House of Love Independent Living

ADMISSION APPLICATION

PART 1. PERSONAL INFORMATION

The information requested will be used for the purpose of determining eligibility for admission and is subject to verification.

1. Full Name of Applicant: _____

2. Street Address:_____

3. City/State _____ Zip Code: _____

E-Mail: _____

4. Telephone:_____ Cell: _____

5. Social Security Number: _____ Medicare Number:_____

Date of Birth: _____ Age: _____Marital Statue: _____

Spouse Name (if applicable) _____

Place of Birth - City_____ State:_____County:_____ Country: _____

5. Insurance:

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6. The House of Love Independent Living requires all resident to have at least two(2) "'Personal Representative" individuals that have the legal authority to act on the resident's behalf to:

A. MAKE HEALTH CARE DECISIONS ON BEHALF OF THE RESIDENT WHEN APPROPRIATE AND/OR:

B. ADMINISTER FINANCES WHEN THE RESIDENT CHOSES NOT TO OR IS UNABLE.

Please list below the individuals you have legally empowered:

Name: _____ Relationship: _____

Phone #: _____ Address: _____

List and attach Type of Legal Authority: - ----------

Name:_____ Relationship:_____

Address:_____ Phone Number:_____

City/State:_____E:mail:_____

List and attach Type of Legal Authority _____

7. Significant Other(s): Children, Relatives or Friends. The House of Love Independent Living will contact the individuals that have the legal authority to act on your behalf. You must indicate to The House of Love who you wish to be notified first; if this is different than indicated on the previous sheet.

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1. Mother's Full Maiden Name: _____
2. Father's Full Name: _____
3. Education Completed- List School and/or Technical Training, Location, Years Attended & Degree

   High School:_____ College_____

   Graduate School: _____

4. Professional Training or Trade School: _____

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5. Occupation (While Employed): _____
6. Spouse's Occupation:_____
7. Did you serve in the Armed Forces of the U.S.?_____ Branch:_____
8. Have you ever been convicted of a crime (excluding minor traffic violations)? Yes:_____No:_____ _
9. If you answered yes to #8, describe in full: _____

   Do you currently receive support services for your day-to-day routine from friends, relatives, and/or employed individuals? Yes: _____ No:_____

10. If the answer to #9 is Yes, explain in detail below.

Types of services received:_____

How often do you require assistance & by whom?_____

11. Religion: _____

12. Church Affiliation: _____

13. Church Address: _____

14. City: _____ State:____ Zip Code_____

14. How did you hear of The House of Love Independent Living? _____

15. Hobbies, interests and/or volunteer service: _____

I certify that all information in this application is true, correct, complete and not misleading as of the date set forth below my signature. I further acknowledge my understanding that any intentional or negligent misrepresentation(s) of the information contained may disqualify me from admission to The House of Love. I understand that if I am accepted to live at The House of Love Independent Living and it is determined that information I provided was not correct, true, incomplete or misleading, it may result in my subsequent discharge from The House of Love.

I understand The House of Love Independent Living is a Christian Personal Care Home, is not under any one denomination or organization of churches. I understand, further, that The House of Love Independent Living's intention in admitting residents is to accept those of different denominations and churches as well as to provide opportunities for study and worship in keeping with the practices of faith-directed lives.

No smoking, fire arms, including explosive material, recreational drugs or disruptive behavior anywhere on campus will be allowed.

I make this application for residence of my own free will and accord. I fully understand that the completion and submission of this application in **NO WAY** guarantees my admission to The House of Love Independent Living.

Signature of Applicant: _____

Date

Consent to Treatment

The Resident acknowledges that the Facility renders services to the Resident under the general and specific instructions of the Resident' s Attending Physician . Resident authorizes and directs Facility to provide routine and emergency care as required for the resident's well-being, health, and safety in accordance with the orders of such physicians.

_____

Resident's Name (Print)

_____

Resident' s Signature

_____

Legal Representative Signature (Family Member)

_____

Responsible Party Signature

_____

Facility Representative Signature

_____

Date

THE HOUSE OF LOVE INDEPENDENT LIVING FACILITY

HEALTH CARE ADMISSION AGREEMENT

This Agreement is made by and between The House of Love Independent Living Facility hereinafter referred to as Facility, and _____ hereinafter referred to as Resident**.**

General Information

This is a legal document creating rights, responsibilities and obligations for each person or party signing this Agreement. Please read this Agreement carefully before you sign it. If you do not understand any provision of this Agreement, please obtain clarification before you sign. If you choose, you may have your legal counsel or other advisor review this Agreement before you sign.

I. References to Parties:

References to **"we," ·'our,"** the **Facility,"** and to **"our Facility"** are references to the **The HOUSE OF LOVE INDEPENDENT LIVING FACILITY.**

References to **"you"** and **·your"** are references to any person signing this Agreement as Resident.

A Legal Representative or *Responsible Party* may also sign this Agreement as applicable.

A **Legal Representative** is an individual who, under independent legal authority, such as a court order has authority to act on the Resident's behalf. Examples of a Legal Representative include a guardian, a conservator, and the holder of a Durable Power of Attorney executed by the Resident. Documents evidencing a person's Legal Representative status must be provided to us. **If you have a court appointed guardian or conservator he or she is required to sign this Agreement**.

A **Responsible Party** is an individual who voluntarily agrees to honor certain specified obligations of the Resident under this Agreement without incurring any personal financial liability. Examples of a Responsible Party include a relative or a friend of the Resident. We may not require a person to sign this Agreement as a Responsible Party unless the person has legal access to or physical control of the Resident's income or resources to pay for the care and services we provide and others that you request. **We may decline to admit any Resident who has no source of payment for all or part of the Resident's stay**.

2. Limitations on the Obligations of a Legal Representative and Responsible Party under this Agreement:

If you sign this Agreement as a Legal Representative or Responsible Party, you incur no financial liability by doing so. We will not require a third party to guarantee payment to us as a condition of admission to, of expedited admission to or of continued stay in our Facility.

3. Obligations of a Legal Representative or Responsible Party under this Agreement:

If you sign this Agreement as a Legal Representative or Responsible Party, you agree to use the Resident's available income and resources to pay for the Resident's care and services.

By signing this Agreement as a Legal Representative or Responsible Party, you also agree to apply for benefits to which the Resident may be entitled, such as Medicaid Program benefits, and to furnish third party payors, such as the Medicaid Program, with information and documentation concerning the Resident which reasonably is available to you and which is necessary to the processing of the Resident's application for third party payor benefits.

4. Rights of Legal Representative or Responsible Party Under this Agreement:

By signing this Agreement as a Legal Representative or Responsible Party, you have the right to participate in the care planning process for the Resident.

5. An accident or incident involving the Resident that results in injury and has the potential for requiring physical intervention;
   a. A significant change in the Resident's physical. mental, or psychosocial status; or
   b. A need to alter the Resident's treatment significantly.

You are also entitled to receive all notices required to be sent to the Resident by current law or by this Agreement.

Payment

It is my understanding that the move-in date will be _____, 2024. The monthly rental amount is $ _____.00 for a shared room. That amount must be paid prior to move-in and no later than _____, 2024.

Beginning on _____, 2024, we shall provide personal care services to you in exchange for payment. You are responsible for paying the for personal care and services we provide to you as described below.

If Resident has to go to the hospital for medical care or intends to go on vacation, all rents are still required to be paid as rent becomes due.

l. Private Payment:

You agree to pay the **Facility** our monthly rate for personal care services we provide to you. Such payment shall be made one month at a time, on the first of each month. All funds are non-refundable. Payments may be paid by cashier's checks, money orders or direct deposit. **No Personal checks are accepted**. **A late fee of $85.00 per day will be charged after the 5th day of each month**.

The basic daily rate includes payment for provider services, use of a bed and the room in which the bed is located, linens, bedding, routine laundry service, regular meals and snacks, certain equipment , social and activity services, and routine personal hygiene items which are required to meet your needs.

2. Collection Costs and Attorneys' Fees:

We will not require you or your Legal Representative or Responsible Party to agree, as a condition of admission, expedited admission, or continued stay in our Facility to pay attorney's fees or any other costs incurred in collecting payment for facility care and services we provide to you.

3. Bed Hold:

If we hold or reserve a vacant bed for you at your request and the charges for the bed are not paid by insurance or any third-party payor, you are responsible for paying our daily charges for the bed for each day we hold or reserve the bed for you. Our bed hold/reservation requirements is based on your daily private basic charge.

4. Credit:

Our Facility does not extend credit nor accept payment in installments. Payments of the aggregate daily rate are due in advance on the first day of each month. **If the monthly payment is not received in full by the 5th of each month, the Resident will incur a daily charge of $85.00 per day until the monthly rate is paid in full**.

Any payment made by you, or any payment made on your behalf (e.g., insurance company or governmental entity), **which is less than the full amount due the Facility under this Agreement shall be treated as *partial payment*** on

your account even if you or someone writes on the cashier's check '·payment in full." **Payments are accepted by cash, cashier's check or direct deposit only. No personal checks are accepted.**

5. Advance Notice of Voluntary Resident Discharge from the Facility:

You may leave the Facility at any time. However, we require a thirty day (30) advance notice of your wish to be discharged from the Facility. We reserve the right to charge you for a one week stay if you leave our Facility without advance notice of your discharge.

Transfer or Discharge Rights

1. Voluntary Transfer or Discharge:

You may discharge yourself from our Facility at any time, subject to our right to charge you for a one (1) week stay if you leave our Facility without our required thirty day (30) advance notice policy. We will assist you as necessary in arranging for your voluntary transfer or discharge.

2. Involuntary Transfer or Discharge:

a. Transfer Within the Facility:

We will not transfer you from room to room within our Facility contrary to your wishes except to meet your health care or safety needs which otherwise could not be met, as documented in your clinical record by your attending physician.

b. Transfer from Unit or Discharge From the Facility:

We may involuntarily transfer or discharge you only for one of the following reasons:

(1) The transfer or discharge is necessary for your welfare because your needs can no longer be met in our Facility;

(2) The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer need the services or our Facility; Your presence is our Facility endangers the safety or health of other individuals;

(3) You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) or private pay for your stay at our Facility, or

(4) We cease to operate as a personal care home facility.

Before we involuntarily transfer or discharge you, we will give you and your Legal Representative or Responsible Party a thirty (30) day advance notice of such transfer or discharge unless such transfer or discharge is based on the safety or health of you or others, or if you have resided in our Facility for less than thirty (30) days.

As a minimum, the written notice will:

(1) Specify the reason(s) for the impending transfer or discharge;

(2) List the effective date of the transfer or discharge; and

(3) **The location to which you will be transferred or discharged**.

The written notice will also inform you that you have the right to appeal the transfer or discharge decision and will provide you with the names and telephone numbers of agencies available to furnish you with legal and other assistance relative to the transfer or discharge.

Personal Property

1. Management of Your Personal Funds:

You have the right to manage your personal financial affairs. The Facility will **not hold and safeguard money for you**.

2. Loss of Personal Property:

We will not require you, or your Legal Representative or Responsible Party, to agree to waive or limit our Facility's liability for loss of your personal property suffered as a result of negligence on the part of facility management, employees or agents. However, our facility is only responsible for loss of personal property that is caused by facility management, employees or agents.

Medical Treatment

1. Right to Refuse Medical Treatment:

By signing this Agreement, you consent to receive the facility care and services we have agreed to provide to you. You consent to routine medical care, as recommended (ordered) by your attending physician.

You have the right to refuse any care or medical treatment. If you are incapable of making your own medical decisions, or become so in the future, we will follow the direction of your legally authorized alternative health care decision maker or guardian.

You have the right to be fully informed about the medical care The House of Love of Independent Living we provide to you. Your inquiries will be handled promptly by our administrative care staff.

2. Appointing a Personal Physician:

You have the right to receive care from an attending physician of your choice. You must provide our Facility with your attending physician's name and telephone number. Our Facility does have a physician credentialing process and your physician must have privileges at.

If you have no attending physician, or do not provide us with the information concerning your attending physician, we will consult with you and assist you in selecting an attending physician of your choice. **If, after consultation, you do not select a physician, we will select an attending physician for you**. If we select an attending physician for you, we will make all reasonable efforts to ensure that the services of the physician are covered by your health insurance, if any, and we will provide you with the physician's name, telephone number and specialty.

In the event of a life-threatening emergency, we will make reasonable efforts to contact your attending physician, and if we are unable to do so, we may obtain the services of another physician. You are responsible for payment of physician services not covered by your insurance programs.

3. Selecting a Pharmacy:

While residing at our Facility, you have the right to utilize the services of a pharmacy of your choice; however, you acknowledge that your choice of pharmacy must meet certain requirements established by this Facility as well as limitations imposed by your health insurance provider. You agree not to bring medications or drugs into our Facility unless those medications or drugs are accurately labeled and delivered to our supervisor in charge and responsible for your care.

Visitors

You have the right to have visits from family members and physicians. Other persons may visit you during our regularly scheduled visiting hours. The only restrictions for visiting hours are during meal times. Breakfast is served at 8:00 a.m., lunch is served at noon and dinner is served at 5:00 p.m. We ask that family members and friends not visit at these times.

Release of Information

Your medical and clinical records are protected under current federal and state guidelines and regulations. Only you, your Legal Representative, Responsible Party, or autho1ized government agencies may have access to your medical and clinical records. Your written consent will be required for the release of information to individuals or entities with the exception of authorized federal and state agencies.

Resident Rules and Regulations

You agree to comply with our Facilities rules, regulations, policies and procedures as we from time to time establish and make available to you. By signing this Agreement, you are attesting that we provided you with a copy of our Facility's rules and regulations.

Insofar as practical, we will provide you with thirty (30) days written advance notice of changes in our rules and regulations. However, should circumstances arise that necessitates an immediate change, a shorter time frame may be used.

Advance Directives

You may provide us with advance directives specifying your wishes as to the care and services you desire to receive in certain situations. Such an advance directive may be a separate form or contained within a Durable Power of Attorney, or Health Care Proxy. While it is not a condition of admission, you may provide us with a Health Care Proxy designating an individual to make health care decisions for you in the event you become incapable of doing so or in the event you are unable to communicate your health care decisions to us. If you have an advance directive, it is important that you provide a copy of the directive to us so that we may inform our staff to ensure that your wishes are respected.

If you require assistance in formulating an advance directive, we will provide assistance to you in accordance with current federal and state guidelines governing advance directives.

Private Duty Nursing Personnel and Physicians

You may, at your expense, engage private duty nursing personnel (e.g., RNs, LPNs, Aides, etc.) and physicians to provide personal care to you. All private duty personnel are required to comply with all facility rules, regulations and policies governing resident care issues. We reserve the right to exclude from the Facility any private duty personnel who fails to comply with our rules, or who has been accused of abuse, neglect, or theft of property.

Miscellaneous

This Agreement shall be interpreted and enforced in accordance with the laws of the State of Texas.

The invalidity or unenforceability of any particular provision of this Agreement shall not affect the validity or enforceability of the remaining provisions. However, instead of such invalid or unenforceable provision, the parties agree that a court may add as part of this Agreement a provision as similar in terms to such illegal, invalid, or unenforceable provision as may be possible and as may be legal, valid, and enforceable.

This Agreement and the Attachments to this Agreement constitute the entire agreement and understanding between you and us with respect to the subject matter of this Agreement and supersede all prior agreements and understandings relating to the subject matter of this Agreement. There are no agreements, understandings, restrictions, warranties, or representation between you and us other than those set forth in this Agreement, or incorporated in this Agreement by reference.

This agreement may be amended only by a document in writing signed by you and us, and no act or omission of any employee or agent of our Facility shall alter, change or modify any of the provisions of this Agreement.

The waiver of any party to this Agreement of any breach or default of this agreement by any other party shall not operate as a waiver of any subsequent breach or default by the other party.

THE PARTIES HEREBY EXECUTE THIS RESIDENT ADMISSION AGREEMENT

Date	Signature Karen Brooks,
Date	Signature Resident
Date	Signature of Legal Representative (if applicable)
Date	Signature of Responsible Party (if applicable)