LAURELWOOD
Assisted Living & Memory Care

When you choose our retirement lifestyle, we simplify things for you.

Your affordable rent includes:

- Basic Cable and all utilities except telephone
- Three delicious, nutritious, chef-prepared meals served daily plus snacks and drinks
- Fun and enriching activity calendar
- Activities Room, Spa Tub, TV lounge, Game Room/library
- Licensed Nurse and/or Caregivers on staff 24/7
- Coordination of care with home care providers, physicians, and others
- Emergency response system monitored around-the-clock.
- Laundry Service one time per week
- Housekeeping one time per week
- Individually controlled central heating and air conditioning in each suite
- Medication management
- Pain Management

Floor plans to choose from:

Floor Plan	*Square Feet*	*Monthly pricing starting*
Assisted Living Studio Suite	300	$3,400
Memory Care Studio	300	$5,800 all-inclusive*
Second Person Fee		$1,200

*All-inclusive means no care level fees, all care is included in the rent

Assisted Living Personalized Care Plan Pricing:

Level 1- $950 Level 2- $1,425 Level 3- $1,900 Level 4- $2,375 Level- 5 $2,850

Community Fee - *One-time fee equal to the following:* $2,000.00

Above pricing for private pay residents, Medicaid Waiver residents monthly pricing will difer.

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ADMISSION APPLICATION

Demographic Information	
Full Legal Name:	
Street Address:	
City, State & Zip:	**Phone #:**
Social Security #:	**Birthday:**
Race:	**Religion:**
Marital Status:	**Maiden Name:**
Sex :	**Primary Language:**
Email:	**Dominant Hand:**

INSURANCE INFORMATION PLEASE FILL OUT COMPLETELY	
Medicare #:	Medicaid #:
Medicare Group #:	
Case Worker:	**Case Worker Phone #:**

Power of Attorney	
Full Name:	
Phone Number:	
Street Address:	
City, State & Zip:	
Email:	
Relationship:	
Spouse Name:	Spouse Phone #:

Resident's Guarantors/Billing statement if not POA	
Full Name:	
Phone Number:	
Street Address:	
City, State & Zip:	
Email:	
Relationship:	
Spouse Name:	Spouse Phone #:

Who is to Receive Residents Mail?	
Billing Statement:	
Cards/Magazines:	
Financial Mail:	

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Current Physician Information			
Primary Care Physician:			
Street Address:			
City:	State:	Zip:	
Phone:		Fax:	

Specialists (Cardiologist, Urologist, Oncologist ETC.)			
Specialty:			
Name:			
Street Address:			
City:	**State:**	**Zip:**	
Phone:		**Fax:**	

Dentist			
Name:			
Street Address:			
City:	**State:**	**Zip:**	
Phone:		Fax:	

Podiatrist			
Name:			
Street Address:			
City:	**State:**	**Zip:**	
Phone:		**Fax:**	

Ophthalmologist			
Name:			
Street Address:			
City:	**State:**	**Zip:**	
Phone:		**Fax:**	

LAURELWOOD
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EMERGENCY CONTACTS

Emergency Contact #1		
Full Name:		Relationship:
Street Address:		
City:	State:	Zip:
Email:		
Cell Phone:		Alternate Phone:
Spouse Name:		
Spouse Phone:		
Emergency Contact #2		
Full Name:		Relationship:
Street Address:		
City:	State:	Zip:
Email:		
Cell Phone:		Alternate Phone:
Spouse Name:		
Spouse Phone:		
Emergency Contact #1		
Full Name:		Relationship:
Street Address:		
City:	State:	Zip:
Email:		
Cell Phone:		Alternate Phone:
Spouse Name:		
Spouse Phone:		

Resident Pre-Made Funeral Information

Funeral Home Name:		Phone #:
Street Address:		
City:	State:	Zip:

Resident Personal Items			
Glasses Y/N	**Hearing Aids Y/N**	**Dentures Y/N**	**Cane Y/N**
Walker Y/N	**Wheelchair Y/N**	**Power Chair Y/N**	**Prosthetics Y/N**

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All PROGRAMS AND SERVICES SHALL BE MADE AVAILABLE WITHOUT REGARD TO RACE, COLOR, CREED, GENDER, NATIONAL ORIGIN OR TOHER UNLAWFUL GROUNDS.

The undersigned hereby applies for residency to Laurelwood Assisted Living and agrees, if accepted, to comply with all current and future policies and procedures of Laurelwood Assisted Living.

Certification: I represent that each and every statement is true and that I have not withheld any information requested above.

Signature: _____ Date: _____

Witness (Staff member): _____Date: _____

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Assisted Living & Memory Care

No Smoking/Vaping Tolerance Policy

I understand that if I am found smoking or vaping on Laurelwood property (this includes outdoors on Laurelwood property) I will be given an immediate 30 day notice to vacate. Laurelwood has a no tolerance policy for smoking and/or vaping on our campus.

X_____

Resident Signature

X_____

Resident Representative Signature

X_____

Laurelwood Representative Signature

MATTRESS COVER POLICY

I understand that I am responsible for providing a mattress encasement cover that is waterproof, & bed bug proof upon move in. Typically found on Amazon (it is like a large pillow case with a zipper.)

Responsible Party: _____ Date: _____

Resident Name: _____ Apt No. _____

LAURELWOOD
Assisted Living & Memory Care

RESIDENT VEHICLE POLICY
ONLY NEEDED IF RESIDENT IS BRINING A CAR

Requirements
For their own health and safety, as well as that of other residents, staff and public, residents who maintain a vehicle on the Community premises are required to provide copies of the following:

- A valid driver's license.
- Proof of liability insurance
- Current registration

Parking
Resident must keep his/her car locked at all times and never leave the keys in the vehicle.

Inoperable or unregistered vehicles are prohibited and community will have any such vehicles towed at the owner's expense.

Liability
You agree to indemnify and defend the Community against any and all claims and liabilities resulting from your use of your vehicle. Community is not responsible for any damage or theft to your vehicle while it is in our parking lot and we recommend that resident maintains comprehensive and collision insurance for his/her vehicle.

By signing below, I agree to the above policy and to the safe operation of this vehicle. I will notify the community if there is a change in the status of any of the following documents.

Driver's License Number	State Expiration Date
Insurance Company Name	Policy Number Effective Dates of Policy
License Plate #	State where registered Expiration Date

Resident's Name (printed): _____

Resident's Signature:_____ Date: _____

Responsible Party's Signature: _____ Date: _____

Community Representative's Signature: _____ Date: _____

LAURELWOOD
Assisted Living & Memory Care

Laurelwood Bus Transportation

Our bus transportation for resident appointments are available:

Monday –	Doctor Appointments Only	9 a.m. – 1 p.m.
Tuesday –	Planned Outing with Activities	9 a.m. – 1 p.m.
Wednesday –	Doctor Appointments Only	9 a.m. – 1 p.m.
Thursday –	Memory Care Outing	9 a.m. – 1 p.m.
Fridays –	Doctor Appointments Only	9 a.m. – 1 p.m.

- All appointments are to be made by resident, family or POA.
- Request an appointment from your Dr. on one of the days/times noted above
- Notify our receptionist 3 days in advance to be placed on the transportation schedule at 937-436-6155.
- This transportation service is a “drop off” and “pick up” service only.
- We only transport within a 20-mile radius, anything outside that radius will be the responsibility of the POA/Resident.
- Your loved one must be able to get in and out of the medical office with little assistance from our driver. If your loved one requires someone to accompany them during the appointment, you must plan and arrange to meet our driver at the appointment. We do not provide staff to stay with any resident during an appointment.
- When the appointment is over, the medical office or resident must call our bus driver’s cell phone to arrange for pick up.
- All special requests must be approved by our Executive Director in advance.
- If you need assistance outside of above hours, please reach out to resources like AAA/WSC for assistance.
- Transportation is subject to change.

Resident’s Name (printed): _____

Resident’s Signature:_____ Date: _____

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Resident Name:_____
Birthdate:_____

Getting to Know You

Favorite Things:

Beverage:
Snack:
Food:
Color:

Do You Like:

To Read:	Y or N	What genre or Author?
Movies:	Y or N	What genre or Shows?
Music:	Y or N	Which Artist or Type?
Crafts:	Y or N	
To Knit or Crochet:	Y or N	

Community Involvement:

Hobbies:
Activities:
Clubs:

Religious Preferences:

Military Background: ☐ N/A

If you served in the military, we would love to know…	
Branch Served:	Years:

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Family & Friends:

Spouse:	How many years together?
Daughter(s):	
Son(s):	
Granddaughter(s) & Ages:	
Grandson(s) & Ages:	
Other:	

Please Circle the Trips you would be interested in:

Shopping	Movie Theater	Bowling
Lunch Outing	Dinner Outing	Picnic
Suggestions for other outings:		

Tell us about your occupation(s):

_____
_____
_____
_____
_____
_____
_____

Any additional Information you would like to share with us:

_____
_____
_____
_____
_____

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PLEASE ATTACH COPIES OR HAVE WITH YOU FOR KATE TO COPY

STATE ID OR DRIVERS LICENSE

SOCIAL SECURITY CARD

MEDICARE CARD

MEDICARE SUPELEMENTAL CARD

MEDICAID CARD INCLUDING BUCKEYE OR MOLINA

ANY ADDITIONAL INSURANCE CARDS

Resident's Admission Document Checklist

1. **Residents Admission Documents-All MUST be signed**
   Resident Admissions Application (including Smoking, Vehicle, Mattress Cover Policies)
   Comprehensive Authorization, Consent and Release
   Statement of Informed Choice
   Items to Bring when Moving In
   Medicaid Approval/Denial Policy
   Insurance Card, Social Security Card and ID card- **Provided by Resident/Family**
   CC Master Uploaded to PCC (Kate Completes this task)

2. **Medical Consent and Signed PCP Forms**
   - ☐ Clark's Pharmacy Consent Forms (5 pg total)
   - ☐ Medical House Calls Consent Froms (1pg total)
   - ☐ Mind Care Consent Froms (3 pages total)
   - ☐ PPG Podiatry Consent Form (1 page Total)
   - ☐ History & Physical
   - ☐ Signed Medication List
   - ☐ DNR* (DNR is not the same as Living Will) *if resident is a full code the Physician will not Sign

3. **State-Specific Legal Documents**
   - ☐ Ohio Power of Attorney for Health Care - Resident must have to move in
   - ☐ Durable Power of Attorney for Health Care
   - ☐ Advance Healthcare Directive and Living Will Information - Ohio
   - ☐ Living Will Declaration

   ** - *Power of Attorney for Health/Financial (resident/responsible party to provide copy)*

4. **Resident Agreement/Documents Usually given at Lease Signing**
   - ☐ Services
   - ☐ Terms and Obligations
   - ☐ House Rules
   - ☐ Fees & Your Fee Summary
   - ☐ ACH Form with Voided Check and two months of Bank Statements
   - ☐ Care Conference Form with CC Master uploaded to PCC
   - ☐ Medicaid Case Worker Information ☐ Private Pay Resident

5. **Resident's Bill of Rights (OH) Community Handbook, Copy of Signed Lease**

I have received and reviewed the above documents:

Resident's Name (printed):_____
Resident or Responsible Party's Signature: _____ Date: _____
Executive Director: _____ Date: _____

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RESIDENT BILL OF RIGHTS

The rights of nursing home residents are protected under Ohio law by Section 3721.13. The rights are summarized below.

Residents have the right to:

- A safe and clean living environment.
- Be free from physical, verbal, mental, and emotional abuse and to be treated at all times with courtesy, respect, and full recognition of dignity and individuality.
- Adequate and appropriate medical treatment, nursing care, and other services that comprise necessary and appropriate care consistent with the program for which the resident contracted without regard to race, color, religion, national origin, age, or payment source.
- Have all reasonable requests and inquiries responded to promptly.
- Have clothes and bed sheets changed as need arises to ensure comfort and sanitation.
- Obtain name and specialty of any physician or other responsible for coordinating care.
- Select staff physician of choice and select attending physician not on staff if so desired.
- Communicate with physician and staff in planning the resident's treatment or care, obtain current medical information on status, have access to medical records and give or withhold informed consent for treatment.
- Withhold payment to physician, if the physician did not visit.
- Confidential treatment of personal and medical records.
- Privacy during medical examinations and personal care.
- Refuse to serve as a research subject.
- Be free from chemical and physical restraint except under close supervision and written orders of physician.
- Obtain pharmacist of choice and to pay fair market price for drugs.
- Exercise all civil rights unless adjudicated incompetent.
- Consume alcoholic beverages unless contradictory to written admission policies.
- Use tobacco unless contradictory to written admission policies.
- Retire and rise on his/her own schedule per request as long as this does disturb others.
- Observe religious obligations and activities, maintain individual and cultural identity, and participate in social and community groups
- Private and unrestricted communications receive and send sealed, unopened correspondence, access to a telephone and private visits.
- Privacy for visits by a spouse or share a room if both are residents of the facility.

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- Have room doors closed and not have them opened without knocking.
- Retain use personal clothing and possessions in a secure manner.
- Be informed in writing of basis rate changes, services offered by the facility and charges for additional services and receive a 30-day notice of changes.
- Received and review itemized bills or charges on a monthly basis.
- Be free from financial exploitation and manage own financial affairs and receive quarterly accounting of financial transactions, if this right is delegated to the home.
- Unrestricted access to property on deposit at the facility.
- Reasonable notice, including explanation, before room or roommate is changed.
- Not to be transferred or discharged except for medical reason, welfare of the resident or residents, non-payment or revocation of the facilities license or certification.
- Voice grievances and recommendations free from restraint, reprisal or discrimination.
- Have significant changes in health status reported to sponsor.
- The right, if the resident has requested the care and services of a hospice care program, to choose a hospice care program licenses under chapter 3712. Of the revised code that best meets the resident's needs.

Signature:_____

Date:_____

Sales Leader Signature: _____ Date:_____

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STATEMENT OF INFORMED CHOICE—ASSISTED LIVING

Assisted living facilities offer a residential alternative that allows senior citizens to preserve a level of independence while receiving personal care services. Our Community is an assisted living facility. Assisted living allows each resident to continue to have freedom, autonomy, and privacy, and because of this, there are risks inherent to assisted living that are similar to the risks associated with independent living, since our Community DOES NOT provide one-on-one, 24-hour nursing care. This Statement of Informed Choice describes certain of the risks inherent in the aging process that cannot be eliminated in the assisted living setting.
In assisted living, we take pride in delivering compassionate and high quality services to our Residents. However, it is not uncommon for Residents to accidentally trip, have trouble ambulating from a chair or bed, or simply fall for any number of reasons. Bones weakened by osteoporosis can break without warning. Some medications can cause dizziness. Residents with dementia can lose depth and spatial perception. In some instances, falls require medical attention and even hospitalization. The risk of falling can be lessened with the use of wheelchairs or walkers, or participation in physical therapy. We can provide additional information regarding these options.

Residents are encouraged to enjoy freedom of movement while living in our Community. Residents who are easily confused, suffer from dementia, or have Alzheimer's disease, occasionally wander in or about the facility premises, or leave the Community altogether. Wandering Residents are often not alert to situations that have the potential to cause themselves injury. Assisted living facilities do not lock their doors and because one-on-one care is not available, we expect that Residents and family members will be realistic and truthful in discussing these issues with the Community. In many cases, a family member is the first to notice changes in their loved one's mental state. If a Resident is experiencing cognitive or memory ability changes we expect family members or other responsible parties to communicate with us to assist in the exploration of appropriate options. For those Residents who begin to show signs of wandering, we will work with the Resident, the family and the Resident's physician to determine the appropriate care and setting needed. As mental and physical conditions change, assisted living may cease to become a viable living option. Another care setting, such as a Skilled Nursing or Memory Loss Facility may be a better choice.

Unfortunately, the aging process can lead to loss of skin integrity, increasing skin breakdown, skin tears, and bruising. Residents may be more prone to this risk if they are receiving assistance with bathing and dressing, using a wheelchair, or are diabetic or otherwise in poor health. At-risk Residents should consider purchasing pressure-reducing surfaces for beds and/or wheelchairs to

reduce the risk of skin breakdowns, and should immediately report any skin breakdown to their physician.
Although we try to prevent damage or loss of property, it occurs. Dentures or hearing aids can be damaged, lost, or accidentally thrown away. While we will do our best to prevent accidents, we are not responsible for guaranteeing that personal property will not be lost or damaged.

In summary, we want our Residents and their family members to understand and acknowledge that our Community does not provide protection from all risks. Other care settings, such as Skilled Nursing Facilities or Memory Loss Facilities offer a higher level of care and protection. We can help Residents evaluate other options for residential settings if risks associated with assisted living are not an acceptable option.

By signing this Agreement, you acknowledge that the Community informed you and that you understand the Community is not risk-free, and that in fact the Community promotes the appropriate exercise of Resident independence and privacy. You affirm that you freely chose to move to our assisted living Community with an awareness of the associated risks.

Resident's Name (printed): _____

Resident's Signature:_____ Date: _____

Responsible Party's Signature: _____ Date: _____

Community Representative's Signature: _____ Date: _____

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COMPREHENSIVE AUTHORIZATION, CONSENT AND RELEASE

Release of Information (circle one) YES or NO
Initial_____

Authorization is hereby granted to Community to release necessary health-related information as well as such professional information, in accordance with the policies of the facility, as may be necessary from the medical and administrative records compiled during your stay. The Community is hereby released from all legal liability that may arise from the release of this information. This information may be used in the treatment, resident transfer, and for third party billing information.

Photography / Publicity Authorization (circle one) YES or NO
Initial_____

Authorization is granted for photos, videotape and film to be taken of the above named resident to be used for the following purposes:

- Resident identification within the Community;
- Medical purposes;
- Scrap books and Community bulletin boards;
- Group photos used during public education programs; and,
- As part of training, educational programs, marketing or publicity efforts to promote awareness of the Community and its programs.

Resident Birthday Information (circle one) YES or NO
Initial_____

If checked and initialed, permission is granted for birthday information (month & day only) to be displayed in the Community newsletter and/or on the Community bulletin boards and for resident to have birthday celebrated during Community activities.

Activities (circle one) YES or NO
Initial_____

If checked and initialed, permission is granted to include the above named resident in activities that are outside the confines of the Community. This permission is granted to allow this resident to go on chaperoned day field trips such as, shopping expeditions, restaurant outings, movies, fairs, etc. As community representatives, we agree to make every effort to advise the responsible

party by telephone prior to a scheduled trip. However, opportunities may arise where prior notice is not possible.

Authorization to Handle Personal Laundry (circle one) YES or NO
Initial_____

I hereby authorize the Community to wash, dry, fold and/or hang my personal laundry. The Community requests that personal clothing sent to the laundry are clearly marked/labeled with your name and room number. Community recommends that delicate items be dry cleaned or hand washed and will not be responsible for damage which occurs during laundering.

By signing below, I hereby consent to the above items as checked and initialed:

Resident's Name (printed): _____

Resident's Signature: _____ Date: _____

Responsible Party's Signature: _____ Date: _____

Community Representative's Signature: _____ Date: _____

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Items to Bring When Moving In

1. At lease signing, Copy of Medicare and all other insurance cards, Social Security card, Financial Power of Attorney, Durable Power of Attorney for Health Care, Living Will, Guardianship papers.

2. 5 days' worth of medications (Give that to the floor nurse on day of move-in)

3. Please remember that a resident's apartment is 300 sq ft. Although, downsizing is hard, you will likely not be able to fit all your belongings from your home. Laurelwood's main priority is the safety and care of our residents and want to avoid potential fall hazards. One of the best ways to prevent fall hazards is to limit the number of personal items moved in. The more space you have, the bigger your apartment will feel.

4. Personal items that include: lamps, pictures, knick-knacks, television/TV stand (if desired), recliner, one bookshelf, small desk with a chair, and/or bistro set (small table and up to two chairs). Please mark all items with resident's name. Mini fridges/microwave are dependent upon health assessment (Not recommended for MC resident). These items are to be moved in during business working hours (8:00am-4:30pm) and are subject to inspection from our maintenance team before entering into the building.

5. Shower chair (if needed). A standard shower liner is provided by Laurelwood; however you are welcome to bring one of your own as well as a shower curtain. You will need to bring additional bath towels & washcloths. There is limited shelf space in the bathroom – a portable shelving unit or cart fits nicely in the corner or under the sink.

6. Toiletries: toothbrush, toothpaste, denture cup, denture cleaner and cream, plastic drinking cup, soap, shampoo, deodorant, powder (if used), lotions, etc. electric razor (please mark with name), facial tissues, cotton balls, cosmetics, hairbrush, comb, hair pins/supplies.

7. Incontinence Supplies: Depends, etc. and wipes, and gloves for routine care.

8. Covered clothes hamper. Please mark with resident's name.

9. Clothing: 7-14 changes of clothing, sweaters, comfortable walking shoes, socks, nightwear, underwear, etc. An appropriate coat/jacket for season. Plastic hangers. A wardrobe is provided that accommodates seasonal clothing. ALL CLOTHING SHOULD BE DISCREETLY MARKED WITH RESIDENT'S NAME WITH A FABRIC MARKER.

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10. REMOVE valuable jewelry, money, debit card, ID card prior to move in. The residence is not responsible for lost or stolen items. It is recommended that the resident obtain renters insurance to cover lost or stolen items, if you plan on storing valuables in resident's apartment.

11. Any electric chair, bed, wheelchair, or recliner that is not in functional working condition is the responsibility of the POA to have fixed or replaced. Due to potential liability issues and possible warranties being voided, Laurelwood maintenance is unable to work on these types of personal items.

12. It is highly recommended that the following is not brought with your loved one up on move-in or in the future:

For Assisted Living residents:

- Money, Debit card, ID card, cleaning supplies, wallets, candle, heather, car keys, cars in parking lot (if resident is not driving or do not have DLs), valuable jewelry, memorabilia are recommended to NOT left with resident.

For Memory care residents:

- Sharp objects (ex. scissors, knife, nail clipper), Space/any heaters, ID card, candle, items with glass (ex. picture frames), heaving item, valuable jewelry, microwave, tools or tools box, décor for holidays with sharp edges (ex. Christmas trees, or stands), extinct cores, petty cash, cleaning supplies, area rugs, etc.,

By signing below, I hereby consent to the above items:

Resident's Name (printed): _____

Resident's Signature:_____ Date: _____

Responsible Party's Signature: _____ Date: _____

Community Representative's Signature: _____ Date: _____

Medicaid Approval/Denial Policy

Scope

Assisted Living Residents/Family that currently or will actively pursue Medicaid approval during their residency at Laurelwood Assisted Living.

Policy

When a Resident applies for Medicaid, their monthly charges at Laurelwood Assisted Living will be adjusted to Medicaid rate. In the event that a Resident is denied Medicaid, monthly charges, both current and retroactive, will be adjusted to private pay rate.

Definitions

- Medicaid pending refers to a Resident with an active application that has been submitted, and an assessment has been completed.
- Medicaid rate refers to the financial cost determined by the State of Ohio. This rate will include the rent rate and patient liability (share of cost for Resident care). It is typically the amount of a Resident's monthly income, minus fifty dollars for personal allowance.
- Private Pay refers to the full out of pocket cost that a Resident is responsible for if they are not eligible to apply or have not officially applied for Medicaid, and/or if the Resident is denied.
- Medicaid approved refers to a Resident being deemed appropriate for financial assistance with covering the cost of their care.
- Medicaid denied refers to a Resident being deemed inappropriate for financial assistance with covering the cost of their care. Typically, this is due to being over-resourced.

Procedure

- Upon lease signing, the Resident and/or Family must communicate financial intentions with the Sales Leader. The following information must be communicated:
    - If a Resident will be private pay during the duration of their residency. (Bank statements must be provided as proof of funds for private pay charges).
    - If they will initially be private pay and will apply for Medicaid when their assets are $2,000 or less. (Bank statements must be provided as proof of funds for private pay and to help determine an approximate timeline of applying).
    - Has applied for Medicaid and is considered pending. (Bank statements must be provided to help determine the Medicaid rate charges).
    - Is already approved for Medicaid prior to moving into facility.

- If a Resident moves into Laurelwood Assisted Living with the intention of applying for Medicaid, they must move in paying the private pay rate until the application has been officially submitted. Once the application has been submitted, the Business Office Manager will adjust the Resident account to Medicaid rate. (This rate is typically the amount of a Resident's monthly income, minus fifty dollars for personal allowance).
- The Resident and/or family must properly communicate the status of their application process with the Business Office Manager. The following steps must be communicated:
    - Official application submission
    - Completion of the assessment
    - Any delays due to further information or documentation being requested from the Resident and/or Family
    - When official approval has been received
    - If a Resident is denied (with reason given for denial).
    - If applicable, when an appeal or new application has been submitted
- If a Resident moves into Laurelwood Assisted Living and is already approved for Medicaid. It is the responsibility of the Resident and/or Family to inform Medicaid of the address change. This should be done within the first week of their move. Not updating the address may cause delays in proper access to benefits and facility claims.
- In the event that a resident is denied for Medicaid:
    - Resident and/or Family must alert the Business Office Manager immediately.
    - Resident billing will be retroactively adjusted to private pay. The balance due must be paid within 30 days.
    - If the denied Resident chooses to appeal or reapply, the Business Office Manager must be notified so billing may be adjusted to Medicaid rate until an appeal decision has been made or an application decision has been made.
- If a Resident becomes ineligible for Medicaid after approval has been granted (due to an inheritance or a home sells), it is the responsibility of the Resident and/or Family to inform Medicaid so services may be discontinued and the Business Office Manager so that private pay charges may be applied to the Resident account. ***Please note, if this situation happens the Resident will have to completely restart the Medicaid process when and if they become eligible again.***

By signing below, I hereby consent to the above items:
Resident's Name (printed):

Resident's Signature: Date:

Responsible Party's Signature: Date:

Community Representative's Signature: Date:

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PAYMENT AUTHORIZATION FORM

I (we) hereby authorize Laurelwood to initiate debit entries to my (our) account indicated below, and to debit or credit the same such account. If this item is returned unpaid, I authorize an additional returned item fee of the maximum amount allowed by the state to be charged to this account.

Checking or Savings Account

Type of Account	Checking ☐ Savings ☐		
Depository Financial Institution Name			
Name on Account			
Billing Address			
Routing Number		Account Number	

Payment Setup Information

☐ Open Balance, Not to Exceed			Amount	$	
☐ Fixed Amount			Is Deposit	☐ Yes	☐ No
☐ Always Pay Current Balance Due	☐ Resident understands they may not receive notification of the varying balance due				
Frequency	☐ One Time	☐ Daily	☐ Monthly Day (1-31):	☐ Weekly (M/T/W/Th/F/Sa/Su)	☐ Semi-Monthly (1st & 15th or 15th & Last) ☐ Yearly
Start Date			End Date / Number of Occurrences		

Authorization

This authorization is to remain in full force and effect for the number of payments authorized above or until Laurelwood has received written notification from me (or us) of its termination, in such time and such manner as to afford Laurelwood a reasonable opportunity to act on it.

Name		Unit #	
ID#		State	
Signature			
Date			

Revoke Authorization

This authorization is no longer valid and should be terminated effective ____/____/____.

Signature	
Date	

For Internal Use Only:
Payment Enabled ☐ Date: ____/____/____ Initials_____
Payment Disabled ☐ Date: ____/____/____ Initials_____

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ATTACH the FOLLOWING or GIVE TO KATE TO COPY

Check for the first month's rent will be due at Lease Signing Prior to move in

Two Most Recent Months
.
of Bank Statements

Copies of the following:
Power of Attorney, Living will
and Advanced Healthcare Directives

LAURELWOOD
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Beauty/Barber Shop Information

The stylist is in facility every Tuesday and has appointment times available between 10am and 2:30pm.

Residents must sign-up for an appointment in advance to receive salon services.

Salon appointments can be made at the Front Desk in person or by calling 937-436-6155.

Available Services:

Shampoo/Set	$19.00
Shampoo/Cut/Set	$30.00
Haircut (Ladies)	$17.00
Haircut (Men)	$15.00
Perm (+Haircut)	$65.00
Color	$55.00
Shampoo/Blow Dry/Iron	$19.00
Shampoo/Cut/Blow Dry/Iron	$30.00

All payments for hair care services must be submitted in advance.

Please make all checks payable directly to our beautician, YOLANDA LOWE.

LAURELWOOD
Assisted Living & Memory Care

Medicaid Waiver Residents

- If you have not had the Medicaid Waiver Assessment completed by Area Agency on Aging, please call their intake department @ 937-223-4357 and schedule the assessment. This must be completed prior to move in, typically takes 10-14 days to complete.
- Provide your Area Agency on Aging case worker name and phone number on the admissions packet page 2.
- To qualify your income must be at least $893.00 a month, this is considered you rent portion.
- The monthly Patient Liability for Assisted Living Waiver is your monthly income minus fifty dollars. (This includes the rent portion) Example: monthly income $1,100 your monthly payment to Laurelwood would be $1,050.

LAURELWOOD
Assisted Living & Memory Care

Payment/Cost Details

- Payment is due on the 10th of every month; ACH withdraw will occur on the 10th.
- Written Check or signed ACH automatic bank withdraw form with a voided check (on page 26 of this packet) is required for first month's rent & community fee payment at time of lease signing.
- Community fee/deposit is nonrefundable.
- First month's payment will be prorated if residents move in after the first of the month.
- If you are enrolled in the ACH withdraw every month you will still receive a monthly statement for your records
- No debit or credit cards accepted.

Monthly Rent includes medication management, all utilities (except to landline telephone), activities in the facility (outings are residents responsibility), transportation services provided by Laurelwood, three meals a day, snacks, housekeeping, laundry, bathing, dressing, and reminder assistance.

Medical HouseCalls

Primary Care for the Homebound Elderly

(513)699-9090

SUPPORTIVE HEALTHCARE

[Type here]

Name: _____ DOB: _____

Social Security Number: _____

Place of residence: _____

Thank you for choosing Supportive Healthcare for your primary care services. Our goal is to provide exemplary care in the place you call home. In order for us to provide these services, consents & financial responsibility must be obtained.

I attest that I have received, read and fully understand the following and consent to them fully and voluntarily. Please check each of the following to state consent and sign below.

_____ General Consent for Care and Treatment

_____ Chronic Care Management (CCM) services

_____ Behavioral Health Integration (BHI) services

_____ Remote Patient Monitoring (RPM) services

_____ Telehealth Services

_____ Electronic Communication

_____ Consent for Financial Responsibility

_____ Notice of Privacy Practices

Patient (or representative) Signature: _____

Printed name of Patient or Representative: _____

Date: _____ Relationship to Patient: _____

Thank you for choosing Supportive Healthcare for your primary care needs. Our goal is to provide exemplary care in the place you call home. For us to provide these services, consents & financial responsibility must be obtained. Please read each section fully before initialing and signing the consent page. We look forward to knowing you.

General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended, however your primary care is our first priority. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate medically necessary treatment and/or procedure for any conditions we may identify through the course of care.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended and (2) you consent to treatment at your home or any institution at which you maintain a residence, whether short or long-term. You have the right to discontinue services by our practice at any point.

You have the right to discuss the treatment plan with your healthcare provider including the purpose, potential benefits or risks, and long-term strategies involved in your care. If you have any questions regarding any treatment plan recommended by your provider, we encourage you to speak up.

I voluntarily request a physician and/or nurse practitioner, physician assistant, or clinical nurse specialist (as well as other health care providers to provide reasonable and necessary medical examinations, testing, and/or treatment for the conditions for which I sought care. I understand that if additional testing or procedures are recommended, I will be asked to read and sign an additional consent form specific to that test or procedure.

Chronic Care Management (CCM), Behavioral Health Integration (BHI), and Remote Patient Monitoring (RPM) Services:

Medical House Calls may provide services to help manage ongoing chronic health conditions and/or behavioral health. These services include access to a care team, comprehensive electronic plans of care, management of transitions and other care management services which can include sharing health information with other providers. I understand that only one provider can furnish and bill CCM services during the calendar month. As with other medical services there may be cost-sharing responsibilities such as copays and deductibles. I understand that Patient has the right to stop services at any time by notifying a member of the Medical House Calls team. For more information, please contact our office at 513-699-9090.

Telehealth Services

I understand that patients can stop using telehealth services at any time by notifying a member of the Medical House Calls team (513-699-9090). I understand that certain services are offered via telehealth and that anyone virtually or physically present during a telehealth visit with a patient may receive Patients personal health information.

Electronic Communication

Supportive Health Care may communicate with patients about their care using email or text messaging. These communications may not be secure and could be assessed by unauthorized third part

Consent for Financial Responsibility

Thank you for choosing Supportive Healthcare as your provider. Providing excellent care is what we are here for and in order to continue providing this service to our patients, financial responsibility must be established. The following policy must be read and agreed to prior to services.

Supportive Healthcare is able to provide medically necessary services to you by ensuring payment in a timely manner. In order to provide these services and ongoing support, we expect our patients to understand and abide by the established policies and procedures including this patient financial responsibility statement.

You are ultimately responsible for all payment obligations stemming from your treatment and care, thus guaranteeing payment for these services. You are responsible for any deductibles, copayments, coinsurance, or non-covered amounts applied to you by your insurance carrier or our policies.

You are responsible for knowing and understanding the benefits provided to you by your insurance carrier. Knowing whether a provider is in-network, requires prior authorization, or even needs a referral will be solely your responsibility. Any denial for reasons such as this will be transferred to you for

payment. If your health coverage has changed or expired, it is your responsibility to alert our offices at 513-699-9090 to give the updated information or make payment arrangements.

By signing the consent signature page, you are agreeing to provide insurance information and allowing Supportive Healthcare to bill and collect payments on your behalf from your insurance carrier. You agree to facilitate the processing of your claims with your insurance should additional information be required or requested. In the event that additional information is not received to process your claims, the balance will be transferred to you and your account treated as self-pay. You further authorize Supportive Healthcare to release information acquired in the course of your treatment and care, including any medical records, notes, tests, diagnostic imaging, labs, or other documents related to this care, where it is necessary to process these claims.

Should incorrect information or omission of information result in untimely filing of claims according to insurance carrier guidelines, these balances will be transferred to you for payment.

Any non-covered or cost sharing amounts due from you once your insurance processes your claims will be billed to you via statement (whether text, electronic, or paper). Timely payment is expected upon receipt of this statement.

Privacy Practice

Supportive health Care is required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

Supportive Healthcare
4850 Smith Road, Suite 250
Cincinnati, OH 45212
513-699-9090
www.supportivehc.com
info@medicalhousecallsllc.com

Patient acknowledges that they have received a copy of this notice and understand their rights within.

Clark's Rx Long Term Care

Pharmacy New Admission Questionnaire

1. If an item is not covered by insurance should we contact you?

   - ☐ Yes, please call on all non-covered items
   - ☐ Yes, please call if the item is over $_____
   - ☐ No, please send all non-covered items
   - ☐ No, never send an item that is not covered by insurance
   - ☐ Other:_____

2. Should Independent Rx LTC provide over-the-counter (OTC) medications?

   - ☐ Yes, please send all OTCs
   - ☐ Yes, please call if the item is over $_____
   - ☐ Yes, please only send OTCs that are covered by insurance
   - ☐ No, I will provide all OTC medications
   - ☐ No, never send an OTC item
   - ☐ Other:_____

3. What is the best phone number to contact you if we need to reach you?

   Phone Number:_____

   Circle One: Cell Phone / Home Phone / Work Phone

4. If there is a charge for a medication, where should the bill be sent?

   Street Address: _____

   City/State/Zip:_____

Patient:_____ Date:_____

Clark's Rx Long Term Care

922 Senate Drive, Centerville, Ohio 45459 ▪ 937.610.3051 ▪ Fax: 937.610.3048

Please fill out the form below so that we can bill your insurance. Attach a photocopy of insurance card if leaving parts of form blank.

Primary Insurance

Insurance Provider:_____ Coverage Start Date:_____

Policy Holder:_____ Relation:_____

Policy ID:_____

RxBin :_____

RxGroup:_____

Secondary Insurance

Insurance Provider:_____ Coverage Start Date:_____

Policy Holder:_____ Relation:_____

Policy ID:_____

RxBin :_____

RxGroup:_____

Tertiary Insurance

Insurance Provider:_____ Coverage Start Date:_____

Policy Holder:_____ Relation:_____

Policy ID:_____

RxBin :_____

RxGroup:_____

922 Senate Drive, Centerville, Ohio 45459 ▪ 937.610.3051 ▪ Fax: 937.610.3048

Credit Card Policy

Dear Long Term Care Customer,

We require that all accounts have a debit/credit card on file. We would like our customers to know they may still pay by check or money order, if they so choose. We are encouraging everyone to provide a debit/credit card number so in the event a bill is not paid at the end of each month, that the card on file will be charged to ensure that pharmacy services are not interrupted due to having a past due account balance. Please fill out the bottom portion of this letter

Sincerely,

The Staff at Clark's Rx Long Term Care

Debit/Credit Card Update

Patient:_____ Facility:_____

Card type (circle):

Visa MasterCard Discover American Express

Card Information

_____

Number Exp. Date Security Code (3- digits)

OR

Opt Out Waiver

If you are choosing to not provide a card to keep on file please sign below. By signing here you acknowledge that if no payments have been made and the account is 60 days past due that the account will be frozen and pharmacy services will not be provided until a payment is made. Any non covered item (including OTC medications) will require POA authorization via phone call or text (937)610-3051 before being delivered if a credit card is not on file. If authorization is not given by the POA, medications could be delayed as a result of choosing to opt out.

_____ _____

Signature Patient/ Guardian/POA Date

922 Senate Drive, Centerville, Ohio 45459 ▪ 937.610.3051 ▪ Fax: 937.610.3048

Pharmacy Services Form

Facility Name:_____

Resident Name:_____

Responsible Party/POA Information:

Name_____Relationship to Resident_____

Address_____City/State/Zip_____

Phone_____Cell Phone_____Email_____

Terms and Conditions

- I agree that facility personnel are authorized to order medications and supplies on behalf of the above named resident.
- I accept responsibility to provide up to date insurance information to the pharmacy.
- I agree to pay all charges incurred for the above named resident that are not covered by third party payers, including Medicaid. This includes all co-pays, non-covered items, over-the-counter items, and supplies that have been specifically ordered for the resident.
- I will pay the entire amount due within the terms of each statement. The pharmacy has the right to discontinue services if the account is past due.
- I agree to pay any costs for collections, including court costs and attorney's fees, for delinquent balances.
- I agree to notify the pharmacy in writing if any changes occur in regards to responsible party or power of attorney information. In addition, I agree to be responsible for payments until this notification is given.
- I understand it is my responsibility to inform the pharmacy of any products or supplies I do not wish to be provided for the resident by the pharmacy.
- I understand that partial packages, refrigerated items, and controlled medications will not be eligible for credit.
- I understand that the pharmacy will not be contacting me regarding the cost of any non-covered medications (including OTCs) prior to dispensing under the cost of $25.00 unless otherwise communicated. Please see the New Admission Questionnaire to customize this amount.

*****If opting out of keeping a form of payment on file, any non covered item will require authorization from this resident's POA via phone call or text (937) 610-3051******

I consent to the release of personal and medical information to any third party payer: governmental agency provided benefit or other person(s)/entity responsible for my treatment charges. In addition, I consent to a similar release of information, as necessary, to initiate and/or continue use of pharmacy, laboratory, or other facility services, and/or transfer to another health care facility.

Signature of Resident/Responsible Party Date

_____ _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Independent Rx Long Term Care will ask you to sign an Acknowledgement that you have received this Notice of Privacy Practices (Notice). This Notice describes how Independent Rx Long Term Care may use and disclose your protected health information in accordance with the HIPAA Privacy Rule. It also describes your rights and Independent Rx Long Term Care's duties with respect to protected health information about you.

Section A: Uses and Disclosures of Protected Health Information

1. Treatment, Payment and Health Care Operations
    a. We will use your health information to provide treatment. This may involve receiving or sharing information with other health care providers such as your physician. This information may be written, verbal, electronic or via facsimile. This will include receiving prescription orders so that we may dispense prescription medications. We may also share information with other health care providers who are treating you to coordinate the different things you need, such as medications, lab work or other appointments. We may also contact you to provide treatment-related services, such as refill reminders, treatment alternatives and other health related services that may be of benefit to you.
    b. We will use your health information to obtain payment. This will include sending claims for payment to your insurance or third-party payer. It may also include providing health information to the payer to resolve issues of claim coverage.
    c. We will use your health information for our health care operations necessary to run the pharmacy. This may include monitoring the quality of care that our employees provide to you and for training purposes.
2. Permitted or Required Uses and Disclosures
    a. Our pharmacists, using their professional judgment may disclose your protected health information to a family member, other relative, close personal friend or other person you identify as being involved in your health care. This includes allowing such persons to pick up filled prescriptions, medical supplies or medical records on your behalf.
    b. We also have contracts with entities called Business Associates that perform some services for us that require access to your protected health information. Examples may include companies that route claims to your insurance company or that reconcile the payments we receive from your insurance. We require our Business Associates to safeguard any protected health information appropriately.
    c. Under certain circumstances Independent Rx Long Term Care may be required to disclose health information as required or permitted by federal or state laws. These include, but are not limited to:
        i. To the Secretary of Health and Human Services for investigations into our compliance with HIPAA rules and to respond to patient complaints.
        ii. To the Food and Drug Administration (FDA) relating to adverse events regarding drugs, foods, supplements and other health products or for post-marketing surveillance to enable product recalls, repairs or replacement.
        iii. To public health or legal authorities charged with preventing or controlling disease, injury or disability.
        iv. To law enforcement agencies as required by law or in response to a valid subpoena or other legal process.
        v. To health oversight agencies (e.g., licensing boards) for activities authorized by law such as audits, investigations and inspections necessary for Independent Rx Long Term Care's licensure and for monitoring of health care systems.
        vi. In response to a court order, administrative order, subpoena, discovery request or other lawful process by another person involved in a dispute involving a patient, but only if efforts have

been made to tell the patient about the request or to obtain an order protecting the requested health information.

vii. As authorized by and as necessary to comply with laws relating to worker's compensation or similar programs established by the law.
viii. Whenever required to do so by law.
ix. To a Coroner or Medical Examiner when necessary. Examples include: identifying a deceased person or to determine a cause of death.
x. To Funeral Directors to carry out their duties
xi. To organ procurement organizations or other entities engaged in procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.
xii. To notify or assist in notifying a family member, personal representative or another person responsible for the patient's care of the patient's location or general condition.
xiii. For certain research purposes.
xiv. To a correctional institution or its agents if a patient is or becomes an inmate of such an institution when necessary for the patient's health or the health and safety of others.
xv. When necessary to prevent a serious threat to the patient's health and safety or the health and safety of the public or another person.
xvi. As required by military command authorities when the patient is a member of the armed forces and to appropriate military authority about foreign military personnel.
xvii. To authorized officials for intelligence, counterintelligence and other national security activities authorized by law.
xviii. To authorized federal officials so they may provide protection to the president, other authorized persons or foreign heads of state or to conduct special investigations.
xix. To a government authority, such as social service or protective services agency, if Independent Rx Long Term Care reasonably believes the patient to be a victim of abuse, neglect or domestic violence but only to the extent required by law, if the patient agrees to the disclosure or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to the patient or to someone else or the law enforcement or public official that is to receive the report represents that it is necessary and will not be used against the patient.

d. During an emergency or disaster relief situation, if you are unconscious or unable to tell us your preference, we may share information to lessen a serious and imminent threat to health or safety.
e. We may contact you for fundraising efforts, but you can request that we not contact you again.

3. Authorized Use and Disclosure
   a. Use or disclosure other than those previously listed or as permitted or required by law, will not be made unless we obtain your written Authorization in advance. You may revoke any such Authorization in writing at any time. Upon receipt of a revocation, we will cease using or disclosing protected health information about you unless we have already taken action based on your Authorization.
   b. Your Authorization is always required for Marketing purposes, Sale of your information, and any sharing of Psychotherapy notes.
4. More Stringent Laws
   a. Some states may have laws that are more stringent than HIPAA. Please refer to the end of the Notice for the laws that may apply.

Section B: Patient's Rights

1. Restriction Requests
   a. You have a right to request a restriction be placed on the use and disclosure of your protected health information for purposes of carrying out treatment, payment or health care operations. Restrictions may include requests for not submitting claims to your insurance or third-party payer or limitations on which persons may be considered personal representatives.

b. Independent Rx Long Term Care is not required to accept restrictions other than payment related uses not required by law that have been paid in full by the individual or representative other than a health plan.
c. If we do agree to requested restrictions, they shall be binding until you request that they be terminated.
d. Requests for restrictions or termination of restrictions must be submitted in writing to the Privacy Officer listed in Section D of this Notice.

2. Alternative Means of Communication
   a. You have a right to receive confidential communications of protected health information by alternate methods or at alternate locations upon reasonable request. Examples of alternatives may be sending information to a phone or mailing address other than your home.
   b. Independent Rx Long Term Care shall make reasonable accommodation to honor requests.
   c. Requests must be submitted in writing to the Privacy Officer listed in Section D of this Notice.
3. Access to Health Information
   a. You have a right to inspect and copy your protected health information. The designated record set will usually include prescription and billing records. You have the right to request the protected health information in the designated record set for as long as we maintain your records.
   b. You have the right to have requested records provided to you in a timely fashion.
   c. You have the right to request that your protected health information be provided to you in your preferred format, including an electronic format if available.
   d. You have the right to have your information disclosed to another person or third-party that you choose.
   e. Requests may be submitted in writing to the Privacy Officer listed in Section D of this Notice.
   f. Any costs or fees associated with copying, mailing or preparing the requested records will be charged prior to granting your request.
   g. Independent Rx Long Term Care may deny your request for records in limited circumstances. In case of denial, you may request a review of the denial for most reasons. Requests for review of a denial must also be submitted to the Privacy Officer listed in Section D of this Notice.
4. Amendments to Health Information
   a. If you believe that your protected health information is incomplete or incorrect, you may request an amendment to your records. You may request amendment to any records for as long as we maintain your records.
   b. Requests must be submitted in writing to the Privacy Officer listed in Section D of this Notice.
   c. Requests must include a reason that supports the amendment to your health information.
   d. Independent Rx Long Term Care may deny amendment requests in certain cases. In case of denial, you have the right to submit a Statement of Disagreement. We have the right to provide a rebuttal to your statement.
5. Accounting of Uses and Disclosures
   a. You have the right to request an accounting of uses and disclosures that are not for treatment, payment or health care operations. This accounting may include up to the six years prior to the date of request and will not include an accounting of disclosures to yourself, your personal representatives or anything authorized by you in writing. Other restrictions may apply as required in the Privacy Rule.
   b. Requests must be submitted in writing to the Privacy Officer listed in Section D of this Notice.
   c. The first accounting in any 12-month period will be provided to you at no cost. Any additional requests within the same 12-month period will be charged a fee to cover the cost of providing the accounting. This fee amount will be provided to you prior to completing the request. You may choose to withdraw your request to avoid paying this fee.
6. Notice of Privacy Practices

a. You have a right to receive a paper copy of this Notice even if you previously agreed to receive a copy electronically.
b. You have a right to request a revised or updated copy of this notice.
c. Please submit a request to the Privacy Officer listed in Section D of this Notice.

Section C: Independent Rx Long Term Care's Duties

Independent Rx Long Term Care is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.
Independent Rx Long Term Care is required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make the new notice provisions effective for all protected health information that we maintain. Any such revised Notice will be made available upon request.

Section D: Contacting Us

1. Additional Questions, Submitting Requests or Complaints
   a. If you have questions about this Notice or how Independent Rx Long Term Care uses and discloses your protected health information please contact our Privacy Officer below.
   b. You may obtain forms needed for request submission from our pharmacy or from our Privacy Officer.
   c. If you believe your privacy rights have been violated you may file a complaint with our Privacy Officer or with the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint.
2. Privacy Officer

   Patrick R. Howell, Pharmacy Manager
   Independent Rx Long Term Care
   922 Senate Dr
   Centerville, OH 454594017
   (937) 610-3051
3. Secretary of Health and Human Services, Office for Civil Rights
   a. For online complaint forms and contact information for the Regional OCR offices: http://www.hhs.gov/ocr/privacy/index.html
   b. Email: OCRComplaint@hhs.gov for assistance or questions about complaint forms

Section E: State Specific Requirements

Version # 3677448-PAAS-2018-3.0
Effective Date
This Notice of Privacy Practices is effective as of 10-02-2019

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Independent Rx Long Term Care's Notice of Privacy Practices.

_____ ____/____/_____
Name of Patient (Please Print) Date of Birth

_____ ____/____/_____
Signature of Patient or Personal Representative Date

_____ _____
Name of Personal Representative (Please Print) Relationship to Patient

Documentation of Good Faith Effort to obtain acknowledgment of receipt of Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient)

I hereby certify that on ___/___/_____ (mm/dd/yyyy), I made a good faith effort to obtain the above patient's written acknowledgement of his/her receipt of Independent Rx Long Term Care Notice of Privacy Practices. However, such acknowledgment was not obtained because:

❑ Patient refused to sign
❑ Patient was unable to sign or initial because:
_____
❑ The Patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
❑ A copy of the Notice was **MAILED / E-MAILED** (circle one) to most recent address on file.
❑ Other Reason:
_____

_____
Printed name of employee completing form

_____ ____/____/_____
Signature of employee completing form Date

**Per HIPAA documentation requirements pharmacy must keep the patient's signature acknowledging receipt of Notice of Privacy Practices for a minimum of six years.*

Patient Name (Printed): _____
DOB (mm/dd/year): ____/____/_____

PATIENT ACKNOWLEDGEMENT AND INFORMED CONSENT FOR TREATMENT

On behalf of myself, or the patient named herein, if applicable, I acknowledge that I understand and hereby consent to all the statements made in this form. Changes or alterations to this form are not binding on MINDCARE and/or its affiliated facilities (each and all of them referred to as "MINDCARE" in this form).

INFORMED CONSENT TO HEALTH CARE SERVICES

I am hereby requesting that health care services be provided to me (or the patient named below) by MINDCARE. I voluntarily consent to all medical treatment and health care-related services that the personnel of MINDCARE considers to be necessary for me or the patient named herein. These services may include examinations, diagnostic, therapeutic or imaging procedures, psychotherapy, psychiatric services, counseling services, behavioral health integration or other care coordination services, the administration of drugs orally or by injection, the retrieval of specimens, and laboratory services, including potentially HIV testing. If I want any HIV testing to be performed anonymously, I will tell my MINDCARE caregiver. My blood may be used to perform routine quality assurance testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

I understand and agree that MINDCARE may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

I understand that my insurance may periodically require me to have an in-person visit with a health provider if I am using telehealth visits. MINDCARE will follow all requirements of my insurance with regard to telehealth visits. As indicated below, I am requesting an exception to the in-person visit requirement for the following reason:

REQUIRED

_____ Travel to an in-person appointment is a hardship to me.

_____Due to unavailability of my provider or myself, I have been unable to schedule an in-person visit.

ASSIGNMENT OF INSURANCE BENEFITS/THIRD-PARTY PAYERS

In consideration of all health care services rendered or about to be rendered to me (or the named patient), I hereby assign to MINDCARE all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding MINDCARE's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by MINDCARE to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

FINANCIAL RESPONSIBILITY

Subject to applicable law and the terms and conditions of any applicable contract between MINDCARE and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the named patient), I agree to be financially responsible and obligated to pay MINDCARE for any balance not paid by my health care insurance under the "Assignment of Insurance Benefits/ Third Party Payers" paragraph above. I also agree to pay for any expense incurred by MINDCARE in collecting the amounts I have agreed to pay, including all court costs, reasonable attorney's fees and all other collection expenses.

USES AND DISCLOSURES OF HEALTH INFORMATION

I have received MINDCARE's Notice of Privacy Practices. The Notice of Privacy Practices explains how MINDCARE may use and disclose confidential health information that identifies me (or the named patient). I consent to let MINDCARE use and disclose health information about me (or the named patient) as described in the Notice of Privacy Practices. In doing so, I consent to the release of my (or the named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by MINDCARE, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent MINDCARE or provide assistance to MINDCARE for the purposes of securing payment from all parties who are potentially liable for payment for my (or the named patient's) health care, including for substance abuse, psychiatric care, psychology care, counseling or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that MINDCARE has already relied on my consent.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to MINDCARE on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from MINDCARE and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from MINDCARE or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

I hereby consent and grant to MINDCARE the right and authority to photograph and/or record me, my image and voice, which could occur in connection with my diagnosis and treatment, and I agree that upon creation such images and/or recordings are owned by MINDCARE. I understand that I have the right to request cessation of recording or filming at any time. I agree to release and forever discharge MINDCARE, its agents, officers, employees and subcontractors from any and all claims arising out of or in connection with the use of these images and/or recordings including, but not limited to, any claims for invasion of privacy, right to publicity or defamation.

By signing below, I am indicating that I have reviewed, understand, acknowledge and consent to the terms described above.

IN PERSON CONSENT	
Signature of Patient or Legal Representative REQUIRED → **X** _____	**Date and Time** _____
Printed Name of Patient REQUIRED → _____	**Relationship of Legal Representative to Patient** (parent, legal guardian, relative or other person who arranges patient's treatment

REQUIRED

Printed Name of Legal Representative, if applicable	of manages patient's affairs, relative or other person who receives Government benefits on patient's behalf)

PREFERRED PODIATRY GROUP

PODIATRY CONSENT FORM

NH-19563
Laurelwood Senior Living
3797 Summit Glen Dr, Dayton
OH, 45449-3661

I hereby request Preferred Podiatry Group (PPG) to assume responsibility for podiatry evaluation and treatment for:

_____ until I cancel service in writing.

(please print patient name)

I understand that PPG takes assignment. All bills shall be directed towards Medicare, Medigap, MMAI and insurance carriers when possible. I am responsible for the deductible and co-insurance when not covered by supplemental insurance or Medicaid. I authorize Medicare and my insurance to send payments directly to PPG. I also authorize the release of any information from any agency or carrier to PPG for purposes of administering the Medicare program. I also authorize PPG to release any required information to any agency, insurance carrier, or Medicare as needed. I acknowledge that Preferred Podiatry Group, P.C. has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can request access to this information. I understand that if I have questions or complaints, I may contact the Privacy Officer at privacy@ppgpc.com. I also understand that I will receive updates if Preferred Podiatry Group, P.C. makes material changes to its Notice of Privacy Practices.

REQUIRED: SIGNATURE AND REFERRING PRIMARY CARE PROVIDER INFORMATION

_____ _____

(Signature of Patient, Guardian, Responsible Party, or Capacity of Signature) Date

For verbal authorizations, the individual who obtained consent from the consenting party should put signature and title on the line above.

If consent was obtained verbally, please print name of consenting party: _____

PCP Name (Last, First)	**Phone Number**	**Last Date Seen by PCP**
Primary Care Provider Address		

PLEASE COMPLETE THE FOLLOWING OR ATTACH RESIDENT'S FACESHEET WITH INSURANCE:

SOCIAL SECURITY NUMBER		PATIENT DOB
MEDICARE NUMBER		MEDICAID NUMBER
SECONDARY INSURANCE	ID NUMBER	GROUP NUMBER
INSURANCE ADDRESS		INSURANCE PHONE NUMBER
RESPONSIBLE PARTY NAME	PHONE NUMBER	EMAIL ADDRESS
ADDRESS	CITY AND STATE	ZIP CODE

LAURELWOOD
Assisted Living & Memory Care

Please have the Primary Care Physician fill out the following paperwork and sign every space that has a X next to it. If they do not have the time to write in the medications, please include an up-to-date medication list with a signature on **both** the paper included and the medication list they are including. **The paperwork must be received a full 48 business hours prior to admission.** They are admitting on _____ **paperwork needs to be turned in no later than** _____

Please bring back or fax back to (937)-436-0480, if you have any questions, please call me at 937-436-6155.

Thank you for all your help!

Kate Schmidt
Sales Director
Laurelwood Assisted Living and Memory Care

HEALTH ASSESSMENT FOR ASSISTED LIVING - OHIO

☐ Initial Assessment ☐ Annual Assessment

RESIDENT NAME_____ DATE_____

VITALS: TEMP_____ PULSE_____ RESP_____ B/P_____ HEIGHT_____ WEIGHT_____

Last FLU Vaccine_____ PNEUMOCOCCUS Vaccine_____

CODE STATUS: ☐ Full Measures ☐ DNR-CC ☐ DNR-CC-Arrest $ Undecided

CURRENT MEDICAL DIAGNOSIS - CHANGES IN MEDICAL DIAGNOSIS	
PSYCHOLOGICAL HISTORY (if applicable)	
DEVELOPMENTAL DIAGNOSIS (if applicable)	
DIETARY REQUIRMENTS	**Food Allergies:** **Diet:** ☐ Residents needs can be met with a regular diet, all diets are no added salt. ☐ Resident needs can be met with a CCHO diet.
CURRENT MEDICATIONS	Allergies
MEDICATION ADMINISTRATION	☐ Resident is mentally & physically capable of self-administration ☐ Resident needs to be reminded to take medications ☐ Resident requires administration of medications
MANTOUX TESTING (Must be COMPLETED within 90 days prior to admission)	Mantoux test provided on : _____ Results ____ mm read on: _____ Mantoux is contraindicated due to: Last chest x-ray completed on _____ ☐ No indications of TB ☐ Active TB cannot be ruled out Annual Mantoux Provided: Results:

HEALTH ASSESSMENT FOR ASSISTED LIVING - OHIO

HEALTH HISTORY & PHYSICAL	**Cognitive Functioning:**
	Sensory Impairments:
	☐ Glasses ☐ Hearing Aid(s) ☐ Dentures ☐ Other
	Physical Impairments:
	Ambulatory Status:
	☐ Independent ☐ Ambulatory with assistive device: ☐ Walker ☐ Cane
	☐ Assist with transfer: ☐ One person ☐ Two person ☐ Non Ambulatory
INDEPENDENT ADL's	**Telephone Use:** ☐ Independent ☐ Assistance needed ☐ Dependent on others
	Shopping: ☐ Independent ☐ Assistance needed ☐ Dependent on others
	Food Preparation: ☐ Independent ☐ Assistance needed ☐ Dependent on others
	Transportation: ☐ Independent ☐ Assistance needed ☐ Dependent on others
	Housekeeping/Heavy Chores: ☐ Staff to perform all tasks
	☐ Does daily tidying/staff to do weekly cleaning and heavy work
	Laundry: ☐ Independent ☐ Assistance needed ☐ Dependent on others
	Managing Legal/Financial Affairs:
	☐ Independent ☐ Assistance needed ☐ Dependent on others
	Yard Work/Maintenance: ☐ Desires staff to complete all maintenance issues
	☐ Unable to perform and staff must complete all maintenance/yard issues
TYPE OF CARE OR SERVICES RESIDENT REQUIRES	Type:
	Amount:
	Frequency:
	Duration:
REQUIRED PHYSICIAN DETERMINATION	Can resident's needs be met in an Assisted Living Community ☐ Yes ☐ No
	Does resident require "specialized care unit" (our secured environment) based on their current Cognitive status, for their safety and well being? ☐ Yes ☐ No
Other Physician Notes	

X PHYSICIAN'S SIGNATURE X _____ DATE X _____ X

ASSISTED LIVING ADMISSION ORDER FORM
Please fax to Clark's Rx upon completion (937.610.3048)

Facility Name:_____ Wing:_____ Room:_____ **IL ☐ AL ☐ MC ☐**

RESIDENT NAME:_____ DOB:_____ Adm. Date:_____

Sex: Male_____ Female_____ Social Security #:_____

Physician name, Printed:_____ Physician Phone:_____

Paytype (Circle one): Private Pay VA

Insurance Provider:_____ ID#:_____ (Please fax copy to Clark's)

Responsible Party Name and relationship:_____ Phone #:_____

Street Address:_____ City:_____ State:_____Zip:_____

Allergies: _____NKDA _____Yes (please list) Diagnosis:_____

_____ _____

MEDICATIONS: (reason needed for PRN's)

	Name	Strength	Route	Frequency	Time	Reason	Indicate if	Date Need
1.							☐ Do not Send	
2.							☐ Do not Send	
3.							☐ Do not Send	
4.							☐ Do not Send	
5.							☐ Do not Send	
6.							☐☐ Do no Send	
7.							☐ Do not Send	
8.							☐☐ Do not Send	
9.							☐ Do not Send	
10.							☐ Do not Send	

Diet:_____
Labs:_____
Additional Orders:_____
Administration of Meds (check only one that applies):
_____ Resident is able to take medications independently **(SELF ADMINISTER)**
_____ Requires assistance with medication _____ Requires medications to be administered

X Physician Signature:_____ Date:_____
TO Verification (Nurse):_____ Date:_____

By signing this document I authorize Clark's Rx to refill the above prescriptions, with the exception of controlled medications, for a period of 1 year or until the date of the next signed Physician Order, unless otherwise indicated on this form.

RESIDENT NAME:_____ DOB:_____ Adm. Date:_____

ADDITIONAL MEDICATIONS: (reason needed for PRN's)

	Name	Strength	Route	Frequency	Time	Reason	Indicate if	Date Need
11.							☐ Do not Send	
12.							☐ Do not Send	
13.							☐ Do not Send	
14.							☐ Do not Send	
15.							☐ Do not Send	
16.							☐☐ Do no Send	
17.							☐ Do not Send	
18.							☐☐ Do not Send	
19.							☐ Do not Send	
20.							☐ Do not Send	
21.							☐ Do not Send	
22.							☐ Do not Send	
23.							☐ Do not Send	
24.							☐ Do not Send	
25.							☐ Do not Send	
26.							☐ Do not Send	
27.							☐ Do not Send	
28.							☐ Do not Send	
29.							☐ Do not Send	
30.							☐ Do not Send	

X Physician Signature:_____ Date:_____
TO Verification (Nurse):_____ Date:_____

DNR COMFORT CARE

DNR IDENTIFICATION FORM

(Check only one box)

☐ **DNRCC** (If this box is checked the DNR Comfort Care Protocol is activated immediately.)

☐ **DNRCC-Arrest** (If this box is checked, the DNR Comfot Care Protocol is implemented in the event of a cardiac arrest or a respiratory arrest.)

Patient Name:		
Address:		
City:	State:	Zip:
Birthdate:	Gender: ☐ M ☐ F	
Signature: (optional)		

Certification of DNR Comfort Care Status (to be completed by the physician)*

(Check only one box)

☐ **Do-Not-Resuscitate Order**—My signature below constitutes and confirms a formal order to emergency medical services and other health care personnel that the person identified above is to be treated under the State of Ohio DNR Protocol. I affirm that this order is not contrary to reasonable medical standards or, to the best of my knowledge, contrary to the wishes of the person or of another person who is lawfully authorized to make informed medical decisions on the person's behalf. I also affirm that I have documented the grounds for this order in the person's medical record.

☐ **Living Will (Declaration) and Qualifying Condition**—The person identified above has a valid Ohio Living Will (declaration) and has been certified by two physicians in accordance with Ohio law as being terminal or in a permanent unconscious state, or both.

Printed name of physician*:	
Signature:	Date:
Address:	Phone:
City/State:	Zip:

*A DNR order may be issued by a certified nurse practitioner, clinical nurse specialist, or a physician assistant when authorized by section 2133.211 of the Ohio Revised Code.

See reverse side for DNR Protocol

Let's get social!

Laurelwood Assisted Living and Memory Care

Scan me!

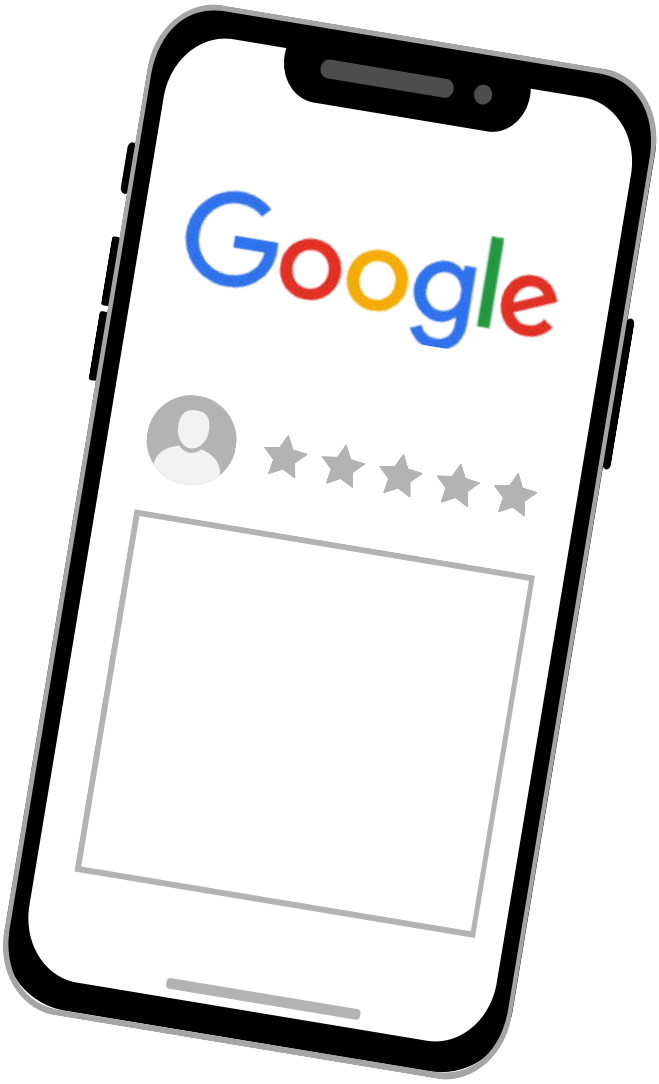
Follow us on Facebook

Get in touch

937-436-6155

3797 Summit Glen Drive
Dayton, OH 45449

Laurelwood Assisted Living and Memory Care



How are we doing? Leave us a Google review!

Get in touch

937-436-6155

3797 Summit Glen Drive

Dayton, OH 45449