding any of the Resident's funds deposited with the Facility.
    2. A record of all transactions regarding the Resident's funds shall be maintained by the Facility in accordance with generally accepted accounting principles.
    3. The Resident shall have reasonable access, upon request, to the above record and shall receive an itemized quarterly statement of his/her account.
    4. The Facility has a surety bond to guarantee the Resident's funds.
    5. All Resident personal funds in excess of $50.00 are kept in a separate interest bearing account. All personal funds that do not exceed $50.00 will be maintained in a non-interest bearing petty cash account.
    6. The facility has no duty to invest the month in the Resident's account to earn income other than interest in a "passbook" or similar account.
    7. If the Resident receives Medicaid benefits, the facility shall notify the Resident when the amount in his/her account reaches Two Hundred Dollars ($200.00) less than the Social Security Income (SSI) resource limit for one person. If the amount in the account, in addition to the value of the Resident's other non-exempt resources, reaches the SSI resource limit for one person, the Resident may lose eligibility for Medicaid or SSI.

Acknowledgement

I acknowledge that I have been advised of my rights to manage my personal financial affairs and that I am not required to deposit personal funds with the facility.

Authorization

_____ I DO NOT authorize the [Insert Facility Name] to hold, safeguard, manage and account for monies.

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_____ I DO authorize the facility to hold, safeguard, manage and account for monies I may deposit with the facility in a Resident Trust Fund (RTF).

Complete The Rest of This Form If Authorization is Given

_____ For Medicaid recipient: I request that my pharmacy bill be deducted from this personal fund for items not on the state approved drug list. Also, personal insurance premiums may be deducted from my funds in my account. These records shall be available for inspected at all times.

All Residents Depositing Personal Funds

_____ I request that petty cash expenses, such as newspapers, personal insurance premiums, may be withdrawn from this account when an invoice or written request is presented to the Business Office. Such requests will be honored with a signed receipt.
I authorize the facility, upon my discharge, by death or otherwise, to apply any of my Personal Funds held by the facility toward any outstanding debt that I may have with the Facility. I understand that any remaining funds, after my debt has been extinguished, will be returned to me or my representative in accordance with federal and state law.
I have been informed that I may change or revoke this authorization by informing the facility in writing in advance of the date that I wish changes to be effective.
The facility is granted permission to collect and deposit all personal funds and to disclose said funds on behalf of the resident for personal needs in accordance with the policy stated above.

This is to certify that approval is hereby granted to [Insert Facility Name] to manage the personal funds of _____, effective _____.

_____	_____	_____
Resident	Signature of Resident	Date
_____	_____	_____
Resident Representative	Signature of Resident Representative	Date

Acceptance

I, the Administrator of [Insert Facility Name], accept authorization of the Resident named above to hold, safeguard, manage and account for this Resident's personal funds.

_____	_____
Administrator/Designee	Date

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[Insert Facility Name]
Address
City, State Zip Code

Medicare Secondary Payer Questionnaire

This form should be completed on admission for every patient receiving services and supplies under Medicare Parts A and B

Date: ____/____/____

Facility Name: _____ Provider Medicare #: _____

Resident Name: _____ HIC #: _____

Resident Date of Birth: _____ Age: _____ Account #: _____

I. **WORK RELATED ACCIDENT.** Is illness/injury due to work related accident: NO ___ GO TO PART II
YES ___ COMPLETE THE FOLLOWING: State date, time and place of accident _____
_____
Covered by Worker's Compensation? Yes ___ No ___ Covered by Federal Black Lung Program? Yes ___ No ___ Give the name and address of the Worker's Compensation or Federal Black Lung Program _____

II. **NON-WORK RELATED ACCIDENT.** Is illness/injury due to a non-work related accident? NO ___ GO TO PART III, YES ___ What type of accident caused illness/injury? Automobile? ___ Give name and address of automobile insurer _____ Insurance claim # _____
Other ____ Give detail of third party payer _____
Was another party responsible for the accident? Yes ___ No ___ Give the name and address of any liability insurer _____ Insurance claim # _____
Is there litigation? Yes ___ No ___ Give name and address of attorney _____

III. **GROUP HEALTH INSURANCE.** IS PATIENT AGE 65 OR OLDER? NO ___ GO TO PART IV
YES ___ Is the patient employed and covered by the Employer's Group Health Plan (EGHP)? No ___ Date of retirement _____ or has not worked in last 5 years ☐ Yes ___ Give name and address of EGHP _____
_____ Patient's ID # _____
Is your spouse employed and covered by the Employer's Group Health Plan (EGHP)? NO ___ Date of retirement _____ or has not worked in the last 5 years ☐, GO TO PART IV, YES ___ Is patient covered under the group health plan of the spouse's employer? NO ___ GO TO PART IV, YES ___ Give the name address of EGHP _____
_____ Spouse's ID # _____

IV. **END STAGE RENAL DISEASE.** Is the patient undergoing kidney dialysis for ESRD and entitled to benefits solely on the basis of ESRD? Yes ___ MEDICARE IS PRIMARY PAYER
NO ___ Is the patient covered by EGHP? YES ___ Give name and address of EGHP _____
_____ Patient's ID # _____
Has the patient been undergoing kidney dialysis for more than 18 months or been entitled to Medicare for more than 12 months? YES ___ MEDICARE IS PRIMARY PAYER, NO ___ MEDICAID IS PRIMARY PAYER.

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V. **DISABLED BENEFICIARY UNDER AGE 65.** Is the patient disabled Medicare Beneficiary under 65? NO ___ MEDICARE IS PRIMARY PAYER
YES ___ Is patient covered by group health insurance plan (GHP) based on the patient's own employment or employment of spouse or parent? YES ___ Give name and address of GHP _____ _____ Patient's ID # _____
NO ___ MEDICARE IS PRIMARY PAYER

VI. **OTHER HEALTH INSURANCE.** Does the patient have other health insurance that will pay for nursing home benefits (not supplementary insurance) before Medicare? NO ___ MEDICARE ID PRIMARY PAYER YES ___ Give name and address of the insurance company _____ _____ Patient's ID # _____

NOTE: WHEN ONE OF THESE CASES EXISTS, MEDICARE IS THE SECONDARY PAYER. THE OTHER INSURANCE BCOMES THE PRIMARY PATER. WHEN A YES IS RECEIVED, THE [Insert Facility Name] MUST BILL THE OTHER PAYMENT SOURCE BEFORE MEDICARE.

_____
Signature – Resident

_____
Signature – Resident's Agent or Representative

_____
Agent's Relationship

_____/_____/_____
Date

NOTE: SIGNATURE IS NOT REQUIRED BY MEDICARE.

VERIFCATION AS NEEDED

Date Verified _____ Primary Insurance Noted ☐ Yes ☐ No Initial of Person Verifying _____

Date Verified _____ Primary Insurance Noted ☐ Yes ☐ No Initial of Person Verifying _____

Date Verified _____ Primary Insurance Noted ☐ Yes ☐ No Initial of Person Verifying _____

If yes, list insurance with contact information. _____
_____
_____

Signature of Person Verifying Primary Insurance _____
_____
_____

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[Insert Facility Name]
Address
City, State Zip Code

[Insert Facility Name]
Address
City, State Zip Code
Phone: _____ Fax: _____

NOTICE OF EXCLUSION FROM MEDICARE BENEFITS (NEMB)
ON ADMISSION

Beneficiary's Name _____ Medicare # _____

- Medicare foes **note** pay for all of your health costs. Medicare only pays for covered benefits. When services are not Medicare covered benefits, Medicare will not pay for them.
- Medicare requires certain eligibility requirements be met for Part A, inpatient coverage in a skilled nursing facility (SNF).

The purpose of this Notice is to inform you that you do not meet Medicare eligibility requirements for coverage under Medicare Part A in a skilled nursing facility (SNF) for the reasons checked below.

- ☐ No qualifying 3-day inpatient hospital stay
- ☐ No days left in this benefit period
- ☐ SNF 30-day transfer requirement not met
- ☐ Daily skilled care meeting Medicare criteria not needed
- ☐ Other _____

- When you receive an item or service is not a Medicare benefit, you are responsible to pay for it personally or through other insurance that you might have. Medicare is considered "other insurance."

PLEASE SIGN BELOW TO SIGNIFY YOUR NOTICE OF AN UNDERSTANDING OF THE SNF ELIGIBILITY REQUIREMENTS LISTED IN THE BOX.

_____
Signature of resident or of the authorized representative

_____ _____
Date Please Print Name

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[Insert Facility Name]
Address
City, State Zip Code

[Insert Facility Name]

ADMISSION AGREEMENT

This Admission Agreement (the "Agreement") is made and entered into this __ day of _July___ 2021, by and between [Insert Facility Name], herein referred to as the FACILITY and_____, herein referred to as the RESIDENT, and certain other undersigned parties.

1. Definitions:

a. A Legal Representative is any person, such as a legal guardian, holding a Power of Attorney. The Facility must receive documentary evidence showing that the Legal Representative does, in fact, have legal authority to act on behalf of the Resident. The Legal Representative may execute this Agreement on the Resident's behalf.

b. Upon the Resident's admission to the Facility, a Power of Attorney shall vest the holder with the authority to make healthcare decisions (as opposed to financial or other non-healthcare decisions) on the Resident's behalf as long as the document is in substantially the form set forth in [Insert State] Code Sections 31-36-10, which relate to durable powers of attorney for healthcare guarantee payment of any Facility charges. The Legal Representative is not required to guarantee payment of any Facility Charges. However, if the Legal Representative has legal access to the Resident's income or resources available to pay for Facility care, he or she agrees to be responsible for utilizing this money to pay for any charges incurred by the above name Resident.

c. A Responsible Party is a family member or other person interested in the Resident's welfare who undertakes certain responsibilities in connection with the Resident's stay in the Facility. If the Resident has a Legal Representative, that person should generally serve as the Responsible Party. The Responsible Party is not required to guarantee payment of any Facility charges. If the Responsible Party has legal access to the Resident's income or resources available to pay for Facility care, he or she agrees to be responsible for utilizing this money to pay for any charges incurred by the above-named Resident.

2. The FACILITY Agrees:

a. To provide basic room and board, general nursing care, social services, dietary services, minor medical supplies, bedding, linen, laundry services, and activities as required by law, or by this Agreement.

b. To assist, provide or obtain as required by law, the services of providers of medical goods and services of the Resident's choice. The providers selected by the Resident shall comply with the Facility's policies and procedures and all federal and state laws and regulations.

c. To arrange, at the Resident's expense, for the transfer of the Resident to the hospital of the Resident's choice, when such a transfer is ordered by the attending

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physician and to attempt to notify the persons designated on the application for Admission of such transfer.

d. At the resident's request, to hold, safeguard, and manage personal funds for the Resident at no additional charge to the Resident, subject to the terms and conditions set forth in the Agreement Concerning Management of Personal Funds contained in this admissions packet.

3. The RESIDENT, Resident Representative and Legal Representative (if applicable) Agree:

a. To select an attending physician who will visit the Resident regularly according to the Facility's policies and procedures and state and federal laws and regulations. As dictated by the Resident and/or Resident Representative shall also designate an alternate physician. If the Resident's attending physician is not available, the Facility will call the designated alternate physician listed on the Freedom of Choice Statement. Reference Addendum A - Freedom of Choice Statement.

b. To select a pharmacy or pharmacist for those pharmaceutical supplies and services not provided by the Facility as part of the basic daily rate. The pharmacy or pharmacist must conform to the medication packaging and delivery systems or procedures utilized by the Facility.

c. To provide the Facility with a copy of any existing written documentation, such as a Living Will and/or a Durable Power of Attorney for HealthCare executed prior to July 1, 2007 or appointment of a HealthCare Agent executed after July 1, 2007, indicating the Resident's choices in connection with the treatment of a terminal illness and/or the withholding or withdrawal of life-sustaining medical treatment. The Facility does not require that the Resident execute or produce such a document as a condition of admission. The Resident and/or the Resident Representative acknowledge receipt of the explanation of the [Insert State] law on Advance Directives and other written information of Advance Directives. Reference Addenda B-1, Advance Directive Definitions, B-2, [Insert State] Advance Directive for HealthCare and B-3, Advance Directive Checklist.

d. To abide by all rules, regulations, policies and procedures as are from time to time established by the Facility. The Resident, Legal Guardian and/or Resident Representative acknowledge receipt of the Rules and Regulations governing the conduct of the Resident and his or her visitors while in the Facility. Amendments to the Rules and Regulations shall be effective upon thirty (30) days notice to the Resident and/or Resident Representative.

e. To give the Facility written notice of intent to vacate at least five (5) days prior, if possible.

f. To initiate and maintain a proceeding in a court of competent jurisdiction to appoint a legal guardian for the Resident within thirty (30) days of a written request from the Facility to do so.

4. The Following Provisions are Applicable to PRIVATE PAY RESIDENTS:

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a. The Resident, Legal Representative and/or Resident Representative (if applicable) acknowledge receipt of the following schedule, which is attached and incorporated into this Agreement. Reference Addendum C, Items and Services Included and Not Included in the Basic Daily Rate for Private Pay Residents.
b. The Resident and/or Resident Representative shall pay all charges accruing under this Agreement, including the basic daily rate, when due.
c. The basic daily semi-private rate is currently $230.00. The first payment shall be in the aggregate amount of the daily charges for each day starting with the day of the Resident's admission to the end of the month. Thereafter, payments shall be due on or before the 10th day each month.
d. The Facility retains the unilateral right to change the basic daily rate and the charges for other items and services provided by the Facility. Such changes shall be effective no sooner than thirty (30) days after the Resident receives written notice of the change.
e. Settlement of all accounts with the Facility shall be made in full by the Resident at the time of discharge. Upon discharge, the Facility shall refund to the Resident, Legal Representative or the Resident Representative, after all charges are paid, the unused portion of the monthly rate pro-rated on a daily basis after deduction of all applicable charges.
f. The Resident and/or Resident Representative shall promptly provide to the facility all necessary forms and documents necessary to apply for eligibility and benefits under the Medicaid program if the Resident appears to meet that program's eligibility requirements. The Facility is authorized, but not obligated to assist in preparing all necessary forms and documents and submit such forms and documents to the appropriate state agencies for a determination of the Resident's eligibility for Medicaid benefits. The Resident and/or the Resident Representative shall certify that the information provided to enable the Facility to assist the Resident to apply for Medicaid benefits is correct. At the discretion of the Facility, the Facility may charge the private pay rate until Medicaid is approved. Any excess funds will be reimbursed to the resident.

5. The Following Provisions are Applicable to MEDICAID AND MEDICAID PENDING RESIDENTS.
a. The Resident and/or the Resident Representative acknowledge receipt of the following schedule, which is attached and incorporated into this agreement: Reference Addendum D, Items and Services Included and Not Included in the Basic Semi-private Daily Rate for [Insert State] Medicaid Residents.
b. The Facility's per diem rate for Medicaid Residents is determined by the [Insert State] Department of Community Health (DCH) in accordance with a reimbursement formula. The [Insert State] Department of Human Resources, Division of Family and Children Services (DFC) will determine what portion of that rate must be paid by the Resident, based on the Resident's monthly income, less any allowable deductions. The Resident's portion, as determined by DFC, shall be

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billed each month in advance by the Facility and shall be due by the 10th day of each month.

c. If the Resident has applied for Medicaid benefits, but has not yet been determined eligible, the Resident and/or the Resident Representative will make a pre-payment/deposit in the amount of one month's daily room rate to the Facility. That amount will be held in escrow by the Facility until the pending application is acted upon. If the Resident's application for Medicaid benefits is denied, the Resident shall be liable to the Facility for all charges accruing from the time of admission at the rate applicable for private pay Residents in the type of accommodation furnished to the Resident, including ancillary charges.

d. In the interim, while the Medicaid application approval is pending, the resident shall pay the estimated DFC amount that must be paid by the Resident to the facility based on the Resident's monthly income, less any allowable deductions. This amount will be held in escrow by the Facility until the pending application is acted upon by DFC. If the individual is declared Medicaid eligible, the total of the payments will be refunded to the resident less any charges due.

e. Settlement of all accounts for items and services provided but not covered or paid for by Medicaid or any other third-party payer shall be made in full at the time of the Resident's discharge.

6. The Following Provisions are Applicable to MEDICARE RESIDENTS.

a. The Resident and/or the Resident Representative acknowledges the receipt of the following schedule, which is attached and incorporated into this Agreement. Reference Addendum E Items and Services Included and Not Included in the Basic Daily Rate for [Insert State] Medicare Residents.

b. Medicare Part A includes a benefit period of one hundred (100) days in a Skilled Nursing Facility (SNF). The first twenty (20) days of skilled care being paid at 100%. The Resident (beneficiary) is liable for payment of coinsurance for the remaining eighty (80) days of skilled care provided under Medicare. Under certain conditions, Medicaid or insurance will pay the coinsurance days of eligible individuals. The Resident is responsible for payment to the Facility for all coinsurance days, unless the Resident is eligible for Medicaid.

c. If the Resident's claim for Medicare payment is denied by the Medicare Administrative Contractor (MAC), the Resident has the right to appeal this decision directly to the MAC. The MAC for the Facility is CahabaGBA. The Facility can act on behalf of the Resident to assist in the appeal. The Resident and/or the Resident Representative will be responsible for payment of all services provided from the date the last Medicare services were provided. If the Resident is eligible for coverage from another source, e.g. Medicaid, Veterans Administration (VA) or insurance for continued SNF services, the Facility will bill the appropriate party.

7. General Agreements:

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a. Consent to Treat. The Resident and/or Resident Representative consent to and authorize the administration of such care, treatment, services and medical or nursing procedures, which, in the judgment of the attending physician, are considered necessary and advisable. I acknowledge that no guarantees have been made as to the effect or results of such treatment.

b. The Resident and/or Resident Representative acknowledge receipt of the following schedules, which are attached and incorporated into this Agreement:
   1. Bed Hold Policy during Hospital Stays and Therapeutic Leaves. Reference Addendum F.
   2. Summary of Resident's Rights. Reference Addendum G.

c. All responsibility of the Facility to the Resident shall terminate in the event the Resident knowingly leaves the Facility against the medical advice of the Resident's attending physician and/or without the approval of the Facility, but with the knowledge of the Facility.

d. The Facility is not responsible for the health, safety or welfare of any Resident who is away from the Facility under the care of any person not directly employed by the Facility.

e. The Facility is required by law to exercise reasonable care toward the Resident; however, the Facility is not the insurer of the health, safety or welfare of the Resident and assumes no liability as such.

f. The Facility is authorized and directed to release information concerning the Resident to insurance companies, third-party payers and/or state and federal agencies and regulatory bodies, in connection with care rendered to the Resident to the extent necessary for the Facility to assist the Resident in obtaining payment and otherwise comply with applicable federal or state laws and regulations.

g. The Facility will provide a location at which the Resident may store a limited amount of money for safekeeping. The Resident will have reasonable access to such money.

h. The Facility will facilitate regular Resident Council Meetings where any changes in the Facility rules and regulations will be addressed and discussed. The time and date for such meetings will be posted.

i. The Resident, Legal Representative and/or Resident Representative shall defend, indemnify and hold the Facility harmless from any and all claims, demands, suits and actions made against the Facility by any person resulting from any damage or injury caused by the Resident to any person or the property of any person or entity, including the Facility.

j. The Facility may terminate this Agreement and transfer or discharge the Resident in accordance with applicable state and federal laws and regulations. The Facility shall give the Resident, Legal Representative and/or Resident Representative advance notice of any reasons for transfer or discharge as required by law. Custody of the Resident shall be assumed by the Legal Representative or Resident Representative upon discharge, if the Facility's Medical Director certifies that this is medically appropriate.

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k. The Resident, Legal Representative and/or the Resident Representative agrees to pay the Facility's costs of collection and reasonable attorney's fees for any legal proceedings arising as a result of the Resident's stay at the Facility. The resident, Legal Representative and/or Resident Representative further agree that the venue and jurisdiction for any legal proceedings arising as a result of the Resident's stay at the Facility shall be State Court in the county in which the Facility is located.

l. Payment of all invoices for goods and services provided by the Facility are due by the 10th of the month.

If any terms or conditions of this Agreement are invalid or unenforceable by reason of any rule of law, Federal or state statute or regulation, this Agreement shall be deemed amended to comply with the relevant law, statute or regulation and shall remain in full force and effect.

The Facility does not discriminate against any person on the basis of race, color, national origin, disability, sex or age in admission, treatment or participation in its programs, service and activities or in its employment. This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and regulations of the U. S. Department of Health and Human Services issued pursuant to these Acts, Title 45 Code of Federal Regulations Part 80, 84 and 91 and other laws pursuant to these acts and regulations.

I have read and understood this entire Agreement and the documents referenced herein as Addenda. I accept all terms and conditions stated in the Agreement and its Addenda.

_____ _____
Signature of RESIDENT Date

_____
Please print name of RESIDENT

_____ _____
Signature of RESIDENT's Representative Date

_____
Please print name of Representative

Relationship to RESIDENT:

____ Legal Representative
____ Representative
____ Guardian
____ Other _____

_____ _____
Signature of FACILITY Representative Date

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[Insert Facility Name]
Address
City, State Zip Code

[INSERT FACILITY NAME]

ADMISSION AGREEMENT

ADDENDUM A
FREEDOM OF CHOICE STATEMENT

NAME OF RESIDENT: _____

It has been explained to me by the staff of the above-named facility and I fully understand that:

A. I may select the physician of my choice, provided that such physician has been given or obtains staff privileges at the Facility. If the physician of my choice is unavailable, the Facility will have the right to seek alternative physician participation to assure the provision of appropriate and adequate care and treatment.

B. I may select the pharmacy or pharmacist of my choice for those pharmaceutical supplies and services not provided by the Facility as part of the basic daily rate provided that the pharmacy or pharmacist must package medication in accordance with the Facility's packaging system.

THE FOLLOWING INDICATES MY CHOICES.

Attending Physician: _____

Alternate Attending Physician: _____

Podiatrist: _____

Dentist: _____

Mortician: _____

Pharmacy: _____

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ADMISSION AGREEMENT ADDENDUM B-1

ADVANCE DIRECTIVES DEFINITIONS

PATIENT SELF-DETERMINATION ACT

The "Patient Self-Determination Act" of 1990 is a federal law that went into effect on December 1, 1991. The legislation was created to ensure the legal right of each competent adult, 18 years and older, to make his/her own medical decisions. The act mandates Medicare and Medicaid certified nursing facilities, as well as other agencies, to give residents information about their right to make decisions concerning medical care including the right to accept or refuse medical or surgical treatment and the right to complete Advance Directives.

In order to make informed decisions, residents are entitled to adequate information about their condition, treatment alternatives, likely risks and benefits of the alternatives and possible consequences.

ADVANCE DIRECTIVES

Advance Directives are written documents that are set up in Advance in case a person is unable to communicate his or her desires about medical treatment. These are documents that state your choices about medical treatment and/or name someone to make choices about medical treatment for you, if you become unable to make decisions. Advance Directives only come into effect when the individual is unable to make medical decisions on his/her own. The intent of the Advance Directives provisions is to enhance an adult individual's control over medical treatment decisions. Whether you choose to execute an Advance Directive is a personal matter and will never be a condition of whether you receive services from a health care provider.

There are two primary purposes of Advance Directives that are recognized in [Insert State]:

1) A document which appoints a health care agent, and
2) A document that directs treatment preferences when a person is in a terminal condition or state of permanent unconsciousness.

The Advance Directive for Health Care form provides a document that allows one or both of these purposes for Advance Directives to be completed on one form.

HEALTH CARE AGENT

A person can appoint a "health care agent" to act for and on their behalf to make decisions related to consent, refusal or withdrawal of any type of health care when the person is unable or chooses not to make health care decisions for him or herself. You should sit down with this agent and discuss your views; thus, giving your health care agent instructions or guidelines, you want them to follow.

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ADMISSION AGREEMENT ADDENDUM B-1

As long as you are competent and able to communicate, you make your own decisions. Your health care agent is involved only when and if it is determined that you are unable to understand or communicate your decisions. You can make changes in, revoke, or cancel the document at any time.

In [Insert State], the current statutory form is the Advance Directive for Health Care. Part One of this form allows a person to appoint a health care agent and back-up agents. Other parts of the Advance Directives for Health Care that substantially comply with this form may be used. If a person has completed a validly executed Durable Power of Attorney for Health Care on or before June 30, 2007, this Advance directive document will remain valid unless you decide to revoke it.

TREATMENT PREFERENCES (formerly Living Will)

Another type of Advance Directive is a document that directs treatment preferences when and only when a person is in a terminal condition or state of permanent unconsciousness. One of the two conditions would have to be established by having two physicians personally examine and certify in writing that the condition exists. Statements about the withholding and withdrawal of life support as well as statements concerning whether the individual would want nourishment or hydration may be declared. The withholding or withdrawal of certain medical procedures does not include the administration of medication to alleviate pain or the performance of any medical procedure deemed necessary to alleviate pain.

In [Insert State], the Treatment Preferences section of the Advance Directive for Health Care form allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. Other forms of Advance Directives for Health Care that substantially comply with this form may be used. If a person has completed a validly executed Living Will on or before June 30, 2007, this Advance Directive document will remain valid unless you decide to revoke it.

These documents can be changed or revoked at any time. If you choose to complete the new Advance Directive for Health Care, it will replace any other Advance directive form that is currently in place.

PHYSICIAN'S ORDERS FOR LIFE SUSTAINING TREATMENT (POLST)

The POLST is a physician order which provides directions regarding end of life care. It is based on a written advance directive(s) and/or conversation the physician has with the person or his/her representative(s). The POLST follows the resident across healthcare settings. It makes a person's wishes for end-of life care known to physicians, nurses, emergency medical personnel and other healthcare staff. It addresses a range of treatment options and enables a person to clearly express treatment preferences regarding life sustaining measures such resuscitation, intensity of care, antibiotics and nutrition and fluids.

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ADMISSION AGREEMENT ADDENDUM B-1

ADVANCE DIRECTIVE PROCEDURES

The facility recognizes the right of competent individuals to control decisions related to his or her medical care in accordance with state laws. This includes the right to consent, the right to refuse or alter treatment plans and to formulate Advance Directives. Adult residents of sound mind and over the age of 18 years of age can execute an Advance Directive for Health Care. These written documents relate to the provision of health care when the resident lacks the capacity to make such decisions. Advance Directives, executed in accordance with applicable state law, will be honored by the facility. Without a written directive, usual facility policy and procedures will be followed. Whether or not a resident chooses to execute an Advance Directive is a personal matter and will never be a condition of providing care or a basis for discrimination for or against the resident.

The Facility is not required to provide care that conflicts with an Advance Directive. In addition, the Facility is not required to implement an Advance Directive if, as a matter of conscience, the Provider cannot implement an Advance Directive.

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[Insert Facility Name]
Address
City, State Zip Code

ADMISSION AGREEMENT

ADDENDUM B-2

[INSERT STATE] ADVANCE DIRECTIVE FOR HEALTHCARE

By: _____ Date of Birth: _____
(Print Name) (Month/Day/Year)

This advance directive for healthcare has four parts:

PART ONE	HEALTHCARE AGENT. This part allows you to choose someone to make healthcare decisions for you when you cannot (or do not want to) make healthcare decisions for yourself. The person you choose is called a healthcare agent. You may also have your healthcare agent make decisions for you after your death with respect to an autopsy, organ donation and final disposition of your body. You should talk to your healthcare agent about this important role.
PART TWO	TREATMENT PREFERENCES. This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.
PART THREE	GUARDIANSHIP. This part allows you to nominate a person to be your guardian should one ever be needed.
PART FOUR	EFFECTIVENESS AND SIGNATURES. This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your healthcare agent, your family and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for healthcare.

Using this form of advance directive for healthcare is completely optional. Other forms of advance directives for healthcare may be used in [Insert State].

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[Insert Facility Name]
Address
City, State Zip Code

ADDENDUM B-2

[INSERT STATE] ADVANCE DIRECTIVE FOR HEALTHCARE

You may revoke this completed form at any time. This completed form will replace any advance directive for healthcare, durable power of attorney for healthcare, healthcare proxy or living will that you have completed before completing this form.

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PART ONE: HEALTHCARE AGENT

[PART ONE will be effective even if PART TWO is not completed. A physician or healthcare provider who is directly involved in your healthcare may not serve as your healthcare agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your healthcare agent. If you are not married, a future marriage will revoke the selection of your healthcare agent unless the person you selected as your healthcare agent is your new spouse]

(1) HealthCare Agent

I select the following person as my healthcare agent to make healthcare decisions for me:

Name: _____

Address: _____

Telephone Numbers: _____
(home, work, mobile)

(2) Back-up HealthCare Agent

[This section is optional.] PART ONE will be effective even if this section is left blank.]

If my healthcare agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my healthcare agent is unavailable or unable or unwilling to act as my healthcare agent, then I select the following, each to act successively in the order named, as my back-up healthcare agent(s):

Name: _____

Address: _____

Telephone Numbers: _____
(home, work, mobile)

Name: _____

Address: _____

Telephone Numbers: _____
(home, work, mobile)

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PART ONE: HEALTHCARE AGENT

(3) General Powers of HealthCare Agent

My healthcare agent will make healthcare decisions for me when I am unable to communicate my healthcare decisions or I choose to have my healthcare agent communicate my healthcare decisions.

My healthcare agent will have the same authority to make any healthcare decision that I could make. My healthcare agent's authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice or other healthcare facility or service:
- Request, consent to , withhold or withdraw any type of healthcare; and
- Contract for any healthcare facility or service for me, and to obligate me to pay for these services (and my healthcare agent will not be financially liable for any services or care contracted for me or on my behalf)

My healthcare agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing healthcare.

My healthcare agent may accompany me in an ambulance or air ambulance if, in the opinion of the ambulance personnel, protocol permits a passenger. My healthcare agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice or other healthcare facility or service if the hospital's protocol permits visitation.

My agent may present a copy of this advance directive for healthcare in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under [Insert State] law:

- My healthcare agent may refuse to act as my healthcare agent:
- A court can take away the powers of my healthcare agent if it finds that my healthcare agent is not acting properly; and
- My healthcare agent does not have the power to make healthcare decisions for me regarding psychosurgery, sterilization or treatment or involuntary hospitalization for mental or emotional illness, mental retardation or addictive disease.

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PART ONE: HEALTHCARE AGENT

(4) Guidance for HealthCare Agent

When making healthcare decisions for me, my healthcare agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then the healthcare agent should make decisions for me that my healthcare agent believes are in my best interest, considering the benefits, burdens and risks of my current circumstances and treatment options.

(5) Powers of HealthCare Agent After Death

(A) Autopsy

My healthcare agent will have the power to authorize an autopsy of my body unless I have limited my healthcare agent's power by initialing below.

_____ (Initials) My healthcare agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) Organ Donation and Donation of Body

My healthcare agent will have the power to make a disposition of any part of my body for medical purposed pursuant to the [Insert State] Anatomical Gift Act, unless I have limited my healthcare agent's power by initialing below.

[Initial each statement that you want to apply.]

_____ (Initials) My healthcare agent will not have the power to make a disposition of my body for use in a medical study program.

_____ (Initials) My healthcare agent will not have the power to donate any of my organs.

(C) Final Disposition of Body

My healthcare agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

_____ (Initials) I want the following person to make decisions about the final disposition of my body:

Name: _____

Address: _____

Telephone Numbers: _____
(home, work, mobile)

I wish for my body to be: _____ (Initials) Buried or _____ (Initials) Cremated

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PART TWO: TREATMENT PREFERENCES

[PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a healthcare agent in PART ONE, or if your healthcare agent is not available, then PART TWO will provide your physician and other healthcare providers with your treatment preferences. If you have selected a healthcare agent in PART ONE, then your healthcare agent will have the authority to make all healthcare decisions for you regarding matters covered by PART TWO. Your healthcare agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.]

(6) Conditions

PART TWO will be effective if I am in any of the following conditions:

[Initial each condition in which you want PART TWO to be effective.]

_____ (Initials) A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

_____ (Initials) A state of permanent unconsciousness, which means I am in any incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

(7) Treatment Preferences

[State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.]

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) _____ (Initials) Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means. OR

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PART TWO: TREATMENT PREFERENCES

(B) _____ (Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication. **OR**

(C) _____ (Initials) I do not want any medication, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

[Initial each statement that you want to apply to option C.]
_____ (Initials) If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.
_____ (Initials) If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.
_____ (Initials) If I need assistance to breathe, I want to have a ventilator used.
_____ (Initials) If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

(8) Additional Statements

[This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your healthcare agent (if you have selected a healthcare agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preference regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your healthcare agent (if you have selected a healthcare agent In PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.]

_____

_____

_____

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PART TWO: TREATMENT PREFERENCES

(9) In Case of Pregnancy

[PART TWO will be effective even if this section is left blank.]

I understand that under [Insert State] law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____ (Initials) I want PART TWO to be carried out if my fetus is not viable.

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PART THREE: GUARDIANSHIP

(10) Guardianship

[PART THREE is optional.] This advance directive for healthcare will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a healthcare agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your healthcare agent and guardian are not the same person, your healthcare agent will have priority over your guardian in making your healthcare decisions, unless a court determines otherwise.]

[State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.]

(A) _____ (Initials) I nominate the person serving as my healthcare agent under PART ONE to serve as my guardian. OR

(B) _____ (Initials) I nominate the following person to serve as my guardian:

Name: _____

Address: _____

Telephone Numbers: _____
(home, work, mobile)

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PART FOUR: EFFECTIVENESS AND SIGNATURES

This advance directive for healthcare will become effective only if I am unable or choose not to make or communicate my own healthcare decisions.

This form revokes any advance directive for healthcare, durable power of attorney for healthcare, healthcare proxy or living will that I have completed before this date.

Unless I have initialed below and have provided alterative future dates or events, this advance directive for healthcare will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE.]

_____ (Initials) This advance directive for healthcare will become effective on or upon _____ and will terminate on or upon _____.

[You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form. A witness:

- Cannot be a person who was selected to be your healthcare agent or back-up healthcare agent in PART ONE;
- Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or
- Cannot be a person who is directly involved in your healthcare.

Only one of the witnesses may be an employee, agent, or medical staff of the hospital, skilled nursing facility, hospice, or other healthcare facility in which you are receiving healthcare (but this witness cannot be directly involved in your healthcare).

By signing below, I state that I am emotionally and mentally capable of making this advance directive for healthcare and that I understand its purpose and effect.

_____ _____
(Signature of Declarant) (Date)

The Declarant signed this form in my presence or acknowledged signing this form to me. Based on my personal observation, the Declarant appeared to be emotionally and mentally capable of making this advance directive for healthcare and signed this form willingly and voluntarily.

_____ _____
(Signature of First Witness) (Date)

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PART FOUR: EFFECTIVENESS AND SIGNATURES

Print Name: _____

Address: _____

_____ _____
(Signature of Second Witness) (Date)

Print Name: _____

Address: _____

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[Insert Facility Name]
Address
City, State Zip Code

[FACLITY NAME]

ADDENDUM B-3
ADVANCE DIRECTIONS CHECKLIST

RESIDENT'S NAME _____

I have been given written materials on my rights to accept or refuse medical and surgical treatments, refuse to participate in experimental research and to formulate Advance Directives.

I understand that I am not required to have an Advance Directive in order to receive medical treatment at this facility.

I understand that the terms of any Advance Directive that I have executed will be followed by the staff and physicians of this facility to the extent permitted by law.

I understand that I may file a complaint with the State Survey and Certification Agency regarding non-compliance with Advance Directive requirements.

PLEASE CHECK ALL OF THE FOLLOWING STATEMENTS THAT APPLY.

____ I have executed an Advance Directive and will provide a copy to the facility. I understand that the staff and physicians of this facility will not be able to follow the terms of my Advance Directive until I provide a copy of it to the staff.

____ I have not executed an Advance Directive and do not wish to discuss Advance Directives further at this time.

____ I have not executed an Advance Directive but would like to obtain additional information about Advance Directives. Information was provided _____. (Facility Representative initial)

____ I have an existing Durable Power of Attorney (DPA) and Living Will (LW) executed prior to July 1, 2007 and will provide copies to the facility. I understand that the staff and physicians of this facility will not be able to follow the terms of my DPA and LW until I provide a copy of it to the staff.

____ Declarant (resident) is unable to comprehend what Advance Directives are, but this was explained to the family as part of the Facility's community education effort. _____ (Facility Representative initial)

ACKNOWLEDGEMENT

By signing here, I acknowledge that the statements listed above were explained to me and that I was given written materials on this subject. In addition, I have indicated whether or not I have an Advance Directive. If the Resident is unable to comprehend the information, the Resident Representative will sign to indicate receipt of the information.

Signature _____ [ ] Resident [ ] Resident Representative

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[Insert Facility Name]
Address
City, State Zip Code

[FACLITY NAME]

ADMISSION AGREEMENT

ADDENDUM C
SERVICES AND SUPPLIES PROVIDED - PRIVATE

Private Pay Room Rates

- Private (1-bed) ---------- $_____
- Semi-Private (2-bed) ---------- $_____

Services and Supplies Included in the Daily Rate

- Room and Board
- Meals and Special Diets
- Nursing Services
- Daily Housekeeping and Laundry Services
- Floor Stock Drugs
- Personal Hygiene Items
- Wheelchairs, Walkers and Other Durable Medical Equipment
- Therapeutic Recreation
- Oxygen and Equipment Rental
- Cable

Services and Supplies Not Included in the Daily Rate

- Physician Visits
- Dental Visits
- Lab Tests and X-Rays
- Rehabilitation Services, Physical Therapy, Occupational Therapy, Speech-Language Pathology and Respiratory Therapy, as ordered by your personal physician. These services are billed to you or, if appropriate criteria are met, to Medicare Part B or your insurance company.
- Prescription Medications and Pharmacy Items.
- Private Duty Nurses
- Beautician and Barber Services. Provided by [Insert Facility Name]
- Personal Telephone* or Television
- Chargeable medical supplies
- Transportation

*Private telephones may be installed in the resident's room at a cost to the resident.

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[Insert Facility Name]
Address
City, State Zip Code

[FACLITY NAME]

ADMISSION AGREEMENT

ADDENDUM D
SERVICES AND SUPPLIES PROVIDED – MEDICAID

Services and Supplies Covered by Medicaid*

- Room and Board – Semi private room
- Meals and Special Diets
- Nursing Services
- Wheelchairs, Walkers and Other Durable Medical Equipment
- Rehabilitation Services: Physical Therapy, Occupational Therapy, Speech-Language Pathology and Respiratory Therapy
- Oxygen and Equipment Rental
- Floor Stock Drugs
- Personal Hygiene Items
- Medical Supplies and Oxygen
- Lab Tests and X-Rays
- Diagnostic Testing
- Therapeutic Recreation (Activities)
- Transportation

Services and Supplies Covered by Medicare Part B That May Be Covered for Medicaid Beneficiaries Eligible for Medicare

- Lab Tests and X-Rays
- Some Diagnostic Testing
- Rehabilitation Services: Physical Therapy, Occupational Therapy and Speech-Language Pathology
- Some Durable Medical Equipment

Services and Supplies Not Covered by Medicaid

- Physician Visits
- Dental Visits
- Disposable briefs
- Private Duty Nurses
- Private Room
- Beautician and Barber Services. Provided by [Insert Facility Name]
- In-Room Telephones. Private telephones may be installed in the resident's room at a cost to the resident.
- Television (Cable). Provided by [Insert Facility Name].

***Services are covered as long as the resident meets the guidelines established by Medicaid to participate in the program.**

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Address
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ADDENDUM D
SERVICES AND SUPPLIES PROVIDED – MEDICAID

*The resident must remain in the Facility for thirty (30) days to be eligible for Medicaid. The application process is usually initiated at time of admission.

Medications

For dual eligible beneficiaries (eligible for Medicare and Medicaid), the prescription drugs are paid by Medicare Part D, if resident is enrolled.

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[Insert Facility Name]
Address
City, State Zip Code

[FACLITY NAME]

ADMISSION AGREEMENT

ADDENDUM E
SERVICES AND SUPPLIES PROVIDED - MEDICARE

MEDICARE PART A CERTIFIED BED

Private Room (only if medically necessary for isolation) ---------- $_____

Semi Private Room ---------- $_____ The charges for the semi-private room include the following services.

- Room and Board
- Routine Nursing Care
- Routine Supplies and Equipment

Medicare, in addition to the room related charges, covers the following ancillary services, when medically necessary and approved.

Pharmacy	Oxygen
Radiology	Physical Therapy
Laboratory	Speech/Language Pathology
Medical Supplies (Chargeable)	Occupational Therapy
X-ray	Respiratory Therapy

Medicare does not pay for personal items and services, which include the following. You can be charged for these items and services.

Personal Laundry	Telephone	Television
Private Room	Transportation	Cable Hookup (Provided by facility)
Private Duty Nurse	Equipment Rental	Beauty Shop (Provided by facility

If you, the Medicare beneficiary, meet the qualifying conditions, Medicare will pay 100% of the daily room rate plus all covered ancillary charges for the first twenty (20) days. You (the beneficiary) are required to pay a portion of the charge for the 21st through the 100th day of coverage for each benefit period. That portion is called coinsurance. The coinsurance amount is established by the Federal government. Medicare pays the remaining portion of the charges up to a set per diem rate which is based on an assessment of your needs. Some supplemental insurance will cover the co-insurance amount. Dual eligible beneficiaries (residents) who are covered for Medicare and Medicaid are not required to pay the coinsurance for Medicare.

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[Insert Facility Name]
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ADDENDUM E
SERVICES AND SUPPLIES PROVIDED - MEDICARE

MEDICARE PART B

When you, the Medicare beneficiary, no longer meet Medicare Part A inpatient qualifying conditions, including coverage criteria, or do not meet Medicare criteria at the time of admission, Medicare Part B may pay 80% of the following ancillary services. You (the beneficiary) will be billed a 20% coinsurance based on the allowable rates for Medicare. There is an annual deductible determined by Medicare Regulations. Medicaid beneficiaries are not required to pay the deductible and coinsurance.

Occupational Therapy	Specific Prosthetic Devices	Laboratory
Speech/Language Pathology Therapy	Surgical Dressing	Parental & Nutritional
Physical Therapy	Radiology	

A list of all charges is available from the facility, upon request

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[Insert Facility Name]
Address
City, State Zip Code

[INSERT FACLITY NAME]

ADMISSION AGREEMENT – ADDENDUM F
BED HOLD POLICY

A. MEDICAID RESIDENTS

1. Hospital Stays
   The Medicaid program will provide payment to hold the Resident's bed for a period of seven (7) days while the Resident is in the hospital
2. Therapeutic Leave
   The Medicaid program will provide payment to hold the Resident's bed while the Resident is away from the facility with a relative or friend, if the Resident's attending physician documents in the medical record that such visits are therapeutic in nature. The Medicaid program allows eight (8) days therapeutic leave per year.
3. Hospital Stays or Therapeutic Leaves Beyond Medicaid Payment Limit
   Arrangements may be made for holding a Resident's bed for days exceeding the established limit of seven or eight days. This arrangement must be made prior to leaving the facility. The Resident will be responsible for payment at the current daily Medicaid rate and there must be a physician's order to be out of the facility. This rate is subject to change quarterly. Alternately, if the Resident's hospitalization or therapeutic leave exceeds the limit of seven or eight days and no bed-hold fee is paid, the Resident will be re-admitted upon the first availability of a bed in a semi-private room if the Resident requires the services provided by the Facility and the Resident is eligible for Medicaid nursing facility benefits.

B. MEDICAID PENDING

There is no bed hold payment until Medicaid is approved. The rules for bed hold for Private pay Residents will apply.

C. MEDICARE RESIDENTS

1. Hospital Stays
   The Medicare program does not provide payments to hold the Resident's bed while the Resident is in the hospital.
2. Medicare/Medicaid Eligible
   If the Resident qualifies for Medicaid, the Medicaid program will provide payment to hold the Resident's bed for seven (7) days while the resident is in the hospital.
3. Medicare/Private
   If the Resident is private pay, the rules for bed hold as described below for a Private Pay Resident will apply. The request to hold the bed must be in writing.

D. PRIVATE PAY RESIDENTS

A vacant bed will be held for the Resident while the Resident is in the hospital or on a therapeutic leave if the Resident, Responsible Party or Legal Representative notifies the Facility in writing of the desire to hold the bed and pays the posted private or semi-private daily rate in effect at the time of the Resident's absence from the Facility. If the Resident chooses not to reserve the bed through payment, the bed will not be held and he/she will be re-admitted to the Facility upon the first availability of a bed in a semi-private room, if the Resident requires the services provided by the Facility.

E. HOSPICE RESIDENTS

There is usually no bed hold payment for residents covered under the Hospice program. In specific situations, the Hospice may approve bed hold payment. The rules for bed hold for Private pay resident will apply.

ACKNOWLEDGEMENT

By signing this Admission Agreement, I understand the Facility's policy for holding a bed for hospital stays and therapeutic leave and acknowledge that I have received the above written information.

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[INSERT FACILITY NAME]

ADMISSION AGREEMENT

ADDENDUM G
RESIDENT RIGHTS (FEDERAL VERSION IN ENGLISH)

The facility shall protect and promote the rights of each Resident, including each of the following rights:

1. The Resident has a right to a dignified existence, self-determination, communication with and access to persons and services inside and outside the facility.

2. The Resident has a right to exercise his or her rights as a Resident of the Facility and as a citizen or resident of the United States, including the right to vote.

3. The Resident has a right to be free of interference, coercion, discrimination or reprisal from the facility in exercising his or her rights.

4. The Resident has the right to be fully informed in a language he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

5. The Resident has the right to refuse treatment and to refuse to participate in experimental research.

6. The Resident has the right to exercise his or her legal rights, including filing a grievance with the State survey and certification agency concerning Resident abuse, neglect and misappropriation of Resident property in the Facility.

7. The Resident has the right to manage his or her financial affairs.

8. The Resident has a right to choose a credentialed attending physician.

9. The Resident has a right to be fully informed in advance about care and treatment and any changes in that care or treatment that may affect the Resident's well-being.

10. The Resident has a right to participate in planning his or her care and treatment or changes in care and treatment unless adjudged incompetent or otherwise found to be incompetent or otherwise found to be incapacitated under the laws of the State.

11. The Resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

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ADDENDUM G
RESIDENT RIGHTS (FEDERAL VERSION IN ENGLISH)

12. The Resident or Legal Representative has the right, upon oral or written request to access all records pertaining to him or herself, including clinical records, within twenty-four hours. After access to his or her records, the Resident or Legal Representative has the right to purchase (at a cost not to exceed the community standard) photocopies of the records or any portions of them upon request and with two days' advance notice to the Facility.

13. The Resident may approve or refuse the release of personal and clinical records to any individual outside the Facility except when:
    a. The Resident is transferred to another health care institution.
    b. Record release is required by law or third party payment contract.

14. The Resident has a right to voice grievances with respect to treatment or care that fails to be furnished, without discrimination or reprisal for voicing grievance

15. The Resident has a right to receive information from agencies acting as client advocates and be afforded the opportunity to contact agencies.

16. The Resident has a right to examine the results of the most recent survey of the Facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the Facility.

17. The Resident has a right to refuse to perform services for the Facility.

18. The Resident has a right to agree to perform voluntary or paid services for this Facility if he or she desires, if there is no medical reason, which would contradict the performing of the services, and if compensation for paid services is at or above prevailing rates.

19. The Resident has the right to privacy in written communications, including the right to send and receive unopened mail promptly. The Resident has a right of access to stationary, postage and writing implements at the Residents own expense.

20. The Resident has the right to immediate access to any of the following:
    a. Any representative of the Secretary of the U.S. Department of Health and Services.
    b. Any representative of the State.
    c. Your individual physician.
    d. The State's long-term care ombudsman.
    e. The agency responsible for the protection of and advocacy for the mentally ill or developmentally disabled individuals.
    f. Immediate family or other relatives of the Resident or others who are visiting subject to the Resident's right to deny or withdraw consent at any time.
    g. Others, subject to your right to deny or withdraw consent at any time.

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ADDENDUM G
RESIDENT RIGHTS (FEDERAL VERSION IN ENGLISH)

21. The Facility must provide reasonable access to any Resident by an entity or individual that provides health, social, legal or other services to the Resident, subject to the Resident's right to deny or withdraw consent at any time.

22. The Resident has a right to have reasonable access to the private use of a telephone.

23. The Resident has a right to retain and use personal possessions, including some furnishings and appropriate clothing, as space permits, unless to do so would infringe on the rights or health and safety of other Residents.

24. You have the right to private visits with your spouse and others with whom you wish to visit.

25. The Resident has a right to share a room with his or her spouse when married if Residents live in the same Facility and both spouses consent to the arrangement.

26. Each Resident has a right to self-administer drugs unless the Facility interdisciplinary team has determined that for the particular Resident this practice is unsafe.

27. Except in medical emergency or if you have been adjudged incompetent, you have the right to be consulted with or notified immediately whenever:
    a. You are involved in an accident which results in injury;
    b. A significant change occurs in your physical, mental or psychosocial status;
    c. There is a need to alter treatment significantly;
    d. A change in your room or roommate assignment occurs; and
    e. To have your attending physician notified, as well as your legal representative or resident representative.

28. You have the right, if you request, to be informed of the identity, purpose and possible reactions to each drug to be administered.

29. The Resident has a right to be free from any physical restraints imposed or psychoactive drugs administered for the purpose of discipline or convenience and not required to treat the Resident's medical symptoms.

30. The Resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion.

31. The Resident has a right to choose activities, schedules and health care consistent with his or her interests, assessments and plans of care.

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ADDENDUM G
RESIDENT RIGHTS (FEDERAL VERSION IN ENGLISH)

32. The Resident has a right to receive advance notice of transfers or discharges of the Resident as required by law. You have the right to have the reason for transfer or discharge to be documented in your medical record. The Resident has a right to receive notice before the Resident's room or roommate is changed. The Resident has the right to refuse a room transfer if the purpose of the transfer is to move Resident between a Medicare certified bed and a non-Medicare certified bed for purposes of Medicare eligibility.

33. You have the right to leave the facility after you give the Administrator or person in charge of the facility notice of your desire to be discharged and the date of the expected departure.

34. The Resident has a right to organize and participate in Resident groups in the Facility.

35. The Resident has a right to participate in social, religious and community activities that do not interfere with the right of other Residents.

36. The Resident has a right to reasonable accommodation of individual needs and preferences except where the health or safety of the Resident or other Residents would be endangered.

37. The Resident has a right to freedom of choice of providers in accordance with applicable law and subject to the provider's compliance with all applicable laws and reasonable rules and regulations of the Facility.

The Facility may not require a third party guarantor of payment, e.g. Responsible Party, to sign the admission agreement as a condition of admission or continued stay. However, the Facility may require any individual who has legal access to Resident's income or resources available, the Agent, to pay for Resident's care, to sign the admission agreement without incurring personal financial liability and to agree to provide payment to Facility from Resident's income or resources.

The Facility will inform Resident verbally and in writing at the time of admission of the Resident's rights during his or her stay in the Facility in a language that resident understands and will notify Resident of any changes made to these rights.

BY SIGNING THIS ADMISSION AGREEMENT, THE RESIDENT AND/OR RESPONSIBLE PARTY/LEGAL REPRESENTATION INDICATE THAT HE/SHE HAS:

- Read this list of rights
- Resolved any questions about the content, conditions or terminology.
- Received a copy of these rights.

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[Insert Facility Name]
Address
City, State Zip Code

[INSERT FACLITY NAME]

ADMISSION AGREEMENT

ADDENDUM H

AUTHORIZATION FOR USE, DISCLOSURE OR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Resident Name: _____ Date _____

I hereby authorize the use and disclosure of my admission and medical information (Protected Health Information) as required by Federal, state or other applicable law. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization.

I agree to allow FACILITY access to my PHI as may be required for services to be provided by [Insert Facility Name].

I authorized the release of the information to any party or insurer permitted by law to request and receive such information for purposes of completing benefit claims on my behalf.

I understand that the individual, organization or entity receiving my PHI may receive financial or in-kind compensation in exchange for using or disclosing the PHI.

Unless otherwise revoked by me, I understand that this authorization will expire upon the completion of the use of the information for the purpose it was intended.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits; except when it concerns research related treatment and health care that is solely for the purpose of creating PHI for disclosure to a qualified third party.

I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.

I hereby release the FACILITY, its employees, officers and health care professionals from any legal responsibility or liability for disclosure my PHI to the extent indicated and authorized herein and in compliance with all applicable Federal and state laws, rules and regulations regarding the confidentiality of my PHI.

I understand that I may revoke this request at any time by providing the facility with my written notice of such revocation.

_____ Date _____
Signature – Resident

_____ Date _____
Signature – Resident Representative

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[INSERT FACLITY NAME]

ADDENDUM I
RESTRAINT INFORMATION

[Insert Facility Name] strives to help each resident reach his/her highest practical well being in an environment that minimizes the use of restraints. We utilize techniques that are based on each resident's medical and clinical needs. Our policies and procedures are in compliance with Federal and State laws, codes and guidelines regarding restraint usage.

Federal law defines "Physical Restraints" as "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement…" "Physical Restraints" include, but are not limited to leg/arm restraints, hand mitts, soft ties or vest, lap cushions, wheelchair safety bars, lap trays the resident cannot remove, geri-chairs or facility practices that meet the definition of a restraint, such as side rails, wheelchair safety bars, placing a resident in a chair that prevents rising.

Federal guidelines provide the following direction when a surrogate makes a decision on behalf of a resident concerning restraint use:

In the case of a resident who is incapable of making a decision, the surrogate may exercise the right based on the same information that would have been provided to the resident. However, the surrogate cannot give the facility permission to use restraints for the sake of convenience or when the restraint is not necessary to treat the resident's medical symptoms. In other words, the facility may not use restraints in violation of the regulation solely because a surrogate or representative has approved or requested them.

ACKNOWLEDGEMENT

By signing this Admission Agreement, I understand the Facility's information on restraints and acknowledge that I have received the above written information. Initials:_____

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[Insert Facility Name]
Address
City, State Zip Code

[INSERT FACILITY NAME]

ACKNOWLEDGEMENT OF RECEIPT OF HOME AND COMMUNITY BASED SERVICES INFORMATION

It is the policy of the State of [State Here] that services are delivered in the least restrictive manner that addresses the needs of the individual while enhancing the promotion of social and community integration. Based on this policy, all potential residents, hereafter referred to as "applicant/consumer," and/or his/her authorized representative will be afforded an opportunity to make an informed choice concerning services.

Once the applicant/consumer is determined to likely require the level of care of care provided in a Nursing Facility, the applicant/consumer or his/her authorized representative will be provided information of alternative services available under home and community based service options as described in the DCH Home and Community Services booklet..

Verification

I have verified that the applicant/consumer or his/her authorized representative has been given information about home and community-based services in the manner outlined above.

_____ _____
Signature of Informant Date

Acknowledgement

I have been informed of home and community-based service options as an alternative to nursing home placement. I have received the information contained in the DCH Home and Community-Based Service manual, which advises me of these options and provides information about how to apply for services.

_____ _____
Signature of Resident or Representative Date

RESIDENT NAME _____

(DMA-385; 04/03)

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[Insert Facility Name]
Address
City, State Zip Code

[Insert Facility Name]

Authorizations and Consents

Residents Name:_____

Personal Laundry:

____ Facility will do personal laundry.

____ Responsible party will do personal laundry.

Care Plans:

____ I do ___ do not want to be invited to Care Plan Conference.

____ I do ___ do not want my representative invited to Care Plan Conference

Voting Registration:

____ I am a Registered Voter and wish to exercise my right to vote.

____ I am a Registered Voter but do not wish to exercise my right to vote.

____ I do wish to participate in Voter Registration.

____ I do not wish to participate in Voter Registration.

Ombudsman Brochure:

____ I have received a copy of the Long Term Care Ombudsman Brochure.

Beauty Shop Authorization:

____ I would like to receive Beauty Shop services from the [Insert Facility Name] volunteers.

____ I would not like the Beauty Shop services to be provided.

Photographs and Audio Visual Recordings:

____ I consent to photographs and/or audiovisual recordings by the FACILITY.

____ I consent to use such photos/audio visuals for marketing, for example in the newspaper, on facility bulletin board, clinical charts for identification.

____ I do not consent to photographs or audiovisual recordings by the FACILITY.

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[Insert Facility Name]
Address
City, State Zip Code

Authorizations and Consents

Residents Name _____

Mail

____ I request that the Administrator designee assist in the opening and/or reading of my personal mail, including the opening of financially related mail addressed to me such as checks, medical bills or statements and Medicare and Medicaid correspondence. I understand that I may change this decision at any time.

____ I do not consent to the opening of my mail. All mail should be given to me or my representative.

Activity Outings

Occasionally the FACILITY will take residents who are physically able on activity outings. I would like to participate in activity outings if physically able. In addition, I release the FACILITY of all responsibility during these activity outings. If I have any questions regarding scheduled outings and events, I understand that I may contact the Activity Director or check the monthly activity calendar.

____ I would like to participate in activity outings.

____ I will not participate in activity outings.

Patient Visitation

- Due to limited space, visits are limited to two (2) persons in the room. There is a designated visiting room in the lobby for a number greater than two (2).

[INSERT FACILITY NAME] IS A SMOKE FREE FACILITY.
We do not allow cigarettes, pipes, electronic cigarettes, cigars etc.
Forms of chewing, snuff, tobacco products or smoke products.

_____ _____ _____
Resident Signature Date

_____ _____
Responsible Party Signature Date

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[Insert Facility Name]
Address
City, State Zip Code

[INSERT FACILITY NAME]

PRIVACY ACT NOTIFICATION STATEMENT

The Centers for Medicare and Medicaid Services (CMS) is authorized to collect these (this) data by (pursuant to) Sections 1819(I), 1919(f), 1819(b)(3)(A), and 1894 of the Social Security Act. The purpose of this data collection is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to study the effectiveness and quality care given in those facilities. This system will also support regulatory, reimbursement, policy and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long Term Care Minimum Data Set (LTCMDS) system of records, System No. 09-70-1516. Information from this system may be disclosed under specific circumstances, to; (1) a congressional office from the record of an individual in response to an inquiry form the congressional office made at the request of that individual; (2) the Bureau of Census; (3) the Department of Justice; (4) an individual or organization for a research evaluation or epidemiological project related to the prevention of disease of (or) disability, or the restoration of health; (5) contractors working for CMS to carry out Medicare/Medicaid functions, collating or analyzing data, or to detect fraud or abuse; (6) an agency of a state government for purposes of determining, evaluating and or/assessing overall or aggregate cost effectiveness, and/or quality of health care services provided in the State, (7) another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds, or to detect fraud or abuse; (8) peer review organizations to perform Title X1 or Title XV111 functions; (9) another entity that makes payments for or oversees administration of health care services for preventing fraud or abuse under specific conditions.

You should be aware that P.O. 100-503 the Computer Matching and Privacy Protection Act of 1988 permits the government to verify information by way of computer matches.

Collection of the social security number is voluntary; however, failure to provide this information may result in the loss of Medicare benefits provided by the nursing home. The social security number will be used to verify the association of information to the appropriate individual.

I have read the above and give my permission to submit the Resident Assessment Instrument and other required documents to the Centers for Medicare and Medicaid Services.

_____ _____
Residents Signature Date

_____ _____
Responsible Party's Signature Date

_____ _____
Legal Representative Signature Date

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[Insert Facility Name]
Address
City, State Zip Code

[INSERT FACILITY NAME]

NOTICE OF PRIVACY PRACTICES (HIPPA)

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS DOCUMENT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Facility is required by applicable federal and state law to maintain the privacy of your Health Information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your Health Information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (April 14, 2003), and will remain in effect until it is replaced.

CLANDESTINE AND HIDDEN CAMERAS

Our facility wants to protect the privacy of residents and their roommates to enjoy a homelike setting free from intrusion and unauthorized monitoring. Most of our rooms are semi-private, meaning that you will share a room with a roommate, whose healthcare will be provided and discussed daily in the room.

Therefore, to protect those privacy rights, the use of clandestine or hidden cameras and listening devices is not permitted in our facility.

You agree and understand that the use of clandestine and hidden cameras are not permitted on [Insert Facility Name] premises. Initials:_____

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for Health Information that we maintain, including Health Information we created or received before we made the changes. Before we make a significant change in our policy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact the Facility using the information listed at the end of this Notice.

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[Insert Facility Name]
Address
City, State Zip Code

NOTICE OF PRIVACY PRACTICES (HIPPA)

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose Health Information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your Health Information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your Health Information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your Health Information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professional, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your Health Information for treatment, payment or healthcare operations, you may give us written authorization to use your Health Information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your Health Information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your Health Information to you, as described in the Patient Rights section of this Notice. We may disclose your Health Information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose Health Information to notify or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your Health Information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose Health Information based on a determination using our professional judgment disclosing only Health Information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of Health Information.

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NOTICE OF PRIVACY PRACTICES (HIPPA)

Marketing Health-Related Services: We will not use your Health Information for marketing communications without your written authorization.

Required by Law: We may use or disclose your Health Information when we are required to do so by law.

Abuse or Neglect: We may disclose your Health Information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your Health Information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the Health Information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials Health Information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected Health Information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your Health Information to provide you with appointment reminders, such as voicemail messages, postcards or letters.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your Health Information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your Health Information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, there will be a charge for each page and postage, if you want copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your Health Information in that format. If you prefer, we will prepare a summary or an explanation of your Health Information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your Health Information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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[Insert Facility Name]
Address
City, State Zip Code

NOTICE OF PRIVACY PRACTICES (HIPPA)

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your Health Information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your Health Information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory explanation as to how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your Health Information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice by e-mail, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your Health Information or in response to a request you made to amend or restrict the use or disclosure of your Health Information or have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your Health Information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Facility Name: _____

Contact Officer: _____

Telephone: _____

Fax: _____

Address: _____

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[Insert Facility Name]
Address
City, State Zip Code

[INSERT FACILITY NAME]

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CHANGES OR REVISIONS TO OUR PRIVACY PRACTICES

We reserve the right to change our facility Notice of Privacy Practices at any time and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise or change our Privacy Practices, we will post a copy of the new or revised notice in our main lobby. You may also obtain a copy from the business office.

PRIVACY NOTICES, INFORMATION RESTRICTIONS, RECORD AMENDMENTS/CORRECTIONS, DISCLOSURES OF INFORMATION, REVOKING AN AUTHORIZATION, INSPECTION AND COPYING OF RECORDS, CONFIDENTIAL COMMUNICATIONS, FILING COMPLAINTS

Should you have any questions concerning our facility's Privacy Practices, obtaining copies of our privacy notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your health information, obtaining a listing of the information we have disclosed concerning your health information, requests to inspect or copy your medical information, requests what we communicate information about your health matters in a certain way, denial of access to your health information, filing complaints or any other concerns you may have relative to our facility's privacy practices, please contact the following person.

[Insert Facility Name]

Telephone Number _____ – Fax Number _____

ACKNOWLEDGEMENT

I certify that I received a copy of this facility's Notice of Privacy Practices and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the facility is committed to protecting my health information.

_____ Date _____
Signature

_____ Date _____
Resident Representative

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[INSERT FACILITY NAME]

DO NOT RESUSCITATE (DNR) DESCRIPTIONS

PERTINENT INFORMATION

State law provides very specific procedures related to cardiopulmonary resuscitation (CPR). This law allows you to indicate if you do not want CPR in the event your heart stops beating or you stop breathing (cardiac or respiratory arrest). This is referred to as a "Do Not Resuscitate" Order (DNR).

DO NOT RESUSCITATE ORDERS

Cardiopulmonary resuscitation (CPR) involves performing chest compressions and mouth-to-mouth breathing when a person goes into cardiac or respiratory arrest in order to attempt to bring him/her back to life. Once CPR is started, it must be continued until the person gets to the hospital. For many, this may not be a desired treatment of choice.

Our facility recognizes a "Do Not Resuscitate" (DNR) order. All that a DNR order means is that the person does not want CPR if they go into cardiac or respiratory arrest. All other care and treatment continues the same.

Residents who can understand what CPR is and its ramifications can make their own decision about whether they would want CPR if their heart stops beating. If the resident cannot understand, an authorized person can consent to the DNR order if the physician has determined the resident to be a candidate for no resuscitation. The decision about whether to have a DNR order should be made based on what the resident would have wanted had they been able to speak for themselves.

The policy of this facility is to perform CPR unless we have a DNR order. We follow the procedure to comply with the state law. If you would want more to proceed with having a DNR order completed, one of the following two forms will need to be completed.

DO NOT RESUSCITATE PROCEDURES:

Under certain specified conditions, an attending physician can order that no attempt be made at cardiopulmonary resuscitation (CPR) on his/her resident, i.e. DNR Order. Unless a DNR Order is entered on the resident's chart, CPR will be performed unless it is "medically futile."

"Medically Futile" is defined to mean that when **all** of the conditions listed below are true. CPR will not be initiated until the physician orders it, even if the resident does not have a DNR order documented on the chart.

1) Resident has no visible respiratory efforts,
2) Resident has no vital signs,
3) Resident is unresponsive to verbal or painful stimulation,
4) Resident's pupils are fixed, dilated and non-reactive to light and
5) Resident's skin is cold to touch.

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[Insert Facility Name]
Address
City, State Zip Code

ADVANCE DIRECTIVES, DNR AND OTHER ACP DOCUMENTS FACE SHEET

If checked, the following Advance Directives or "DNR" Orders have been executed and are complete:

____ FULL CODE

____ Treatment Preferences (For example, ADFHC [Part two], Living Will)

(If there is a health care agent appointed, confer with the health care agent regarding treatment preferences once resident is in a terminal condition or permanent state of unconsciousness.)

____ Health Care Agent (For example, ADFHA [Part One] or DPAHC prior to 7/1/07).

(If DPAHC indicates co-agents, these agents are equal and both need to be listed and identified as such. Back-up agent means that person(s) the declarant has named to act successively in the order listed.)

Agents Listed	Phone Number	Back-Up Agents
_____	_____	
_____	_____	[ ]
_____	_____	[ ]

_____ DO NOT RESUSCITATE ORDER

_____ PHYSICIAN'S ORDERS FOR LIFE SUSTAINING TREATMENT (POLST)

_____ OTHER REQUESTS

[ ] BEQUEATH BODY [ ] ORGAN OR TISSUE DONOR

Request based on: [ ] Driver's License [ ] Advance Directive [ ] Other _____

[ ] OTHER DIRECTIVES: _____

Guardian: [ ] Yes [ ] No If yes, List Name _____

RESIDENT _____

(Send Face Sheet and copies of all documents in the event of hospitalization.)

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[INSERT FACILITY NAME]

EVACUATION AGREEMENT

Resident Name: _____

It is the policy of this Facility to provide quality care for our residents. Unfortunately, there are times where natural and man-made disasters make it impossible to maintain a safe environment and meet the needs of the resident. In these events, evacuation may be necessary. Please indicate your preference for evacuation in such an emergency.

_____ The Resident Representative will be available to pick up and care for me during times of crises.

_____ In the event my Resident Representative cannot be contacted, refuses to come or time does not allow contact, the signature below gives the Facility authorization to evacuate me according to Facility procedure.

_____ The Resident Representative will not be able to pick up or care for me in the case of crisis. I (the Resident) will be evacuated by the Facility.

_____ There is no resident representative. The resident will be evacuated by the Facility.

Based on advice from the [State Here] Emergency Management Agency or County Emergency Management Coordinator the CEO or designee will order evacuation. At this time we evacuate to:

[Insert Name]
[Insert Address]
[Insert City], [Insert State] [Insert Zip Code]

_____ Date _____
Signature of Resident

_____ Date _____
Signature of Resident Representative

To Staff: Reference Face Sheet for Resident Representative and phone number

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[Insert Facility Name]
Address
City, State Zip Code

[INSERT FACILITY NAME]

CONSENT FOR MEDICAL TREATMENT

RESIDENT'S NAME _____

I voluntarily consent to medical treatment at [Insert Facility Name] as may be necessary or beneficial in the professional judgment of my physician, his/her assistants or his/her designees.

I understand that most physicians on the medical staff are independent contractors (not employees of [Insert Facility Name]) for whose treatment and care [Insert Facility Name] is not responsible.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the effect of such diagnostic procedures and medical treatment of my condition.

I have read the foregoing consent, am aware of its contents and fully understand same.

Resident _____ Date _____
Signature

Resident Representative _____ Date _____
Signature

Witness: _____

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[Insert Facility Name]
Address
City, State Zip Code

[INSERT FACILITY NAME]

Resident Immunization Informed Consent Authorization

Instructions: This document shall be **initiated** upon admission by the Admissions Coordinator and communicated to the DON. The original will be maintained in the resident's financial file. A copy will be filed in the Residents' medical record.

RESIDENT: _____ PHYSICIAN: _____

TUBERCULOSIS TESTING

A Tuberculin (Mantoux) skin test will be administered on admission and annually thereafter. If the resident has been **treated for Tuberculosis** or had a **positive skin test** in the past he/she should **NOT** receive the Tuberculin (Mantoux) Skin Test and alternative testing will be ordered by the physician.

Please answer the following questions as accurately as possible.

Are you allergic to the TB Skin test, if known? NO ___ YES ___
Do you/resident have a history (diagnosis) of Tuberculosis? NO ___ YES ___
Have you/resident ever had a POSITIVE Tuberculin (Mantoux) Skin Test? NO ___ YES ___
If yes, was the POSITIVE SKIN TEST followed up with the Health Department? NO___ YES___

Name/Location of Health Department _____
_____

This authorization shall remain in effect until changes are executed.

Resident/Responsible Party Initial _____

INFLUENZA IMMUNIZATION

The Centers for Disease Control (CDC) suggests that the influenza vaccine can minimize the effect of influenza. This facility offers influenza vaccine to its residents at the time of admission and annually thereafter. Vaccines are offered from October 1 to March 31 of each year.

Please provide the following information as accurately as possible.

Are you allergic to eggs? ___ NO ___ YES ____ Unknown
Date of last vaccine, if known:_____
I DO DO NOT (circle one) want myself/my relative _____ (Name)
to have the influenza vaccine. If **do not** want, why? _____
_____.

This authorization shall remain in effect until changes are executed.

Resident/Responsible Party Initial _____

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[Insert Facility Name]
Address
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PNEUMOCOCCAL IMMUNIZATION

All adults 65 years of age or older should receive the Pneumococcal Polysaccharide Vaccine (PPV) once in a lifetime, with certain exceptions. Persons 65 years or older may be administered a second dose of vaccine (booster vaccine) if they received the first dose of vaccine more than five (5) years earlier and were 65 years old or less than 65 years old at the time.

The CDC recommends a second (booster) dose for immunocompromised persons. This booster may be administered five (5) years after the first booster with a physician's order.

Please provide the following information as accurately as possible.

Date of last immunization, if known. _____

Are you allergic to the Pneumococcal Vaccine? ___ NO ___ YES ____ Unknown

I DO DO NOT (circle one) want myself/my relative _____, (Name) to have

the Pneumococcal Vaccine. If do not want, why? _____
_____.
This authorization shall remain in effect until changes are executed.

Resident/Responsible Party Initial _____

EDUCATIONAL MATERIALS

Please review the educational materials that are being provided to you. [Insert Facility Name] admissions and nursing staff will address any questions that you have.

Please sign below to acknowledge of receipt of education materials on the vaccines described on this form and provided in flyers provided by the facility.

The signature below authorizes the information stated and initialed above.

Resident/Responsible Party _____ Date: _____

Witness _____ Date: _____

Resources for further information on immunizations:
www.cdc.gov/flu and www.cdc.gov/vaccines

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INFLUENZA (FLU)

Influenza (flu) is a contagious disease caused the influenza virus, which is spread from person to person through coughing or sneezing. **The best way to prevent the flu is by getting the flu vaccination each year.**

October or November is the best time to get immunized but you may get immunized in December or later since flu season begins as early as October and can last as late as May.

Symptoms of the flu may include fever, cough, sore throat, chills, headache, muscle aches, runny nose, and/or fatigue. Complications from the flu may include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening chronic medical conditions, such as congestive heart failure, asthma or diabetes.

The influenza immunization is recommended for:

- People 65 years of age and older.
- Residents of long term care facilities, housing persons with chronic medical conditions.
- People who have long term health problems with
    - Heart disease
    - Lung disease
    - Asthma
    - Kidney disease
    - Metabolic disease, such as diabetes and
    - Anemia and other blood disorders.
- People with certain muscle or nerve disorders than can lead to breathing and swallowing problems
- People with weakened immune system due to
    - HIV/AIDS,
    - Long term treatment with steroids and/or
    - Cancer treatment with x rays or drugs
- And others.

People should not be immunized without consulting a physician including the following.

- People who have severe allergies to chicken eggs.
- People who have had a severe reaction to an influenza immunization in the past.
- People who developed Guillain-Barre' Syndrome within six weeks of getting an influenza immunization previously.
- People who have a moderate or severe illness with a fever should wait to get immunized until their symptoms have lessened.

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INFLUENZA (FLU)

The influenza immunization is safe and effective and generally has few side effects. You cannot get the flu from the vaccine. There may be some soreness, redness or swelling at the injection site. Other possible mild side effects include a headache and low-grade fever for a day after immunization. As with any medicine, there are very small risks that serious problems could occur after getting an immunization. However, the potential risks associated with the flu are much greater than the potential risks associated with the influenza immunization.

To learn more visit CDC's website at www.cdc.gov/flu or call your local or state health department.

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PNEUMONIA

Pneumococcal disease (pneumonia) is a serious disease that causes much sickness and death. Pneumonia is an inflammation of the lung caused by infection with bacteria, viruses and other organisms. It is often a complication of a pre-existing condition and triggered when a person's defense system is weakened, most often by a simple viral upper respiratory tract infection or a case of influenza, especially in the elderly.

Drugs such as penicillin were once effective in treating these infections; but the disease has become more resistant to these drugs, making treatment of pneumonia more difficult. This makes prevention of the disease through vaccination/immunization even more important.

The pneumococcal polysaccharide vaccine (PPV) protects against 23 types of pneumococcal bacteria. It is recommended for all adults 65 years of age or older. The PPV can be given at anytime of the year and is an once-in-a-lifetime vaccination/immunization for most people. However, a second dose is recommended for those people aged 65 and older who got their first dose when they were under 65, if five (5) or more years have passed. A second dose may be recommended by your physician if you have certain medical conditions.

The PPV is a very safe vaccine/immunization. Approximately 50% of persons given the vaccine/immunization develop mild side effects such as redness or pain at the injection site. Fever, muscle aches and severe local reactions have been reported in less than 1% of those vaccinated. As with any medicine, there are very small risks that serious problems or allergic reactions (hives, difficulty breathing, and/or shock) could occur after getting a vaccine/immunization. However, getting the disease is much more likely to cause serious problems than getting the vaccine/immunization.

To learn more visit CDC's website at www.cdc.gov/vaccines or call your local or state health department.

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[Insert Facility Name]
Address
City, State Zip Code

[INSERT FACILITY NAME]

INITIAL DISCHARGE PLANNING

Resident Name: _____

Resident's Overall Expectation: ☐ Discharge to community ☐ Remain in this facility
☐ Discharge to another facility ☐ Unknown or uncertain

Source of Information [for resident's expectations]: ☐Resident ☐Family/significant other
☐ Guardian or Legally Authorized Representative ☐ None of the above

If discharge from the facility is anticipated or uncertain, complete the following information:

Where did resident live prior to admission (address)? _____

Lived: ☐ Alone ☐ With: _____

Is this where resident plans to return? ☐ Yes ☐ No

If no, Where will resident live? _____

Does resident have concerns about home environment or support system? (stairs, finances, etc.)

☐ Yes ☐ No Comments: _____

Does resident have family/friends capable of and willing to provide assistance post-discharge?

☐ Yes ☐ No ☐ Unknown ☐ No family / friends

Who will be the primary caretaker? _____

Will resident need post discharge assistance with ADL? ☐ Yes ☐ No ☐ Unknown

Other identified needs / resources for discharge to community. _____

_____

_____

Anticipated level of independence to enable discharge to community: _____

_____

Previous service providers (Name and Contact Information):

Primary Physician: _____

Does resident wish to return to care of this physician at discharge? ☐ Yes ☐ No ☐ Uncertain

Pharmacy: _____

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INITIAL DISCHARGE PLANNING

Does resident wish to use this pharmacy at discharge? ☐ Yes ☐ No ☐ Uncertain

Home Health ./ Medical Equipment Providers: _____

Does resident wish to use this agency at discharge? ☐ Yes ☐ No ☐ Uncertain

_____ _____
Signature, Title Date

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[Insert Facility Name]
Address
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PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) [INSERT STATE-SPECIFIC INFORMATION]

Patient's Name _____ _____ _____
(First) (Middle) (Last)

Date of Birth _____ Gender: Male ☐ Female ☐

A CODE STATUS Check One	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing. ☐ Attempt Resuscitation (CPR). ☐ Allow Natural Death (AND) – Do Not Attempt Resuscitation. **Signature of a concurring physician is needed for this section to be valid if this form is signed by an Authorized Person who is not the Health Care Agent. See additional guidance under III on back of form.* When not in cardiopulmonary arrest, follow orders in B, C and D.
B Check One	MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing. ☐ Comfort Measures. Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. *Do not transfer to hospital for life-sustaining treatment.* ☐ Limited Additional Interventions: In addition to treatment and care described above, provide medical treatment, as indicated. DO NOT USE intubation or mechanical ventilation. *Transfer to hospital if indicated. Generally avoid intensive care unit.* ☐ Full Treatment: In additional to treatment and care described above, use intubation, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.* Additional Orders (e.g., dialysis):
C Check One	ANTIBIOTICS ☐ No antibiotics. Use other measures to relieve symptoms. ☐ Determine use or limitations of antibiotics when infection occurs. ☐ Use antibiotics if life can be prolonged. Additional Orders:
D Check One In Each Column	ARTIFICALLY ADMINISTERED NUTRITION/FLUIDS Where indicated, always offer food or fluids by mouth if feasible
	☐ No artificial nutrition by tube. ☐ Trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. Additional Orders:
	☐ No IV fluids. ☐ Trial period of IV fluids. ☐ Long-term IV fluids. Additional Orders:

DISCUSSION AND SIGNATURES

The basis for these orders should be documented in the medical record. To the best of my knowledge, these orders are consistent with the patient's current medical condition and preferences and comply with the requirements of applicable [State Here] law.

Physician Name: License No.: State:	Physician Signature:	Date: Phone:
Concurring Physician Name (*if needed, see III.i. on back of form):* License No.: State:	Concurring Physician Signature (if needed):	Date: Phone:
Patient or Authorized Person Name: ****authorized person may NOT sign if patient has decision making capacity*	Patient or Authorized Person Signature:	Date: Phone:

Relationship to patient (check all that apply):
☐ Self ☐ Health Care Agent ☐ Spouse ☐ Court-Appointed Guardian ☐ Son or Daughter ☐ Parent ☐ Brother or Sister

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[Insert Facility Name]
Address
City, State Zip Code

[INSERT STATE-SPECIFIC INFORMATION]

GUIDANCE FOR COMPLETING THE POLST FORM

1. Completion of a POLST for is always voluntary.
2. Any Section of a POLST form which is not completed implies full treatment for interventions discussed in that section.
3. A POLST form may be executed/created:
   a. When a patient has a serious illness or condition and the attending physician's reasoned judgment is that the patient will die within the next 365 days OR
   b. At any time if a person has been diagnosed with dementia or another progressive, degenerative disease or condition that attacks the brain and results in impaired memory, thinking, and behavior.
4. **If the patient has decision making capacity**, that the patient chooses whether to complete and sign the POLST form with his or her physician. An authorized person may NOT sign the POLST form for a patient who has decision making capacity.
5. **If the patient lacks decision making capacity**, the POLST form may be signed by an "authorized person," which includes, in the following order of priority:
   a. The agent named on the patient's durable power of attorney for health care or a health care agent named on the patient's advance directive for health care
   b. A spouse
   c. A court-appointed guardian
   d. Son or daughter (age 18 or older)
   e. Parent
   f. Brother of sister (age 18 or older)
6. If an authorized person completes and signs the POLST form, treatment choices should be based in good faith on what the patient have wanted if the patient understood his or her current circumstances

ADDITIONAL GUIDANCE FOR HEALTH CARE PROFESSIONALS

I. **When a POLST form is signed by the Patient** and Attending Physician, all orders may be implemented without restriction.
II. **When a POLST form is signed by the patient's Health Care Agent** and Attending Physician:
   i. **If Section A indicates Allow Natural Death – Do Not Attempt Resuscitation**, this order may be implemented when the patient is a "candidate for non-resuscitation"* as defined in [Insert State] Code Section 31-39-2(4). However, a concurring physician signature is NOT required per [Insert State] Code Section 31-92-4(c).
   ii. **Orders in Sections B, C and D may be implemented without restriction.**
III. **When a POLST form is signed by an Authorized Person (other than the patient's Health Care Agent)** and Attending Physician:
   i. **If section A indicates Allow Natural Death – Do Not Attempt Resuscitation**, this order may be implemented when the patient is a "candidate for non-resuscitation"* as defined in [Insert State] Code Section 31-39-2(4). A concurring physician signature is REQUIRED per [Insert State] Code Section 31-39-4(c).
   ii. **Orders in B, C, or D may be implemented when patient is:**
      a. In terminal condition OR
      b. State of permanent unconsciousness OR
      c. Diagnosed with dementia or another progressive, degenerative disease or condition that attacks the brain and results in impaired memory, thinking and behavior.
IV. **The status of resuscitation orders during surgery or other invasive procedures should be reviewed** by the physician with the patient or patient's "authorized person" (as defined above).
V. Copies of the original POLST form are valid.
VI. The POLST form shall remain effective unless revoked by the attending physician upon the consent of the patient or the patient's authorized person.
VII. An attending physician who issues an order using the POLST form and who transfers the patient to another physician shall inform the receiving physician and the health care facility, if applicable, of the order.

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VIII. A health care facility may impose additional administrative or procedural requirements regarding a patient's end of life care decisions, including the use of a separate order form. If the patient is in a health care facility, the attending physician should check with the facility to ensure these orders are valid.

*[Insert State] Code Section 31-91-2(4) defines a candidate for non-resuscitation" to mean a patient who, based on a reasonable degree of medical certainty:

A. Has a medical condition which can reasonably be expected to result in the imminent death of the patient;
B. Is in a non-cognitive state with no reasonable possibility of regaining cognitive functions; or
C. Is a person for whom CPR would be medically futile in that such resuscitation will likely be unsuccessful in restoring cardiac and respiratory function or will only restore cardiac and respiratory function for a brief period of time so that the patient will likely experience repeated need for CPR over a short period of time or that such resuscitation would be otherwise medically futile.

SUBSEQUENT REVIEW OF THE POLST FORM

This form should be reviewed when (i) the patient is transferred from one care setting or care level to another (ii) released to return home (iii) there is substantial change in the patient's health status, or (iv) the patient's treatment preferences change. If this POLST is voided, replaced, or becomes invalid, then draw a line through Sections A through D, write "VOID" in large letters with date and time, and sign by the line. After voiding the form, a new form may be completed. *If no new form is completed, full treatment and resuscitation may be provided.*

Date/Time of Review	Location of Review	Print Name of Reviewer	Outcome of Review	Physician Signature
			☐ No Change ☐ Form Voided, new form completed ☐ Form Voided, no new form	
			☐ No Change ☐ Form Voided, new form completed ☐ Form Voided, no new form	

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