RESIDENT ADMISSION PACKET

_____

Name of Resident

CHECKLISTS:

FOR FACILITY:

____ Acknowledgement of Receipt of Forms on Admission
____ Determination Form
____ Doctor's Authorization
____ Consent for Resident Stay in the Facility
____ Preliminary Admission Data
____ Residency Agreement
____ Resident's Preferences
____ Resident's Rights
____ Agency Phone Numbers
____ Internal Facility Requirements
____ Emergency Orientation
____ Release of Liability
____ Daily Routine
____ Resident's Orientation
____ Pneumonia/Influenza Shots
____ Advance Directives

Use this Forms Only When Applicable
_____ Authorization to Take Places
_____ Resident Transportation Recording Form
_____ Resident Medical Release Form
_____ Consent and Authorization to Release Photo
_____ Residency Agreement (ALTCS)
_____ Residency Discharge Form
_____ For Respite Residents Form
_____ Resident Leave of Absence

Provide These Copies1 to Resident or their representative with their signature: _____ Residency Agreement
_____ Addendum to Residency Agreement
_____ Resident's Rights
_____ Agency Phone Numbers
_____ Internal Facility Requirements
_____ Emergency Orientation
_____ Daily Routine
_____ Resident's Orientation

ACKNOWLEDGEMENT OF RECEIPT OF FORMS ON ADMISSION

The resident and/or the resident's representative acknowledges receipt

of: A Signed Residency Agreement

Scope of Services

Resident Rights

Health Care Directives

_____ _____ Resident or Resident's Representative Date

_____ _____ Facility Representative Date

PRELIMINARY ADMISSION DATA

RESIDENT'S DATE OF ACCEPTANCE: _____ MARITAL STATUS: S / M / D / W LAST NAME:_____FIRST NAME:_____DOB:_____

SOCIAL SECURITY#: _____REFFERED BY:_____

MEDICARE #: _____SECONDARY INSURANCE NAME/NUMBER:_____

ADDRESS BEFORE ADMISSION:_____

_____

NOTE: HOME WILL NEED A COPY OF EACH INSURANCE CARD FOR EMERGENCY PURPOSES

Emergency contact/ POA: _____Relationship:_____
Address: _____
Cell Phone: _____Home Phone:_____ Other:_____
Alternate Emergency contact: _____Relationship:_____
Address: _____

Cell Phone: _____Home Phone:_____ Other:_____
Primary Care Physician: _____
Address: _____
Phone Numbers: _____
Other Medical Practitioners (If applicable): _____
Address: _____
Phone Numbers: _____
Home Health/ Hospice Agency Use (If applicable): _____
Address: _____
Phone Numbers: _____
Case Manager: _____
Address: _____
Phone Numbers: _____
Clergy/Chaplain:
_____ Address:
_____ Phone
Numbers: _____
Mortuary: _____
Address: _____
Phone Numbers: _____

RESIDENT/ POA SIGNATURE: _____*DATE*: _____
FACILITY REPRESENTATIVE SIGNATURE: _____*DATE*: _____

RESIDENCY AGREEMENT

This is an agreement between _____and _____ who asserts that he/she is legally empowered to incur and discharge and conduct the personal and legal affairs of _____hereafter known as the Resident.
Date of occupancy:_____.

BASIC MONTHLY FEE

The basic monthly fee is based on the type and amount of care required by the Resident as described on the Preliminary Admission and Resident Health Status forms. Should the resident's condition change requiring more care, the monthly fee may increase, or the resident may be referred to a facility where appropriate care is available.

The basic monthly fee of $ _, _ _ _._ _ provides for __semi- private/__ private room and furnishings, bed and bathing linen, personal care needs as ordered by the primary care provider and as outlined in the Resident Service Plan, all meals and snacks as provided for on the facility's menus, laundry service, housekeeping including cleaning of room and making of bed, social recreational and rehabilitative activities not required by a professional or quasi-professional person, generic toiletries (limited to shampoo,

soap, Kleenex, napkins, toilet paper), medication control and administration, access to common areas of the facility (dining, living, social areas and secured yard), and input into menu and activity calendar planning.

The resident is responsible for all required medications including prescription and nonprescription drugs, nursing services above and beyond what is provided by the facility including the yearly, bi-yearly, quarterly or other required charges for the development and review of the Service Plan, medical treatment including primary provider care, podiatrist, dental and surgical care, medical and treatment supplies, incontinence supplies (including garments, skin barriers, special cleansing soaps or lotions, indwelling catheters and related supplies), mobility devices and their routine maintenance and repair, supplies and equipment needed to maintain independence in performance of Activities of Daily Living, personal toiletries (including but not limited to combs, hairbrushes, hairspray, hairnets, tooth paste, tooth brush, denture cup, denture cleaning supplies, deodorants, skin lotions and creams and utensils for cleaning nails and ears) vitamins or food supplements, special equipment for eating or instilling liquid nutrition, special activities outside the facility, and transportation to and from health care appointments.

The monthly charge shall begin on the day the resident moves in and will be prorated to the beginning of the month. Payment will be due on the same calendar day of each month thereafter. The Resident or Resident's representative agrees to pay the monthly fee on or before the due date, and should the fee remain unpaid for seven days after the due date, which will fall on the **1st** day of each month, a late fee of **ten percent** of the monthly fee will be added.

A hold bed contract will be provided to the Resident or Resident's representative.
A $__, __ __ __.00 "move in fee" (move in fee is non-refundable) is required of the resident or resident's representative party. This will be due upon date of admission to the care facility.

REFUNDS

The **first TWO month's rent** is non-refundable. In the event of a termination of the Residency Agreement after the first month, the resident or his/her representative must give the company a 30 days written notice prior to the intended move-out date or the remainder of the months' rent will be forfeited.

Deductions will be made from the resident's Personal Fund (if any) and/or any refunds due to the resident for any of the following:

- Damage to the facility that exceeds normal wear and tear. For example, broken windows, doors, furniture, light fixtures, damaged wall paneling, molding, drapes/curtains, etc. caused by any acting out or abnormal behavior of the resident.
- Any outstanding costs for long distance telephone calls, beautician services, medical supplies, nutritional supplements, incontinence garments, clothing, medications or personal toiletries incurred by the facility at the request of the resident's representative or as itemized in the resident's Residency Agreement on the resident's behalf.

Deductions will not be made for routine cleaning of carpets or floors, painting of walls, cleaning of furniture or drapes/ curtains or other items considered as normal wear and tear in the facility. Funds being refunded will be returned as soon as all deductions or fees are made (if any) by the terms of the facility's policy and as spelled out in this Residency Agreement, but not to exceed 30 days from the date of the resident's actual discharge from the facility. Included with the refund will be a written statement that includes:

- The disposition of the resident's personal property.
- An accounting of all fees, resident personal funds, or deposits owed to the resident; and
- An accounting of any deduction from the fees or deposits.

TERMINATIONS

The management will provide the Resident or Resident's representative 30 days written notice before terminating the Residency Agreement except in the following circumstances:

The management will terminate the Residency Agreement without notice if:

- Without notice, if the resident exhibits behavior that is an immediate threat to the health and safety of the resident or other individuals in an assisted living facility.
- With a 14 calendar day written notice of termination of residency:
    a. for non payment of fees, charges, or deposit, or
    b. The resident requires continuous:
        i. Medical services
        ii. Nursing services, unless the licensee is a nurse, or
        iii. Behavioral health services
        iv. The primary condition for which the individual needs assisted living services is a behavioral health issues;
        v. The Services needed by the individual are not within the assisted living faclity's scope of services and a home health agency or hospice service agency is not involved in the care of the individual;
        vi. The Assisted living facility does not have the ability to provide the assisted living services needed by the individual; or
        vii. The individual requires restraints, including the bedrails.
- With a 30-calendar day written notice of termination of residency, for any other reason.

The Resident or the Resident's representative may terminate the Residency Agreement without notice due to neglect, abuse, exploitation or if conditions exist which place the Resident in imminent danger to life, health or safety, if substantiated by a governmental agency.

The Resident or Resident's representative may terminate the Residency Agreement after providing 30 days written notice to the management for documentation of the facility's failure to comply with the Service Plan or Residency Agreement.

The management will include with any written notice of termination of the Residency Agreement the following information:

1. The date of notice;
2. The reason for termination;
3. The policy for refunding fees, charges, or deposits;
4. The deposition of a resident's fees, charges, and deposits; and
5. Contact information for the State Long-Term Care Ombudsman.

The manager shall also provide the following to a resident when the manager provides a written notice of termination of residency:

1. A copy of the resident's current service plan, and
2. Documentation of the resident's freedom from infectious tuberculosis.

If this facility issues a written notice of termination of residency to a resident or the resident's representative because the resident needs services the assisted living facility is either not licensed to provide or is licensed to provide but not able to provide, a manager shall ensure that the written notice of termination of

residency includes a description of the specific services that the resident needs that the assisted living facility is either not licensed to provide or is licensed to provide but not able to provide.

GRIEVANCES

The Resident or Resident's representative has the right to file a grievance against any management decision to terminate the Residency Agreement or any other issue affecting the care of the Resident.

STEP 1. A Resident or Resident's representative shall explain in writing the grievance to the manger. The written grievance will include the cause of the grievance and provide a suggested remedy. A grievance must be brought within 10 working days from the day the decision, service or lack of service was observed. The manager, either alone or in collaboration with the licensee (owner), if the two positions are distinct and separate, shall reach a decision and communicate it in writing to the resident or Resident's representative within 10 working days of receipt of the written grievance.
Every effort should be made to settle grievances at this stage.

STEP 2. If the Resident or Resident's representative feel the decision of the manager and/or licensee is still unfair, the Resident or Resident's representative shall respond in writing within 10 working days, requesting reconsideration of the issue.

The response should again offer suggestions on what would be considered a fair compromise of the situation. The manager shall then form a committee of three individuals including the manager, the individual who developed the service plan (if different from the manager) or a nurse and another individual affiliated with the facility i.e. resident, caregiver, volunteer, to meet together and review the grievance. The manager will make a written reply of the committee's decision to the Resident or Resident's representative second written response within 10 working days.
The Resident or Resident's representative may choose to be present during the committee meeting to represent the case of the Resident.

STEP 3. If the Resident or Resident's representatives still feel that the decision of management has not resolved the problems, he or she should seek outside counsel through the Arizona Department of Health Services office of Home and Community Based Licensure of through the DES Long Term Care Ombudsman or any other persons or Resident advocacy agencies.
Any reply which is not appealed by the Resident or Resident's representative within the time allowed at each level shall be considered settled and binding on the part of the Resident or Resident's representative and the facility.

TEMPORARY ABSENCE FROM THE FACILITY

During short periods of absence from the facility for recreational or medical reasons the daily fee continues uninterrupted until such time notice is given that the Resident will not be returning, the storage fee for storage of the Resident's belongings will be a daily fee prorated from the monthly fee. The storage fee will terminate once the belongings are removed from the facility or the Resident or Resident's representative grants written permission for disposal of the belongings.

RATE AND FEE INCREASES

The facility will provide a minimum of 30 days advance written notice before any fee or charge increases for any service or care the Resident receives while living in the facility unless the fee increase is

based upon changes in the Resident's health, medical, emotional or functional care needs as specified in the service plan. In this instance the fee increase will begin as soon as the Resident or Resident's representative is notified in writing. All written notifications will include the effective date and the reason(s) for the fee increase.

ADDITIONAL SERVICES AND CHARGES

The following services are available for additional charges:
Transportation to and from health care appointments at $ _____ / hour
Haircuts by a cosmetologist at $ _____
Hair washed and set by a beautician at $ _ _._ _
Hair perms by a beautician at $ _ _._ _
Service Plan including assessment and written instructions for care by contract nurse at:
Initial fee of $ _____ b. Every 3 or 6 months (as needed) the fee of $ _____

RESIDENT PERSONAL FUND

Family and representative are encouraged to shop online and have items delivered directly to the home or pay directly for outside services whenever possible. Personal funds account is only initiated after receiving a written request that is provided voluntarily by the resident, by the resident's representative, or by a court of competent jurisdiction. The resident's personal funds account should not exceed $2,000. In addition, the facility will charge a $50 annual fee to manage the account. A copy of the record of the resident's personal funds account will be given to the resident or the resident's representative every three months or as requested during normal business hours. Resident funds shall be disbursed during normal business hours within 24 hours of the resident's or resident's representative's written request. The manager will notify the resident's representative, family member, public fiduciary, or trust officer, if the manager or manager's designee determines or believes that a resident is incapable of handling financial affairs.

ADMISSION/HOLD BED FEE

In addition to the monthly costs, a non refundable fee in the amount of $500.00 is due at the time of move in or in advance if the resident or their representative wishes to hold a bed for the prospective resident. This charge is non-refundable and will be applied towards the second month's rent if resident still living at the facility.

PAYMENTS

Payments are accepted in the form of cash, personal checks, cashier's check, bill pay and bank transfer/deposit. Statements will be issued monthly. Monthly fees and/or charges are due on the _____ of the month. Payments made after the due date will be subject to a late fee of $50 per day. If payment is not received by the 3rd day after due date, the company will give written notice of intent to

terminate this agreement and the resident will need to be removed from the premises within 14 days of the notice. At the time of the move-out, the default charges prorated to the actual move-out date, and any other outstanding fees will be due immediately. In the event that the resident is not moved and/or the amounts due are not paid, the company reserves the right to have the resident transported to the residence of the responsible party or place the resident in the care of Adult Protective Services and take legal action to receive funds.

DISCLAIMERS

This facility will not assume responsibility for jewelry or other valuables of the Resident. Please do not leave large sums of cash, expensive jewelry, etc. with the Resident.
The management and staff assume no liability for injuries or other occurrences while the Resident is away from the facility. Individuals taking Residents from the facility will be requested to sign out and in.

RESPONSIBILITIES OF ALL PARTIES

The Resident and Resident's representative are expected to comply with the Internal Facility Rules, primary care provider orders, and Service Plan.
The management will insure that the Resident lives in a clean and safe environment with nutritious food and a caring and pleasant staff. The facility staff will comply with the Internal Facility Rules, primary care provider orders, and Service Plan.

The facility has sleeping staff at night. Caregivers shall respond to resident's needs and make rounds every 2-3 hours.

ADDENDUM

During the night hours, resident will be checked on his/her condition every two hours, and will be documented accordingly on a Night Time Alert Log Sheet, following the schedule below:

- 12 midnight
- 2 AM
- 4 AM
- 6 AM

For live-in caregivers, who work from 6am-10pm and non-awake staff(s) will conduct rounds every two (2) hours. The facility will provide call bell at resident's bedside to alert the caregiver(s) if assistance is required.

RESIDENT/ POA SIGNATURE: _____
DATE: __ __ / __ __ / __ __ __ __

MANAGER/MANAGER DESIGNEE SIGNATURE _____
DATE: __ __ / __ __ / __ __ __ __

Resident's Preferences

Please check all that applies:
Activities

	Coloring Books		**Cut Coupons**
	Play Cards		**Play Tic Tac Toe**
	Play Bingo		**Play up words**
	Trivia Challenge		**Tie beads**
	Play Cards		**Play Rummy-O**
	Walking		**Play Scrabble**
	Crafts		**Crossword Puzzle**
	Play Monopoly		**Play Connect Four**
	Toss a ball		**Trivia Challenge**

Please provide us your preferences on the following:

Food/Beverages

Daily Routine

Activities/Hobbies/Interests

RN/PCP Special Instructions:

_____

_____

_

RESIDENT/ POA SIGNATURE: _____
DATE: __ __ / __ __ / __ __ __ __

MANAGER/MANAGER DESIGNEE SIGNATURE _____
DATE: __ __ / __ __ / __ __ __ __

RESIDENT'S RIGHTS:

A resident has the following rights:

1. Not to be discriminated against bas on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;

2. To receive assisted living services that support and respect the resident's individuality, choices, strengths, and abilities;
   a.) Resident will be able to choose their roommate if all parties agreed and will be processed within 48hours upon request.
   b.) Resident will have an opportunity to decide what to do every day including scheduling changes

3. To receive privacy in:
   a.) Care for personal needs;
   b.) Correspondence, communications, and visitation; and
   c.) Financial and personal affairs;

4. To maintain, use, and display personal items unless the personal items constitute a hazard;

5. To choose to participate or refuse to participate in social, recreational, rehabilitative, religious, political, or community activities;

6. To review, upon written request, the resident's own medical record;
7. To receive a referral to another health care institution if the assisted living facility is not authorized or not able to provide physical health services or behavioral health services for the resident;

8. To choose access services from a health care provider, health care institution, or pharmacy other than the assisted living facility where the resident is residing and receiving services or a health care provider, health care institution, or pharmacy recommended by the assisted living facility

9. To participate or have the resident's representative participate in the development of, or decisions concerning

the resident's service plan; and

10. To receive assistance from a family member, a resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

RESIDENT/POA SIGNATURE: _____ DATE: __ __ / __ __ / 20 __ __

FACILITY REPRESENTATIVE: _____ DATE: __ __ / __ __ / 20 __ __

Current Telephone Numbers

Pursuant to A.A.C. R9-10-803(D)(3)(a-d), these telephone numbers must be conspicuously posted in the Assisted Living Facility.

A. The Arizona Department of Health Services Bureau of Residential Facilities Licensing
602-364-2639
http://www.azdhs.gov/als/residential/index.htm

B. D.E.S. Adult Protective Services (APS):
1/877/SOS-ADULT (767-2385)
http://www.azdes.gov

C. The D.E.S. Long Term Care Ombudsman:
602-542-6454
http://www.azdes.gov

D. The Arizona Center for Disability Law:
602-274-6287
http://www.acdl.com

INTERNAL FACILITY REQUIREMENTS

(HOME RULES)

The purpose of Internal Facility Requirements is to provide guidelines for preventing rude or harsh behavior. They are designed to promote feelings of safety and belonging to all individuals while in the facility. EMPLOYEES, RESIDENTS AND VISITORS ARE EXPECTED TO ABIDE THESE RULES

VISITING HOURS: OPEN UNLESS OTHERWISE DISCUSSED

EMPLOYEES, RESIDENTS AND GUESTS: are expected to demonstrate respect, courtesy and manners by:

a. Avoiding profanity, loud discussions and topics generally considered inappropriate in mixed **c**ompany,
b. Respecting the privacy of each resident,
c. Avoiding racial, ethnic and religious slurs or comments,
d. Keeping the volume of talking, radios, stereos and televisions at a level which is not distracting or intrusive.

SMOKING IS PERMITTED: with approval by the manager outside our facility only. Employees, residents and visitors must maintain safety at all time with smoking appliances. Residents who are deemed not safe when smoking alone will need to surrender their smoking appliances and will only be allowed to smoke under the supervision of a responsible adult.

ALCOHOLIC BEVERAGES ARE NOT ALLOWED: on the premises without physician's written orders.

ALL MEDICATIONS (PRESCRIPTION & NON-PRESCRIPTION): must be prescribed by the resident's physician (PA or NP) and the facility must have a written order from the physician before the medication can be used by the resident. Bringing medications into the facility and using them without a written physician's order is grounds for termination of the Residency Agreement.

Medications include vitamins, minerals, antacids, pain medication, laxatives, stool softeners, herbal supplements, and nutritional supplements.
Non-prescription and Over the Counter drugs are the same thing.
If the resident or resident's representative are providing the medication and refills, prescriptions must be delivered to the facility in a timely manner.
The manager can suggest pharmacies which will deliver and bill the resident or resident's representative directly.

NUTRITION AND MEALS: Menus are preplanned and may be reviewed by the resident, resident's representative or family member upon request. Dietary planning and food preparation is done in accordance with Arizona Department of Health Service Administrative Rules and in consideration of the resident's personal preferences.
Special religious dietary needs must be arranged for by the resident or resident's representative.
The facility provides:

A minimum of three meals daily with snacks,
Food which is attractive, nutritious and appetizing,
Special diets as ordered by the physician and within reason as to cost.
We invite the resident and resident's representative to make suggestions or request special food items or preparation to the facility manager.

TELEVISIONS, RADIOS AND STEREOS: are permitted in the resident's room as long as they do not disturb other residents. Residents have the right to select programming of their choice on personal appliances. However the facility appliances may be used at any time for social and/or recreational activities.

ATTRACTIVE AND SERVICEABLE CLOTHING: must be provided by the resident or the resident's representative. This includes underclothing, nightwear, and shoes that fit properly. Five sets of clothing are sufficient and must be marked with name tags or laundry pen. A washing machine and dryer are available for residents wishing to do their own laundry. If the resident is incapable or does not desire to do their own laundry, the facility will provide that service.

PERSONAL FURNITURE: is permitted as space allows and with the manager's approval. Linens are provided by the facility. Residents bringing their own beds which are larger, are expected to furnish their own linens.

IN CASE OF AN EMERGENCY: we will make every effort to contact the Resident's physician and act upon his instructions. If unable to reach the physician, we will activate the Emergency Medical Services.
A **"NO RESUSCITATION"** or living will order does not negate emergency treatment if there is injury or illness
A **"NO RESUSCITATION"** or living will order is respected in terms of receiving a resident in event of death and respecting resident's last wishes in the matter.
WE ARE NOT LIABLE: for injuries or other occurrences while the Resident is away from the facility. Individuals taking residents from the facility will be requested to sign out and in to facilitate planning care for the resident.

RESIDENT/POA SIGNATURE: _____ DATE: __ __ / __ __ / 20 __ __

FACILITY REPRESENTATIVE SIG.: _____DATE: __ __ / __ __ / 20 ____

EMERGENCY ORIENTATION REVIEWED & SIGNED

Resident will be oriented to the emergency procedures of the Assisted Living Facility within twenty four hours of their admission. He/ She will be oriented to the following by explanation and/ or demonstration:

Entry/ exit doors
How to open and close windows
Location and use of fire extinguishers
Smoke alarms and their locations
Assembly areas during drill or emergencies
Location and operation of phones
The evacuation plan
Location of emergency phone numbers
Drills for evacuation

Staff Evacuation/Fire drills will be conducted at least every three months on each shift.

Resident fire drills will be conducted at least every six months

I, _____, acknowledge that I have been oriented in these areas of emergency policy and procedures within twenty-four hours of admission.

_____ __ __ / __ __ / 20

___ RESIDENT/POA SIGNATURE Date

_____ __ __ / __ __ / 20

___ FACILITY REPRESENTATIVE SIGNATURE Date

RELEASE OF LIABILITY

RESIDENT'S LAST NAME: _____ FIRST NAME: _____

I, the undersigned, request that the management and staff of the facility provide transportation to

and from the physician, clinic, hospital, and for recreational activities for _____.

I further agree that the management and staff of the facility will not be held liable for any injury

_____ might receive in the event of any type of accident.
(Resident's name)

I also understand that while the staff or facility will follow policies and procedures to minimize the risk of incidents or falls, it can't be held liable for any accidental falls that may occur while in the facility.

RESIDENT/POA SIGNATURE: _____ DATE: __ __ / __ __ /20 __ __

FACILITY REPRESENTATIVE SIG.: _____DATE: __ __ / __ __ / 20 __ __

DAILY ROUTINE FOR RESIDENTS

6:00-7:30 AM Begin awaking and dressing for breakfast

7:30-9:00 AM Breakfast in dining room

9:00-9:30 AM Out for a walk / Morning Activities

9:30-10:00 AM News and Views

10:00-11:30 PM Group Exercises, Incoming Activities and Beverage Break

11:30-12:30 PM Noon Meal (main meal of the day)

12:30-2:00 PM Nap/Personal Time

2:00-3:00 PM Snack/Beverage break/Personal time

3:00-5:00PM Activities as scheduled

5:00-5:30 PM Evening Meal (light meal of the day)

5:30-8:00 PM TV/Personal Time

8:00 PM Bed/Snack if desired
TV, Radios, voices turned low to quiet

Available to all: Newspaper
TV Sitting Areas
Library
Outdoor Patio
Movies
Snacks if hungry

RESIDENT ORIENTATION

_____ _____
Resident Name Move-In Date

Please check in each space below as the corresponding task is completed:

_____ Review the resident's service plan with him/her and have the resident and/or responsible party sign the service plan

_____ Give the resident a copy of his/her Resident Services Schedule

_____ Provide an orientation to all common area locations, including the dining room, beauty/barber shop, social/recreational areas and public restrooms

_____ Give the resident a current Activity Schedule

_____ Provide an orientation to the resident's room

_____ Explain how to use the emergency call system

_____ Explain emergency procedures and procedures for fire

drills _____ Explain the sign-in/sign-out procedures

_____ Give the resident a key to his/her mailbox

_____ Provide the resident with _____ keys to his/her room Staff

signature: _____ Date: _____

Resident/Responsible Party Signature:
_____ Date: _____

PNEUMONIA AND INFLUENZA SHOTS

In accordance to Arizona Legislative Law 2000, chapter 101, HB 2013, all residents in an assisted living facility are required to take Influenza and Pneumonia vaccinations.

The Department requires that a resident's record contain documentation of vaccinations administration that includes: the date the vaccine was offered and administered, the type of vaccines administered, and the signature of the individual administering the vaccines.

The Department does not require documentation of vaccination administration if:

a. The resident or the representative refuses the vaccination and signs and dates documentation that the resident has received information in the risk and benefits;

b. The primary care provider provides documentation that the vaccinations is medically contraindicated;

c. The primary care provider provides documentation that the resident receives pneumonia vaccination

within the last 5 year or the current recommendation from the "Center for Disease Control and Prevention".

Thus, we are requesting your permission on the resident's behalf to give pneumonia and influenza shots.

_____ I AGREE that INFLUENZA shot be given to _____

_____ I DO NOT AGREE that INFLUENZA shot be given to _____

_____ I AGREE that a PNEUMONIA shot be given to _____

_____ I DO NOT AGREE that a PNEUMONIA shot be given to _____

I understand Medicare or the Insurance may deny payment for this vaccine. If denied I agree to personally responsible for the payment.

_____ _____

Resident/Representative Name and Signature Date

ADVANCE DIRECTIVES

Resident Name: _____

Dear: _____ (Resident Representative)

Advance Directives are documents signed in "advance" which state a member's legally valid choices about medical treatment or name a specific person to make decisions about his or her medical treatment when the member is unable to make those decisions or choices by themselves.

PROCEDURES:

1. Prior to move-in, provide all residents (or legal representative with information regarding Advanced Directives. 2. By federal law, all health care agencies must comply with a member's wishes in the Advance Directive. If an Advance Directive cannot be honored for any reason – including moral, religious or professional reasons – the facility or agency must immediately inform the member and make arrangements for that member to be transferred to a facility where their Advance Directives will be honored.
3. Put the resident's original copies of the advanced directives in the resident records folder. Ideally, copies of the living will or durable power of attorney for health care should be given to every doctor providing care for the resident.

This facility is required to have the following on file within 30 days of resident moved in.

- _____ General Power of Attorney
- _____ Health Care Power of Attorney
- _____ Durable Mental Health Care Power of Attorney
- _____ Living Will (End of Life Care)
- _____ Pre-hospital Medical Care Directive DNR (Do Not Resuscitate) *This form will be on Orange Paper**
- _____ Other: _____
  _____

By signing below, the signer has read and understands this statement. (Please choose one).

_____ I acknowledge that advance directives has been offered to me and I will provide a copy of the above checked documents in a timely manner.

_____
Signature or Resident or POA/Representative Date

_____ I refused to provide this facility any documents written above.

_____ _____
Signature or Resident or POA/Representative Date

Signature Manager/Manager Designee: _____

Code Status: _____

Prepared by: _____ Date: _____

AUTHORIZATION TO TAKE PLACES

Resident Name: _____ Admission Date: _____

ACKNOWLEDGEMENT

This is to authorize _____(Facility Name) to take the above named resident to reasonable place i.e., movies, park, church, doctor's and/or medical appointment, etc.

_____(Facility Name) and its staff will not be liable for any mishap or accidents while in transit to and from the home and/or the venues of entertainment.

_____ _____

Authorized Representative Date

RESIDENT MEDICAL RELEASE FORM

Authorization to Release Resident's Medical Information

Date: _____

Resident: _____

Dear: _____

I hereby authorized and request that you release and deliver to:

_____

Facility Name

all of medical records, charts, files, progress notes, reports, service plans and such other information relative to the treatment provided to the Resident while at this facility and all to the extent said information is available and within your possession. You are further requested not to disclose any information concerning Resident's past/present medical condition or personal information, to any other person within my express written permission.

The facility is permitted to release the above materials to contracted parties involved with the resident's service plan.

Thank you for your cooperation.

_____ _____

Manager Date

CONSENT AND AUTHORIZATIONS
RESIDENT PHOTO RELEASE

Resident Name: _____ Date: _____

Specific authorization is required for the following and mus t be agreed to by either the resident or his/her legal representative.

I, _____ hereby consent and

Resident or Representative

Authorize _____ to take and release

Name of Facility

photographs of the above resident. I agree to permit photographs to be used for the following purposes by circling either **yes or no**.

YES NO To memorialize resident participation in activities, parties or event to be viewed by the public

YES NO To assist in helping to locate the resident in the event of unauthorized absence from the community or while on/off site activities

YES NO To reproduce and use in a variety of public relations mediums, such as, newspaper, and/or editorial use: advertising, audiovisual presentations, displays, videotaping, exhibition materials, education and research purposes.

YES NO To post photographs on bulletin boards, shadowboxes, scrapbooks, websites, facebooks or other placements for advertising purposes

YES NO In addition, photos will be taken of each resident and will be kept confidential. The photos will be placed in the resident's record in the facility.

Resident Signature: _____ Date: _____

Facility Representative: _____ Date: _____

Title: _____