STATEMENT OF CHARGES

Financial Agreement

_____ sets forth the financial arrangement for

providing care to _____. The signature below indicates that the Resident/Responsible Party understands and acknowledges the financial terms and conditions identified from the Admission and Financial Agreement:

1. **OBLIGATIONS OF RESIDENT/RESPONSIBLE PARTY:**
    a. To be responsible for co-pay amounts as applicable;
    b. To pay the basic rate, co-pay, or vendor payment on or before the 10th of each month;
    c. To notify the facility at least thirty (30) days in advance of discharge;
    d. Upon Discharge Resident and Responsible Party agrees to pay outstanding amounts related to the Residents care during their care and treatment, or completes a payment schedule for the payment of the outstanding balance;
    e. The Resident and Responsible Party is and remains obligated to pay Facility for services and supplies not covered by Medicaid or the Medicare programs;
    f. If Resident and Responsible Party chooses to have services which his/her insurance refuses to pre-authorize, Resident and Responsible Party shall pay Facility for those services;
    g. Resident and Responsible Party shall notify Facility immediately of any change in Resident's Insurance status or coverage;
    h. Upon admission, the Resident/Responsible Party agrees to pay, in advance, a sum equal to a prorated one-month's stay.
2. **ESTIMATED CHARGES RELATED TO CARE AND TREATMENT:**
    a. Residents expected length of stay and care and expected Payor source(s):

    _____

    _____

    b. Residents calculated monthly charges are listed and explained so as to make sure that the Resident and/or Responsible Party are aware of the monthly costs of the facilities care and treatment to the Resident:

    _____

    _____

Printed Name: _____
Resident/Responsible Party

Signature: _____ Date: _____
Resident/Responsible Party

Printed Name: _____
Facility Representative

Signature: _____ Date: _____
Facility Representative

Admission Agreement

_____, ("Facility") located at

_____ is a licensed long-term care facility and does enter into this Admission Agreement and Financial Agreement ("Agreement") with

_____("Resident/Responsible Party") to

provide long-term care for_____("Resident") under the terms and conditions set forth below.

1. **RESPONSIBLE PARTY.** Resident authorizes "Responsible Party" to be his/her agent herein is:

   _____Court appointed legal guardian of Resident

   _____Attorney in fact for Resident under a durable power of attorney

   _____Family member_____(specify)

   _____other individual authorized by Resident

2. **AUTHORITY.** Resident authorizes Responsible Party to make

   _____Financial decision

   _____Medical decisions (Facility has been provided with a Durable Power of Attorney, Advance Directive or other appropriate instrument) Admission, care, and discharge decisions

   _____Other decisions related to Resident's personal property and well-being.

   _____Responsible party shall be Facility's primary contact person for Resident outside Facility.

3. **NONDISCRIMINATION** Facility provides care on a non-discriminatory basis so that all residents are admitted and receive benefits and services without regard to race, religion, color, national origin, age, sex, disability, marital status or source of payment.
4. **NURSING CARE**. Facility shall provide twenty-four (24) hour nursing and personal care to Resident.
5. **ROOM AND BOARD.** Facility shall provide room and board to Resident.
6. **PHYSICIAN.**
   a. A physician shall personally approve in writing a referral order to admit Resident to Facility. A physician shall provide documentation of an initial medical evaluation, including history, physical examination, diagnoses and an estimate of discharge potential and rehabilitation potential within seventy-two (72) hours of admission. Resident shall remain under the care of a physician throughout the stay in Facility.
   b. Resident/Responsible Party shall designate a physician to serve as Resident's attending physician and requests that Facility contact this physician or his/her designated alternate whenever medical services are necessary. Attending physician shall be one who agrees to see Resident either by visitation in Facility or through office visits. Resident/Responsible Party further authorizes Facility to obtain on behalf of Resident, the services of any other physician licensed to practice medicine in this state, at Resident's sole expense, whenever, in Facility 's discretion, medical services are required and the attending physician is not available. Resident/Responsible Party is responsible for payment of physician's fees.

c. Resident shall be seen by a physician at least once every thirty (30) days for the first ninety (90) days after admission, and at least once every sixty (60) days thereafter.
d. In case of emergency or if medical orders cannot be obtained upon admission, Facility's Medical Director may give temporary orders until Resident's Attending Physician is available.

7. **AUTHORIZATION.** Resident/Responsible Party hereby authorizes and directs Facility to provide such services as is required for Resident's well-being, health, and safety as Facility and Resident's physician, in their discretion, deem appropriate.
8. **TRANSPORTATION.** Where alternate means of transportation are not available, Facility shall transport Medicaid residents to the Medicaid medical provider of choice in the service area for physician ordered non-emergency medical services, including routine ambulance services involved in the certification or re- certification of Resident. Non-emergency ambulance transport of severely disabled Medicaid residents to and from scheduled medical appointments who cannot be transferred by other means without endangering their health or safety, shall be billed to Medicaid upon receipt of prior authorization from the Oklahoma State Department of Health or its designee.

   Charges for emergency ambulance services for Medicaid residents shall also be billed to Medicaid. Upon request, Facility shall transport, or arrange for the transport, of non-Medicaid residents to their medical and health care providers at Facility's standard rates for such services.

9. **DENTAL SERVICES.** Facility will enroll any resident that chooses in Sterling Dental which is a dental service. The resident is responsible for the cost.
10. **PRESCRIPTION AND PHARMACY SERVICES.**
    a. Resident/Responsible Party will designate a pharmacy provider of choice. This pharmacy shall be duly licensed in the State of Oklahoma and qualified to provide pharmacy services consistent with applicable state and federal regulations. The pharmacy shall agree to provide services on a 24-hour basis for emergency medications, deliver medications to Facility on a timely and reasonable basis, packaged and labeled in accordance with Oklahoma State Board of Pharmacy laws and regulations. In the absence of a designated pharmacy, Facility is authorized to use a duly licensed pharmacy of its choice, including one operated by an affiliate of Facility. Resident has the right to be informed of prices before purchasing items or services from Facility except in an emergency.
    b. Facility shall not charge Medicare residents for over-the counter drugs.
    c. Facility shall not charge Medicaid recipients for over-the-counter drugs, non-legend drugs (with the exception of insulin), and alcoholic beverages prescribed for medicinal purposes or for legend drugs not by the Medicaid Vendor Drug Program. Generic name medications may be used unless otherwise ordered, in writing, by Physician.
    d. All medications must be prescribed by a licensed physician, dentist or podiatrist or other individual authorized by Oklahoma law to prescribe. All medications must be administered according to Resident's assessment. Medications shall be administered by qualified staff unless Facility 's interdisciplinary team determines that practice of self-administration by Resident is safe.

11. **ANCILLARY SERVICES.** Resident/Responsible Party shall pay for diagnostic, consultant, laboratory, therapeutic and rehabilitative services ordered by Resident's physician and received by Resident which are not covered by Medicaid, Medicare or other third-party payment plan.

12. **MEDICAL SUPPLIES AND EQUIPMENT.** Medical accessories and equipment prescribed by Resident's physician and required to provide treatment ordered by Resident's physician such as, cannulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids and equipment,

wheelchairs, crutches, canes, walkers, trapeze bars, mattresses, and hospital type beds, enteral pumps and oxygen equipment are paid by Medicaid for Medicaid residents.
Resident/Responsible Party shall pay for medical equipment and accessories for non-Medicaid residents when not covered by Medicare or other third-party payor.

Medical supplies such as band aids, cotton balls, alcohol, swabs and tongue depressors are included in Facility 's Basic Charges. Other medical supplies will be billed to Resident/ Responsible Party or, if applicable, Resident's Medicaid, Medicare, or third-party provider.

Resident/Responsible Party shall pay for routine services, appliances and equipment (such as eyeglasses, hearing aids and medical equipment) requested and received by or on behalf of Resident for convenience rather that medical need which are not covered by Medicaid, Medicare, or other third-party payment plan.

13. **PERSONAL ITEMS AND SERVICES.** Routine personal hygiene items and services are included in Facility's Basic Charges. Resident/Responsible Party shall pay for personal items and services not covered in Facility's Basic Charges such as: specific name brand items not furnished by Facility, cosmetics and grooming items and services in excess of those covered by Medicaid or Medicare, privately hired nurses, aides and sitters, personally used televisions, radios, telephones, and reading materials, gifts, smoking materials and other personal comfort items.

14. **PASSES.** Resident may leave Facility for therapeutic home visits on passes with permission of Resident's Attending Physician and (if applicable) Responsible Party. Facility administration shall be notified of all passes in advance and Resident shall be signed out at the nurses' station when leaving and upon return.

15. **HOSPITAL TRANSFERS.** If a physician orders Resident transferred to a hospital, Facility shall arrange to have Resident transferred and notify Responsible Party of the transfer.

16. **BEDHOLD POLICY.** Upon request, Facility shall hold Resident's bed when Resident is away from Facility for hospitalization or therapeutic home visits, as long as the applicable bed hold fee is paid.

    The daily bed hold fee is the current daily rate of _____for private pay and 75% of the then current Medicaid Rate for Medicaid recipients. These charges may be updated at any time by the Facility. Medicaid allows each resident to leave the Facility for up to 72 consecutive hours at any one time for therapeutic home visits. The days are counted in 24-hour periods from midnight to midnight. There is no limit on the number of Medicaid therapeutic visits, however; these must be broken by a return to the Facility for an overnight stay. The resident's bed will be reserved as long as the bed hold charges are paid. Bed hold charges may be discontinued at any time if the Resident/Responsible Party notifies the business office and removes all personal belongings from the room.

17. **TRANSFERS AND DISCHARGES.** If Resident is transferred from Facility, or is on a therapeutic home leave (in excess of 72 hours for Medicaid residents), without arranging for a bed hold, Facility shall process the discharge of Resident. If Resident desires to be readmitted after discharge, Resident shall be treated as a new applicant for purposes of admission. Medicaid residents who are medically eligible shall be readmitted to the first available bed.
    Except in an emergency, Resident shall not be transferred or discharged without prior consultation with Resident, Resident's attending physician and Responsible Party and written notification describing the reason(s) for the transfer or discharge and Resident's right to appeal the transfer or discharge. Resident may be transferred and discharged if:

a. Necessary to Resident's welfare and Resident's needs cannot be met in Facility;
b. Resident no longer needs services provided by Facility;
c. Resident is endangering the safety of other persons or individuals in Facility;
d. Resident fails, after reasonable and appropriate notice, to pay, or have paid under Medicare or Medicaid for goods and services provided by Facility;
e. Facility ceases to participate in the program that pays for Resident's care; or
f. Resident has not resided in Facility for thirty (30) days.
g. Written notice will be given to Resident/Responsible Party for all planned discharges and transfers. Thirty (30) days written notice will be given for discharges and transfers planned pursuant to subsection (d) and (e), above. All other discharges or transfers will be made as soon as practical.

18. **RELOCATION WITHIN FACILITY.** Except in an emergency, Facility shall give Resident/Responsible Party advance notice of relocation to another room. The notice will explain the reason(s) for the relocation, the effective date and the room to which the Resident is being relocated.

19. **FACILITY CHARGES.**

i. Items and services included in Facility's' Basic Charges:
- nursing services
- medically related social services
- dietary services, including a dietary consultant and the provisions of regular, special and supplemental diets, including tube feeding, as ordered by the physician
- over-the-counter drugs
- regular laundry service (except dry cleaning)
- room and bed, including housekeeping and maintenance services
- linens and bedding
- management of resident funds in a Facility -based personal account
- activities program

ii. Items and services that are not included in Facility's Basic Charges may be charged to Resident/Responsible Party if not covered by Medicaid, Medicare, or other third-party payer. The following items are not included in Basis Charges:
- Prescription drugs
- Beautician or barber services (in excess of services covered by Daily Rate)
- Therapies – physical, occupational, speech, respiratory
- Medical, podiatric, optometric, dental, Geriatric psychiatric and other ancillary services
- Laboratory, x-ray, and diagnostic services
- Hospitalization expenses (including emergency room fee)
- Ambulance and other emergency medical transportation
- Transportation for medical appointments or hospital stays (non-Medicaid residents)
- Other (non-medical) transportation
- Clothing
- Dry cleaning services
- Telephone/Television and/or radio for personal use
- Cable TV or Telephone costs or fees

a. **MEDICARE COVERED SERVICES:**

The Medicare Program will reimburse the Facility for certain skilled services such as nursing services and certain therapies ordered by a physician. Reimbursable routine services include:

dietary services, activities programs, room and bed, maintenance services, and customary personal hygiene items and services as required to meet the needs of Residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services (other than Beauty Shop fees), bathing, and basic personal laundry.

b. **NON-COVERED MEDICARE SERVICES:**

Resident/Responsible Party will be required to pay certain other "Allowable Charges" which include, but are not limited to, the following:

i. Fees for certain products and services not covered under the Medicare Program, such fees are identical to the fees charged to private pay patients/residents of the Facility for the same products and services.

j. Fees for certain products and services that are more expensive than the products and services covered under the Medicare program (e.g., a private room), as requested by a Resident/Responsible Party, are not fully covered under Medicare. The fees for these more expensive products and services will be based on the difference between the Facility 's fees for the products or services charged to private pay residents and customary charges for the products and services covered under the Medicare program. The Facility will inform the individual requesting the additional or more expensive products or services that there will be a specified charge for the products or services.

k. Certain deductible and co-insurance amounts under the Medicare Program.

c. **MEDICAID COVERED SERVICES:**

The Medicaid Program will reimburse the Facility for certain skilled services such as nursing services and certain therapies ordered by a physician, and for medical equipment and supplies necessary to meet the needs of the Residents. Reimbursable routine services include: dietary services, activity programs, room and bed, maintenance services, medical supplies including, but not limited to, tongue depressors, swabs, band-aids, cotton balls, and alcohol; hygiene care of the hair (other than Beauty Shop fees), including trimming male Resident's hair, regular laundry services, other than dry cleaning, and basic personal items that are essential in maintaining personal health, hygiene, and cleanliness of Residents, including, but not limited to, toothbrush, toothpaste, shampoo, shaving cream, razors, razor blades, sanitary napkins, comb or hair brush, soap, body lotion, denture adhesive, denture cleaner, facial tissues, and cloth or disposable briefs (diapers).

d. **MEDICAID NON-COVERED SERVICES:**

To the extent permitted by law, the Resident's monthly Social Security and pension funds, minus the personal allowance retained by Resident (or other allowance as set by law), shall be paid to the Facility.

The Resident may purchase from the Facility certain miscellaneous products and services that are not covered by Medicaid. An itemized list of fees for these additional products and services is available in the Admission Office and may be reviewed by the Resident/Responsible Party upon request during normal business hours of the Admissions Office.

e. **PRIVATE PAY ROUTINE SERVICES:**

The Resident will reimburse the Facility for routine services ("Routine Services") which include routine nursing services; routine dietary services, routine activities programs; and routine room and board maintenance services. Beauty shop fees are not included in the daily rate. The

Resident/Responsible Party shall pay a deposit of one-month basic room and board prior to admission. Each subsequent monthly payment is due on or before the 10th day of the month.

f. **PRIVATE PAY ANCILLARY SERVICES:**

The Resident may purchase from the Facility services and products that are not included in Routine Services. An itemized list of fees for these additional services and products is provided to the Resident/Responsible Party with the Contract, is available in the Admissions Office and may be reviewed by the Resident/Responsible Party upon request during normal business hours of the Admissions Office. The Resident shall pay for ancillary services at the end of the month in which such services are rendered.

i. **ASSIGNMENT OF BENEFITS.**

In consideration of services rendered and to be rendered by the Facility, Resident hereby assigns to the Facility his or her right to reimbursement from Medicare, Medicaid, or any insurance company paying benefits to him or her for services rendered by the Facility and authorizes the Facility to receive payments from Medicare, Medicaid, or such insurance company pursuant to this agreement. Resident acknowledges that, to the extent that Medicare, Medicaid, or such insurance company refuses to pay for any services rendered to him or her at the Facility, Resident shall remain personally liable for payment for these services to the extent permitted by applicable law. Resident agrees to cooperate with the Facility in collecting all proceeds due from Medicare, Medicaid, or such insurance company. Resident understands that he or she is not required to assign his or her benefits to the Facility. If Resident does not wish to assign his or her benefits to the Facility now or in the future, Resident can provide notice to Facility of his or her election and thereafter this section will be of no further force and effect unless Resident again elects to assign his or her benefits to the Facility.

j. **BENEFITS DISALLOWANCE.**

If the Resident's third-party eligibility or coverage is denied or terminated for any reason, Resident and Responsible Party shall pay, from Resident's assets, and all unpaid charges for care previously rendered to the extent permitted by law.

NO CERTIFIED FACILITY MAY REQUIRE AS A CONDITION OF ADMISSION, EITHER IN ITS CONTRACT OF ADMISSION OR BY ORAL PROMISE PRIOR TO SIGNING THE CONTRACT, THAT RESIDENT REMAIN IN PRIVATE PAY STATUS FOR A SPECIFIED PERIOD OF TIME.

20. **BILLING CHARGES AND REFUNDS.**

a. Facility, a Medicaid certified nursing Facility, accepts applicable Medicaid payment for residents who are financially and medically eligible for Medicaid. In the event that Medicaid does not pay Basic Charges for reimbursable items and services for any reason, Resident/Responsible Party shall pay Facility the current applicable rate for Basic Charges for the non-covered days of service and any additional items and services provided to the Resident.

b. Medicaid eligible residents must pay or arrange to have paid to Facility applied income, including but not limited to Social Security. Payment shall be made monthly on or before the 10th day of the month.

c. If unable to pay for goods and services provided pursuant to this Agreement, Resident/ Responsible Party shall apply without delay for all available federal and/or state assistance. Responsible Party shall provide Resident and Facility with any and all assistance required to complete such application.

d. Facility assists residents in applying for Medicaid and may assist Resident in applying for any other available public assistance. Resident/Responsible Party shall continue to pay Facility pursuant to this

Agreement and applicable law while any application for Medicaid is pending, unless and until eligibility is determined and retroactive adjustment is required.

e. When Resident is not financially eligible for Medicaid, Resident/Responsible Party shall pay the rate of

_____per day to cover Basic Charges associated with caring for Resident, and shall pay for all other reimbursable items and services provided to Resident not covered in Facility's Basic Charges or reimbursed by a third-party payer. Resident/Responsible Party shall pay Basic Charges for the first month at the time of admission. Basic Charges and any additional amounts due for reimbursable items and services shall be billed on a monthly basis following admission and are due and payable within ten **(10)** days to **Facility.**

f. Facility may change the Basic Charges rate at any time with advance written notice.

g. Upon request, Resident/Responsible Party shall receive a refund of any unearned portion of Basic Charges to which Resident is entitled, provided all terms of this Agreement have been met. All refunds shall be made within thirty (30) days following discharge.

h. Unless other arrangements are made, accounts which are not paid by the 10th of each month shall be charged interest at the rate of ten percent (18%) per annum until paid.

i. Resident/Responsible Party shall assign to Facility the right to receive payments for any unpaid charges for goods and services that Facility is authorized to bill to residents.

j. Resident/Responsible Party shall not take any action, including but not limited to setting up a trust, purchasing an annuity or otherwise transferring resources of Resident, that will divest Resident of assets or income or impair Resident/Responsible Party's ability to comply with this Agreement.

21. **PERSONAL BELONGINGS.** Resident/Responsible Party shall complete and sign Facility's written inventory form listing Resident's personal belongings at the time of admission. An original inventory shall be retained by Resident/Responsible Party as a receipt and a copy will be kept with Resident's records. Additions and deletions to the inventory shall be brought to the attention of Facility's Administration so that records are current. Resident/Responsible Party may ask Facility to accept Resident's personal property items for safekeeping. Facility assumes no liability for the security of personal items retained by Resident or kept in Resident's room. All articles retained by Resident, (including dentures, hearing aids, eye glasses, jewelry and documents) shall be the responsibility of Resident. At the time of transfer or discharge, Facility shall be accountable only for Resident's personal property items Facility has accepted for safekeeping. All personal property must be removed within seventy-two (72) hours of discharge unless alternate arrangements are made with Facility Administration.

22. **OBLIGATIONS OF RESIDENT/RESPONSIBLE PARTY.**
    a. Provide spending money for Resident on an as needed basis;
    b. Provide wash and wear clothing, properly labeled and marked in sufficient quantities for Resident to maintain a neat appearance;
    c. Pay, out of Resident's funds and resources, all reimbursable items and services relating to Resident's care not covered in Facility 's Basic Charge and not reimbursed by Medicaid, Medicare or other third-party payer;
    d. To the extent possible, assist in transfer and transportation of Resident;
    e. Refrain from bringing into Facility items not permitted for Resident. (See list provided)
    f. Abide by rules and regulations by licensing and contracting agencies as to charges, refunds, supplies, equipment and medicine.
    g. Understanding the Resident Rights.

23. **SPECIAL ARRANGEMENTS/GRANT OF AUTHORITY**

☐ **authorizes** ☐**does not authorize** visits from medical professionals deemed necessary for rendering care to Resident upon written permission of Resident's Attending Physician with professional services fees billed directly to Resident's account or to insurance as applicable.

☐ **authorizes** ☐ **does not authorize** Facility to have personal laundry done for Resident in house and to have dry cleaning provided by an outside source at the expense of Resident/Responsible Party.

☐ **authorizes** ☐ **does not authorize** Resident's participation in activities within the scope of Resident's mental and physical capabilities, as authorized by Resident's Attending Physician.

☐ **authorizes** ☐ **does not authorize** Facility to take photographs of Resident and to use and disseminate identifying information as may be necessary for use in conjunction with the Resident's care.

☐ **authorizes**☐ **does not authorize** Facility to use the Resident's name, personal background, other information regarding Resident, and all media and audio-visual materials incorporating Resident's name or personal background information for Facility marketing and publicity, informational and educational presentations, and other uses as the staff of Facility deem appropriate.

☐ **authorizes** ☐ **does not authorize** Facility to hold, safeguard, manage, and account for Resident's personal funds. Resident/Responsible Party appoints the Facility to act as Resident's agent and hold for the Resident's benefit such monies and other items of value as may be delivered from time to time to the Executive Director for the Resident's behalf.

Facility is authorized to pay from personal funds of Resident for items or services ordered by Resident and not covered in the Basic Charges. Facility shall oversee and maintain at all times a complete, accurate and current accounting of Resident's personal fund account. Facility shall provide Resident/Responsible Party with a quarterly statement of Resident's personal fund account. Facility may commingle Resident's personal funds with those of private pay residents.

☐ **authorizes** ☐**does not authorize** Facility to ☐ open and/or ☐ read all mail received by the resident upon receipt. The resident or responsible party has the right to revoke this authorization at any time with written notice to Facility.

24. **MISCELLANEOUS.**

a. Acknowledgement of Rights and Responsibilities of Resident. Resident/Responsible Party acknowledges receipt of Facility's admission policies, rules, and regulations and statement of Resident's Rights. Facility reserves the right to revise the policies and statement of rights as required from time to time in order to comply with applicable laws and regulations.

i. All rules and regulations governing resident conduct and responsibilities in our Resident Handbook,

ii.. Residents' Bill of Rights under the Omnibus Budget Reconciliation Act of 1987,

iii. Information regarding advance directives and Resident's right to make decisions about medical care (Patient Self-Determination Act),
iv. Protection of Resident Funds policy,
v. Information regarding Electronic Monitoring,
vi. Notice of Privacy Practices.

b. Contributions, Donations and Gifts. Contributions, donations and/or gifts made to facility by a governmentally assisted resident, his or her Responsible Party or family are given solely at their discretion, and in no way affect the eligibility for admission or availability of or access to the normal services provided to all residents. Facility does not solicit or in any way require such contributions, donations and/or gifts.

c. Termination. This agreement may be terminated by Resident/Responsible Party or by Facility upon appropriate written notice, pursuant to the transfer and discharge provisions in this Agreement, or by mutual agreement.

d. Liability Facility shall exercise such reasonable care toward Resident as his/her known condition(s) may require, however, Facility shall not be liable for injuries or damages sustained by Resident of any kind unless caused by the willful act or negligence of Facility or its staff. Facility is not an insurer of the health and safety of Resident and assumes no liability as such. Facility shall not be responsible for Resident when Resident is on leave from Facility.

e. Parties Bound. Resident/Responsible Party acknowledge that they have received and reviewed this agreement and the same shall be binding on Resident, Responsible Party, and Resident's heirs, executors and administrators.

25. **GOVERNING LAW**. This agreement shall be interpreted, construed and governed under the laws of the State of Oklahoma and is performable in the county that the facility is physically located in.

26. **NOTICES.** Any and all notices required or permitted to be given under this Agreement shall be sufficient if furnished in writing, sent by certified mail addressed as follows or at such other address as a party may, from time- to-time, notify the other in writing:

TO FACILITY:

TO ESIDENT/RESPONSIBLE PARTY:

27. **ENTIRETY OF THIS AGREEMENT.** Except as provided herein, this Agreement, and all attachments, supersedes all other agreements, either oral or in writing, between the parties, and contains all of the covenants and agreement between the parties. Each party to the Agreement acknowledges that no representations, inducements, promises, or agreements, orally or otherwise, have been made by any party or anyone acting on behalf of any party, that are not embodied in this Agreement and, except as provided herein, that no other agreement, statement, or promise shall be valid or binding. This Agreement may be amended only by mutual agreement, reduced to writing and signed by both parties.

28. **AMENDMENT DUE TO REIMBURSEMENT CHANGES.** If the governmental agencies who administer Medicare or Medicaid, or any other payer, or any other federal, state, or local

government or agency adopts any law, rule, regulation, standard or interpretation at any time while this Agreement is in effect which affects the method or amounts of reimbursement or payment for services rendered under this Agreement, or which otherwise materially affects the obligations of Facility , Facility may give Resident/Responsible Party notice of its intent to amend this Agreement or, if applicable, increase charges in a fashion that is equitable and reasonable in order to comply with the change in government law, rule, regulation, or standard or interpretation.

29. **SAVINGS CLAUSE.** In case any one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal, or unenforceable in any aspect, such invalidity, illegality, or unenforceability shall not affect any other part of the Agreement and this Agreement shall be construed as if such invalidity or unenforceable provision has never been contained herein.

30. **ASSIGNABILITY.** This agreement is fully assignable by Facility; in the event that Facility is sold or licensed is transferred such that a new licensee operates Facility, this agreement shall be automatically assigned to the new licensee and shall be fully binding upon both parties.

THE UNDERSIGNED ACKNOWLEDGE THAT EACH OF THEM HAS READ AND UNDERSTAND THIS AGREEMENT, AND THAT EACH OF THEM VOLUNTARILY CONSENT TO ALL OF ITS TERMS.

Printed Name: _____
Resident/Responsible Party

Signature: _____ Date: _____
Resident/Responsible Party

Printed Name: _____
Facility Representative

Signature: _____ Date: _____
Facility Representative

What is the Advance Directive?

Oklahoma's Advance Directive for Health Care allows you, if you are 18 years of age or older, to inform physicians and others of your wishes to provide, decline or withdraw life-sustaining medical care and to donate specified organs when you have been diagnosed by your attending physician and another physician to be in a terminal condition, a persistently unconscious state, or an end-stage condition. The Advance Directive also allows you to appoint a Health Care Proxy to make certain decisions on your behalf. If you have completed an Advance Directive and been diagnosed as terminally ill or persistently unconscious by two physicians as defined in the Advance Directive and your attending physician does not want to comply with your wishes, that physician must act promptly to arrange for your care by another physician or health care provider. After you complete an Advance Directive, you may revoke it in whole or in part at any time and in any manner, without regard to your mental or physical condition. A revocation is effective upon your communication to your attending physician or other care provider or a witness to the revocation. Make copies of your Advance Directive for your personal records, your family, your physician, your attorney, your Health Care Proxy and alternate Health Care Proxy. If your physician is unwilling to comply with the Advance Directive, the physician must tell you.

If you signed a Directive to Physicians or other Advance Directive for Health Care under Oklahoma law prior to 2006, it is recommended that you complete the new Advance Directive because of additional options under the existing law.

Advanced Directive Glossary

Advance Care Planning – Is a process used to identify and update the residents' preferences regarding care and treatment at a future time including situations in which the resident subsequently lacks the capacity to do so. For example, when a situation arises in which life sustaining treatments are a potential option for care and the resident is unable to make his or her choices known.

Advance Directive - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

Artificial Nutrition and Hydration: Artificial nutrition and hydration supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

Capacity - In relation to end-of-life decision-making, a patient has medical decision-making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

Cardiopulmonary Resuscitation - Cardiopulmonary resuscitation **(CPR**) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

Do-Not-Resuscitate (DNR) Order - A DNR order is a physician's written order instructing healthcare providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

Emergency Medical Services (EMS) - A group of governmental and private agencies that provide emergency care, usually to persons outside of healthcare facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

Healthcare Agent - The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

Health Care Decision Making – Refers to consent, refusal to consent, or withdrawal of consent to health care, treatment, services or a procedure to maintain, diagnose, or treat an individual's physical or mental condition.

Health Care Decision Making Capacity – Refers to possessing the ability (as defined by state law) to make decisions regarding health care and related treatment choices.

Hospice - Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice and palliative care involve a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the person's needs and wishes. Support is provided to the persons loved ones as well.

Intubation - Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

Life-Sustaining Treatment - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and other treatments.

Living Will - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians", "healthcare declaration," or "medical directive."

Mechanical Ventilation - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea).

Medical Power of Attorney (a.k.a Medical Power of Attorney) - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a healthcare proxy, durable power of attorney for healthcare or appointment of a healthcare agent. The person appointed may be called a healthcare agent, surrogate, attorney-in-fact or proxy.

Palliative Care - A comprehensive approach to treating serious illness that focuses on the physical, psychological and spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering and controlling pain and symptoms.

Power of Attorney - A legal document allowing one person to act in a legal matter on another's behalf regarding to financial or real estate transactions.

Respiratory Arrest - The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop breathing, resulting in cardiac arrest.

Surrogate Decision-Making - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for people without advance directives.

Treatment – Refers to interventions provided for purpose of maintaining/restoring health and well-being, improving functional level or relieving symptoms.

Ventilator - A ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

Withholding or Withdrawing Treatment - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

Advanced Directive for Health Care (Living Will)

Frequently Asked Questions

Q: What is an Advance Directive for Health Care?
A: An Advance Directive for Health Care is a written legal document which allows you to instruct your attending physician whether or not you wish to be given life-sustaining treatments and artificially administered nutrition (food) and hydration (water) and to give other medical directions that impact the end of life. Its purpose is to recognize your right to control some aspects of your medical care and treatment, primarily the right to decline medical treatment or direct that it be withdrawn even if death ensues. An Advance Directive for Health Care may include a living will, the appointment of a health care proxy (a proxy is a person authorized to act for another) and directions for organ donation.

Q: Who can sign an Advance Directive for Health Care? A: Any person of sound mind who is 18 or older.

Q: Does the signing of an Advance Directive require witnesses and a notary public?
A: An Advance Directive must be signed before two witnesses who are 18 or older. The witnesses cannot be beneficiaries under your will, nor may they be persons who would inherit your property if you died without a will. An Advance Directive is not required to be notarized.

Q: When does an Advance Directive go into effect?
A: An Advance Directive goes into effect when your attending physician and another physician determine that you are no longer able to make decisions regarding your medical treatment and you are in one of the three conditions explained on next page. Advance Directives do not determine your medical treatment in situations that do not affect your continued life, such as routine medical treatment and non-life- threatening medical conditions.

Q: What conditions does an Advance Directive cover?
A: An Advance Directive covers three conditions: 1) terminal condition, 2) persistently unconscious and
3) end-stage condition.

Q: What does "terminal condition" mean?
A: A terminal condition is an incurable, irreversible condition that, even with the administration of life- sustaining treatment (such as putting a person on a respirator, dialysis, pacemakers, surgery, blood transfusions and antibiotics) will, in the opinion of your attending physician and another physician, result in death within six months.

Q: What does the term "persistently unconscious" mean?
A: "Persistently unconscious" means an irreversible condition as determined by your attending physician and another physician, in which thought and awareness of self and environment are absent.

Q: What is an "end-stage condition"?
A: An "end-stage condition" means a condition caused by injury, disease or illness which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective.

Q: What is the living will portion of an Advance Directive?

A: In the living will portion of your Advance Directive (Section I) you may direct that your life not be extended by life-sustaining treatment if you 1) are in a terminal condition, 2) are persistently unconscious or 3) have an end-stage condition. Alternatively, you can direct that you are to be given life-sustaining treatment if you are in any of those three conditions.

You also have the ability to direct whether or not you wish to receive artificially administered nutrition (food) and hydration (water) if you are unable to take food and water by mouth in each of the three conditions described. Artificially administered food and water normally involves the surgical insertion of a feeding tube into your stomach.

Oklahoma law does provide that even if life-sustaining treatment or artificially administered nutrition and hydration are withheld or withdrawn, you shall be provided with medication or other medical treatment to alleviate pain, and you will be provided with oral consumption of food and water if you are able to eat or drink.

Q: What is the health care proxy portion of an Advance Directive?
A: A health care proxy is a person who is authorized to make medical treatment decisions for you in the event that you are unable to make such decisions. Section II of Oklahoma's Advance Directive allows you to appoint a health care proxy (such as your spouse or adult child) to make whatever medical treatment decisions you could make if you were able. You can also appoint an alternate (back-up) health care proxy to serve in the event your health care proxy is unable or unwilling to serve. Your physician is directed to follow the instructions of your health care proxy. While your health care proxy can make decisions regarding life-sustaining treatment and artificially administered food and water, such decisions must be in accord with your wishes on those subjects as you specify in the living will portion of your Advance Directive. Therefore, it is important that you discuss these subjects in advance with your health care proxy and that you choose someone who supports your wishes as set forth in your living will.

Q: May I direct organ donation in my Advance Directive?
A: Yes; Section III, titled "Anatomical Gifts," gives you the opportunity to direct the donation of your entire body or designated body organs.

Q: What happens if my attending physician does not want to comply with my wishes as expressed in my Advance Directive?
A: In that case, your attending physician is required, as promptly as practicable, to take all reasonable steps to arrange for your care by another physician.

Q: Is the Advance Directive honored by my attending physician if I am pregnant?
A: Oklahoma law provides that a person who has been diagnosed as pregnant and whose attending physician is aware of the diagnosis will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless the person has, in her own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.

Q: Can I be required to complete an Advance Directive?
A: No. It is illegal for anyone to require that you execute an Advance Directive as a condition of receiving health care services or health insurance coverage. It is also illegal for anyone to modify your life insurance coverage, or to refuse to issue life insurance coverage to you, because you have executed an Advance Directive.

Q: Are Directives to a Physician or Advance Directives executed under prior laws still valid?
A: Yes. If you signed a Directive to Physicians under the Oklahoma Natural Death Act, which was the law in effect prior to Sept. 1, 1992, or an Advance Directive for Health Care under the law in effect prior to May 2006, it remains valid until you revoke it. However, it is recommended that you consider signing a new Advance Directive for Health Care because of additional options available to you under the current law.

Q: Does the Advance Directive require my signature more than one time?
A: The Advance Directive requires that your initial multiple times but requires your signature only once at the end. Remember that this is a legal document, and if questions arise concerning portions that seem unclear, you may wish to discuss them with your physician and/or attorney.

Q: How is the Advance Directive different from a Do-Not-Resuscitate (DNR) Consent?
A: A DNR consent form deals only with the subject of cardiopulmonary resuscitation (CPR) in the event of a cardiac or respiratory arrest. In such a document, a person can state that the person does not consent to the administration of CPR in the event the person's heart stops beating or the person stops breathing.

Q: If I sign an Advance Directive how am I protected from a misjudgment by a physician?
A: Oklahoma law requires that both your attending physician and another physician who has examined you determine that you are incapable of making an informed decision regarding your health care, including the provision, withholding or withdrawal of life-sustaining treatment. This determination has to become part of your medical record.

Q: Can I revoke a signed Advance Directive?
A: Yes. An Advance Directive may be revoked by you, either entirely or as to any part, at any time and in any manner, regardless of your mental or physical condition. The revocation becomes effective when you (or a person who witnessed the revocation) notify your attending physician or other health care provider of the revocation.

Q: If I have signed more than one Advance Directive, which one will be effective?
A: In the event you signed more than one valid Advance Directive, none of which have been revoked by you, the most recently signed Advance Directive will be considered your last wishes and the one given effect.

Q: Is a document executed in another state and similar to Oklahoma's Advance Directive for Health Care honored in Oklahoma?
A: If you signed an Advance Directive in another state, which provides for the withholding or withdrawal of life-sustaining treatment or for the appointment of another to provide, withhold or withdraw life- sustaining treatment, and that document complied with the law of the state in which signed, it is valid in Oklahoma to the extent it does not exceed authorizations under Oklahoma law. However, Oklahoma residents should sign an Advance Directive that complies with the Oklahoma law, if at all possible.

Q: After signing an Advance Directive, to whom should I give copies?
A: You should consider making copies of your Advance Directive for your personal records, your family, your physician, your attorney, your health care proxy and alternate health care proxy. Have additional copies ready to take with you when you require hospitalization or other care as your health care providers will need a copy for your medical record. You should keep a list of persons to whom you have given a copy of your Advance Directive so that if you later change it or revoke it, you may collect the copies.

Q: Where can I acquire a copy of an Advance Directive?
A: A copy of an Advance Directive for Health Care may be obtained from the Oklahoma Bar Association, or your attorney.

ADVANCE DIRECTIVE/DNR CONSENT ADMISSION ACKNOWLEDGMENT

Resident Name: _____ Date of Birth: _____

Resident SSN: _____

1. PLEASE READ THE FOLLOWING FOUR STATEMENTS AND INITIAL EACH STATEMENT THAT APPLIES.
    a. _____ I have been given written materials about my right to accept or refuse medical treatments.
    b. _____I have been Informed of my rights to formulate a Do-Not-Resuscitate (DNR) Consent or Advance Directive including a Living will, health Care Proxy and a Durable Power of Attorney for health care.
    c. _____I understand that I am not required to have an Advance Directive or DNR Consent in order to receive medical treatment at this health care facility.
    d. _____I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.
    e. _____ A copy of my Advance Directive and/or DNR has been given to the facility.

2. PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

    ☐ I currently HAVE an Advance Directive

    ☐ I currently DO NOT have an Advance Directive

3. PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

    ☐ I currently HAVE a DNR consent

    ☐ I currently DO NOT have a DNR Consent

IF THE RESIDENT IS CAPABLE OF MAKE MEDICAL DECISIONS, HIS/HER SIGNATURE IS REQUIRED:

Residents Signature: _____ Witness' Signature: _____

Date: _____ Printed Name: _____

Date: _____

IF THE RESIDENT IS NOT CAPABLE OF MAKING MEDICAL DECISIONS, THEN THE PATIENTS LEGAL REPRESENTATIVE WILL SIGN THEIR ACKNOWLEDGMENT:

Responsible Party Signature:_____ Witness' Signature: _____

Printed Name: _____ Printed Name: _____

Date: _____ Date: _____

Antibiotic Stewardship Program					
Date Implemented:	1/1/2023	*Date Reviewed/ Revised:*		*Reviewed/ Revised By:*	

Policy:

It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.

Policy Explanation and Compliance Guidelines:

1. The Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the Antibiotic Stewardship Program and receives support from the Administrator and other governing officials of the facility.
    a. Infection Preventionist – coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff.
    b. Director of Nursing – serves as back up coordinator for antibiotic stewardship activities, provides support and oversight, and ensures adequate resources for carrying out the program.
    c. Administrator – provides adequate resources for carrying out the program and ensures review of antibiotic use and resistance data at QAPI meetings.
2. The Medical Director, Consultant Pharmacist, and Attending Physicians support the program via active participation in developing, promoting, and implementing a facility-wide system for monitoring the use of antibiotics.
    a. Medical Director – serves as the primary medical point of contact for the program and serves as a liaison between the facility and other medical staff members.
    b. Consultant Pharmacist – reviews antibiotics prescribed to residents during their medication regimen review and serves as resource for questions related to antibiotics.
    c. Attending Physicians – prescribe appropriate antibiotics in accordance with standards of practice and facility protocols.
3. Licensed nurses participate in the program through assessment of residents and following protocols as established by the program.
4. The program includes antibiotic use protocols and a system to monitor antibiotic use.
    a. Antibiotic use protocols:
        i. Nursing staff shall assess residents who are suspected to have an infection and complete an SBAR form prior to notifying the physician.
        ii. Laboratory testing shall be in accordance with current standards of practice.
        iii. The facility uses the (*CDC's NHSN Surveillance Definitions, updated McGeer criteria, or other surveillance tool*) to define infections.
        iv. The *Loeb Minimum Criteria* may be used to determine whether to treat an infection with antibiotics.
        v. All prescriptions for antibiotics shall specify the dose, duration, and indication for use.
        vi. Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized.
    b. Monitoring antibiotic use:
        i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made (e.g., antibiotic time-out).
        ii. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness.
        iii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness.
        iv. Monitor during each monthly medication regimen review when the resident has been prescribed or is taking an antibiotic or any antibiotic regimen review as requested by the QAA committee.

v. Random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness (process measure).
vi. Antibiotic use shall be measured by (*monthly prevalence, antibiotic starts, and/or antibiotic days of therapy*).
vii. At least one outcome measure associated with antibiotic use will be tracked monthly, as prioritized from the facility's infection control risk assessment and other infection surveillance data. Examples include tracking *C. difficile* infections, antibiotic resistance, adverse drug events related to antibiotic use, or costs related to antibiotic use.
viii. A review of the facility's antibiogram will be performed every 18-24 months to guide development or revision of antibiotic use protocols or prescribing practices.

5. Nursing will monitor the initiation of antibiotics on residents and conduct an "antibiotic timeout" within 48-72 of antibiotic therapy to monitor response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings.
6. New or changed orders for antibiotics based on the antibiotic timeout recommendations will be obtained from the practitioner.
7. At least annually or per facility policy, feedback shall be provided on the facility's antibiotic use data in the form of a written report shared with administration, medical and nursing staff, resident and family council, and the QAA Committee.
8. At least annually or per facility policy, each attending physician shall be provided feedback on his/her antibiotic use data in the form of a written report (i.e "antibiotic report card") to improve prescribing practices and resident outcomes. Feedback may include:
    a. Information from medical record reviews for new antibiotic starts to determine whether the resident had signs or symptoms of an infection;
    b. Laboratory tests ordered and the results;
    c. Order documentation including the indication for use, dosage and duration;
    d. Clinical justification for the use of an antibiotic beyond the initial duration ordered such as a review of laboratory reports/cultures in order to determine if the antibiotic remains indicated or if adjustments to therapy should be made.
9. Education regarding antibiotic stewardship shall be provided at least annually to facility staff, prescribing practitioners, residents, and families.
10. The elements of the program and associated protocols are reviewed on an annual basis and as needed as part of the facility's review of the overall infection prevention and control program.
11. Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to:
    a. Action plans and/or work plans associated with the program.
    b. Assessment forms.
    c. Antibiotic use protocols/algorithms.
    d. Data collection forms for antibiotic use, process, and outcome measures.
    e. Antibiotic stewardship meeting minutes.
    f. Feedback reports.
    g. Records related to education of physicians, staff, residents, and families.
    h. Annual reports.
12. Data obtained from antibiotic stewardship monitoring activities is discussed in the facility's QAPI meetings.

References:

Centers for Medicare & Medicaid Services. *Appendix PP: Guidance to Surveyors for LTC Facilities, State Operations Manual*: (October 2022 Revision), 42 C.F.R. 483.80, F881

Centers for Disease Control and Prevention. *The Core Elements of Antibiotic Stewardship for Nursing Homes*. Atlanta, GA: US Department of Health and Human Services, CDC; 2015. Available at: http://www.cdc.gov/longtermcare/index.html. Accessed May 2022.

Assignment of Benefits

Resident's Name:_____

Resident's Medicare #:_____

Resident's Medicaid #:_____

Long-term Care (LTC) Insurance Company: _____

LTC Policy #: _____

Name of Insurance Company:_____

Policy #:_____

_____request payment of authorized Medicare, Medicaid and/or other insurance benefits be made to

_____for any service furnished to me.

I authorize any holder of medical and other information to release my information, medical and otherwise, to determine my benefits related services.

Printed Name:_____
Resident/Responsible Party

Signature: _____Date: _____
Resident/Responsible Party

Printed Name: _____
Facility Representative

Signature: _____ Date: _____
Facility Representative

Parc Place Medical Resort

MUTUAL ARBITRATION AGREEMENT – READ CAREFULLY

It is understood and agreed by Parc Place Medical Resort and _____ ("Resident", or "Resident Authorized Representative", hereinafter collective the "Resident") that any legal dispute, controversy, demand or claim (hereinafter collectively referred to as "claim" or "claims"), that arises out of or relates to the Resident Admission Agreement or any service or health care provided by Parc Place Medical Resort to the Resident, shall be resolved exclusively by binding arbitration to be conducted at a place agreed upon by the parties by a Neutral Arbitrator, who is agreed upon by both parties in accordance with the code of Procedures of The American Arbitration Association which is hereby incorporated into this agreement. The Parties agree that any dispute will not be settled by a lawsuit and that they will not resort to court process except to the extent that applicable state or federal law provides for judicial review of the proceedings or the judicial enforcement of arbitration awards.

This agreement to arbitrate includes, but is not limited to, any claim for payment, nonpayment or refund of services rendered to the Resident by Parc Place Medical Resort, violations of any right granted to the Resident by law or by the Resident Admission Agreement, breach of contract, fraud, or misrepresentation, negligence, gross negligence, malpractice, wrongful death, or any other claim based on any departure from accepted standards of medical or health care or safety whether found in tort or in contract. However, this agreement to arbitrate shall not limit the Resident's right to file a grievance or complaint, formal or informal, with Parc Place Medical Resort or any appropriate state of federal agency.

The parties agree that damages awarded, if any, in an arbitration conducted pursuant to this Arbitration Agreement shall be determined in accordance in accordance with the provisions of the state or federal law applicable to a comparable civil action, including any prerequisites to, credit against or limitations on, such damages.

It is the intention of the parties to this Arbitration Agreement that it shall inure to the benefit of and bind the parties, their successors and assigns, including the agents, employees and servants of Parc Place Medical Resort, and all persons whose claim is derived through or on behalf of the Resident, including that of any parent, spouse, child, guardian, executor, administrator, legal representative, or heir of the Resident.

All claims based in whole or in part on the same incident, transactions, or related course of care of service provided by Parc Place Medical Resort to the Resident shall be arbitrated in one proceeding. A claim shall be waived and forever barred if it arose prior to the date upon which notice of arbitration is given to Parc Place Medical Resort or received by the Resident, and is not presented in the arbitration proceeding.

THE PARTIES UNDERSTAND AND AGREE THAT BY ENTERING THIS ARBITRATION AGREEMENT THEY ARE GIVING UP AND WAVERING THEIR CONSTITUTIONAL RIGHT TO HAVE ANY CLAIM DECIDED IN A COURT OF LAW BEFORE A JUDGE AND A JURY.

The Resident understand that (1) he/she has the right to seek legal counsel concerning this agreement, (2) the execution of this Arbitration Agreement is not precondition to the furnishing of services to the Resident by Parc Place Medical Resort, and (3) this Arbitration Agreement may be rescinded by written notice to Parc Place Medical Resort from the Resident within thirty (30) days of signature. If not rescinded within thirty (30) days, this Arbitration Agreement shall remain in effect for all care and services subsequently rendered at Parc Place Medical Resort, even if such care and services are rendered following the Resident's discharge and readmission to Parc Place Medical Resort.

This agreement shall be governed by and interpreted under Federal Arbitration Act 9 U.S.C. $$ 1-16.

_____ _____ _____

Resident / Representative Signature | Date | Resident / Representative Printed Name

_____ _____ _____

Facility's Agent Signature | Date | Facility's Agent Printed Name

AUTHORIZATION TO RELEASE HEALTH INFORMATION RECORDS

Resident's Name: _____

Please check the following item which correctly identifies your interest in the residents' health information records:

☐ I am the resident noted above.

☐ I am the resident's legal decision maker under state law, and I am entitled to receive the medical records under state law.

☐ I am the resident's attorney-in-fact, and I have attached to this authorization a valid Power of Attorney or Durable Power of Attorney for Health Care (DPHAC) that grants me the power to request the resident's medical records.

☐ I am the resident's legal guardian, and I have attached to this authorization a valid appointment of guardianship from a probate court.

☐ If the resident is deceased, I am the executor/administrator of the resident's estate and I have attached to this authorization a valid appointment as such from a probate court.

☐ The resident has executed a legally binding instrument granting me the authority to obtain his/her medical records, and I have attached a copy of that instrument to this authorization.

☐ The resident's legally authorized representative has executive a legally binding instrument granting me the authority to obtain the resident's medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so (e.g., a power of attorney or probate court order).

UNDERSTANDINGS AND AGREEMENTS OF REQUESTOR

1. This authorization is voluntary.
2. This authorization will expire two months from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying the Provider in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against the Provider for the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the Provider if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the Provider.
6. The provider may not place conditions on treatment, payment, enrollment or eligibility for benefits on whether I sign an authorization when the prohibition on conditioning of authorization applies
7. I understand that I must provide the Provider with at least twenty-four (24) hours' notice before coming to the Providers location to review records.
8. I understand that after I have reviewed the records, I must provide the Provider with two (2) working days advance notice of any copies of the records that I would like to pick up at the Providers location.
9. I understand that if I request that records be copied and sent to me that the Provider will make a good faith effort to send those records to me in a reasonable amount of time.
10. I understand that if I wish to have copies made of the records, the Provider will charge a fee for copying the records.
11. The Provider will notify me of the total amount due for copying and shipping of the requested records; I agree that the Provider will only send me the requested information once they have received payment in full for those costs.

Requestor's Signature: _____

Printed Name: _____

Date: _____

Witness' Signature: _____

Printed Name: _____

Date: _____

Bed Hold Policy Statement

Our facility shall inform residents upon admission and prior to a transfer for hospitalization or therapeutic leave of our bed-hold policy.

Policy Interpretation and Implementation

1. Upon admission and when a resident is transferred for hospitalization or for therapeutic leave, designated person will provide information concerning our bed-hold policy.

2. When emergency transfers are necessary, the facility will provide the resident or resident representative with information concerning our bed-hold policy within 24 hours of such transfer.

3. The bed-hold will include any charges that the resident may incur as well as the time limit established by the State Medicaid Plan for which the facility will reserve the resident's bedspace.

4. Our State Medicaid Plan will not pay for holding a Medicaid resident's bed.

5. A copy of the resident's bed-hold or release record will be filed in the resident's medical record.

6. A Medicaid resident who elects not to pay for non-covered services and whose hospitalization or therapeutic leave exceeds the bed-hold period established by the State Medicaid Plan will be readmitted when a bed in a semi-private room becomes available.

7. Our facility will not charge, solicit, accept, or receive payments as a precondition of admission or expedited admission for holding a bed space during a Medicaid resident's hospitalization or therapeutic leave.

8. Inquiries concerning bed-hold policies should be referred to the Executive Director.

Skilled Nursing Facility:

Beneficiary's Name:

Identification Number:

Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)

Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements.

Beginning on_____, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.

Care:	Reason Medicare May Not Pay:	Estimated Cost:

WHAT TO DO NOW:

- Read this notice to make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to get the care listed above.

Note: If you choose Option 1, we may help you use any other insurance that you may have, but Medicare can't require us to do this.

OPTIONS: Check only one box. We can't choose a box for you.
☐ **Option 1.** I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but **I can appeal to Medicare** by following the directions on the MSN.
☐ **Option 2.** I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. **I cannot appeal because Medicare won't be billed.**
☐ **Option 3.** I don't want the care listed above. I understand that I'm not responsible for paying, and **I can't appeal to see if Medicare would pay**.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you request that we bill Medicare and in 90 days you have not gotten a decision on your claim or if you have other questions about this notice, call **1-800-MEDICARE** (1-800-633-4227) /**TTY:** 1-877-486-2048. You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

Signing below means that you've received and understand this notice. You'll also get a copy for your records.

Signature of Patient or Authorized Representative*	Print Name	Date
Signature Facility Representative	**Print Name**	**Date**

* If a representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed.

«${facility.facility_name}»

Co-Pay Acknowledgment

Resident's Name: «${resident.full_name}»

Admission Date: _«${resident.admission_date}»

Primary Insurance & Policy #:

Secondary Insurance & Policy #:

We are pleased that you have selected our facility for your loved one's rehabilitation and/or nursing needs.

According to our records, your Primary Insurance Payor will pay for the first days of your stay.

Your Co-Pay start Day is:

Deductible:

Co-Pay amount:

Out of Pocket:

Any days used at another facility will count in the 20 skilled days. We cannot be responsible for the discrepancy in days if we are not notified by you of the previous skilled stay at another facility.

As a courtesy, The Facility will attempt to verify your health insurance benefits, and or necessary authorizations for you. Please be aware, this is only "A Quote of Benefits/Authorizations." We cannot guarantee payment or verify that definite eligibility of benefits conveyed to us or to you by your carrier will be accurate or complete. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Printed Name: «${resident.full_name}» «${responsible_party.full_name}»
Resident/Responsible Party

Date: _____

Signature: _____
Resident/Responsible Party

Printed Name: _____
Facility Representative

Signature: _____ Date: _____
Facility Representative

Consent to Treat

_____consent to/ and authorize
(Residents Name)

_____and its qualified personal to treat me and
(Facility Name)
to recommend and/or order laboratory tests, other specialized tests and/or evaluations as needed under a physician's order for my continued medical care while residing at the facility.

_____ _____
Resident Name Resident Date of Birth

Printed Name: _____
Resident/Responsible Party

Signature: _____ Date: _____
Resident/Responsible Party

Signature:_____
Facility Representative

Printed Name:_____
Facility Representative

Date: _____

Coordination of Hospice Services

Date Implemented:		*Date Reviewed/ Revised:*	01/01/2023	*Reviewed/ Revised By:*	

Policy:

When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being.

Policy Explanation and Compliance Guidelines:

1. The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care.
2. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the extent possible.
3. The plan of care will identify the care and services that each entity will provide in order to meet the needs of the resident and his/her expressed desire for hospice care.
    a. The hospice provider retains primary responsibility for the provision of hospice care and services that are necessary for the care of the resident's terminal illness and related conditions.
    b. The facility retains primary responsibility for implementing those aspects of care that are not related to the duties of the hospice.
4. The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility.
5. The facility will monitor and evaluate the resident's response to the hospice care plans.
6. The facility will maintain communication with hospice as it relates to the resident's plan of care and services to ensure each entity is aware of their responsibilities.
7. The plan of care will include directives for managing pain and other uncomfortable symptoms and will be revised and updated as necessary.
8. The facility will monitor for medications and medical supplies to ensure they are provided by hospice as indicated in the plan of care for palliation and management of the terminal illness.
9. All residents receiving hospice will continue to receive the same facility services as residents who have not elected hospice. This includes, but is not limited to the following: ongoing comprehensive and quarterly assessments, personal care/support with activities of daily living, medication administration, physician visits, medication regimen review, social services and activities programming, nutritional support and services, and ongoing monitoring of resident conditions.
10. The facility will immediately contact and communicate with the hospice staff, attending physician/practitioner and the family resident representative regarding any significant changes in the resident's status, clinical complications or emergent situations.

References:

Centers for Medicare & Medicaid Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities.* (October 2022). F684: Quality of Care.

FACT SHEET FOR RECIPIENTS AND CAREGIVERS

EMERGENCY USE AUTHORIZATION (EUA) OF THE JANSSEN COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER

You are being offered the Janssen COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2. This Fact Sheet contains information to help you understand the risks and benefits of receiving the Janssen COVID-19 Vaccine, which you may receive because there is currently a pandemic of COVID-19.

The Janssen COVID-19 Vaccine may prevent you from getting COVID-19. There is no U.S. Food and Drug Administration (FDA) approved vaccine to prevent COVID-19.

Read this Fact Sheet for information about the Janssen COVID-19 Vaccine. Talk to the vaccination provider if you have questions. It is your choice to receive the Janssen COVID-19 Vaccine.

The Janssen COVID-19 Vaccine is administered as a **single dose**, into the muscle.

The Janssen COVID-19 Vaccine may not protect everyone.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please visit www.janssencovid19vaccine.com.

WHAT YOU NEED TO KNOW BEFORE YOU GET THIS VACCINE

WHAT IS COVID-19?

COVID-19 is caused by a coronavirus called SARS-CoV-2. This type of coronavirus has not been seen before. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Common symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

WHAT IS THE JANSSEN COVID-19 VACCINE?

The Janssen COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19.

The FDA has authorized the emergency use of the Janssen COVID-19 Vaccine to prevent COVID-19 in individuals 18 years of age and older under an Emergency Use Authorization (EUA).

For more information on EUA, see the "**What is an Emergency Use Authorization (EUA)?**" section at the end of this Fact Sheet.

WHAT SHOULD YOU MENTION TO YOUR VACCINATION PROVIDER BEFORE YOU GET THE JANSSEN COVID-19 VACCINE?

Tell the vaccination provider about all of your medical conditions, including if you:

- have any allergies,
- have a fever,
- have a bleeding disorder or are on a blood thinner,
- are immunocompromised or are on a medicine that affects your immune system,
- are pregnant or plan to become pregnant,
- are breastfeeding,
- have received another COVID-19 vaccine,

WHO SHOULD GET THE JANSSEN COVID-19 VACCINE?

FDA has authorized the emergency use of the Janssen COVID-19 Vaccine in individuals 18 years of age and older.

WHO SHOULD NOT GET THE JANSSEN COVID-19 VACCINE?

You should not get the Janssen COVID-19 Vaccine if you:

- had a severe allergic reaction to any ingredient of this vaccine.

WHAT ARE THE INGREDIENTS IN THE JANSSEN COVID-19 VACCINE?

The Janssen COVID-19 Vaccine includes the following ingredients: recombinant, replication-incompetent adenovirus type 26 expressing the SARS-CoV-2 spike protein, citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl-β-cyclodextrin (HBCD), polysorbate-80, sodium chloride.

HOW IS THE JANSSEN COVID -19 VACCINE GIVEN?

The Janssen COVID-19 Vaccine will be given to you as an injection into the muscle.

The Janssen COVID-19 Vaccine vaccination schedule is a **single dose**.

HAS THE JANSSEN COVID-19 VACCINE BEEN USED BEFORE?

The Janssen COVID-19 Vaccine is an unapproved vaccine. In an ongoing clinical trial, 21,895 individuals 18 years of age and older have received the Janssen COVID-19 Vaccine.

WHAT ARE THE BENEFITS OF THE JANSSEN COVID-19 VACCINE?

In an ongoing clinical trial, the Janssen COVID-19 Vaccine has been shown to prevent COVID-19 following a single dose. The duration of protection against COVID-19 is currently unknown.

WHAT ARE THE RISKS OF THE JANSSEN COVID-19 VACCINE?

Side effects that have been reported with the Janssen COVID-19 Vaccine include:

- Injection site reactions: pain, redness of the skin and swelling.
- General side effects: headache, feeling very tired, muscle aches, nausea, and fever.

There is a remote chance that the Janssen COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Janssen COVID-19 Vaccine. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing,
- Swelling of your face and throat,
- A fast heartbeat,
- A bad rash all over your body,
- Dizziness and weakness.

Blood clots involving blood vessels in the brain, abdomen, and legs along with low levels of platelets (blood cells that help your body stop bleeding), have occurred in some people who have received the Janssen COVID-19 Vaccine. In people who developed these blood clots and low levels of platelets, symptoms began approximately one to two-weeks following vaccination. Most people who developed these blood clots and low levels of platelets were females ages 18 through 49 years. The chance of having this occur is remote. You should seek medical attention right away if you have any of the following symptoms after receiving Janssen COVID-19 Vaccine:

- Shortness of breath,
- Chest pain,
- Leg swelling,
- Persistent abdominal pain,
- Severe or persistent headaches or blurred vision,
- Easy bruising or tiny blood spots under the skin beyond the site of the injection.

These may not be all the possible side effects of the Janssen COVID-19 Vaccine. Serious and unexpected effects may occur. The Janssen COVID-19 Vaccine is still being studied in clinical trials.

WHAT SHOULD I DO ABOUT SIDE EFFECTS?

If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to **FDA/CDC Vaccine Adverse Event Reporting System (VAERS)**. The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html. Please include "Janssen COVID-19 Vaccine EUA" in the first line of box #18 of the report form.

In addition, you can report side effects to Janssen Biotech, Inc. at the contact information provided below.

e-mail	Fax number	Telephone numbers
JNJvaccineAE@its.jnj.com	215-293-9955	US Toll Free: 1-800-565-4008 US Toll: (908) 455-9922

You may also be given an option to enroll in **v-safe**. **V-safe** is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. **V-safe** asks questions that help CDC monitor the safety of COVID-19 vaccines. **V-safe** also provides live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: www.cdc.gov/vsafe.

WHAT IF I DECIDE NOT TO GET THE JANSSEN COVID-19 VACCINE?

It is your choice to receive or not receive the Janssen COVID-19 Vaccine. Should you decide not to receive it, it will not change your standard medical care.

ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES JANSSEN COVID-19 VACCINE?

Currently, there is no FDA approved alternative vaccine available for prevention of COVID-19. Other vaccines to prevent COVID-19 may be available under Emergency Use Authorization.

CAN I RECEIVE THE JANSSEN COVID-19 VACCINE WITH OTHER VACCINES?

There is no information on the use of the Janssen COVID-19 Vaccine with other vaccines.

WHAT IF I AM PREGNANT OR BREASTFEEDING?

If you are pregnant or breastfeeding, discuss your options with your healthcare provider.

WILL THE JANSSEN COVID-19 VACCINE GIVE ME COVID-19?

No. The Janssen COVID-19 Vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.

KEEP YOUR VACCINATION CARD

When you receive the Janssen COVID-19 Vaccine, you will get a vaccination card to document the name of the vaccine and date of when you received the vaccine.

ADDITIONAL INFORMATION

If you have questions or to access the most recent Janssen COVID-19 Vaccine Fact Sheets, scan the QR code using your device, visit the website or call the telephone numbers provided below.

QR Code	Fact Sheets Website	Telephone numbers
	www.janssencovid19vaccine.com.	US Toll Free: 1-800-565-4008 US Toll: (908) 455-9922

HOW CAN I LEARN MORE?

- Ask the vaccination provider.
- Visit CDC at https://www.cdc.gov/coronavirus/2019-ncov/index.html.
- Visit FDA at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.

Contact your local or state public health department.

WHERE WILL MY VACCINATION INFORMATION BE RECORDED?

The vaccination provider may include your vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. For more information about IISs visit: https://www.cdc.gov/vaccines/programs/iis/about.html.

CAN I BE CHARGED AN ADMINISTRATION FEE FOR RECEIPT OF THE COVID-19 VACCINE?

No. At this time, the provider cannot charge you for a vaccine dose and you cannot be charged an out-of-pocket vaccine administration fee or any other fee if only receiving a COVID-19 vaccination. However, vaccination providers may seek appropriate reimbursement from a program or plan that covers COVID-19 vaccine administration fees for the vaccine recipient (private insurance, Medicare, Medicaid, HRSA COVID-19 Uninsured Program for non-insured recipients).

WHERE CAN I REPORT CASES OF SUSPECTED FRAUD?

Individuals becoming aware of any potential violations of the CDC COVID-19 Vaccination Program requirements are encouraged to report them to the Office of the Inspector General, U.S. Department of Health and Human Services, at 1-800-HHS-TIPS or TIPS.HHS.GOV.

WHAT IS THE COUNTERMEASURE INJURY COMPENSATION PROGRAM?

The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses for certain people who have been seriously injured by certain medicines or vaccines, including this vaccine. Generally, a claim must be submitted to the CICP within one (1) year from the date of receiving the vaccine. To learn more about this program, visit www.hrsa.gov/cicp or call 1-855-266-2427.

WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?

The United States FDA has made the Janssen COVID-19 Vaccine available under an emergency access mechanism called an EUA. The EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

The Janssen COVID-19 Vaccine has not undergone the same type of review as an FDA-approved or cleared product. FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, and available alternatives. In addition, the FDA decision is based on the totality of scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of these criteria must be met to allow for the product to be used during the COVID-19 pandemic.

The EUA for the Janssen COVID-19 Vaccine is in effect for the duration of the COVID-19 declaration justifying emergency use of these products, unless terminated or revoked (after which the products may no longer be used).

Manufactured by:
Janssen Biotech, Inc.
a Janssen Pharmaceutical Company of Johnson & Johnson
Horsham, PA 19044, USA

For more information, call US Toll Free: 1-800-565-4008, US Toll: (908) 455-9922 or go to www.janssencovid19vaccine.com

Revised: Apr/23/2021

cp-205985v3

Scan to capture that this Fact Sheet was provided to vaccine recipient for the electronic medical records/immunization information systems.

Barcode Date: 02/2021

FACT SHEET FOR RECIPIENTS AND CAREGIVERS
EMERGENCY USE AUTHORIZATION (EUA) OF THE MODERNA COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER

You are being offered the Moderna COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2. This Fact Sheet contains information to help you understand the risks and benefits of the Moderna COVID-19 Vaccine, which you may receive because there is currently a pandemic of COVID-19.

The Moderna COVID-19 Vaccine is a vaccine and may prevent you from getting COVID-19. There is no U.S. Food and Drug Administration (FDA) approved vaccine to prevent COVID-19.

Read this Fact Sheet for information about the Moderna COVID-19 Vaccine. Talk to the vaccination provider if you have questions. It is your choice to receive the Moderna COVID-19 Vaccine.

The Moderna COVID-19 Vaccine is administered as a 2-dose series, 1 month apart, into the muscle.

The Moderna COVID-19 Vaccine may not protect everyone.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please visit www.modernatx.com/covid19vaccine-eua.

WHAT YOU NEED TO KNOW BEFORE YOU GET THIS VACCINE

WHAT IS COVID-19?
COVID-19 is caused by a coronavirus called SARS-CoV-2. This type of coronavirus has not been seen before. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

WHAT IS THE MODERNA COVID-19 VACCINE?
The Moderna COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19.

The FDA has authorized the emergency use of the Moderna COVID-19 Vaccine to prevent COVID-19 in individuals 18 years of age and older under an Emergency Use Authorization (EUA).

For more information on EUA, see the "**What is an Emergency Use Authorization (EUA)?**" section at the end of this Fact Sheet.

WHAT SHOULD YOU MENTION TO YOUR VACCINATION PROVIDER BEFORE YOU GET THE MODERNA COVID-19 VACCINE?

Tell your vaccination provider about all of your medical conditions, including if you:

- have any allergies
- have a fever
- have a bleeding disorder or are on a blood thinner
- are immunocompromised or are on a medicine that affects your immune system
- are pregnant or plan to become pregnant
- are breastfeeding
- have received another COVID-19 vaccine

WHO SHOULD GET THE MODERNA COVID-19 VACCINE?

FDA has authorized the emergency use of the Moderna COVID-19 Vaccine in individuals 18 years of age and older.

WHO SHOULD NOT GET THE MODERNA COVID-19 VACCINE?

You should not get the Moderna COVID-19 Vaccine if you:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine

WHAT ARE THE INGREDIENTS IN THE MODERNA COVID-19 VACCINE?

The Moderna COVID-19 Vaccine contains the following ingredients: messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate trihydrate, and sucrose.

HOW IS THE MODERNA COVID-19 VACCINE GIVEN?

The Moderna COVID-19 Vaccine will be given to you as an injection into the muscle.

The Moderna COVID-19 Vaccine vaccination series is 2 doses given 1 month apart.

If you receive one dose of the Moderna COVID-19 Vaccine, you should receive a second dose of the same vaccine 1 month later to complete the vaccination series.

HAS THE MODERNA COVID-19 VACCINE BEEN USED BEFORE?

The Moderna COVID-19 Vaccine is an unapproved vaccine. In clinical trials, approximately 15,400 individuals 18 years of age and older have received at least 1 dose of the Moderna COVID-19 Vaccine.

WHAT ARE THE BENEFITS OF THE MODERNA COVID-19 VACCINE?

In an ongoing clinical trial, the Moderna COVID-19 Vaccine has been shown to prevent COVID-19 following 2 doses given 1 month apart. The duration of protection against COVID-19 is currently unknown.

WHAT ARE THE RISKS OF THE MODERNA COVID-19 VACCINE?
There is a remote chance that the Moderna COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Moderna COVID-19 Vaccine. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

Side effects that have been reported in a clinical trial with the Moderna COVID-19 Vaccine include:

- Injection site reactions: pain, tenderness and swelling of the lymph nodes in the same arm of the injection, swelling (hardness), and redness
- General side effects: fatigue, headache, muscle pain, joint pain, chills, nausea and vomiting, and fever

Side effects that have been reported during post-authorization use of the Moderna COVID-19 Vaccine include:

- Severe allergic reactions

These may not be all the possible side effects of the Moderna COVID-19 Vaccine. Serious and unexpected side effects may occur. The Moderna COVID-19 Vaccine is still being studied in clinical trials.

WHAT SHOULD I DO ABOUT SIDE EFFECTS?
If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to **FDA/CDC Vaccine Adverse Event Reporting System (VAERS)**. The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html. Please include "Moderna COVID-19 Vaccine EUA" in the first line of box #18 of the report form.

In addition, you can report side effects to ModernaTX, Inc. at 1-866-MODERNA (1-866-663-3762).

You may also be given an option to enroll in **v-safe. V-safe** is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. **V-safe** asks questions that help CDC monitor the safety of COVID-19 vaccines. **V-safe** also provides second-dose reminders if

needed and live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: www.cdc.gov/vsafe.

WHAT IF I DECIDE NOT TO GET THE MODERNA COVID-19 VACCINE?
It is your choice to receive or not receive the Moderna COVID-19 Vaccine. Should you decide not to receive it, it will not change your standard medical care.

ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES MODERNA COVID-19 VACCINE?
Currently, there is no FDA-approved alternative vaccine available for prevention of COVID-19. Other vaccines to prevent COVID-19 may be available under Emergency Use Authorization.

CAN I RECEIVE THE MODERNA COVID-19 VACCINE WITH OTHER VACCINES?
There is no information on the use of the Moderna COVID-19 Vaccine with other vaccines.

WHAT IF I AM PREGNANT OR BREASTFEEDING?
If you are pregnant or breastfeeding, discuss your options with your healthcare provider.

WILL THE MODERNA COVID-19 VACCINE GIVE ME COVID-19?
No. The Moderna COVID-19 Vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.

KEEP YOUR VACCINATION CARD
When you receive your first dose, you will get a vaccination card to show you when to return for your second dose of the Moderna COVID-19 Vaccine. Remember to bring your card when you return.

ADDITIONAL INFORMATION
If you have questions, visit the website or call the telephone number provided below.

To access the most recent Fact Sheets, please scan the QR code provided below.

Moderna COVID-19 Vaccine website	Telephone number
www.modernatx.com/covid19vaccine-eua	1-866-MODERNA (1-866-663-3762)

HOW CAN I LEARN MORE?

- Ask the vaccination provider
- Visit CDC at https://www.cdc.gov/coronavirus/2019-ncov/index.html
- Visit FDA at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization
- Contact your state or local public health department

WHERE WILL MY VACCINATION INFORMATION BE RECORDED?

The vaccination provider may include your vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. This will ensure that you receive the same vaccine when you return for the second dose. For more information about IISs, visit: https://www.cdc.gov/vaccines/programs/iis/about.html.

CAN I BE CHARGED AN ADMINISTRATION FEE FOR RECEIPT OF THE COVID-19 VACCINE?

No. At this time, the provider cannot charge you for a vaccine dose and you cannot be charged an out-of-pocket vaccine administration fee or any other fee if only receiving a COVID-19 vaccination. However, vaccination providers may seek appropriate reimbursement from a program or plan that covers COVID-19 vaccine administration fees for the vaccine recipient (private insurance, Medicare, Medicaid, HRSA COVID-19 Uninsured Program for non-insured recipients).

WHERE CAN I REPORT CASES OF SUSPECTED FRAUD?

Individuals becoming aware of any potential violations of the CDC COVID-19 Vaccination Program requirements are encouraged to report them to the Office of the Inspector General, U.S. Department of Health and Human Services, at 1-800-HHS-TIPS or TIPS.HHS.GOV.

WHAT IS THE COUNTERMEASURES INJURY COMPENSATION PROGRAM?

The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses of certain people who have been seriously injured by certain medicines or vaccines, including this vaccine. Generally, a claim must be submitted to the CICP within one (1) year from the date of receiving the vaccine. To learn more about this program, visit www.hrsa.gov/cicp/ or call 1-855-266-2427.

WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?

The United States FDA has made the Moderna COVID-19 Vaccine available under an emergency access mechanism called an EUA. The EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

The Moderna COVID-19 Vaccine has not undergone the same type of review as an FDA-approved or cleared product. FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, and available alternatives. In addition, the FDA decision is based on the totality of the scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of

these criteria must be met to allow for the product to be used during the COVID-19 pandemic.

The EUA for the Moderna COVID-19 Vaccine is in effect for the duration of the COVID-19 EUA declaration justifying emergency use of these products, unless terminated or revoked (after which the products may no longer be used).

Moderna US, Inc.
Cambridge, MA 02139

Patent(s): www.modernatx.com/patents
Revised: Mar/26/2021

Scan to capture that this Fact Sheet was provided to vaccine recipient for the electronic medical records/immunization information systems.

Barcode Date: 04/2021

FACT SHEET FOR RECIPIENTS AND CAREGIVERS

EMERGENCY USE AUTHORIZATION (EUA) OF THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 12 YEARS OF AGE AND OLDER

You are being offered the Pfizer-BioNTech COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2. This Fact Sheet contains information to help you understand the risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine, which you may receive because there is currently a pandemic of COVID-19.

The Pfizer-BioNTech COVID-19 Vaccine is a vaccine and may prevent you from getting COVID-19. There is no U.S. Food and Drug Administration (FDA) approved vaccine to prevent COVID-19.

Read this Fact Sheet for information about the Pfizer-BioNTech COVID-19 Vaccine. Talk to the vaccination provider if you have questions. It is your choice to receive the Pfizer-BioNTech COVID-19 Vaccine.

The Pfizer-BioNTech COVID-19 Vaccine is administered as a 2-dose series, 3 weeks apart, into the muscle.

The Pfizer-BioNTech COVID-19 Vaccine may not protect everyone.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please see www.cvdvaccine.com.

WHAT YOU NEED TO KNOW BEFORE YOU GET THIS VACCINE

WHAT IS COVID-19?

COVID-19 disease is caused by a coronavirus called SARS-CoV-2. This type of coronavirus has not been seen before. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

WHAT IS THE PFIZER-BIONTECH COVID-19 VACCINE?

The Pfizer-BioNTech COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19.

The FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine to prevent COVID-19 in individuals 12 years of age and older under an Emergency Use Authorization (EUA).

For more information on EUA, see the "**What is an Emergency Use Authorization (EUA)?**" section at the end of this Fact Sheet.

WHAT SHOULD YOU MENTION TO YOUR VACCINATION PROVIDER BEFORE YOU GET THE PFIZER-BIONTECH COVID-19 VACCINE?
Tell the vaccination provider about all of your medical conditions, including if you:

- have any allergies
- have a fever
- have a bleeding disorder or are on a blood thinner
- are immunocompromised or are on a medicine that affects your immune system
- are pregnant or plan to become pregnant
- are breastfeeding
- have received another COVID-19 vaccine
- have ever fainted in association with an injection

WHO SHOULD GET THE PFIZER-BIONTECH COVID-19 VACCINE?
FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine in individuals 12 years of age and older.

WHO SHOULD <u>NOT</u> GET THE PFIZER-BIONTECH COVID-19 VACCINE?
You should not get the Pfizer-BioNTech COVID-19 Vaccine if you:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine.

WHAT ARE THE INGREDIENTS IN THE PFIZER-BIONTECH COVID-19 VACCINE?
The Pfizer-BioNTech COVID-19 Vaccine includes the following ingredients: mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.

HOW IS THE PFIZER-BIONTECH COVID-19 VACCINE GIVEN?
The Pfizer-BioNTech COVID-19 Vaccine will be given to you as an injection into the muscle.

The Pfizer-BioNTech COVID-19 Vaccine vaccination series is 2 doses given 3 weeks apart.

If you receive one dose of the Pfizer-BioNTech COVID-19 Vaccine, you should receive a second dose of this same vaccine 3 weeks later to complete the vaccination series.

HAS THE PFIZER-BIONTECH COVID-19 VACCINE BEEN USED BEFORE?
The Pfizer-BioNTech COVID-19 Vaccine is an unapproved vaccine. In clinical trials, approximately 23,000 individuals 12 years of age and older have received at least 1 dose of the Pfizer-BioNTech COVID-19 Vaccine.

WHAT ARE THE BENEFITS OF THE PFIZER-BIONTECH COVID-19 VACCINE?
In an ongoing clinical trial, the Pfizer-BioNTech COVID-19 Vaccine has been shown to prevent COVID-19 following 2 doses given 3 weeks apart. The duration of protection against COVID-19 is currently unknown.

WHAT ARE THE RISKS OF THE PFIZER-BIONTECH COVID-19 VACCINE?
There is a remote chance that the Pfizer-BioNTech COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Pfizer-BioNTech COVID-19 Vaccine. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

Side effects that have been reported with the Pfizer-BioNTech COVID-19 Vaccine include:

- severe allergic reactions
- non-severe allergic reactions such as rash, itching, hives, or swelling of the face
- injection site pain
- tiredness
- headache
- muscle pain
- chills
- joint pain
- fever
- injection site swelling
- injection site redness
- nausea
- feeling unwell
- swollen lymph nodes (lymphadenopathy)
- diarrhea
- vomiting
- arm pain

These may not be all the possible side effects of the Pfizer-BioNTech COVID-19 Vaccine. Serious and unexpected side effects may occur. Pfizer-BioNTech COVID-19 Vaccine is still being studied in clinical trials.

WHAT SHOULD I DO ABOUT SIDE EFFECTS?
If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS). The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html. Please include "Pfizer-BioNTech COVID-19 Vaccine EUA" in the first line of box #18 of the report form.

In addition, you can report side effects to Pfizer Inc. at the contact information provided below.

Website	Fax number	Telephone number
www.pfizersafetyreporting.com	1-866-635-8337	1-800-438-1985

You may also be given an option to enroll in v-safe. V-safe is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. V-safe asks questions that help CDC monitor the safety of COVID-19 vaccines. V-safe also provides second-dose reminders if needed and live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: www.cdc.gov/vsafe.

WHAT IF I DECIDE NOT TO GET THE PFIZER-BIONTECH COVID-19 VACCINE?
It is your choice to receive or not receive the Pfizer-BioNTech COVID-19 Vaccine. Should you decide not to receive it, it will not change your standard medical care.

ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES PFIZER-BIONTECH COVID-19 VACCINE?
Currently, there is no approved alternative vaccine available for prevention of COVID-19. Other vaccines to prevent COVID-19 may be available under Emergency Use Authorization.

CAN I RECEIVE THE PFIZER-BIONTECH COVID-19 VACCINE WITH OTHER VACCINES?
There is no information on the use of the Pfizer-BioNTech COVID-19 Vaccine with other vaccines.

WHAT IF I AM PREGNANT OR BREASTFEEDING?
If you are pregnant or breastfeeding, discuss your options with your healthcare provider.

WILL THE PFIZER-BIONTECH COVID-19 VACCINE GIVE ME COVID-19?
No. The Pfizer-BioNTech COVID-19 Vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.

KEEP YOUR VACCINATION CARD
When you get your first dose, you will get a vaccination card to show you when to return for your second dose of Pfizer-BioNTech COVID-19 Vaccine. Remember to bring your card when you return.

ADDITIONAL INFORMATION
If you have questions, visit the website or call the telephone number provided below.

To access the most recent Fact Sheets, please scan the QR code provided below.

Global website	Telephone number
www.cvdvaccine.com	1-877-829-2619 (1-877-VAX-CO19)

HOW CAN I LEARN MORE?
- Ask the vaccination provider.
- Visit CDC at https://www.cdc.gov/coronavirus/2019-ncov/index.html.
- Visit FDA at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.
- Contact your local or state public health department.

WHERE WILL MY VACCINATION INFORMATION BE RECORDED?
The vaccination provider may include your vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. This will ensure that you receive the same vaccine when you return for the second dose. For more information about IISs visit: https://www.cdc.gov/vaccines/programs/iis/about.html.

CAN I BE CHARGED AN ADMINISTRATION FEE FOR RECEIPT OF THE COVID-19 VACCINE?
No. At this time, the provider cannot charge you for a vaccine dose and you cannot be charged an out-of-pocket vaccine administration fee or any other fee if only receiving a COVID-19 vaccination. However, vaccination providers may seek appropriate reimbursement from a program or plan that covers COVID-19 vaccine administration fees for the vaccine recipient (private insurance, Medicare, Medicaid, Health Resources & Services Administration [HRSA] COVID-19 Uninsured Program for non-insured recipients).

WHERE CAN I REPORT CASES OF SUSPECTED FRAUD?
Individuals becoming aware of any potential violations of the CDC COVID-19 Vaccination Program requirements are encouraged to report them to the Office of the Inspector General, U.S. Department of Health and Human Services, at 1-800-HHS-TIPS or https://TIPS.HHS.GOV.

WHAT IS THE COUNTERMEASURES INJURY COMPENSATION PROGRAM?
The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses of certain people who have been seriously injured by certain medicines or vaccines, including this vaccine. Generally, a claim must be submitted to the CICP within one (1) year from the date of receiving the vaccine. To learn more about this program, visit www.hrsa.gov/cicp/ or call 1-855-266-2427.

WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?
The United States FDA has made the Pfizer-BioNTech COVID-19 Vaccine available under an emergency access mechanism called an EUA. The EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

The Pfizer-BioNTech COVID-19 Vaccine has not undergone the same type of review as an FDA-approved or cleared product. FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, available alternatives. In addition, the FDA decision is based on the totality of scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of these criteria must be met to allow for the product to be used in the treatment of patients during the COVID-19 pandemic.

The EUA for the Pfizer-BioNTech COVID-19 Vaccine is in effect for the duration of the COVID-19 EUA declaration justifying emergency use of these products, unless terminated or revoked (after which the products may no longer be used).

Manufactured by
Pfizer Inc., New York, NY 10017

Manufactured for
BioNTech Manufacturing GmbH
An der Goldgrube 12
55131 Mainz, Germany

LAB-1451-4.2a
Revised: 10 May 2021

Scan to capture that this Fact Sheet was provided to vaccine recipient for the electronic medical records/immunization information systems.

Barcode Date: 05/2021

COVID-19 Vaccine Consent Form

Section 1: Information about person to receive vaccine (*please print*)

NAME (Last)	(First)	(M.I.)
DATE OF BIRTH: month_____ day_____ year _____		

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you can get the updated COVID-19 vaccine. A "yes" answer to any of the questions does not necessarily mean the vaccine cannot be given, but additional questions may be asked.

Please mark **Yes** or **No** for each question.	**Yes**	**No**	**Don't Know**
1. Do you have a health condition or undergoing treatment that makes you moderately or severely immunocompromised?	☐	☐	☐
2. Have you ever had any severe allergic reaction that has required treatment with epinephrine or caused you to go to the hospital? Please list:_____	☐	☐	☐
3. Have you ever had an allergic reaction to a component of a COVID-19 vaccine or a previous dose of COVID-19 vaccine?	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	☐	☐	☐
4. Do you have a history of any of the following: (Mark any that apply) ☐ Myocarditis or pericarditis ☐ Multisystem Inflammatory Syndrome ☐ An immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT) ☐ Thrombosis with thrombocytopenia syndrome (TTS) ☐ Guillain-Barré Syndrome (GBS) ☐ COVID-19 disease within the past 3 months ☐ Vaccinated with mpox (orthopoxvirus) vaccine in the last 4 weeks?	☐	☐	☐

Section 3: Education (Check each box after reading)

I acknowledge that I am aware of the following:

☐ COVID-19 is a contagious virus that can be spread from person to person through respiratory droplets. COVID-19 can cause mild to severe illness and death has occurred in some people.

☐ The updated COVID-19 vaccine is recommended for me to help prevent the spread of the disease to residents, friends, family and staff. This vaccine may protect me from getting COVID-19, or minimize the symptoms if I get infected.

☐ I understand that the updated COVID-19 vaccine will help protect me by creating an antibody (immune system) response without having to experience sickness.

- ☐ I understand that there can be side effects associated with the vaccine such as pain, swelling, redness to the injection site. I may potentially experience tiredness, headache, muscle pain, chills, fever or nausea.
- ☐ I understand that the vaccine may be given as a single or multiple dose(s) of the current updated formulation based on my vaccination history, immune status, and manufacturer's recommendations.
- ☐ I have been given a copy of the most current Emergency Use Authorization Fact Sheet/VIS for the _____ *(insert brand)* COVID-19 vaccine and have been educated on the risks, benefits, and potential side effects of the vaccine.

Section 4: Consent

CONSENT FOR VACCINATION:

- ☐ I have been educated on and understand the risks, benefits and potential side effects of the updated COVID-19 vaccine and hereby give consent for _____ *(resident or staff name)* to receive the _____ *(brand)* COVID-19 vaccine.

_____ _____

(Resident, Resident representative, or staff member signature) *(Date)*

Section 5: Declination

DECLINATION OF VACCINE:

- ☐ I have been educated on and understand the risks, benefits, and potential side effects of the updated COVID-19 vaccine, but at this time I decline the updated COVID-19 vaccination for the following reason(s):

  _____.

  I understand that I can change my mind at any time and accept the updated COVID-19 vaccination at a later time and will receive current education at that time.

_____ _____

(Resident or Resident representative signature) *(Date)*

DENTAL CONSENT FORM

Resident Name: _____

Resident Medicaid Number: _____

Resident DOB: _____

Facility: _____

1. I authorize the dental care provider or designated staff to perform certain dental procedures as necessary.

2. I authorize Sterling Medicaid Services, LLC to file claims with the corresponding Medicaid agency for services rendered.

3. HIPAA COMPLIANT: the dental care provider and designated staff agree to comply with the Health Insurance Portability and Accountability Act of 1996, "HIPAA" and to maintain the confidentiality of individually identifiable health information of the resident patients provided by the facility.

Resident/ Responsible Party
Authorized Person's Signature _____

Print Name: _____

Date: _____

Sterling Medicaid Services, LLC
PO Box 891330, Oklahoma City, OK 73189-1330

Paragon Geriatric Associates
Stephen L. Vernier, MD
5601 NW 72nd St., Ste 245
Warr Acres, OK 73132
Office number: 405-400-7557
Fax number: 844-519-1328

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

_____
Patient Name (printed)

_____ _____
Signature of Patient or Legal Guardian Date

Paragon Geriatric Associates
Stephen L. Vernier, MD
5601 NW 72nd St., Ste 245
Warr Acres, OK 73132
Office number: 405-400-7557
Fax number: 844-519-1328

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Paragon Geriatric Associates (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items (including billing) and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care.

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I also consent to having a photo taken to place in the Electronic Medical Record for identification purposes.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Consent to Treat

I consent to/authorize Stephen L. Vernier, MD, to treat me and to recommend and/or order laboratory tests, other specialized tests, and/or evaluations as needed for my continued medical care while Dr. Vernier is my attending physician.

_____
Patient Name (printed)

_____ _____
Signature of Patient or Legal Guardian Date

INFLUENZA AND PNEUMONIA HISTORY AND REQUEST FORM

RESIDENT:_____ ADMIT DATE: _____

Pneumococcal Vaccine Information:

- The pneumococcal vaccine is indicated for immunization against infections caused by the fourteen (14) most prevalent types of pneumococcal responsible for 80% or more of serious pneumococcal diseases in the United States and the rest of the world.
- Immunization is indicated for persons with chronic illnesses in which there is an increased risk for pneumococcal disease, such as: Diabetes mellitus, Cardio-Respiratory disease, Liver disease, and Kidney system disease, and persons fifty (50) years of age or older.
- The vaccine may not be effective in persons undergoing treatment causing therapeutic suppression of the immune system.
- The vaccine has shown to have impaired serum antibody response in persons who have received extensive chemotherapy and/or splenectomy for the treatment of Hodgkin's disease.
- The adverse reaction observed in clinical studies was not serious and of short duration. The vaccine is associated with a relatively low incidence of adverse reactions as compared with injectable vaccines presently used.
- The pneumococcal vaccine occasionally causes Low grade fever (less than 100 degrees F) within the first twenty-four (24) hours. However rare, fever over 102 degrees F and visibly seen swelling has been reported with the pneumococcal vaccine. Rare severe reactions of anaphylactic reactions have been reported.
- If you received the vaccine **before the age of 65** and it has been 5 years or more it is recommended that you receive another vaccine.
- If you received the vaccine **after the age of 65**, you DO NOT need another vaccine unless recommended by your physician.
- **Contraindications** of the pneumococcal vaccine include: High sensitivity to a component of the vaccine.

Influenza Vaccine Information:

- It is recommended that residents who live in a Nursing Home setting receive the influenza vaccine on a yearly basis. The vaccine is given between the months of October – May.
- The Influenza vaccine may have side effects such as:
  - Slight Discomfort or generalized discomfort
  - Soreness at injection site
  - Redness at injection site
  - Fever (occasionally occurs)
  - Muscle aches (occasionally occurs)

If you decide to have vaccinations our Nurses will answer any questions you have such as: the potential side effects, complications from vaccinations, and potential Adverse/Negative Outcome from vaccines before signing consent injection form for vaccine administration.

Please initial the following statement if this is a TRUE statement:

_____To the best of my knowledge, I have not had an anaphylactic **reaction to eggs**, a sensitivity to **Thimerosal,** or an allergy to **Aminoglycoside** drugs.

Please share your vaccine History for our records:

_____I have already received the pneumococcal vaccine since age 65. Date_____(approx. date)

_____I do not wish to receive the pneumococcal vaccine at this time.

_____I wish to receive the pneumococcal vaccine.

_____I **do not want to receive** the annual Influenza vaccine.

_____I **want to receive** the annual Influenza vaccine in the Influenza season.

The last time I had the Influenza vaccine was**:**_____

Resident Signature	Date:
Resident Legal Representative for Healthcare decision Signature/Relationship	Date:
Facility Representative Signature/Title	Date:

EDUCATION/INFORMED CONSENT FOR INFLUENZA VACCINATION

Resident Name:	Record #	Room #	Physician:

Why you should you get vaccinated?

Influenza (flu) is a contagious disease which spreads from person to person through coughing, sneezing, or with close contact.
Flu is caused by Influenza viruses and can develop suddenly and can last for several days. Symptoms of Influenza include:

- ✓ Fever --- Chills --- Sore throat --- muscle aches --- fatigue --- cough --- headache --- runny or stuffy nose

Complications of Influenza can include:

- ✓ Pneumonia --- ear infections --- dehydration --- sinus infection --- worsening of chronic health conditions such as COPD and Asthma, other lung or heart disease.

The Influenza vaccine is recommended for people who are at risk of complications from Influenza; or people who can spread Influenza to those at high risk for complications from Influenza. Such people that should take Influenza vaccine:

- ✓ People over age 65
- ✓ Resident of a long-term care center/assisted living center
- ✓ People who have chronic health problems, such as:
- Heart disease --- Kidney disease --- Respiratory disease --- Asthma --- Diabetes----- Nerve or Muscle disease
- Weak immune system from cancer or steroid treatment.

The Influenza vaccine prevents serious Influenza in most people and thereby reducing serious flu related illnesses.
People should know it cannot prevent illnesses caused by other viruses that mimic "flu-like" symptoms

When should you get vaccinated?

- ✓ Influenza vaccines are updated annually related to the Influenza viruses is always changing from season to season. Therefore, it is recommended to get an annual vaccination during regional 'Flu season' which is usually from October to May. The recommended time is to get vaccinated is early in October or November for it takes about two (2) weeks for protection to develop after being vaccinated, and to be protected during the flu season.

Potential Side Effects, Adverse Effects, Negative Outcomes of Influenza Vaccination being given:

Allergic reactions to Influenza vaccine is rare but can occur if:

- ✓ A person has a severe egg allergy,
- ✓ A person has severe allergy to any vaccine components such as **Thimerosal,** or an allergy to **Aminoglycoside** drugs; or
- ✓ A person had a severe reaction after a previous dose of Influenza vaccine.

A person with any of these issues or concerns should consult with physician prior to taking Influenza vaccine.
A person should also speak with physician if have ever had **Guillain-Barre Syndrome (GBS)** or is presently ill.
Potential side effects from the vaccine may include:

- ✓ Slight discomfort --- Redness &/or Soreness at injection site --- Fever --- Muscle aches

The Vaccine could cause serious problems, such as allergic reactions. The risk of the vaccine causing serious harm, or death is rare but may occur.

Parts of this document were excerpted from the Centers for Disease Control and Prevention, Influenza Vaccine – What You Need to Know, Vaccine Information Statement (VIS-CDC 8/7/2015), and National Foundation for Infectious Disease, and Immunization Action Coalition.

INFORMED CONSENT TO ADMINISTRATION OF VACCINE INJECTION

I have read the above information or it has been explained to me and I understand the adverse effects and potential negative outcome. Understanding the benefits, adverse effects and potential negative outcomes that may occur from receiving the INFLUENZA VACCINE. Please **INITIAL** appropriate response:

_____I hereby **GIVE** the facility permission to administer an Influenza vaccination ANNUALLY in the fall, unless medically contraindicated.

I understand this immunization will be given to me ANNUALLY as long as I reside in the facility unless otherwise contraindicated by my physician.

_____I hereby **DO NOT GIVE** the facility permission to administer the Influenza vaccination annually.

Resident Signature	Date:
Resident Legal Representative for Healthcare decision Signature/Relationship	Date:
Facility Representative Signature/Title	Date:

EDUCATION/INFORMED CONSENT FOR PNEUMONIA VACCINATION

Resident Name:	Record #	Room #	Physician:

Why you should you get vaccinated?

Pneumococcal disease is caused by *Streptococcus pneumoniae*, a bacterium that has more than 90 sero-types. When these bacteria invade the lungs, they can cause pneumonia. They can also invade the bloodstream, causing bacteremia (infection in blood), and/or invade the tissues and fluids surrounding the brain and spinal cord causing meningitis. Pneumococcal disease can also cause middle ear infection and sinus infection.

The treatment of pneumococcal infections have become more difficult to treat with antibiotics drugs such as Penicillin because the disease has become more resistant to these drugs. Therefore, prevention is more important to reduce risk.

Pneumonia may have sudden onset illness and have the following symptoms:

- ✓ Shaking chills --- Fever --- Shortness of breath or rapid breathing --- Cough (productive or non-productive) --- Chest pain that is worsened by deep breathing

Pneumococcal meningitis can manifest as:

- ✓ Stiff neck --- Fever --- Mental confusion --- Disorientation --- Eyes sensitivity to light

Pneumococcal infection of the bloodstream have symptoms may manifest as:

- ✓ Chills --- Fever --- Shortness of breath --- Cough --- Chest pain --- stiff neck --- Mental confusion --- Joint pain

The Pneumococcal polysaccharide vaccine (PPV) is recommended for the following:

- ✓ People 65 years of age or older --- Residents of Long-term care facilities ---
- ✓ People with Impaired immune system weakened by cancer, cancer treatments, or HIV infection
- ✓ People without a functioning spleen and those with sickle cell disease
- ✓ People with chronic medical conditions such as:
- ✓ Alcoholism --- Diabetes --- Heart disease --- Liver disease --- Kidney disease --- Lung disease (excluding asthma)

When should you get vaccinated?

- ✓ If you are over the age 65 it is recommended that you have the one dose of the PPV that is needed. However, under some situations your physician may want you to have a second dose.
- ✓ If you are under the age 65 your physician may want you to have the PPV due to your specific health condition.
- ✓ However, a second dose is recommended once you are 65 or older; or if it been five (5) or more years have passed since the first dose.

Potential Side Effects, Adverse Effects, Negative Outcomes of Pneumococcal Vaccination being given:

The vaccine may be less effective in some people, such as people with lower resistance to infection. However, these people should still be vaccinated because they are more likely to get seriously ill from pneumococcal disease.

Potential side effects from the vaccine may include:

- ✓ Slight discomfort --- Redness &/or Soreness at injection site --- Low grade Fever --- Muscle aches --- Rash --- Joint aches

The Vaccine could cause serious problems, such as allergic reactions. The risk of the vaccine causing serious harm, or death is rare but may occur.

Parts of this document were excerpted from the Centers for Disease Control and Prevention, Pneumococcal Polysaccharide Vaccine – What You Need to Know, Vaccine Information Statement (VIS-CDC 8/7/2015), and National Foundation for Infectious Disease, and Immunization Action Coalition.

INFORMED CONSENT TO ADMINISTRATION OF VACCINE INJECTION

I have read the above information or it has been explained to me and I understand the adverse effects and potential negative outcome. Understanding the benefits, adverse effects and potential negative outcomes that may occur from receiving a PNEUMOCOCCAL VACCINE. Please **INITIAL** appropriate response:

_____I hereby **GIVE** the facility permission to administer a pneumococcal vaccination, unless medically contraindicated or contraindicated by my physician. To the best of my knowledge, I have not received the pneumococcal vaccination since age 65; or I am not sure if/when I had the pneumococcal vaccination.

I understand this immunization is to be given once unless otherwise recommended by my physician.

_____I hereby **DO NOT GIVE** the facility permission to administer a pneumococcal vaccination.

Resident Signature	Date:
Resident Legal Representative for Healthcare decision Signature/Relationship	Date:
Facility Representative Signature/Title	Date:

Interim COVID-19 Visitation

Date Implemented:		*Date Reviewed/ Revised:*	09/28/2022	*Reviewed/ Revised By:*	

Policy:

This facility will allow visitation of all visitors and non-essential health care personnel and can be conducted through different means based on the facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, and outdoors. The visitation will be person-centered, consider the resident's physical, mental, and psychosocial well-being, and support their quality of life. Exceptions will be in accordance with current CMS directives and CDC recommendations, or as directed by state government (whichever is more stringent).

This facility is committed to the psychosocial welfare of each resident and recognizes the importance of visitation.

Policy Explanation and Compliance Guidelines:

1. The Infection Preventionist will monitor the status of the COVID-19 situation through the CDC website and local/state health department, and will keep facility leadership informed of current directives/recommendations and the need for restricting visitation if indicated.
2. The facility will communicate this visitation policy through multiple channels. Examples include signage, calls, letters, social media posts, emails, and recorded messages for receiving calls.
3. Non-essential staff, as designated in emergency preparedness plans, will be notified through routine and emergency communication procedures for staff.
4. The core principles of COVID-19 infection prevention will be adhered to and as follows:
    a. The facility will provide guidance (e.g., posted signs at entrances) about recommended actions for visitor who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19.
    b. Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation.
    c. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control).
    d. Visitors will be counseled about their potential to be exposed to COVID-19 in the facility.
    e. Hand hygiene, using an alcohol-based hand rub, will be performed by the resident and the visitors before and after contact.
    f. A face covering or mask (covering the mouth and nose) in accordance with CDC guidance.
    g. Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, and other applicable facility practices will be conducted.
    h. Cleaning and disinfection of highly touched surfaces in the facility and in designated visitation areas after each visit will be performed.
    i. Staff will adhere to the appropriate use of personal protective equipment (PPE).
    j. The facility will utilize effective strategies of cohorting residents (e.g., separate areas dedicated to COVID-19 care).
    k. The facility will conduct resident and staff testing as per current CMS/CDC guidance.
    l. Physical barriers such as clear Plexiglass dividers or curtains may also be used to reduce the risk of transmission.
    m. Visitors who are unable to adhere to these principles of COVID-19 infection prevention will not be permitted to visit or will be asked to leave.
5. Outdoor visitation will be conducted in a manner that reduces the risk of COVID-19 transmission as follows:
    a. Visits will be held outdoors whenever practicable and will be facilitated routinely barring weather conditions or a resident's health status.

b. The facility will have an accessible and safe outdoor space (*designate space*) in which to conduct outdoor visitation.
c. All appropriate infection control and prevention practices will be followed when conducting outdoor visitations.

6. Indoor visitation will be conducted in a manner that reduces the risk of COVID-19 transmission based on the following guidelines:
    a. The facility will allow indoor visitation at all times and for all residents and will not limit the frequency and length of visits, the number of visitors, or require advance scheduling of visits.
    b. Visits will be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents.
    c. Physical distancing should be encouraged during peak times of visitation and large gatherings (e.g., parties, events).
    d. If the facility's county COVID-19 community transmission is **high**, everyone in a healthcare setting should wear face coverings or masks.
    e. Regardless of the community transmission level, resident and their visitors when alone in the resident's room or in a designated visitation area, may choose not to wear face coverings or masks and may choose to have close contact (including touch). Residents (or their representative) and their visitors should be advised of the risks of physical contact prior to the visit. If a roommate is present during the visit, it is safest for the visitor to wear a face covering or mask.
    f. For residents who are on transmission-based precautions or quarantine, visits may occur in the resident's room and the resident should wear a well-fitted facemask (if tolerated). Visitors will be made aware of the potential risk of visiting and precautions necessary in order to visit and should adhere to the core principles of infection prevention.
7. When a new case of COVID-19 among staff or residents is identified, the facility will immediately begin an outbreak investigation and adhere to CMS regulations and guidance for COVID-19 testing, including expanded screening testing, testing of individuals with symptoms and outbreak testing. See *Coronavirus Testing Policy.*
8. Visits will be allowed during outbreak investigations, but visitors will be made aware of the potential risk of visiting during the outbreak investigation and adhere to the core principles of infection prevention. If visiting, during this time, residents and their visitors should wear face coverings or masks during the visits, regardless of vaccination status, and visits should ideally occur in the resident's room. The facility may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.
9. While an outbreak investigation is occurring, the facility should limit visitor movement in the facility and visitors should go directly to the resident's room or designated visitation area and physically distance themselves from other residents and staff, when possible.
10. Visitors will be notified about the potential for COVID-19 exposure in the facility (e.g. appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection and prevention, including effective hand hygiene and use of face coverings.
11. Compassionate care visits will be allowed at all times.
12. Visits required under the federal disability rights laws and protection and advocacy (P & A) programs will be allowed at all times. If the resident is in transmission-based precautions or quarantine and is in a county where the level of community transmission is substantial or high in the past 7 days, the resident and P & A representative should be made aware of the potential risk of visiting and the visit should take place in the resident's room.
13. Ombudsmen who plan to visit a resident in transmission-based precautions or quarantine in the facility in a county where the level of community transmission is high in the past 7 days, the ombudsman and resident, will be made aware of the potential risk of visiting and the visit should take place in the resident's room.
14. Alternative communication methods (phone or other technology) may be used if the resident or Ombudsman program requests it in lieu of an in-person visit.

15. Visitor testing may be offered, if feasible, in facilities in counties with high levels of community transmission. If the facility does not offer testing, the facility should encourage visitors to be tested on their own before coming to the facility (e.g., within 2-3 days).
16. The facility may ask about a visitor's vaccination status, however, visitors will not be required to be tested or vaccinated (or show proof of such) as a condition of visitation. If the visitor declines to disclose their vaccination status, the visitor should wear a face covering or mask at all times. *(Refer to state or local guidance if more stringent.)*
17. All healthcare workers will be permitted to come into the facility as long as they are not subject to a work exclusion or showing signs or symptoms of COVID-19. This includes personnel educating and assisting in resident transitions to the community.
18. Communal activities (including group activities, communal dining, and resident outings):
    a. Communal activities and dining may occur while adhering to the core principles of COVID-19 infection prevention. The safest approach is for everyone, particularly those at high risk for severe illness, to wear a face covering or mask while in the communal areas of the facility.
    b. Communal activities and dining do not have to be paused during an outbreak, unless directed by the state or local health department. Residents who are on transmission-based precautions should not participate in communal activities and dining until the criteria to discontinue transmission-based precautions has been met.
    c. Residents are permitted to leave the facility as they choose. The facility will remind the resident and any individual accompanying the resident to follow all recommended infection prevention practices such as wearing a face covering or mask, especially for those at high risk for severe illness and when community transmission is high, performing hand hygiene and to encourage those around them to do the same.
    d. Upon the resident's return, the facility should take the following actions:
        i. Screen residents upon return for signs or symptoms of COVID-19.
            a) If the resident or family member reports possible close contact to an individual with COVID-19 while outside the nursing home, the facility will follow the current CDC guidance in regards to testing and quarantine.
            b) If the resident develops signs or symptoms of COVID-19 after the outing, the facility will follow the current CDC guidance for residents with symptoms of COVID-19.
    e. In most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) except in certain situations as per the current CDC empiric transmission-based precaution guidance.
    f. The facility will monitor residents for signs and symptoms of COVID-19 daily.
    g. Residents who leave the facility for 24 hours or longer should be managed as a new admission or readmission and follow current CDC guidance.

References:

Centers for Disease Control and Prevention. *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic.* Located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html. Accessed September 23, 2022.

Centers for Medicare and Medicaid Services. *Nursing Home Visitation Frequently Asked Questions (FAQs).* September 23, 2022.

Centers for Medicare & Medicaid Services. (September 23, 2022) *QSO-20-39-NH: Nursing Home Visitation-COVID-19 (REVISED).*

LONG TERM CARE FACILITY COMPLAINT PROCEDURE

1. Any person with personal knowledge or substantial specific information who believes State or Federal regulations have been violated may file a complaint.

2. A complaint may be made in writing, by telephone, e-mail or in person.

3. The name of the complainant will remain confidential unless otherwise indicated by the complainant.

4. If a regulatory concern is alleged to have been violated, the department will schedule an unannounced investigation, and will make written findings available.

5. A written report will be provided to the complainant and the facility after the findings are made. The investigative report may be sent to one other person at the request of the complainant.

6. The investigative report will include the following:
    a. Nature of the allegation(s)
    b. Written findings
    c. Deficiencies, if any, related to the complaint investigation
    d. Other relevant information

7. Information in #5 above will be available to the public.

Complaint contact information: Long Term Care
Complaint and Incident Division

Mailing address: Oklahoma State Department of Health
Protective Health Services
123 Robert S Kerr Ave., Suite 1702
Oklahoma City, OK 73102-6406

E-mail address: LTCComplaints@health.ok.gov

Telephone: 1-800-747-8419

Any person who willfully or recklessly makes a false request for an investigation without a reasonable basis in fact for such a request shall be liable in a civil suit for any actual damages suffered by a facility and for any punitive damages set by the court or jury. (63 O.S. 1-1940)

Authorized by: Keith Reed
Commissioner of Health

OKLAHOMA State Department of Health

Revised 05/23/2022

Medicare Secondary Payor Questionnaire Fact Sheet

20.1 - General Policy (Excerpt)

(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

Based on the law and regulations, providers, physicians, and other suppliers are required to file claims with Medicare using billing information obtained from the beneficiary to whom the item or service is furnished. Section 1862(b)(6) of the Act, (42 USC 1395y(b)(6)), requires all entities seeking payment for any item or service furnished under Part B to complete, on the basis of information obtained from the individual to whom the item or service is furnished, the portion of the claim form relating to the availability of other health insurance. Additionally, 42 CFR 489.20(g) requires that all providers must agree "to bill other primary payers before billing Medicare."

Thus, any providers, physicians, and other suppliers that bill Medicare for services rendered to Medicare beneficiaries must determine whether or not Medicare is the primary payer for those services. This must be accomplished by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary's MSP status. Exceptions to this requirement are discussed below in 1, 3 and 6. If providers, physicians or other suppliers fail to file correct and accurate claims with Medicare, and a mistaken payment situation is later found to exist, 42 CFR 411.24 permits Medicare to recover its conditional or mistaken payments.

Section 20.2.1, "Admission Questions to Ask Medicare Beneficiaries," is a model questionnaire that may be used to determine the correct primary payers of claims for all beneficiary services furnished by a hospital.

NOTE: Providers are required to determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary prior to submitting a bill to Medicare. It must accomplish this by asking the beneficiary about other insurance coverage. The model questionnaire in Section 20.2.1 lists the type of questions that should be asked of Medicare beneficiaries for **every** admission, outpatient encounter, or start of care. Exceptions to this requirement are discussed below in 1, 3 and 6.

EXCEPTIONS

These questions may be asked in connection with online access to Common Working File (CWF) or the X12 270 transmission and the X12 271 response. (See §20.2.) If the provider lacks access to CWF, or does not have a copy of the 271 response, it will follow the procedures found in §20.2.1. The X12 270 Transaction Set is used to transmit Health Care Eligibility Benefit Inquiries from health care providers, insurers, clearinghouses and other health care adjudication processors. The X12 270 Transaction Set can be used to make an inquiry about the Medicare eligibility of an individual. The X12 271 Transaction Set is the appropriate response mechanism for Health Care Eligibility Benefit Inquiries.

NOTE: There may be situations where more than one payer is primary to Medicare (e.g., liability insurer and GHP). The provider, physician, or other supplier must identify all possible payers.

This greatly increases the likelihood that the primary payer is billed correctly. Verifying MSP information means confirming that the information previously furnished about the presence or absence of another payer that may be primary to Medicare is correct, clear, and complete, and that no changes have occurred.

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer

When Does Medicare Pay First

List of Common Situations when Medicare May pay first or second

If the **Individual**…..	And this **Condition** exists….	Then this program **Pays First**	And this program **Pays Second**
Is age 65 or older, and covered by a Group Health Plan (GHP) through current employment or spouse's current employment	The employer has 20 less than 20 employees	Medicare	Group Health Plan (GHP)
Is age 65 or older, and covered by a GHP through current employment or spouse's current employment	The employer has 20 or more employees, or the employer is part of a multi-employer group with at least one employer employing 20 or more individuals	Group Health Plan (GHP)	Medicare
Has an employer retirement plan and is age 65 or older	The individual is entitled to Medicare	Medicare	Retiree Coverage
Is under age 65. Disabled, and covered by a GHP through his/her current employment or a family member's current employment	The employer has less than 100 employees	Medicare	Group Health Plan (GHP)
Is under age 65. Disabled, and covered by a GHP through his/her current employment or a family member's current employment	The employer has more than 100 employees or the employer is part of a multi-employer group with at least one employer employing 100 or more individuals	Group Health Plan (GHP)	Medicare
Has End-Stage Renal Disease (ESRD) and GHP Coverage	Is in the first 30 months of Medicare eligibility or entitlement	Group Health Plan (GHP)	Medicare
Has ESRD and GHP Coverage	After 30 months of Medicare eligibility or entitlement	Medicare	Group Health Plan (GHP)
Has ESRD and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage	Is in the first 30 months Medicare eligibility or entitlement	COBRA	Medicare
Has ESRD and COBRA coverage	After 30 months of Medicare eligibility or entitlement	Medicare	COBRA
Is covered under Workers' Compensation (WC) because of a job-related illness or injury	The individual is entitled to Medicare	Workers' Compensation (for health care items or services related to job-related illness or injury)	Medicare
Was in an accident or other situation where no-fault or liability insurance is involved	The individual is entitled to Medicare	No-fault or liability insurance for accident- or other situation-related health care services claimed or released	Medicare
Is age 65 or older or is disabled and covered by Medicare and COBRA	The individual is entitled to Medicare	Medicare	COBRA

https://www.cms.gov/search/cms?keys=mln+products+downloads+msp+fact+sheet

«${facility.facility_name}»

Notice of Medicare Non-Coverage

Resident Name: __**«${resident.full_name}»**_____

Resident Number: **«${resident.medical_record_no}»**

The Effective Date Coverage of Your Current Skilled Nursing Services Will End:

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Skilled/Rehab services after the effective date indicated above.
- **You may have to pay for any services you receive AFTER the above date**.

Your Right to Appeal This Decision

- You have the right to an immediate, *independent* medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask for an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: **888-315-0636** to appeal, or if you have questions.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call your QIO at: **888-315-0636.**
- If you belong to a Medicare health plan: Call your plan at the number given below.

  Plan contact information _____

Additional Information (Optional):

Beneficiary's Name: «${resident.full_name}»_____

On _____ at _____, I, _____, spoke
(date) (time) (facility representative)
with _____ via phone # _____, and informed them
(name/relationship)
that skilled services will be ending on _____ and financial liability will begin on
(Effective date)
_____ . If you are not in agreement, you may file an expedited appeal through
(date)
Kepro/QIO at 1**-888-315-0636** before noon on _____ ; if you
(Day before effective date)
miss the deadline to request an immediate appeal, you may have other appeal rights, for

Original Medicare call the QIO at **1-888-315-0636**; for a Medicare Health Plan, call your plan

at: _____.
(MA Plan phone number)

_____
(facility representative)

_____
_____
(Facility Signature, title) (date)

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Printed Name: «${resident.full_name}»_____«${responsible_party.full_name}»
Resident/Responsible Party

Signature: _____
Resident/Responsible Party

Date: _____

NOTICE OF FACILITY'S HOSPICE RELATIONSHIP

and

RESIDENT'S/ RESPONSIBLE PARTY ACKNOWLEDGEMENT OF RIGHT TO CHOOSE HOSPICE

Dear Resident,

This Facility allows for the provision of Hospice Services to you, the Resident, only through a contractual relationship with Hospice Providers.

The Hospice Provider(s) with which this Facility contracts may change from time to time. There may be times when this Facility contracts with only one (1) Hospice Provider and there may be times when it contracts with more than one (1) Hospice Provider. Attached is a list of the Hospice(s) with which this facility contracts presently.

If you become eligible for Hospice care, you have the right to choose any Hospice provider with which this nursing facility contracts. Attached is a list of the Hospice(s) with which this facility contracts presently. If you are not admitting to Hospice at this time, the list of Hospice Providers may change if and when you are admitted to Hospice care.

Please understand that Hospices have their own staff and provide services that are defined by Federal and State Regulation and are distinct from or in addition to those services provided by our nursing facility. We, as a nursing facility, are responsible to Federal and State authorities for coordinating the care that Hospices provide to residents in our facility. For that reason, we choose carefully those Hospices with which we contract.

Cura HPC is included in the attached list of contracted Hospices. We are pleased to report that the individual who owns the company that is licensed to operate this nursing facility also owns an interest in Cura HPC. By virtue of that common interest, our nursing facility has been able to develop a relationship with Cura HPC that gives this Facility a greater voice in the care that Cura HPC staff provides our residents.

Thank you for choosing to become a part of our family.

LIST OF HOSPICE PROVIDERS WITH WHOM THIS FACILITY CONTRACTS

1. Cura Hospice HPC
2. ____
3. ____

NOTICE OF PRIVACY PRACTICES

This Notice Describes How Your Medical Information May Be Used and Disclosed and How You Can Get Access to This Information

PLEASE REVIEW IT CAREFULLY

1. OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMAITON (PHI)

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information as required by the privacy regulation issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We are required to abide by the privacy practices described in this notice including any future revisions that we may make to the notice as may become necessary or authorized by law. This notice takes effect April 14, 2003 and will remain in effect unless we replace it.

Individually identifiable information about your past, present, or future health or condition, the provisions of health care to you, or payment for health treatment or services you receive is considered protected health information (PHI). As such, this notice explains how, when and why we may use or disclose your PHI and your rights and our obligations regarding this. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure of such information.

We reserve the right to change this notice at any time and to make the revised or changes notice effective for health information we already have about you as well as any information we receive in the future about you. Any revised changed notices will be posted on the bulletin board of this facility and we will provide you with a copy of our updated notice upon request.

2. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

We use or disclose PHI for a variety of reasons and have a limited right to do so for purposes of treatment, payment, or for operations of our facility. For other uses, you must give us your written authorization to release your PHI unless law permits or requires us to make the use or disclosure without your authorization. Should it become necessary to release your PHI to an outside party, we will require the party to have a signed agreement with us that the party will extend the same degree or privacy protection to your information as we do. For example:

a. Use and Disclosure Related to Treatment: We may disclose your PHI to those involved in providing medical and nursing care services and treatments to you. (i.e., nurses, nursing assistants, nursing students, therapists, medical records personnel, consulting physicians, diagnostic laboratories, home health/hospice agencies, family members, etc.)
b. Use and Disclosures Related to Payment: We may use or disclose your PHI to bill and collect payment for services or treatments we provide to you. (i.e., insurance facility, health plan or another third party to obtain payment for services we provided to you, etc.)
c. Use and Disclosures Related to Health Care Operations: We may use or disclose your PHI as necessary for our health care operations. (i.e., taking your photograph for medication identification purposes to evaluate the effectiveness of the care and services received; for auditing, care planning, treatment and learning purposes; to other health care providers to study how our facility is performing in comparison to other facilities or what we can do to improve the care and services we provide to you. When information is combined, we remove all information that would identify you so that others may use the information in developing research on the delivery of health care services without learning your identity.)
d. Use and Disclosures Related to Treatment Alternatives, Health-Related Benefits and Services: We may use or disclose your PHI to inform you of treatment alternatives or health-related benefits and services that may of interest to you. (i.e., medications or treatments directly related to the treatment or medical condition.)

3. USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION.

For uses and disclosures of your PHI beyond treatment, payment and operations, we are required to have your written authorization, except as permitted by law. You have the right to revoke an authorization at any time to stop future uses and disclosures except to the extent that we have already undertaken an action in reliance upon your authorization. Your revocation request must be provided to us in writing (see last page for facility contact). Examples include:

a. To an attorney for use in a civil litigation claim.
b. To an insurance or pharmaceutical facility for the purpose of providing you with information relative to insurance benefits or new medications that may be of interest to you.
c. To another individual or facility.

4. USES OR DISCLOSURES OF INFORMATION BASED UPON YOUR VERBAL AGREEMENT

We may disclose a limited amount of PHI if we provide you with an advance oral or written notice and you do not object or if it is not otherwise prohibited by law. However, if there is an emergency and you are unable to object (because you were not present or you were incapacitated, etc.), disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. When disclosure is made in this case, we will only disclose health information relevant to the person's involvement in your care. For example, if you are sent to the emergency room, we may only inform the person that you suffered an apparent heart attack, stroke, etc. and/or we may provide information on your prognosis or progress. You will be informed and given an opportunity to object to further disclosures of such information as soon as you are able to do so.

a. Information used or disclosed in the Facility: We may use or disclose your name and room number as well as your religious affiliation to a member of the clergy. Information concerning your general condition or room location may be provided to callers or visitors when they ask for you by name. You may object to the release of this information.
b. Information Disclosed to Family Members, Friends or Others Involved in Your Care: We may use or disclose your PHI to family members and friends who are involved in or who pay for your care; to disaster relief organizations for the purposes of family/friend notifications regarding your general condition, location and/or status. You may object to the release of this information.

5. USES AND DISCLOSURES OF INFORMATION THAT DOES NOT REQUIRE YOUR CONSENT OR AUTHORIZATION

State and federal laws and regulations either require or permit us to use and disclose your PHI without your consent or authorization as in the following:

a. When Required by Law: We may use or disclose your PHI when required by law. (i.e., suspected abuse, neglect or domestic violence, reporting adverse reactions to medications or injury from a health care product, or in response to a court order or subpoena.)
b. For Public Health Activities for the Purpose of Preventing or Controlling Disease, Injury or Disability: We may disclose your PHI when we are required to collect information about diseases or injuries (i.e. exposure to a disease or your risk for spreading or contracting a communicable disease or condition, product recalls, or to report vital statistics <births/deaths> to the public health authority.)
c. For Health Oversight Activities: We may disclose your PHI to a protection and advocacy group, the state agency responsible for inspecting our facility or to other agencies responsible for the monitoring of the health care system for such purposes as reporting or investigation of unusual incidents or to ensure that we are in compliance with applicable state and federal laws and regulations and civil rights issues.
d. To Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations or Tissue Banks: We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death; to a funeral director for the purposes of carrying out your wishes and/or for the funeral director to perform his/her necessary duties. If you are an organ donor, we may disclose your

PHI to the organization that will handle your organ, eye or tissue donation for the purposes of facilitating your organ or tissue donation or transplantation.

e. For Research Purposes: We may disclose your PHI to researchers when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the information and has approved the research. We will obtain your written authorization before permitting any researcher to use your information.
f. To Avert a Serious Threat to Health or Safety: We may disclose your PHI to avoid a serious threat to your health or safety or to the health or safety of others and will only be released to those law enforcement agencies or individuals who have the ability or authority to prevent or lessen the threat of harm.
g. For Specific Government Functions: We may disclose PHI of military personnel and veterans, when requested by military command authorities, to authorized federal authorities for the purposes of intelligence, counterintelligence, and other national security activities or to correctional institutions.

6. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

You have the following rights concerning the use or disclosure of your PHI that we create or that we may maintain on our premises:

a. To Request Restrictions on Uses and Disclosures of Your PHI: You have the right to request that we limit how we use or disclose your PHI for treatment, payment or health care operations and to request a limit on what we disclose about you to someone who is involved in your care or the payment for your care or services. Such requests must be submitted in writing. We are not required to agree to your restriction request if the information is needed to provide any emergency care or treatment to you
b. The Right to Inspect and Copy Your Medical and Billing Records: You have the right to copy and inspect your medical and billing records and you must submit a written request to us. We may charge you a reasonable fee for the paper, labor, mailing and/or retrieval costs. We will provide you with fee information prior to such service. We will respond within thirty (30) days of such receipt of such request. We will provide you with written notice of any denials of your request. If such review is granted or required by law, we will select a licensed health care professional not involved in the original denial process to review your request. We will abide by the reviewer's decision.
c. The Right to Amend or Correct Your Health Information: You have the right to amend or correct your PHI if you have reason to believe that certain information is incomplete or incorrect. You have the right to make such requests for as long as we maintain/retain your health information. You must request this in writing and we will respond within sixty (60) days of receipt of your request. We may deny your request if:
    i. It is not in writing;
    ii. It does not contain a reason to support the request;
    iii. The information was not created by us, unless the person or entity that created it is no longer available to make the amendment;
    iv. It is not a part of the health information kept by or for our facility;
    v. It is not a part of the information which you would be permitted to inspect /copy;
    vi. The information is already accurate and complete.
d. If your request is denied, we will provide you with a written notification of the reason(s) of such denial.
e. The Right to Request Confidential Communication: You have the right that we communicate with you about your health matters in a certain way or location (i.e. you may request us to not send information to a certain family member's address. You must notify us in writing and indicate the information you wish to limit and identify to whom such restrictions apply.)
f. The Right to Request an Accounting of Disclosures of PHI: You have the right that we provide you with a listing of when, to whom, for what purpose and what content of your PHI that we have released over a period of time. This will not include any information we have made for purposes of treatment, payment or health care operations or that which was released to your family or any disclosures made for national security purposes, or any releases pursuant to your authorization. The first accounting you request during a twelve (12) month period will be free. There may be a reasonable fee for additional requests during the

twelve (12) month period. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

g. The Right to Receive a Paper Copy of This Notice: You have the right to a paper copy of this notice, upon request, by contacting us at the information provided below.

7. HOW TO FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you have reason(s) to believe that we have violated your privacy rights, our policies and procedures, or disagree with a decision we made concerning access to your PHI, you have the right to file a complaint with us or the Secretary of the Department of Health and Human Services. Complaints may be filed without fear of retaliation in any form.

If you have further questions or need additional information regarding this Privacy Notice, you may contact us at:

Executive Director

NOTICE OF PRIVACY PRACTICES

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We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information as required by the privacy regulation issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We are required to abide by the privacy practices described in this notice including any future revisions that we may make to the notice as may become necessary or authorized by law. This notice takes effect April 14, 2003 and will remain in effect unless we replace it.

Individually identifiable information about your past, present, or future health or condition, the provisions of health care to you, or payment for health treatment or services you receive is considered protected health information (PHI). As such, this notice explains how, when and why we may use or disclose your PHI and your rights and our obligations regarding this. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure of such information.

We reserve the right to change this notice at any time and to make the revised or changes notice effective for health information we already have about you as well as any information we receive in the future about you. Any revised changed notices will be posted on the bulletin board of this facility and we will provide you with a copy of our updated notice upon request.

2. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

We use or disclose PHI for a variety of reasons and have a limited right to do so for purposes of treatment, payment, or for operations of our facility. For other uses, you must give us your written authorization to release your PHI unless law permits or requires us to make the use or disclosure without your authorization. Should it become necessary to release your PHI to an outside party, we will require the party to have a signed agreement with us that the party will extend the same degree or privacy protection to your information as we do. For example:

a. Use and Disclosure Related to Treatment: We may disclose your PHI to those involved in providing medical and nursing care services and treatments to you. (i.e., nurses, nursing assistants, nursing students, therapists, medical records personnel, consulting physicians, diagnostic laboratories, home health/hospice agencies, family members, etc.)
b. Use and Disclosures Related to Payment: We may use or disclose your PHI to bill and collect payment for services or treatments we provide to you. (i.e., insurance facility, health plan or another third party to obtain payment for services we provided to you, etc.)
c. Use and Disclosures Related to Health Care Operations: We may use or disclose your PHI as necessary for our health care operations. (i.e., taking your photograph for medication identification purposes to evaluate the effectiveness of the care and services received; for auditing, care planning, treatment and learning purposes; to other health care providers to study how our facility is performing in comparison to other facilities or what we can do to improve the care and services we provide to you. When information is combined, we remove all information that would identify you so that others may use the information in developing research on the delivery of health care services without learning your identity.)
d. Use and Disclosures Related to Treatment Alternatives, Health-Related Benefits and Services: We may use or disclose your PHI to inform you of treatment alternatives or health-related benefits and services that may of interest to you. (i.e., medications or treatments directly related to the treatment or medical condition.)

3. USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION.

For uses and disclosures of your PHI beyond treatment, payment and operations, we are required to have your written authorization, except as permitted by law. You have the right to revoke an authorization at any time to stop future uses and disclosures except to the extent that we have already undertaken an action in reliance upon your authorization. Your revocation request must be provided to us in writing (see last page for facility contact). Examples include:

a. To an attorney for use in a civil litigation claim.
b. To an insurance or pharmaceutical facility for the purpose of providing you with information relative to insurance benefits or new medications that may be of interest to you.
c. To another individual or facility.

4. USES OR DISCLOSURES OF INFORMATION BASED UPON YOUR VERBAL AGREEMENT

We may disclose a limited amount of PHI if we provide you with an advance oral or written notice and you do not object or if it is not otherwise prohibited by law. However, if there is an emergency and you are unable to object (because you were not present or you were incapacitated, etc.), disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. When disclosure is made in this case, we will only disclose health information relevant to the person's involvement in your care. For example, if you are sent to the emergency room, we may only inform the person that you suffered an apparent heart attack, stroke, etc. and/or we may provide information on your prognosis or progress. You will be informed and given an opportunity to object to further disclosures of such information as soon as you are able to do so.

a. Information used or disclosed in the Facility: We may use or disclose your name and room number as well as your religious affiliation to a member of the clergy. Information concerning your general condition or room location may be provided to callers or visitors when they ask for you by name. You may object to the release of this information.
b. Information Disclosed to Family Members, Friends or Others Involved in Your Care: We may use or disclose your PHI to family members and friends who are involved in or who pay for your care; to disaster relief organizations for the purposes of family/friend notifications regarding your general condition, location and/or status. You may object to the release of this information.

5. USES AND DISCLOSURES OF INFORMATION THAT DOES NOT REQUIRE YOUR CONSENT OR AUTHORIZATION

State and federal laws and regulations either require or permit us to use and disclose your PHI without your consent or authorization as in the following:

a. When Required by Law: We may use or disclose your PHI when required by law. (i.e., suspected abuse, neglect or domestic violence, reporting adverse reactions to medications or injury from a health care product, or in response to a court order or subpoena.)
b. For Public Health Activities for the Purpose of Preventing or Controlling Disease, Injury or Disability: We may disclose your PHI when we are required to collect information about diseases or injuries (i.e. exposure to a disease or your risk for spreading or contracting a communicable disease or condition, product recalls, or to report vital statistics <births/deaths> to the public health authority.)
c. For Health Oversight Activities: We may disclose your PHI to a protection and advocacy group, the state agency responsible for inspecting our facility or to other agencies responsible for the monitoring of the health care system for such purposes as reporting or investigation of unusual incidents or to ensure that we are in compliance with applicable state and federal laws and regulations and civil rights issues.
d. To Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations or Tissue Banks: We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death; to a funeral director for the purposes of carrying out your wishes and/or for the funeral director to perform his/her necessary duties. If you are an organ donor, we may disclose your

PHI to the organization that will handle your organ, eye or tissue donation for the purposes of facilitating your organ or tissue donation or transplantation.

e. For Research Purposes: We may disclose your PHI to researchers when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the information and has approved the research. We will obtain your written authorization before permitting any researcher to use your information.
f. To Avert a Serious Threat to Health or Safety: We may disclose your PHI to avoid a serious threat to your health or safety or to the health or safety of others and will only be released to those law enforcement agencies or individuals who have the ability or authority to prevent or lessen the threat of harm.
g. For Specific Government Functions: We may disclose PHI of military personnel and veterans, when requested by military command authorities, to authorized federal authorities for the purposes of intelligence, counterintelligence, and other national security activities or to correctional institutions.

6. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

You have the following rights concerning the use or disclosure of your PHI that we create or that we may maintain on our premises:

a. To Request Restrictions on Uses and Disclosures of Your PHI: You have the right to request that we limit how we use or disclose your PHI for treatment, payment or health care operations and to request a limit on what we disclose about you to someone who is involved in your care or the payment for your care or services. Such requests must be submitted in writing. We are not required to agree to your restriction request if the information is needed to provide any emergency care or treatment to you
b. The Right to Inspect and Copy Your Medical and Billing Records: You have the right to copy and inspect your medical and billing records and you must submit a written request to us. We may charge you a reasonable fee for the paper, labor, mailing and/or retrieval costs. We will provide you with fee information prior to such service. We will respond within thirty (30) days of such receipt of such request. We will provide you with written notice of any denials of your request. If such review is granted or required by law, we will select a licensed health care professional not involved in the original denial process to review your request. We will abide by the reviewer's decision.
c. The Right to Amend or Correct Your Health Information: You have the right to amend or correct your PHI if you have reason to believe that certain information is incomplete or incorrect. You have the right to make such requests for as long as we maintain/retain your health information. You must request this in writing and we will respond within sixty (60) days of receipt of your request. We may deny your request if:
    i. It is not in writing;
    ii. It does not contain a reason to support the request;
    iii. The information was not created by us, unless the person or entity that created it is no longer available to make the amendment;
    iv. It is not a part of the health information kept by or for our facility;
    v. It is not a part of the information which you would be permitted to inspect /copy;
    vi. The information is already accurate and complete.
d. If your request is denied, we will provide you with a written notification of the reason(s) of such denial.
e. The Right to Request Confidential Communication: You have the right that we communicate with you about your health matters in a certain way or location (i.e. you may request us to not send information to a certain family member's address. You must notify us in writing and indicate the information you wish to limit and identify to whom such restrictions apply.)
f. The Right to Request an Accounting of Disclosures of PHI: You have the right that we provide you with a listing of when, to whom, for what purpose and what content of your PHI that we have released over a period of time. This will not include any information we have made for purposes of treatment, payment or health care operations or that which was released to your family or any disclosures made for national security purposes, or any releases pursuant to your authorization. The first accounting you request during a twelve (12) month period will be free. There may be a reasonable fee for additional requests during the

twelve (12) month period. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

g. The Right to Receive a Paper Copy of This Notice: You have the right to a paper copy of this notice, upon request, by contacting us at the information provided below.

7. HOW TO FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you have reason(s) to believe that we have violated your privacy rights, our policies and procedures, or disagree with a decision we made concerning access to your PHI, you have the right to file a complaint with us or the Secretary of the Department of Health and Human Services. Complaints may be filed without fear of retaliation in any form.

If you have further questions or need additional information regarding this Privacy Notice, you may contact us at:

Executive Director

OPTOMETRY CONSENT FORM

Facility Name_____

I hereby request an optometry evaluation and treatment for: _____
(print patient name)

Patient Date of Birth_____

Medicare #_____ Medicaid #_____

Medicare Replacement Plan_____ ID#_____

Supplemental Insurance_____ ID#_____

***Sign Here** _____ **Date**_____
(signature of patient, guardian, or responsible party)

All bills shall be directed towards Medicare and insurance carriers when possible. Patient is responsible for the deductible and co-insurance when not covered by supplemental insurance or Medicaid. I authorize Medicare and my insurance carriers to send payments directly to the optometrist. I also authorize the release of any information from any agency or carrier to the optometrist for purposes of administering the Medicare program. I authorize the optometrist to release any required information to any agency, insurance carrier, or Medicare as needed. I have read and understand the facility's &/or the optometrist privacy policies regarding the handling of protected health information.

PRIMARY CARE DOCTOR AUTHORIZATION:

I am authorizing this patient to have an annual eye health exam with an optometrist.

Primary Care Doctor Signature_____

Mobile Eye Care of Oklahoma, PLLC
530 W Interstate 240 Service Road Oklahoma City, OK 73139

PharMerica

Client (Resident) Agreement for Services

Our Pharmacy has been chosen to provide pharmacy services at _____ and we will be working with your facility in providing and managing your medications while staying in the Facility. Pharmerica – Sand Springs would like for you to sign this form to ensure compliance with Medicare and other governing agencies.

Authorization to Assign Benefits to Provider

I request that payment of authorized Medicare and other benefits be made on my behalf to Pharmerica – Sand Springs for products and services that they have provided me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical information including medical records to be released to Pharmerica – Sand Springs, as well as, any federal state or accrediting body or agency as required by the Regulatory, Licensing or Accrediting Body, in order to determine these benefits or compliance with current healthcare standards. Pharmerica – Sand Springs bills third-party as a courtesy. I understand that I am fully responsible for all deductibles, coinsurance and disallowables, including charges related to delivery before the verification of insurance benefits.

Primary Insurance #: _____ Group #:_____ Effect. Date_____

Secondary Insurance#: _____ Group #:_____ Effect. Date_____

HIPAA Release

In accordance with the HIPAA Privacy Regulations, Pharmerica – Sand Springs may disclose to a member of your family, other relative, or any other person identified by you, the protected health information directly relevant to such persons involved with your care or payment related to your healthcare. Please assist us by identifying below individuals who are involved in your care and/or in the payment of your care to whom limited amount of information may be released. If there are no such individuals, please indicate none.

1)_____2)_____3)_____

Please read the following carefully before signing. Your signature on this page evidences you understanding and agreement to these terms as listed. Patient personal information will be kept confidential by Pharmerica – Sand Springs. Patient must notify Pharmerica – Sand Springs of any medical status change such as a doctor's prescription, hospitalization, acquiring an infectious disease or change in residence. Patient agrees to notify Pharmerica – Sand Springs of Advance Directives being in place and any changes thereof.

Patient Agreement

I understand and agree that I am responsible for ALL charges for services that are not covered by Medicare, Medicaid, or other medical insurance program, under which I am entitled to benefits. Agree to provide Pharmerica – Sand Springs all documents and other information necessary for Pharmerica – Sand Springs to obtain direct payment from such third-party payers. I agree to pay all deductible amounts and other charges not covered by the assignment of benefits. Pharmerica – Sand Springs reserves the right to discontinue services for any account with a past due balance. I understand that upon discharge from the Facility, I may be responsible for payment of medications released to client/resident. I also agree to pay Pharmerica – Sand Springs for all collection fees, attorney fees, court costs and other expenses involved in collecting any charges hereunder. The customer acknowledges that he/she has not received any representations of promises concerning the pharmacy services or the terms of this agreement other than that as set forth herein. As a resident of a nursing facility, I agree to allow the nurse/facility rep to sign/acknowledge receipt of all equipment or services including prescription medications as well as receipt of all patient education materials. This agreement shall be governed by and construed in accordance with the laws of the state of Oklahoma.

_____	_____	_____
Resident printed name	Resident signature	Dated

Resident's Agent or Representative (if resident unable to sign) _____

Relationship _____

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

Long Term Care – Minimum Data Set (MDS) System of Records Revised 04/28/2007
(Issued: 9-6-12, Implementation/Effective Date: 6/17/13)

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT IF 1974 (5 USC 552a). THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. **AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.** Authority for maintenance of the system is given under Sections 1102(a), 1819(b)(3)(A), 1819(f), 1919(b)(3)(A), 1919(f) and 1864 of the Social Security Act.

The system contains information on all residents of long-term care (LTC) facilities that are Medicare and/or Medicaid certified, including private pay individuals and not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer data containing other party liability insurance information necessary for appropriate Medicare claim payment.

Medicare and Medicaid participating LTC facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information is also used by the Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. 42 CFR§483.20, requires LTC facilities to establish a database, the Minimum Data Set (MDS), of resident assessment information. The MDS data are required to be electronically transmitted to the CMS National Repository.

Because the law requires disclosure of information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures. These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS LTC System of Records.

2. **PRINCIPLE PURPOSE OF THE SYSTEM FOR WHICH INFORMATION IS INTENDED TO BE USED.** The primary purpose of the system is to aid in the administration of the survey and certification, and payment of Medicare/Medicaid LTC services which include skilled nursing facilities (SNFs), nursing facilities (NFs) and non-critical access hospitals with a swing bed agreement.
   Information in this system is also used to study and improve the effectiveness and quality of care given in these facilities. This system will only collect the minimum amount of personal data necessary to achieve the purposes of the MDS, reimbursement, policy and research functions.

3. **ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM.** The information collected will be entered into the LTC MDS System of Record, System No. 09-70-0528. This system will only disclose the minimum amount of personal data necessary to accomplish the purposes of the disclosure. Information from this system may be disclosed to the following entities under specific circumstances (routine uses), which include:
   a. To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS;
   b. To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent for purposes of contributing to the accuracy of CMS' proper payment of Medicare benefits and to enable such agencies to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with federal funds and for the purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or Medicaid eligibility;

c. To assist Quality Improvement Organizations (QIOs) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Title XI or Title XVIII of the Social Security Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans;
d. To assist insurers and other entities or organizations that process individual insurance claims or oversees administration of hear care services for coordination of benefits with the Medicare program and for evaluating and monitoring Medicare claims information of beneficiaries including proper reimbursement for services provided;
e. To support an individual or organization to facilitate research, evaluation, or epidemiological projects related to effectiveness, quality of care, prevention and disease or disability, the restoration or maintenance of health, or payment related projects;
f. To support litigation involving the agency, this information may be disclosed to The Department of Justice, courts or adjudicatory bodies;
g. To support a national accrediting organization whose accredited facilities meet certain Medicare requirements for inpatient hospital (including swing bed) services;
h. To assist a CMS contractor (including but not limited to fiscal intermediaries and carriers) that assists in the administration of a CMS- administered grant program to combat fraud, waste and abuse in certain health benefit programs; and
i. To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste and abuse in a health benefits program funded in whole or in part by Federal funds.

4. **EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION.** The information contained in the LTC MDS System of Records is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, e.g., thorough medical history, inappropriate and potentially harmful care may result. Moreover, payment for services by Medicare, Medicaid and third parties, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

Printed Name: _____
Resident/Responsible Party

Signature: _____ Date: _____
Resident/Responsible Party

NOTE: Residents or their representative must be supplied with a copy of the notice. This notice may be included in the admissions packet for all new nursing home admissions, or distributed in other ways to residents or their representative(s). Although signature of receipt is NOT required, providers may request to have the Resident or his or her Representative sign a copy of this notice as means to document that notice was provided and merely acknowledges that they have been provided with this information.

Resident Information Sheet

«${facility.facility_name}»

Admission Date «${census.admission.date}»

First Name: «${resident.first_name}» Middle Name: «${resident.middle_name}»

Phone Number: _ «${resident.phone_home}» Church/Religion:_____

Sex: Male Female Veteran: Yes No

Marital Status: Married Not Married Divorced Widowed

Occupation:_____ Highest Education:_____

Race:_____ Citizenship:_____ Primary Language:_____

Insurance Information:

Medicare Number: «${resident.medicare_no}» Part A Part B (please check)

Medicare Supplement Insurance Carrier: «${resident.other_healthcare_coverage}» Policy Number: _____

Insurance Carrier: «${insurance_primary.company_name}» Policy Number: _____

Long-Term Care Insurance Carrier: _____ Policy Number: _____

Medicare Supplement Insurance Carrier: _____ Policy Number: _____

Secondary Insurance or Other Benefits:_____

Medicaid Number: «${resident.medicaid_no}» County: «ƒ{resident.county} Caseworker: _____

Will you be applying for Medicaid? Yes or No If yes, when? _____

Have you ever been denied Medicaid? Yes or No If yes, when? _____

What county were you denied? _____ Reason for Denial?_____

Responsibly Party Information:

Responsible Party: «${responsible_party.full_name}» Relationship: «${responsible_party.relation}»

Email Address: «${responsible_party.email}» Phone: «${responsible_party.phone_home}»

Work Phone: «${responsible_party.phone_office}» Address: «${responsible_party.address1}»

City: «${resident.city}» State:_____ Zip: _____

Social Security Number:_____ Date of Birth: _____

Employer:_____ Date of Employment: _____

Power of Attorney:_____ Phone/Email:_____

Attorney (if involved in your financial affairs) May we contact Yes No

Name/Firm: _____ Phone/Email: _____

Health Related Information

Admit From:_____ Transition of Care Plan: Home LTC Assisted

Living Allergies:_____ Diet/Restrictions:_____ Assistive

Primary Physician: «${primary_physician.full_name}» Phone: «${primary_physician.phone_office}»

Fax: «${primary_physician.phone_fax}»

Eye Physician:_____ Phone:_____ Fax:

Pharmacy Preference: «${pharmacy.name}» Phone: «${pharmacy.phone}» Fax: «${pharmacy.fax}»

Hospital Preference:_____ Phone:_____ Fax:

Specialty Physician/Other:_____Phone:_____Fax:

Emergency Contact Information

You are giving permission for health information to be shared with the following individuals:

Emergency Contact #1 (check all that apply) is also my ☐Responsible Party ☐POA-Financial ☐POA-Care ☐Next of Kin ☐Alternate Contact ☐Care Conference Person ☐Guardian

Name/Relationship_____

Home Phone: «${emergency_contact_1.phone_home}» Cell Phone: «${emergency_contact_1.phone_other}»

Email: «${emergency_contact_1.email}»

Address: «${emergency_contact_1.address1}»_____City: «${emergency_contact_1.city}»State:_____

Zip:_____

Emergency Contact #2 (check all that apply) is also my ☐Responsible Party ☐POA-Financial ☐POA-Care ☐Next of Kin ☐Alternate Contact ☐Care Conference Person ☐Guardian

Name/Relationship_____

Home Phone: «${emergency_contact_2.phone_home}» Cell Phone: «${emergency_contact_2.phone_other}»

Email: «${emergency_contact_2.email}»

Address: «${emergency_contact_2.address1}»

City: «${emergency_contact_2.city}» State:_____Zip:_____

In the event of death, I direct you to notify:

Name/Relationship: _____ Phone: _____

Funeral Home:_____, City:_____State:_____

Undertaker: _____ Phone: _____

Printed Name: «${resident.full_name}» «${responsible_party.full_name}»
Resident/Responsible Party

Signature: _____ Date:
Resident/Responsible Party

Printed Name: _____
Facility Representative

Signature: _____ Date: _____
Facility Representative

Resident Rights					
Date Implemented:	1/1/2023	*Date Reviewed/ Revised:*		*Reviewed/ Revised By:*	

Policy:

The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

The facility will also provide the resident with prompt notice (if any) of changes in any State or Federal laws relating to resident rights or facility rules during the resident's stay in the facility. Receipt of any such information must be acknowledged in writing.

Policy Explanation and Compliance Guidelines:

1. Prior to or upon admission, the social service designee, or another designated staff member, will inform the resident and/or the resident's representative of the resident's rights and responsibilities.
2. Information about resident rights and responsibilities will be given to the resident both orally and in writing.
3. Information about resident rights will be given to the resident in a language that the resident understands to the extent possible, considering impediments which may be created by the resident's health and mental status.
4. If a resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate the information concerning rights and responsibilities in a language familiar to the resident will be made available and implemented.
5. The facility will have written translations of its statements of rights and responsibilities in commonly encountered foreign languages, if/as applicable.
6. Large print texts of the facility's statement of resident rights and responsibilities should be available.
7. The facility will promptly inform residents of any changes to State or Federal laws relating to resident rights or facility rules. Receipt of any such changes must be acknowledged in writing.
8. A posting of names, addresses and phone numbers of all pertinent state client advocacy groups will be available in the facility.
9. The facility prominently displays written information regarding how to apply for and use Medicare and Medicaid benefits.
10. All residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression.
11. The facility will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the responsibility of the facility to properly care for its residents. Training topics will be appropriate to the individual's role.

References:

Centers for Medicare & Medicaid Services. *State Operations Manual, Appendix PP: Guidance to Surveyors for Long Term Care Facilities* (October 2022). 42 C.F.R. §483.10. F550 – Resident Rights/Exercise of Rights.

Centers for Medicare & Medicaid Services. *State Operations Manual, Appendix PP: Guidance to Surveyors for Long Term Care Facilities* (October 2022). 42 C.F.R. §483.10. F557- Respect, Dignity/Right to Have Personal Property.

Centers for Medicare & Medicaid Services. *State Operations Manual, Appendix PP: Guidance to Surveyors for Long Term Care Facilities* (October 2022). 42 C.F.R. §483.95. F942 – Resident's Rights and Facility Responsibilities Training.

Resident Rights

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

1. **Exercise of rights**. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
    a. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights.
    b. In the case of a resident who has not been adjudged incompetent by the State court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by State law.
    c. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.
    d. The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the resident representative.
    e. The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation or rights, except as limited by State law.
2. **Planning and implementing care**. The resident has the right to be informed of, and participate in, his or her treatment, including:
    a. The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.
    b. The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:
        i. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.
        ii. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.
        iii. The right to be informed, in advance, of changes to the plan of care.
        iv. The right to receive the services and/or items included in the plan of care.
        v. The right to see the care plan, including the right to sign after changes to the plan of care.
    c. The right to be informed in advance, of the care to be furnished and the type of care giver or professional that will furnish care.
    d. The right to be informed by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.
    e. The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.
    f. The right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate.
    g. Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.
3. **Choice of attending physician**. The resident has the right to choose his or her attending physician.

4. **Respect and dignity**. The resident has a right to be treated with respect and dignity, including:
    a. The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.
    b. The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.
    c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents.
    d. The right to be free from involuntary searches of both body and personal possessions.
    e. The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.
    f. The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.
    g. The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.
    h. The right to refuse to transfer to another room in the facility, if the purpose of the transfer is:
        i. To relocate a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or
        ii. To relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.
        iii. Solely for the convenience of staff.
    i. A resident's exercise of the right to refuse transfer does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

5. **Self-determination**. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to:
    a. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.
    b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.
    c. The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.
    d. The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident’s right to deny visitation when applicable, and in a manner, that does not impose on the rights of another resident.
    e. The resident has a right to organize and participate in resident groups in the facility.
    f. The resident has a right to participate in family groups.
    g. The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) or other residents in the facility.
    h. The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
    i. The resident has a right to choose to or refuse to perform services for the facility and the facility must not require a resident to perform services for the facility. The resident may perform services for the facility, if he or she chooses, when:
        i. The facility has documented the resident’s need or desire for work in the plan of care:
        ii. The plan specifies the nature of the services performed and whether the services are voluntary or paid;
        iii. Compensation for paid services is at or above prevailing rates; and
        iv. The resident agrees to the work arrangement described in the plan of care.
    j. The resident has the right to manage his or her financial affairs. This includes the right to

know, in advance, what charges a facility may impose against a resident's personal funds.

6. **Information and communication**. The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.
    a. The resident has the right to access personal and medical records pertaining to him or herself.
    b. The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:
        i. Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes:
            — A description of the manner in protecting personal funds,
            — A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources
            — A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and
            — A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
    c. Information and contact information for State and local advocacy organizations, including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program and the protection and advocacy system;
    d. Information regarding Medicare and Medicaid eligibility and coverage;
    e. Contact information for the Aging and Disability Resource Center; or other No Wrong Door Program
    f. Contact information for the Medicaid Fraud Control Unit; and
    g. Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
    h. The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overhead. This includes the right to retain and use a cellular phone at the resident's own expense.
    i. The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:
        i. Privacy of such communications consistent with this section; and
        ii. Access to stationary, postage, and writing implements at the resident's own expense.
    j. The resident has the right to have reasonable access to, and privacy of, their use of electronic communication such as email and video communications and for internet research:
        i. If the access is available to the facility
        ii. At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
        iii. Such use must comply with state and federal law.

k. The resident has a right to:
    i. Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and
    ii. Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

7. **Privacy and confidentiality**. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.
    a. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.
    b. The resident has a right to secure and confidential personal and medical records.
        i. The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.

8. **Safe environment**. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

9. **Grievances**. The resident has the right to:
    a. Voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished; and the behavior of staff and of other residents; and other concerns regarding their LTC facility stay.
    b. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have.

Printed Name: _____
Resident/Responsible Party

Signature: _____ Date: _____
Resident/Responsible Party

Relationship: _____

Residents' Financial Funds, Interest Bearing Accounts & Surety Bonds

Created by ODH in consultation with ODJFS/Medicaid

(Oct. 2012 - this guidance supersedes any previously issued guidance)

1. **MULTI-FACILITY SURETY BONDS**
   - **a.** Can the operator of a nursing home who also operates a residential care facility have one surety bond?
   - **b.** Can the operator of multiple nursing homes have one surety bond that covers all the nursing homes?
   - **c.** Can the operator of multiple RCFs) have one surety bond that covers all the RCFs?

Yes, provided that the home provides assurances regarding the security of residents' funds.

"Home" is defined to include a nursing home or a residential care facility. See ORC 3721.01 (A)(1)(a). Section 3721.15(D) of the Ohio Revised Code (ORC) requires that "each home that manages the financial affairs of residents shall purchase a surety bond or otherwise provide assurance satisfactory to the director of health, or, in the case of a home that participates in the Medicaid program, to the director of job and family services, to assure the security of all residents' funds managed by the home." (Emphasis Added).

The statutory language "each home" implies that each individual nursing home or residential care facility is required to purchase a surety bond to cover the funds managed by the individual home. However, the statutory language also allows for the requirement to be met in the alternative manner (through assurances regarding the security of residents' funds). Therefore, a single surety bond that covers multiple RCFs and NHs is sufficient provided that each home is specifically covered by the bond and provided that the bond covers the full amount of all resident funds on deposit in all the entity's facilities.

For surety bonds covering multiple facilities when Medicaid-certified nursing facilities are included, OAC 5101:3-3-16.5(I)(1)(e) and OAC 5101:3-3-15.5(I)(3) (the Medicaid rule) require that:

> (I)(1)(e) If an entity purchases a surety bond that covers more than one of its facilities, the surety bond shall protect the full amount of all resident funds on deposit in all the entity's facilities.
>
> (I)(3) A NF provider or entity who operates multiple facilities shall submit copies of either the multi-facility surety bond or a reasonable alternative to the multi-facility surety bond to ODJFS for review and approval. If the NF provider, surety company, or issuer of an ODJFS-approved surety bond alternative cancels the surety bond or reasonable alternative to a surety bond, they shall notify ODJFS by certified mail thirty days prior to the effective date of cancellation.

Copies of the multi-facility surety bonds for Medicaid-certified facilities should be sent to the Surety Bond Designee, BLTCSS, Office of Medical Assistance, P.O. Box 182709, Columbus, OH 43218-2709.

2. **POOLED RESIDENT FUND ACCOUNTS**

Can an operator of a home "pool" multiple residents' funds into one account in order to meet the minimum threshold for an interest-bearing account with separate accounting for each resident?

Yes, provided that the home can ensure proper management of resident funds and provided that nursing facility residents' personal needs account ("PNA") funds are pooled only with funds of other nursing facility residents.

ORC 3721.15 (B) states that "a home that manages a resident's financial affairs shall deposit the resident's funds in excess of one hundred dollars, and may deposit the resident's funds that are one hundred dollars or less, in an interest-bearing account…." (Emphasis Added)

The statute does not specifically require a separate account for each resident, but does require that interest earned on the resident's funds be credited to the resident's account. Additionally, rule 3701-17-61 (C) (5) requires that a residential care facility allow a resident access to his or her funds during normal bank business hours within the community.

For Medicaid certified homes, OAC 5101:3-3-16.5(D)(2) provides as follows:

> (2) Funds in excess of fifty dollars. If a resident's PNA account funds are in excess of fifty dollars, the NF provider shall deposit the funds in an interest-bearing account (or accounts) that is separate from any of the NF provider's operating accounts within five banking days from the date the balance exceeds fifty dollars.

OAC 5101:3-3-16.5 provides in part as follows:

> (E) Accounting and records.
>
> (1) A NF provider shall establish and maintain a system that ensures full, complete, and separate accounting of each resident's PNA account funds.
>
> (2) A NF provider shall not commingle a resident's accounts or funds with the provider's accounts or funds, **or with the accounts or funds of any individual other than another NF resident.**

The Medicaid rule also states that "if pooled accounts are used, the provider shall prorate interest per resident on the basis of actual earnings or end-of-quarter balance." The rule also requires that a provider "establish and maintain a system that ensures full, complete and separate accounting of each residents' PNA funds."

Therefore, managing a pooled account may present some challenges (i.e., tracking and dividing interest, providing accountings, providing account access, etc). While a pooled account is legally permissible, homes should evaluate their internal resources and consult with banking experts to discuss options that will ensure the proper management of funds. Additionally, nursing facility residents' personal needs account ("PNA") funds can only be pooled with funds of other nursing facility residents.

3. MULTI FACILITY POOLED RESIDENT FUND ACCOUNTS

Is it permissible to pool resident funds from multiple homes into one interest bearing account?

It depends.

a. Can the operator of a nursing home who also operates a residential care facility have one interest-bearing account for resident funds? **Not if the nursing home is Medicaid-certified.**
b. Can the operator of several nursing homes have one interest-bearing account for resident funds? **Yes, given the conditions below**.
c. Can the operator of several RCFs have one interest-bearing account for resident funds? **Yes, given the conditions below**.

The requirement for "homes" and for homes that are also "NF providers" are different.

"A home that manages" (singular) implies that each residential care facility and nursing home will manage the funds of their own residents. (See ORC 3721.15 (B) cited above). Homes are required to deposit funds in excess of one hundred dollars into an interest-bearing account, but there is not an explicit requirement that the interest-bearing account be used solely by one home. While multiple homes may share an interest-bearing bank account, management of funds deposited remains the responsibility of each individual home.

Similarly, a "NF provider" (singular) implies that each NF provider will manage the funds of their own residents. (See OAC 5101:3-3-16.5 cited above). NF providers are required to deposit funds in excess of fifty dollars into an interest-bearing account, but there is not an explicit requirement that the interest-bearing account be used solely by one NF provider. However, NF residents' accounts or funds may be comingled only with accounts or funds of other NF residents, and may not be comingled with the provider's accounts or funds or with the accounts or funds of any individual other than another NF resident. Subject to this commingling limitation, multiple NF providers may share an interest-bearing bank account, but management of funds deposited remains the responsibility of each individual home.

Chronic Care Management and Remote Patient Monitoring

Patient Name _____

Facility_____

By signing below, I authorize TapestryHealth to provide monthly Chronic Care Management (CCM) and/or Remote Patient Monitoring (RPM) services. These programs have been explained to me and I am aware that these services can be provided by TapestryHealth even if I am being treated by another primary care physician.

The services are approved by Medicare, Medicaid and most insurances. In certain cases, a copay may apply. If I have transitioned my Medicare benefits to Hospice, then I will not be included in this program.

I am aware that I may discontinue receiving these Care Management Services at any time by informing TapestryHealth and am agreeing to these services.

_____ _____

Signature of Patient/Person Authorized to Make Medical Decisions Date

---

I am declining the Chronic Care Management and Remote Patient Monitoring Services.

_____ _____

Signature of Patient/Person Authorized to Make Medical Decisions Date

****Please send the name and medical record number of any individual declining this service to:**
Caremanagement@tapestryhealth.com

Tuberculosis Skin Test (Tuberculin PPD) Informed Consent

Information: Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. A person with TB can die if they do not get treatment. The Mantoux tuberculin skin test (TST) is a standard method of determining whether a person is infected with Mycobacterium tuberculosis.

What is TB?

"TB" is short for a disease call tuberculosis. TB is spread through the air from one person to another. TB germs are passed through the air when someone who is sick with TB disease of the lung or throat coughs, speaks, laughs, sings or sneezes. Anyone near the sick person with TB disease can breathe TB germs into their lungs.

TB germs can live in your body without making you sick. This is called latent TB infection. This means you have only inactive (sleeping) TB germs in your body. The inactive germs cannot be passed on to anyone else. However, if these germs wake up or become active in your body and multiply, you will get sick with TB disease.

When TB germs are active (multiplying in your body), this is called TB disease. These germs usually attack the lungs. They can also attack other areas of the body such as the brain, the kidneys, or the spine. TB disease will make you sick. People with TB disease may spread germs to people they spend time with every day.

Precautions/Contraindications: In those who are older or those who are being tested for the first time, it may take longer than 72 hours for reaction to develop. Immediate reaction may also occur.

Why is Two-Step Testing Conducted?

Two-step testing is useful for the **initial** skin testing of adults who are to be going to be retested periodically, such as health care workers or nursing home residents. This two-step approach can reduce the likelihood that a boosted reaction to a subsequent TST will not be misinterpreted as a recent infection.

Reactions to PPD can also be affected if the patient: 1. Is receiving certain drugs (corticosteroid or immunosuppressive agents). 2. Has recently received immunizations with certain virus vaccines (measles, mumps, rubella, and influenza). 3. Has recently had viral infections (measles, mumps, influenza, others). Highly sensitive persons may suffer blistering, ulceration, or death of tissue at the site of injection and/or other allergic reactions. A scar may form in those cases. Therefore, if a patient has ever had a positive reaction to a TB skin test, he/she should not receive another test.

Tell your health care worker if you have ever had a "positive" reaction to a TB skin test or TB blood test, or if you have been treated with TB drugs in the past.

I HAVE READ AND UNDERSTAD THE INFORMATION ABOVE AND GIVE CONSENT TO RECEIVE MANTOUX TUBERCULIN SKIN TEST.

_____

Residents Name

Printed Name: _____

Resident/Responsible Party

Signature: _____ Date: _____

Resident/Responsible Party

Tuberculosis Skin Test (Tuberculin PPD) Informed Consent

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I HAVE READ AND UNDERSTAD THE INFORMATION ABOVE AND GIVE CONSENT TO RECEIVE MANTOUX TUBERCULIN SKIN TEST.

Signature: _____ Date: _____

Resident Representative: _____ Date: _____

Staff Member: _____ Date: _____