Pre-Admission Questionnaire

Name _____ Date of Assessment _____Potential Discharge Date_____

Social Security Number _____ DOB _____

Insurance _____ ID Number _____

POA _____ Conservator _____

Representative Payee _____

Who Receives your check? _____

What is their contact number? _____

What is their address? _____

_____

What is your income amount?

Is your check deposited on the Direct Express Card? ___Yes ___No

If yes, what is the phone number connected with this account and the address?

_____

Understand we will not be able to accept you until our office makes a connection with your payment source.

Do you have a balance with any pharmacy? __Yes __No

if yes how much and what pharmacy and number? _____

What's the name of the previous home you lived in and the contact number?

_____

Forms to complete prior to admission:

TB skin test or chest x-ray

Consent Form for Influenza and Pneumococcal Vaccine

Vaccination Received (Flu/ Pneumococcal)

Covid Vaccination Card

Covid Testing 48 hours before admission/discharge

Medication Orders for one month

Signed form stating that you wish to reside at Rose of Sharon's Senior Villa

Sharon's Senior Services
"Taking care of those who once took care of you."

I, _____ agree to come to Rose of Sharon's Senior Villa. I understand that this facility is not a locked down facility. I have not been forced nor coerced to reside at Rose of Sharon's Senior Villa. I understand that I must pay Rent/ Room and Board/ Personal Care. Before moving into Rose of Sharon's Senior Villa I was told the amount I am responsible for paying. I understand that Rose of Sharon's Senior Villa may become the Representative Payee over my check if I am being accepted through the CHOICES program, private pay, or VA. If I am a Centerstone client I must secure my funds to be sent to Rose of Sharon's Senior Villa by my Rep Payee, Conservator, or my Direct Express Card/Social Security Check. If you receive a Social Security Check or SSI you will need to call the Social Security Administration and have your check sent to: 5410 Lee Avenue Chattanooga, TN 37410.

This form must be signed and dated prior to being admitted along with the pre-admission questionnaire completed.

_____ _____
Future Resident/Client Date

_____ _____
Conservator Date

_____ _____
Representative Payee

_____ _____ _____
Resident's Signature POA Signature Date

Sharon's Senior Services

(Rose of Sharon's Senior Villa/ Sharon's Personal Care/ Sharon's Adult Day Center)

Consent

The COVID-19 vaccination is recommended for elderly and high-risk patients, their household contacts, healthcare personnel and anyone who wishes to reduce the chance of contacting COVID-19.

I have read the FACT sheet for Recipients and Caregivers.

I understand that as with any medication, series problems even death occur, the risks from the vaccine are much smaller than the risks from the disease. If mild or moderate problems occur, they are fever, aches, or soreness, redness, swelling where the sot was given. I understand that Sharon's Senior Services or any personas acting as their agent are not responsible for any adverse reactions that I may sustain. I have been offered information on COVID-19 vaccination; I consent to the administration of the COVID-19 vaccine.

Name _____ Dept _____

Date ____/____/____ Manufacture _____

Declination

I understand that I am at risk for exposure to COVID-19 and may risk for developing COVID. I have been given the opportunity to be vaccinated at Sharon's Senior Services. However, I declined the COVID-19 shot at this time. I understand that by declining the vaccine, I many continue to be at risk for COVID and I may also put patients and my other contacts at risk for COVID. Should I want the vaccine, I should notify my physician or Sharon' s Senior Services.

_____ _____

Signature Date

_____ _____

POA Signature Date

Sharon's Senior Services (Rose of Sharon's Senior Villa/ Sharon's Personal Care, Sharon's Adult Day) Center
Assumption of Risk and Waiver of Liability Relating to Coronavirus/ COVID-19

The novel coronavirus, COVID-19 has been decaled a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact and high contact surfaces. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations prohibited the congregation of groups and people. Sharon's Senior Services have put in place preventative measures to mitigate the spread of COVID-19; however, Sharon's Senior Services and the management cannot guarantee that anyone will not become infected with COVID-19 by participating in any activities within the business or outside of the business.

By signing this agreement, you acknowledge the contagious nature of COVID-19 and voluntarily assume the risk for yourself to be exposed to or infected by COVID-19 by working in or outside of the company. I understand that the risk of becoming exposed to or infected by COVID-19 at Sharon's Senior Services may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Sharon's Senior Services or any activities and utilization of our facility may result from the actions, omission, or negligence of myself and others, including but not limited to Sharon's Senior Services volunteers, management, clients, and family members.

I voluntarily agree to assume all the foregoing risks and accept sole responsibility for any injury to those I am responsible for and myself, including but not limited to, Personal injury, disability, illness, damage, loss, claim, liability, death, or any expense of any kind that I or the party I am responsible for. I am legally responsible for, and I hereby, release covenant not to sue, discharge, and hold harmless and indemnify Sharon's Senior Services, staff, residents, and management responsible of any claims.

I further agree to take all steps necessary to comply with he Executive and Emergency Orders issued by the World Health Organization (WHO), the Federal Government, the Sate of Tennessee, and Sharon's Senior Services.

_____

Print Name

_____ _____

Signature Date

_____ _____

POA Signature Date

Rose of Sharon's Senior Villa
Consent Forms for Influenza and Pneumococcal Vaccines

Please discuss any question you may have or request for me information, with the nurse or the attending physician.

Influenza Vaccine: The influenza vaccine has been shown to protect older adults from hospitalization and deaths, resulting from an influenza Infection. The Advisory Committee on Immunization Practices recommends that influenza vaccines be provided to tall residents of nursing facilities, annually prior to the Influenza season. Reaction at the site of injection may occur. This facility usually conducts an organized vaccine campaign between October and mid-November, before the beginning of the influenza season, However, influenza vaccine will be offered to residents and to new arrivals through the end of January of the subsequent year.

INFLUENZA VACCINE

_____ YES, I wish to receive the influenza vaccine on an annual basis while I am a resident in this facility.

_____NO, I do not wish to receive the influenza vaccine this year.

Resident's Name _____ Date _____

PNEUMOCOCCAL VACCINE: The Pneumococcal Polysnecharide Vaccine is effective against 23 pneumococcal types which causes 90% od all pneumococcal pneumonia and is effective for approximately 6 years. Anyone 65 years of age or older or having chronic health problems is considered high risk for exposure to and complication from pneumococcal infections such as pneumonia septicemia, and manicurist, The AGIP currently recommends a singe does of the vaccine for persons 65 years of age and older who have not been previously vaccinated or whose vaccinated or whose vaccination status is unknown. A one-time revaccination is recommended for persons 65 years of age and older who have been vaccinated for the 1st time when they were 60 years of age or younger. Local site reactions are expected in 5-10% of vaccine recipients. Less than 1% of vaccines have reported slight elevation of body temperature but sever allergic reactions have not been documented.

_____ YES, I wish to receive pneumococcal vaccine according to the recommended schedule.

_____NO, I do not wish to receive the pneumococcal vaccine at this time (This vaccine will be offered again at a later time).

Resident or Responsible Party Signature _____ Date _____

CENTERSTONE

Consent to Treatment

Client Name: _____ Client ID: _____

I hereby seek and consent to take part in the treatment provided by Centerstone. I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that after my treatment with Centerstone begins, I have the right to refuse or express choices regarding the services I receive, for any reason. However, I will make every effort to discuss my concerns about my progress with my treating professional before ending therapy. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I understand that my appointment times are being reserved for me and that efficiency of scheduling often depends on my keeping my appointment as scheduled. I understand that repeated missed appointments may delay my treatment progress and failure to cancel 24 hours before an appointment may result in a fee being added to my account.

I understand that my services may be provided in person or thru telehealth, depending on circumstances and my individual needs. Telehealth includes telephone and various video forms.

If I am a TennCare recipient, I understand that I am eligible for transportation services. I can consult my Benefits Guide for more information or contact the TennCare Advocacy Line at 1-800-758-1638. The transportation provider for this area may be reached at:

- AMERICHOICE or AMERIGROUP: Tennessee Carriers: 1-866-405-0238
- BlueCare or TNCare Select: Southeast Transportation: 1-866-473-7565 or 1-866-570-9445

I am aware that an agent of my insurance company, or other third-party payer, may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. This information may be shared until all claims are processed for this treatment episode. I also request payment be made to Centerstone. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below indicates that I have received:

- Copy of the TennCare Kids Brochure (if applicable)
- Orientation to services including health and safety features as applicable at clinic locations
- Copy of my rights and responsibilities via either the Centerstone Client Resource Guide or the annual Client Rights Update

☒ **I, the undersigned, agree and consent to participate in the mental health services offered, which may include service by telehealth methods**

Guardian Statement

☒ **I attest that I have the legal authority to provide consent on behalf of the client by signing as the Guardian/Conservator. For purposes of consent, unless declared incompetent, individuals ages 16 and older have the right to consent to mental health treatment with proof of their date of birth.**

_____ _____

Signature of Client (ages 16 and older) Date

_____ _____

Signature of Parent/Legal Guardian/Power of Attorney Date

_____

Printed Name of Legal Representative (circle relationship above)