RESIDENT INFORMATION

FIRST NAME _____ M.I._____ LAST NAME _____

ADDRESS _____ UNIT _____ CITY _____ STATE_____ ZIP _____

PHONE _____ D.O.B. _____

SOCIAL SECURITY _____ MEDICARE _____ MEDICAID _____

OTHER INSURANCE _____ ID _____ GROUP _____

ADMISSION DATE 06/27/23 _____ SIG DATE 06/27/23 _____

SIGNER FIRST NAME STEVE _____ SIGNER LAST NAME BROGDON _____

ADDRESS _____ UNIT _____ CITY _____ STATE_____ ZIP _____

PHONE 1 _____ PHONE 2 _____ EMAIL _____

RELATIONSHIP _____

FORM SIGNED BY _____

ATTENDING PHYSICIAN DR. JAMES KRABLIN _____ ADDRESS 4334 NW EXPRESSWAY _____

CITY OKLAHOMA CITY _____ STATE OK _____ ZIP 73116 _____ PHONE 405-590-1200 _____

NURSING FACILITY _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

ADMINISTRATOR _____ CELL PHONE _____

ADMINISTRATOR EMAIL _____

PHARMACY PHARMCARE OKC _____

FACILITY WEBSITE _____ RESIDENT ID # _____

CONTACT INFORMATION

Please use the following information to contact the Center or the Administrator with any questions regarding the Center's handling of your health information.

Center Name: _____

Center Phone: _____

Center Address: _____ State: _____ Zip: _____

Administrator: _____

Administrator Phone: _____

Administrator Email: _____

Website: _____

Resident Number: _____

Use the Resident Number to pay Online at the facility website

Admissions Coordinator: Steve Brogdon (580) 399-1252 Email: SBrogdon@ihsholding.com

Attending Physician: DR. JAMES KRABLIN

Physician Address: 4334 NW EXPRESSWA City: OKLAHOMA CITY State: OK Zip: 73116

Physician Phone : 405-590-1200

DO NOT RESUSCITATE (DNR) ORDER ACCEPTANCE OR DECLINATION REPORT

Resident Name: _____ _____ _____ Date: 06/27/23

The above-named individual has been offered assistance in developing a DO NOT RESUSCITATE (DNR) ORDER, and has indicated the following:

☐ I do not wish to complete a DO NOT RESUSCITATE (DNR) ORDER at this time, but have been provided with a form for review.

☐ I have already completed a DO NOT RESUSCITATE (DNR) ORDER , know it's current location, and will promptly provide a copy to this facility.

☐ There is a copy of my DO NOT RESUSCITATE (DNR) ORDER in my chart at this Facility.

☐ Resident is cognitively unable to complete an DO NOT RESUSCITATE (DNR) ORDER, and no other person has POA or Guardianship authority to complete one at this time.

Additional comments:

_____

_____

_____

_____ 06/27/23

Signature of Resident or Representative Date

_____ 06/27/23

Signature of Facility Representative Date

ADVANCE DIRECTIVE ACCEPTANCE OR DECLINATION REPORT

Resident Name: _____ _____ _____ Date: 06/27/23

The above-named individual has been offered assistance in developing an ADVANCE DIRECTIVE, and has indicated the following:

☐ I do not wish to complete an Advance Directive at this time, but have been provided with a form for review.

☐ I have already completed an Advance Directive, and its location is known by my medical proxy, POA, or attorney.

☐ There is a copy of my Advance Directive in my chart at this Facility.

☐ Resident is cognitively unable to complete an Advance Directive at this time.

Additional comments:

_____

_____

_____

_____ 06/27/23

Signature of Resident or Representative Date

_____ 06/27/23

Signature of Facility Representative Date

ASSIGNMENT OF BENEFITS

Patient Name: _____

Patient Medicare Number:_____ Patient Medicaid Number: _____

Private/Other Insurance: _____ Insurance ID: _____

Subscriber Name: _____

I, _____, request payment of authorized Medicare, Medicaid and/or other insurance benefits to be made to

_____ for any services furnished to me. I authorize any holder of medical and other information about me to release to Medicare, Medicaid and/or other insurance and their agents such information needed to determine these benefit-related services.

Authorization to treat:

I consent to and authorize the administration and performance of medical care by _____ under a physician's order for skilled nursing care and/or long term nursing care.

_____ 06/27/23

(Signature) (Date)

MEDICARE PART A: SKILLED NURSING FACILITY (SNF)
EXPLANATION OF BENEFITS AND CO-PAYMENTS

Benefit Period:

If a patient has had a three-midnight consecutive hospital stay within a 30-day period prior to the SNF admission and his/her care needs meet certain coverage criteria, up to 100 days of care in a SNF could be available, in each "spell of illness."

Deductibles and Co-Payments:

Medicare covers all costs for the first 20 days.

A co-payment of 200.00 per day is required for days 21-100. The beneficiary (or another payment source) is liable for partial payment (co-insurance) for each day of approved coverage from the 21st through the 100th day. The co-insurance is based on a formula in the Medicare rules and regulations.

Benefit Period Further Defined:

Benefit periods are divided into units of 100 days. A benefit period begins the day a beneficiary enters the hospital. It continues while the patient is in a SNF and receiving a daily skilled level of care up to the 100th day or until an individual does not require or receive a covered level of care for 60 consecutive days. The 60-day period breaks the "spell of illness" and allows the beneficiary to be eligible for another benefit period (100 days). The beneficiary does not have to leave the facility or the Medicare certified bed. It is possible under the program for a beneficiary to have multiple benefit periods (Reference: 42 CRF 409.60).

Therefore, a spell of illness can be broken if:

1. The beneficiary leaves the facility and is not in a hospital or nursing home for 60 consecutive days, or:
2. The beneficiary drops below a Medicare-covered level of skilled nursing care in the facility for 60 consecutive days.

I have read and understand the above explanations regarding SNF benefits, coverage and co-payment rules.

_____ 06/27/23 _____

(Signature) (Date)

Notice of Exclusions from Medicare Benefits Skilled Nursing Facility (NEMB-SNF)

Date of Notice: 06/27/23

NOTE: You need to make a choice about receiving these health care items or services.

It is not Medicare's opinion, but our opinion, that Medicare will not pay for the item(s) or service(s) described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare will not pay for a particular item or service does not mean that you should not receive it. There may be a good reason to receive it. Right now, in your case, **Medicare will not pay for –**

Items or Services:	
We believe that Medicare will not pay for the following reason. (See the reason checked off below.)	
☐ No qualifying 3-day inpatient hospital stay. ☐ No days left in this benefit period. ☐ Care not ordered or certified by a physician. ☐ Daily skilled care not needed. ☐ SNF transfer requirement not met. ☐ Facility/Bed not certified by Medicare.	☐Care not given by, nor supervised by, skilled nursing or rehabilitation staff. ☐Items or services not furnished under arrangements by the skilled nursing facility. ☐ **Other**: _____

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself or through other insurance that you may have. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost $** _____.)

Your other insurance is: _____

Please choose one option. Check on box. Sign and date this notice.

☐ **Option 1. YES** I want to receive these items or services and get an official Medicare decision about coverage. Please submit a claim, with any evidence supporting my need for these items or services, to Medicare for its official decision. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have.

I understand that I can appeal if Medicare decides not to pay. Medicare will send me notice of its official decision not to pay that explains its decision in my case. That notice will explain how I can appeal Medicare's decision not to pay. If I do not hear from Medicare about its official coverage decision within 90 days, I can telephone Medicare at ( )_____ . TTY/TDD: ( ) _____.

☐ **Option 2. YES** I want to receive these items or services. Do NOT submit a claim to Medicare. I agree to be fully and personally responsible for payment of any amount for which my other insurance will not pay. I realize I cannot appeal to Medicare.

☐ **Option 3. NO** I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Patient's name	Identification Number
Signature of the patient or the authorized representative	Date 06/27/23

SCREEN FOR MEDICARE SECONDARY PAYER (MSP)

Beneficiary Name: _____ _____ HIC#_____ Admit Date 06/27/23

PLEASE COMPLETE ALL SECTIONS OF THIS FORM TO IDENTIFY ALL POSSIBLE PAYORS
There may be more than one insurer primary to Medicare, e.g. Automobile and Group Health Plan

Must be completed for all admissions and readmissions (Part A & B) for all payor sources.

Part I

Was illness/injury/condition: (1) Due to a work-related accident/condition and covered by Worker's Compensation Plan or (2) due to the Federal Black Lung Program or (3) covered by a Government Program such as a research grant?

☐ **No**: Go to Part II

☐ **Yes**: Medicare is Secondary Payor for claims related to illness/injury/condition. Complete the following the following information and go to Part II.

Date of injury/illness/condition began: _____ Name and address of WC plan or Federal Black Lung Program or

Government Program: _____

Policy or ID# _____ Date Benefit Began: _____

Name and Address of Employer: _____

Part II

Was illness/injury due to a non-work-related accident?

☐ **No**: Go to Part III

☐ **Yes**: Complete the following information and go to Part III

What type of accident caused illness/injury? (check one)

☐ Automobile: Medicare is Secondary Payor for claims related to accident.

Date of accident: _____ Name and address of no-fault or liability insurer: _____

_____

Insurance Claim # _____

☐ Non-Automobile (enter accident type): _____ Date of Accident: _____

Was another party responsible for this accident?

☐ No

☐ Yes: Medicare is Secondary Payor for claims related to accident.

Name of responsible party: _____ Name and address of liability insurer: _____

_____

Insurance claim # _____

Part III

Has the Department of Veteran Affairs authorized and agreed to pay for care at this Center?

☐ No: Go to Part IV

☐ Yes: Medicare is Secondary Payor. Go to Part IV

SCREEN FOR MEDICARE SECONDARY PAYER (MSP)

Part IV

1. Is the Resident 65 or over?

☐ No: Go to Part V ☐ Yes: Continue

2. Is the Resident or Spouse employed, and is the Resident covered by Resident or Spouse Group Health Plan (GHP) of 20 or more employees?

☐ No: Date of Retirement(s) Spouse _____ Resident _____ - Go to Part V
☐ No: Spouse Never Employed No: Spouse never employed - Go to Part V
☐ Yes: Medicare is Secondary Payor. Complete the following information and go to Part V.
Name of Employer _____ Name of GHP _____
Policy ID # _____ Group ID # _____
Name of policyholder/insured: _____ Relationship to Resident: _____

Part V

1. Is the Resident a disabled Medicare Beneficiary under age 65?

☐ No: Go to Part VI ☐ Yes: Continue

2. Is Resident or Spouse employed and is the Resident covered by Resident or Spouse Group Health Plan (GHP) of 100 or more employees?

☐ No: Date of Retirement(s) Spouse _____ Resident _____ - Go to Part VI
☐ No: Spouse Never Employed No: Spouse never employed - Go to Part VI
☐ Yes: Medicare is Secondary Payor. Complete the following information and go to Part VI.
Name of Employer _____ Name of GHP _____
Policy ID # _____ Group ID # _____
Name of policyholder/insured: _____ Relationship to Resident: _____

Part VI

1. Check One:

☐ Resident is NOT undergoing kidney dialysis. MSP Questionnaire is complete.

☐ Resident is age 65 or over and undergoing kidney dialysis for ESRD. Continue.

☐ Resident is disabled and undergoing kidney dialysis for ESRD. Continue.

☐ Resident is entitled to benefits solely on the basis of ESRD. Continue.

2. Is the Resident covered under a Group Health Plan?

☐ No: MSP Questionnaire is complete
☐ Yes: Complete the following information if not completed in Part IV or V and Continue
Name of Employer _____ Name of GHP _____
Policy ID # _____ Group ID # _____
Name of policyholder/insured: _____ Relationship to Resident: _____

3. Has the Resident completed the ESRD 30-month coordination period? Date Dialysis began: _____

☐ No: Medicare is Secondary Payor. See GHP. ☐ Yes: MSP Questionnaire is complete

_____	06/27/23	_____	06/27/23
Resident or Representative Signature	Date	Witness Signature	Date

OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Consent for Release of Information and Appointment of Representative

Date _____

Case name _____

Case # _____

County # _____

Supervisor # _____ Worker # _____

Consent Agreement

I, STEVE BROGDON Check any that apply:
Name

☐ resident ☐ client ☐ health care proxy ☐ parent

☐ guardian ☐ personal representative ☐ legal custodian

living at:

_____ _____ _____ _____
Street address City State ZIP code

request(s) that OKDHS release all pertinent information necessary to assist in processing the nursing home care application completed on 06/27/23 concerning:
Date of application

Name of client/resident _____

_____ _____ _____
Date of birth Social Security number Phone number

to:

Name of facility and/or facility representative _____

I understand that this consent allows OKDHS staff to communicate in person, by telephone, or in writing with the above named facility regarding my application.

I understand that the records requested are protected under Federal and State confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by regulation. State and federal laws and regulations prohibit any further disclosure of such records by:

_____
Name of facility and/or facility representative

without my specific written consent or except as otherwise permitted by such regulations. I also understand that this consent may be revoked in writing to OKDHS at any time unless action has already been taken based upon it. This consent expires upon approval or denial of the nursing home care application.

This release of information has been explained to me and consent has been given of my own free will.

Signature of resident or resident representative authorizing release — Date: 06/27/23

Signature of facility representative — Date: 06/27/23

Appointment of Representative

At this time, I also appoint:

Name of facility and/or facility representative _____

to be the authorized representative for:

Name of client/resident _____

to assist in completing and processing his/her or my nursing home care application and/or review. I understand that while the above named appointee is my authorized representative, I am still responsible for providing complete and accurate information to OKDHS regarding my nursing home care application.

I understand that

_____
Name of facility and/or facility representative

will **NOT** charge me any fee for this service.

This appointment of representation form has been explained to me and consent given of my own free will. This authorization will continue unless revoked in writing by the client or facility representative.

Signature of resident or resident representative authorizing release — Date: 06/27/23

Signature of facility representative — Date: 06/27/23

Withdrawal of Consent

I wish to withdraw my consent for OKDHS staff to communicate in person, by telephone, or in writing with the facility named below regarding my application.

Name of facility and/or facility representative

Signature of resident or resident representative authorizing release — Date

Purpose

Part I of Form 08MA013E is used by the nursing facility to secure the permission of the client, the client's spouse, guardian or other responsible party to allow OKDHS to release all information necessary for the nursing facility to assist the client in processing the nursing home care application. The nursing facility representative who asks the client or other responsible party to sign this form must advise the client or person signing the form that:

- he or she is not required to sign this form in order to be approved for help in paying nursing facility costs;
- this form cannot be used to give permission to disclose information concerning the client's medical condition;
- the permission granted by this form is understood to cover only the period of time that the nursing home care application is pending;
- once the application is approved or denied, permission must be obtained again to release other information; and
- the client or person signing the form may revoke the consent in writing at any time unless action has already been taken based upon the consent.

Part II of Form 08MA013E is used by the nursing facility to secure the permission of the client or other responsible person to be appointed as the client's authorized representative. The client must sign this part of the form unless he or she is unable to complete or understand the application process. In addition to advising the client of the information shown in Part I, the nursing facility representative must also:

- advise the client OKDHS will only release information regarding the application or review to the client or his or her authorized representative;
- review the information on the application or review form, including the client's rights and responsibilities, with the client for accuracy and understanding;
- advise the client once the nursing facility is appointed as the authorized representative, this designation will continue until either the nursing facility or the client revokes this appointment in writing to OKDHS; and
- notify OKDHS of any change in the client's address.

When only the first part of this form is signed by the client, OKDHS staff may communicate with the nursing facility representative and/or the responsible person who completed the application for the client. When Part II is completed, OKDHS staff must communicate only with the client or the authorized representative.

Part III of Form 08MA013E is used by the client, the client's spouse, guardian or other responsible party to withdraw permission for OKDHS staff to release any information to the nursing facility to help process the nursing home care application.

Routing Information

To give consent or appoint an authorized representative, the facility representative sends the original to the local OKDHS human services center (HSC) and gives a copy to the person or persons who sign the form. OKDHS staff retains the form or an imaged copy of the form in the case record.

If withdrawing consent, the client, the client's spouse, guardian or other responsible party sends the original to the local OKDHS HSC. OKDHS staff sends the original to the nursing facility and retains the form or an imaged copy of the form in the case record.

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

RESIDENT FUNDS POLICY

Protection of Resident Funds.

1. You have the right to manage your financial affairs, and we may not require you to deposit personal funds with us.

2. Management of personal funds. Upon your written authorization, we must hold, safeguard, manage, and account for your personal funds deposited with us, as specified in paragraphs 3 through 8 of this Exhibit.

3. Deposit of funds.

(i) Funds in excess of $50. We must deposit any of your personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of our operating accounts and that credits all interest earned on your funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

(ii) Funds less than $50. We must maintain your personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

4. Accounting and records. We must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of your personal funds entrusted to us on your behalf.

(i) The system must preclude any commingling of your funds with our funds or with the funds of any person other than another resident.

(ii) The individual financial record must be available to you through quarterly statements upon request.

5. Notice of certain balances. We must notify you if you are covered by Medicaid or Social Security Insurance (SSI).

(i) When the amount in your account reaches $200 less than the (SSI) resource limit for one person, determined by Federal Law; and

(ii) That, if the amount in the account, in addition to the value of your other nonexempt resources, reached the SSI resource limit for one person, you may lose eligibility for Medicaid or SSI.

6. Conveyance upon death. Upon your death, if you have personal funds deposited with us, we must convey your funds within 30 days, and a final accounting of those funds, to the individual or probate court administering your estate.

7. Assurance of financial security. We must purchase a surety bond, or otherwise assure the security of all of your personal funds deposited with us.

8. Limitation on charges to personal funds. We may not impose a charge against your personal funds for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts).

9. We must purchase a security bond, or otherwise provide assurance satisfactory to the U.S. Secretary of Health and Human Services, to assure the security of all personal funds of residents deposited with us.

OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Date: _____
Case name: _____
Case number: _____
Client ID number: _____
County number: _____
Supervisor/worker number: __ / __

Management of Recipient's Funds

I. Certifying non-receipt of recipient's personal funds

The undersigned hereby certifies this 06/27/23, _____ that neither he or she nor

_____

has in his, her, or its possession any money or other items of value belonging to:

_____
Name of recipient

Money or other items of value will be the responsibility of:

Name	Administrator		
Street address	City	State	Zip

II. Request to handle recipient's funds and other items of value

I hereby request that the administrator of the facility, whose name appears on Page 2 of this form, to hold in trust for me, until further notice $_____ and/or the other items of value as listed:

I further request that the administrator hold in trust for me the amount in my monthly budget for maintenance standards until otherwise directed. I authorize the Administrator to expend in my behalf such monies in the trust for items that are not included in the payment for care.

_____ 06/27/23
Signature of recipient Date

_____ 06/27/23
Signature of responsible person Date

Name of witness		Date	
Street address	City	State	Zip

III. Acknowledgment of patient's funds

This is to acknowledge receipt of $ _____ and/or the other items as listed:

which is held in trust by me and used by or on behalf of the recipient.

I agree that an accounting of these funds will be kept on Form 08MA021E (ABCDM-99), Ledger Sheet for Recipient's Account, showing the amounts received or expended, items purchased, and balance on hand. This form covers funds and/or personal items of value received in a facility:

☐ at the time of the recipient's admission ☐ on a date later than the admission date.

In the event this recipient leaves the facility or the facility no longer handles the funds, final accounting will be made on Form 08MA085E (ABCDM-96-A), Accounting - Recipient's Personal Funds and Property.

_____ _____

Signature of administrator Date

PharmcareUSA

CLIENT AGREEMENT FOR SERVICES

FOR PHARMCAREUSA USE ONLY

Welcome to PharmcareUSA

Our Pharmacy has been chosen to provide pharmacy services at _____ Nursing Facility, we will be working with your facility in providing and managing your medications while staying in the facility. PharmcareUSA pharmacies kindly ask that you sign this form to ensure that we remain in compliance with Medicare and all other governing agencies. By execution of this Agreement, I consent and/or elect Pharmcare as my primary pharmacy to provide my pharmacy services.

PATIENT DOCUMENT ACKNOWLEDGEMENT (PATIENT ADMISSION PACKET)

☑ ***PharmcareUSA*** Protected Health Information (can also be found on our website ***www.pharmcareusa.com***)

☑ Grievance/complaint procedure ☑ Patient Bill of Rights & Responsibilities Statement ☑ Warranty/Equipment (only applicableif pharmacy provides equipment)

☑ ***PharmcareUSA*** Mission Statement ☐ Billing & Collection Policies (upon request)

☐ Supplier Standards – The products and/or services provided to you by PharmcareUSA are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters. The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

We may need to reach you for billing questions would you please provide us with your preferred method of contact:

☐ Cell Phone #: _____ ☐ Text Message #: _____ ☐ Home Phone #: _____

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER (PERMISSION TO BILL YOUR INSURANCE)

I request that payment of authorized Medicare & other benefits be made on my behalf to ***PharmcareUSA*** for products & services that they have provided me. I further authorize a copy of this agreement to be used in place of the original & authorize any holder of medical information including medical records to be released to ***PharmcareUSA***, 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. ***PharmcareUSA*** bills third-party as a courtesy; I understand that I am fully responsible for all deductibles, coinsurance & disallowables, including charges related to delivery before the verification of insurance benefits.

Primary Insurance #: _____ **Group #:** _____ **Effective Date:** _____

Secondary Insurance #: _____ **Group #:** _____ **Effective Date:** _____

INSTRUCTIONS TO CUSTOMER/RETURN DEMONSTRATION & ACKNOWLEDGMENT

As a resident of a nursing facility, I agree to allow the nurse/facility representative to sign/acknowledge receipt of all prescription medications and/or other equipment/supplies as well as receipt of all Patient Education materials. I have had my financial responsibilities explained to me and agree with the terms of this document.

HIPAA RELEASE (SEE HIPAA PRIVACY NOTICE INCLUDED WITH THIS PACKET)

In accordance with the HIPAA Privacy Regulations, ***PharmcareUSA*** 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 involvement with your care or payment related to your health care. Please assist us by identifying below individuals who are involved in your care and/or in the payment of your care to whom a 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 your understanding and agreement to these terms as listed. Patient personal information will be kept confidential by *PharmcareUSA*. Patient must notify *PharmcareUSA* of any medical status change such as a doctor's prescription, hospitalization, acquiring an infectious disease or change in residence. Patient agrees to notify *PharmcareUSA* of Advance Directives being in place and any changes thereof.

PAYMENT 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 programs or plans, public or private, under which I am entitled to benefits. I agree to provide ***PharmcareUSA*** all documents and other information necessary for ***PharmcareUSA*** 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. I agree to pay a late fee of 1.5% on any balance not paid within 30 days. ***PharmcareUSA*** reserves the right at any time to discontinue services for any account with a past due balance. I understand that upon from a discharge from a nursing facility, I may be responsible for payment of medications released to client/resident. I also agree to pay ***PharmcareUSA*** for all collection fees, attorney's fees, court costs, and other expenses involved in collecting any charges hereunder. The customer acknowledges that he has not received any representations of promises concerning the pharmacy services or the terms of this agreement other that as set forth herein. **As a resident of a nursing facility I agree to allow the nurse/facility representative 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 (other than the conflict law rules) of the state the servicing ***PharmcareUSA*** is located. ***PharmcareUSA*** may assign this agreement to any successor to ***PharmcareUSA***'s business.

Resident Printed Name:_____ **Resident Signature** ✖_____ **Date** 06/27/23

Patient's Agent or Representative STEVE BROGDON **DATE** 06/27/23

Relationship to Patient (if resident unable to sign, Legal guardian, Representative Payee, Relative, Representative of institution providing care or Assisting Governmental Agency) _____

☐ Please mail statement to Responsible Party – (Name) STEVE BROGDON (Address)_____

(Town)_____ (State)_____ (Zip Code)_____

PharmcareUSA

Patient's Bill of Rights and Responsibilities

As a patient, you have the responsibility to:

- Give accurate and complete health information.
- Provide a safe environment for your healthcare providers
- Inform your Pharmacy Provider of when you will not be able to keep a scheduled health care visit.
- Participate in the development and update of, your plan of care.
- Adhere to your developed/updated plan of care.
- Request further information concerning anything you do not understand.
- Give information, regarding concerns or problems to Pharmacy Provider staff member.
- Agree to notify your provider of any hospitalization or change in customer insurance, address, telephone number, and physician or when the need for rental equipment is no longer needed.
- Protect rental equipment and pumps as to prevent damage or loss.
- Care for rental equipment and pumps according to the manufacturers recommendations.
- Return rental equipment and pumps including all accessories at time of discharge and/or when it is no longer in use.

Patient will or has the right to:

- Be informed of the services offered to you by your pharmacy provider.
- Be fully informed in advance of all of your rights and responsibilities for receiving services in the alternative care setting.
- Receive a timely response from your pharmacy regarding your request for services in the alternative care setting.
- Be admitted for service only if your Pharmacy provider has the ability to provide safe, appropriate and professional care at the level of intensity neede relating to physician orders.
- Be given information on your pharmacy provider's policies and procedures as well as charges for services, including your coverage or non-coverage o services, prior to care.
- Receive orally or in writing upon request and in advance of receiving care or services, an approximate maximum dollar amount, of any care an services for which the patient will be responsible as well as payment expected from third parties.
- Request and receive an itemization of charges for services rendered, regardless of the source of that payment.
- Be advised of any changes in charges within 30 business days after the provider becomes aware of a change.
- Be fully informed of any financial benefits when referred to an organization.
- Choose your alternative care setting provider and be able to communicate with the provider.
- Change your provider after services have begun within limits of your health insurance, medical assistance or other health regimens or requirements.
- A coordinated transfer of services when there will be a change.
- Properly trained personnel to perform assigned tasks, with proof upon request of education/training qualifications of the staff providing your care.
- Be given appropriate and professional quality health care services without discrimination against your race, national origin, religion, sex, sexua preference, disability, age, diagnosis or disease state.
- Care that is considerate of your personal cultural and ethnic preferences.
- Be advised in advance of the discipline and frequency of services; be involved in the development of a plan of care that will meet your unique healtl needs. Receive appropriate instruction and education regarding the plan. With regular assessments and update of such plan.
- Be given coordinated care.
- Be free from chemical and physical restraints except as authorized in writing by a physician.
- Participate in discussions on ethical issues concerning your care, and be involved in decisions to withhold resuscitation, and or forgo / withdraw lif sustaining care.
- Be informed of the name of the person supervising the care, and how to contact that person
- Privacy and confidentiality of all records, communications, and personal information as stated in the ***Notice of Privacy Practices***.
- The receipt of a privacy notice.
- Review all of your health records upon request, unless otherwise indicated by physician or state law. If allowed by state law, you have the right to cop your records upon request and at reasonable cost.
- Be informed in a reasonable time, of anticipated termination of service or plans for transfer to another provider.
- Refuse all or part of your care and to be informed of the expected outcome of such action.
- Be referred elsewhere if denied services based solely on your inability to pay.
- Receive a written explanation if denied service for any reason and, be given information regarding needed community resources upon request.
- Access a directory of other licensed agencies or providers of service.
- Voice a grievance/complaint regarding treatment or care, that was (or failed to be) furnished, or regarding the lack of respect for property by anyon who is furnishing services on behalf of your pharmacy provider and in doing so will not be subjected to discrimination or reprisal.
- Voice a complaint with, and/or suggest a change in health care services and/or staff without being threatened, restrained, or discriminated against.
- Outcome and follow-up action by your pharmacy provider will communicated verbally to patient/caregiver within 72 hours or the third business da after a holiday or weekend day from initial complaint.
- ***Any complaints may be addressed to:***
  PharmcareUSA Attn: Corporate Compliance Officer
  Box 70 Hydro, OK 73048
  Phone: 866-403-2003
- With the expectation that the complaint will be handled confidentially or you may voice any complaint to: State Board of Pharmacy o the State you are residing in.

PharmcareUSA

Approved OMB #0938-0975

Medicare Prescription Drug Coverage and Your Rights

You have the right to get a written explanation from your Medicare drug plan if:

- Your doctor or pharmacists tells you that your Medicare drug plan will not cover a prescription drug in the amount or form prescribed by your doctor.
- You are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription drug.

The Medicare drug plan's written explanation will give you the specific reasons why the prescription drug is not covered and will explain how to request an appeal if you disagree with the drug plan's decision.

You also have the right to ask your Medicare drug plan for an exception if:

- You believe you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary," or
- You believe you should get a drug you need at a lower cost-sharing amount.

What you need to do:

- Contact your Medicare drug plan to ask for a written explanation about why a prescription is not covered or to ask for an exception if you believe you need a drug that is not on your drug plan's formulary or believe you should get a drug you need at a lower cost-sharing amount.
- Refer to the benefits booklet you received from your Medicare drug plan or call 1-800-MEDICARE to find out how to contact your drug plan.
- When you contact your Medicare drug plan, be ready to tell them:
    1. The prescription drug(s) that you believe you need.
    2. The name of the pharmacy or physician who told you that the prescription drug(s) is not covered.
    3. The date you were told that the prescription drug(s) is not covered.

Mission Statement

Long Term Care Pharmacy Services

The mission of PharmcareUSA Pharmacies is to provide comprehensive pharmacy services to assisted living facilities, skilled nursing facilities and other institutional healthcare facilities, and to deliver the most appropriate and cost effective pharmaceutical care.

By maintaining a professional staff experienced in the specialized needs of the long term care population, PharmcareUSA strives to reduce the costs associated with long term healthcare while improving the quality of care provided to the residents of its customer facilities.

PharmcareUSA

HIPAA NOTICE OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice. The terms "information" or "health information" in this notice include any information We maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide a revised notice by direct mail to you reflecting that change within 60 days of the change and we will otherwise post the revised notice on our website ***www.pharmcareusa.com.*** We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

For purposes of this Notice of Privacy Practices, "We" or "Us" refer to any pharmacy or other service that is affiliated with PharmcareUSA.

HOW WE USE OR DISCLOSE INFORMATION

We must use and disclose your health information to provide that information:

- ✓ To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- ✓ To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.
- ✓ We are prohibited by law to "sell" your protected health information.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- ✓ **For Payment** of copays or other payments due us, to determine your coverage, and to process claims for pharmacy services you receive, we may tell your Physician if a prescribed medication is not covered by your insurance.
- ✓ **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your *Physicians* or hospitals to help them provide medical care to you.
- ✓ **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your medication therapy. For example, we might talk to your *Physician* to suggest a medication therapy that could help improve your health or we may analyze data to determine how we can improve our services.
- ✓ **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law as of February 17, 2010.
- ✓ **For Plan Sponsors.** If your coverage is through an employer sponsored group health *Plan*, We may share summary health information and enrollment and disenrollment information with the *Plan* sponsor. In addition, we may share other health information with the *Plan* sponsor for *Plan* administration if the *Plan* sponsor agrees to special restrictions on its use and disclosure of the information in accordance with Federal law.

We may use or disclose your health information for the following purposes under limited circumstances:

- ✓ **As Required by Law.** We may disclose information when required to do so by law.
- ✓ **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an *Emergency*, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, We will use our best judgment to decide if the disclosure is in your best interests.
- ✓ **For Public Health Activities** such as reporting or preventing disease outbreaks.
- ✓ **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- ✓ **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- ✓ **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.

- ✓ **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- ✓ **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an *Emergency* or natural disaster.
- ✓ **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- ✓ **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- ✓ **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- ✓ **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- ✓ **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- ✓ **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- ✓ **To Business Associates** that perform functions on Our behalf or provide Us with services if the information is necessary for such functions or services. Our business associates are required, under contract with Us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in Our contract. As of February 17, 2010, Our business associates also will be directly subject to Federal privacy laws.
- ✓ **For Data Breach Notification Purposes.** We may use your contact information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your *Plan* through which you receive coverage. Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on the back of your ID card.

WHAT ARE YOUR RIGHTS

The following are your rights with respect to your health information:

- ✓ **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on *Dependent* access that authorize your dependents to request certain restrictions. **Please note that while We will try to honor your request and will permit requests consistent with Our policies, We are not required to agree to any restriction.**
- ✓ **You have the right to request** that a provider not send health information to us in certain circumstances if the health information concerns a health care item or service for which you have paid the provider out of pocket in full.
- ✓ **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal requests to receive confidential communications, but requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- ✓ •**You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, you have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
- ✓ •**You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested *Amendment*. Mail

your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

- ✓ **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which Federal law does not require us to provide an accounting.
- ✓ **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may also obtain a copy of this notice at Our website, www.pharmcareusa.com

EXERCISING YOUR RIGHTS

- ✓ **Contacting your Pharmacy Provider.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number located on your prescription or call PharmcareUSA Corporate Offices at 1-866-403-2003
- ✓ **Submitting a Written Request.** Mail to us your written requests for modifying or cancelling a confidential communication, for copies of your records, or for *Amendments* to your record, at the following address:

PharmcareUSA
PO BOX 70
Hydro, OK 73048

- ✓ **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with Us at the address listed above. Attn: Corporate Compliance Officer.
- ✓ **You may also notify the *Secretary of the U.S. Department of Health and Human***

PROTOCOL FOR RESOLVING COMPLAINTS FROM MEDICARE BENEFICIARIES

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of service. Service, equipment and billing complaints will be communicated to management, upper management and corporate compliance. These complaints will be documented in the Medicare Beneficiaries Complaint Log, and completed forms will include the patients name, address, telephone number, and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of the actions taken to resolve the complaint.

All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company.

The patient will be informed of this complaint resolution protocol at the time of set-up of service.

PharmcareUSA

Patient / Resident Complaint Form

Date of Complaint: __/__/____ **Recipient of Complaint:** _____

Beneficiary/Patient Name: _____

Beneficiary / Patient Address:
_____
_____
_____

Beneficiary / Patient Phone #: _____
Beneficiary / Patient Medicare ID #: _____
DMEPOS Involved: _____

Name of Nursing Facility beneficiary/resident resides in:

Beneficiary/ Patient Complaint: _____

Investigation Warranted: ____Yes ____No, explain **Name of Decision Maker:** _____

Reason for No Investigation: _____

Summary of Investigation and Resolution (Action Taken): _____

Date Complaint Closed: __/__/____ **Complaint Logged:** _____Yes

Reviewed by DMEPOS Coordinator / Corporate Compliance Officer or Pharmacy Manager:
Signature:

PHARMACY USE ONLY:

Once the beneficiary has filed a complaint, CMS Quality Standards dictate that the DMEPOS Coordinator must notify the Beneficiary within five days (A) if an investigation is being conducted When and investigation is warranted, CMS Quality Standards dictate that within 14 days, the DMEPOS Coordinator must have conducted an investigation and provided results to the Beneficiary. All documentation regardng a complaint (including Beneficiary correspondence) shall be maintained in the Pharmacy with the corresponding complaint form and made available upon request, to CMS. For detailed procedure see Section 4: Consumer Services - DMEPOS Medicare Beneficiary Complaints

Medicare Part D Assistance Request

Basic Information to provide Assistance:

Residents Name: _____
Do you have Original Medicare or HMO, PPO, etc? _____
Do you get help from State Medicaid, SSI or have applied for Soc Sec Extra Help? _____

Please select one of the following:

- _____ *I need assistance choosing another Medicare Part D plan that would better benefit my prescription drug needs.*
- _____ *I am unable to complete a Medicare Part D plan enrollment on my own and would like for Pharmcare staff to do so on my behalf. (Requires disclosure data.)*
- _____ *I am unable to switch to another Medicare Part D plan that would better benefit my prescription drugs needs on my own and would like for Pharmcare staff to do the enrollment to switch on my behalf. (Requires disclosure data.)*

Disclosure Data:
Full disclosure data is required by Medicare for completing enrollment on behalf of the resident:

All information provided must match what is on record at Medicare. Please use the red/white/blue Medicare card to complete:

Full Name of Beneficiary: _____ Medicare Claim #: _____

Pt's Full Address : _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Parts of Medicare Coverage entitled to: Part A _____ Effective Date: _____
Part B _____ Effective Date: _____

Authorization for the above request:
I authorize Pharmcare to release medical or other information about me to the Centers for Medicare and Medicaid Services and/or private Part D insurance plans to determine the best plan for me and to also complete an enrollment on my behalf if checked above.

Beneficiaries signature: _____ Date: _____

Complete below only if patient is unable to sign:

Representatives Signature: _____ Date: _____ Printed Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Reason beneficiary cannot sign: _____

Advance Notification of Representative Payment

Name of Wage Earner, Self-Employed Person or SSI Claimant	Social Security Number – –
Name of Beneficiary (if other than above)	Relationship to Wage Earner, Self-Employed Person or SSI Claimant

I understand and agree with the following.

Need for Representative Payee

The Social Security Administration (SSA) has decided that I need someone to manage my benefits. Because of this, SSA will send my benefits to a representative payee. It is the duty of the representative payee to use my benefits for my best interests.

Choice of Representative Payee

SSA has selected _____ to be my representative payee.

My Right to Appeal

I understand that I have the right to appeal SSA's decision. I can appeal the choice of who will be the representative payee. In most cases, I can also appeal the decision that I need a payee. If I appeal, I will have the right to review the evidence in file and submit new evidence. I understand that I can have a friend, lawyer or someone else to help me.

I understand that I must file an appeal within 60 days. If I file after the 60 day period, I must have a good reason for not having filed this appeal on time. I have to ask for the appeal in writing. I will contact an SSA office if I wish to appeal.

Signature

06/27/23

Date

Witnesses are required only if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

AUTHORIZATIONS, ACKNOWLEDGEMENTS, AND CONSENTS

A. HEALTH CARE MEDICAL CONSENT

_____The Resident and/or Additional Party(s), knowing that the Resident's condition requires health care, diagnosis and medical treatment, does hereby voluntarily agree to such diagnostic procedures and health care services, to such medical and nursing treatment, which may be administered to or performed on the resident under the general or specific instructions of his/her attending physician, or assistants or designees of the attending physician, unless or until otherwise specifically advised by the Resident, his/her attorney-in-fact, guardian, or proxy decision-maker as set forth in the Admission Agreement.

B. AUTHORIZATION FOR EMERGENCY TREATMENT

_____If, in the opinion of the nurse in charge at the time, emergency medical treatment is necessary for the health, safety or general welfare of the Resident, and the Resident is unable to give written or verbal consent to treatment because of his/her condition, the Center is hereby authorized to provide such emergency treatment and care as may be required in the best judgement of the nurse in charge, consistent with existing doctor's orders and Resident's advance directives. Further, the Resident hereby consents to the Center's obtaining the services of a physician other than the Resident's personal physician in the event same is unavailable for an emergency involving the Resident.

C. CONSENT TO USE OR DISCLOSE INFORMATION

_____Protected health information may be used or disclosed by the Center to carry out treatment, payment, or health care operations. The Center's Notice of Privacy Practices contains additional information about the uses and disclosures of protected health information. The resident has the right to review the notice prior to signing this consent. The Resident has the right to request restrictions on uses and disclosures of protected health information. However, the Center does not have to agree to the request. The Resident has the right to revoke the consent in writing, except to the extent that the Center has taken action and reliance on the consent. The Resident consents to the center and any other holder of medical or other information about Resident to disclose all, or any part of, the Resident's medical record to any person, entity, or agency which is, or may be, liable under a contract with the Center or with the Resident for payment of all or part of the Center charges for services or for furnishing a portion of the Resident's care or Resident's services. Further, the Resident consents to the use or disclosure by this Center of such information as is needed for treatment or health care operations, or for the continuity of patient care to any health care facility or provider (physician, hospital, nursing facility, clinic, doctor's office, etc.) to which Resident is transferred.

D. PHYSICIAN DESIGNATION

_____The Resident or Additional Party hereby designates Dr. DR. JAMES KRABLIN as the Resident's attending physician. Should the Resident's attending physician be unavailable, and if medical attention is deemed necessary by the Center, the Center is authorized to arrange for the services of any other physician. The Resident and/or Additional Party (s), as applicable, hereby agree to pay the reasonable charges of such physician.

E. PHARMACEUTICAL SERVICE

_____ The Center is serviced by PHARMCARE OKC, a duly licensed pharmacy conducting business in compliance with applicable governing regulations, and making deliveries twenty-four (24) hours a day to fill physician orders for prescriptions. The Resident may request the use of another pharmacy for filling prescriptions ordered by the physician. The pharmacy selected by the Center may be used for filling prescriptions in the event of an emergency, or if medication is not delivered to the Center by the family, Additional Party or designated pharmacy within twenty-four (24) hours.

BEAUTY AND BARBER SERVICES

_____Shampoos, shaves, and routine nail care are provided by the Center and are included as part of the daily rate. In addition, the Center can arrange for a professional barber or beautician to provide services to the Resident at the Resident's expense. Resident agrees to pay for the services of professional barbers or beauticians whenever such services are requested and provided.

AUTHORIZATION TO HAVE MAIL OPENED

_____The Resident has the right to send and promptly receive mail unopened. If the Resident wishes his/her incoming mail to be opened and (if needed) read to the Resident by Center staff, the Center will do so. Resident has the right to revoke this authorization at any time upon notice to the Center.

H AVAILABLE SERVICES AND CHARGES

_____ The Resident or Additional acknowledges receipt of information regarding the items and services included in the basic rate as well as information on items and services not included in the basic rate and the charges therefor.

PERSONAL PROPERTY

_The Resident and/or Additional Party (s) will provide a written inventory of the Resident's personal belongings for the Center's records. Liability for the security of personal items retained by the Resident or in the Resident's room will not be assumed by the Center. At the time of transfer or discharge, the Center will assume accountability only for the Resident's personal property items left in the Center's control. The Administrator must be notified by the Resident or an Additional Party of items to be secured. All personal property must be removed within 72 hours of discharge unless special arrangements have been made with administration. Property that remains unclaimed for longer than 30 days after transfer or discharge may be disposed of by the Center.

ACKNOWLEDGEMENT AND ACCEPTANCE OF RISKS

_____Resident acknowledges that no statement in Center brochures or representations made by any representative or employee of the Center is a guarantee of the Resident's health or safety, or of particular results concerning the Resident's care. Resident further acknowledges that no representations have been made that the services to be provided by the Center are of a particular standard, quality, or grade. Resident acknowledges that it has not relied upon any representations of Center employees or representatives or on any written materials, including brochures produced by or for the Center, in deciding to seek admission to the Center.

AUTHORIZATION FOR PHOTOGRAPHY, VIDEO RECORDING AND/OR AUDIO RECORDING

_____The Resident or legal representative authorizes the Center to use imaging/ electronic recording techniques such as photography, videotaping and/or audio recording as needed for treatment and/or healthcare operations, and as noted in the Notice of Privacy Practices, at any time during the Resident's stay at the Center. The Center understands that the Resident has a right to privacy and these images/records cannot be used for any other purposes and cannot be disclosed without a completed and signed authorization.

PHOTO RELEASE FOR FACILITY

_____Resident grants permission to the Facility, its representatives and employees to photograph and video Resident and Resident's property in connection with the above-identified subject. I authorize IHS Management, its assigns and transferees to copyright, use, and publish the same in print and/or electronically. I agree that IHS Management may use such photographs of me with or without my name and for any lawful purpose, including for such purposes as publicity, illustrations, and web content.

INCONTINENCE SUPPLIES

_____Adult incontinence care briefs are the responsibility of Resident and/or Resident's Responsible Party. These materials are not provided by the Facility.

OUTSIDE APPOINTMENTS

_____All outside medical appointments (specialists, treatments, follow-up visits, etc) must be made through the Facility. The Facility will not be responsible for transportation or monetary reimbursements to service providers for any outside appointments not arranged by the Facility.

POLICIES PROVIDED PER STATE AND FEDERAL REGULATIONS

1. **Statement of Resident Rights under federal and state law**
2. **Statement of Center Rules and Regulations**
3. **Information concerning Resident's attending physician**
4. **Center Bed Hold Policy**
5. **Information about application for and use of Medicaid and Medicare benefits**
6. **Notice of Privacy Practices**
7. **Description of the manner of protecting Resident's personal funds**
8. **Personal Needs Trust Account Agreement, if desired**
9. **Information regarding Advance Directives, both orally and in writing.**
10. **Abuse Policy**
11. **Abuse by Another Resident Policy**
12. **Center Smoking Policy**
13. **Provision of Eyeglasses and hearing Aids**
14. **Lost or Stolen Items**
15. **Personal Property**
16. **Destruction of Medications**
17. **Refunds**
18. **Waiver of Admission Contract**
19. **Long Term Care Complaint Procedure**
20. **Resident Responsibilities**
21. **Resident Rights**
22. **Non-Discrimination Policy**
23. **Hospice Policy and Disclosure of Ownership**
24. **List of Available Hospice Services**

I hereby acknowledge receipt of the above documents.

	06/27/23
(Signature)	**(Date)**

RESIDENT RIGHTS

As resident of this facility, each resident has the right to a dignified existence and to communicate with individuals and representatives of their choice. The facility will protect and promote their rights as designated below.

Each resident in the facility has the right to:

1. Exercise their civil and religious liberties and be encouraged to do so.
2. Be informed of all their rights, privileges, and the rules and regulations of the facility (firearms and weapons are not permissible).
3. Be informed of the facility and State's bed hold policy for a hospitalization.
4. Be informed of all services available and all costs, including those charges covered or not covered under Medicare, Medicaid, VA, and the basic diem rate.
5. Be informed of their health status, including diagnosis and prognosis, significant changes, and planned treatment.
6. Participate in or refuse to participate in any treatment.
7. Issue advance directives (durable power of attorney and living will) which will be properly executed.
8. Receive a prompt response to all responsible requests and inquiries.
9. Be transferred or discharged only after a 30-day written notice for medical reasons, the welfare of themselves or others, and/or for non-payment.
10. Be encouraged to exercise their rights as a resident and citizen, complain and suggest without any fear or coercion or retaliation.
11. Receive adequate and appropriate health care, medical treatment, and protective support services.
12. Be treated at all times courteously, fairly, and with the fullest measure of dignity.
13. Manage their personal affairs, if possible or if delegated, to receive an accounting every three months.
14. Be free of verbal, psychological, physical, and sexual abuse at all times.
15. Refuse to serve as a medical research subject.
16. Have their personal and medical records treated as confidential.
17. Be treated with consideration and respect for their personal privacy.
18. Refuse to perform work.
19. Receive unopened private mail.
20. Take part in various activities of the nursing facility unless medically contraindicated.
21. Have their own clothing and possessions as space allows.
22. Use tobacco in accordance with applicable policies, rules, and laws.
23. Consume alcoholic beverages only under the order of a physician.
24. Have privacy for visits with their spouse or significant other. Spouses or significant others that are residents in the same facility are permitted to share a room unless one of their physicians documents in the medical record reasons why such an arrangement would have an adverse effect on the health status of the resident.
25. Have their choice of pharmacy, hospice and physician. See Hospice Policy and disclosure of ownership and a list of available hospices under contract with this facility.
26. Withhold payment for physician visitation and any other services not rendered or ordered.
27. Have ample opportunity, at reasonable hours, to visit with family, friends and clergy in private.

28. Retire and rise in accordance with reasonable requests.
29. Be free of physical and chemical restraints unless medically prescribed.
30. Review and/or have photocopies of their records made by the facility and name those individuals to whom records may be given.
31. Have access and privacy to a telephone.
32. Have all facility services wheelchair accessible in accordance with ANSI regulations.
33. Have a copy made available to the resident and/or guardian of these rights, responsibilities, and the facility rules at the time of admission.
34. When a physician indicates it is appropriate, the facility shall immediately notify the resident's next of kin or representative of the resident's death or when the resident's death is imminent.
35. Every resident shall have the right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the State Department of Health with respect to the facility and any plan of correction in effect.
36. Right to participate, see and be informed of changes to their 48-hour baseline care plan.
37. Right to participate, see, sign and be informed of changes to their comprehensive care plan.
38. Right to participate, see and be informed of changes their discharge plan.
39. Right to be informed in advance of the care to be furnished and type of care giver or professional that will furnish care.
40. Right to receive written notice before any change in room or roommate.
41. Their right to refuse and appeal a transfer or discharge decision as well as room change.

_____ 06/27/23 _____

Resident Signature or Legal Representative Date

RESIDENT RESPONSIBILITIES

Resident responsibilities refer to the rules and regulations governing individual residents in their dealings with The Center, staff, and other residents. They are not intended to limit the rights of Residents, but merely to provide the Resident with information concerning his/her responsibilities to the Facility. Questions should be referred to the Administrator, Director of Nursing Services, or to the Social Services Department.

ADMINISTRATION

1. A Resident may not be admitted without a legal guardian and/or representative to act on the Resident's behalf should it become necessary.
2. All necessary paperwork must be completed by the admitting physician at the time of admission or via telephone and signed within five (5) working days.
3. Residents are expected to be considerate toward other residents, staff members and visitors. Verbal and physical abuse from Residents will not be tolerated, and will be the cause for discharge from The Center.
4. Residents are not expected to pay employees or to give them gifts to perform routine or special services. However, small acts of kindness such as cookies, cakes, or candy are permitted and may be accepted by the staff.
5. Long distance calls will be at the expense of the Resident. Private lines may be installed in the Resident's personal room. All expenses for the installation and use of a private phone must be paid by the Resident, representative, or guardian. Cell phones are allowed, and they are the responsibility of the Resident.
6. Residents are encouraged to maintain only a minimum amount of money in their possession. Questions concerning personal funds should be referred to the Administrator or Social Services staff.
7. All valuables should be taken home by the legal guardian or representative. Such valuables may be retained by the Resident. However, The Center cannot be responsible for such items.
8. Residents are expected to maintain good relations with their roommates. Problems that arise should be discussed with the Director of Nursing or Social Services staff. Residents occupying semi-private rooms are expected to share their rooms equally with their roommates.
9. Religious, social and activity programs are conducted in the Facility. Residents are encouraged to attend all programs. Bedside programs are provided for those Residents who are not able to come to the Activity Area. Family and friends are encouraged to participate in our scheduled activities.
10. Residents may not leave the premises without signing out at the nurse's station. Employees will not be permitted to sign residents out unless authorized in writing from the representative or Administrator.
11. Smoking is permitted in designated areas only. Smoking regulations are posted throughout The Center. Smoking regulations must be followed at all times. Some smoking restrictions may apply to certain Residents. Please check with the nursing staff.
12. Residents are expected to be observant of the rights of others.
13. Televisions and radios, including those in the Residents' rooms, should not be played loudly or past 9 pm unless otherwise agreed upon by both Residents in a semi-private room.
14. Room lights must be turned off at bedtime so as not to disturb other Residents. Night-lights may be left on at all times for the safety of the Residents.
15. Residents or visitors should not talk loudly or disturb other Residents.
16. Personal wheelchairs, walkers, canes, and other special equipment for the private use of the Resident is the responsibility of the Resident or representative.
17. Residents are prohibited from keeping any weapons designed to do bodily harm (i.e. guns, knives, razor blades, sticks (other than canes, scissors, etc.)
18. Residents may not leave the Facility for overnight visits unless approved by the Resident's attending physician, and such overnight visits must be in accordance with current Medicare/Medicaid regulations.
19. When fire or other drills are conducted, Residents and visitors are expected to follow the instructions issued by the person in charge.
20. It is the responsibility of the Resident's representative to notify the Administrator if the Resident's bed is to be held should the Resident transfers out for a hospital stay.

(Signature)

06/27/23

(Date)

SMOKING POLICY

PURPOSE: *To provide maximum safety to all residents at all times. It is the intent of this Center to provide an environment that allows those residents who wish to smoke the opportunity to do so in a safe environment with optimal safety to themselves, other residents, volunteers, visitors, and staff members.*

POLICY: This policy applies to ALL employees and residents.

SMOKING INSIDE THE CENTER IS STRICTLY PROHIBITED. SMOKING IN BED IS STRICKLY PROHIBITED.

"No Smoking" signs will be posted in all areas where oxygen is in use. Smoking will be allowed in smoking areas ONLY.

1. The nursing staff will conduct an evaluation upon admission to establish frequency and guidelines for each resident who wishes to smoke.
2. There is a designated smoking area.
3. Smoking by employees will be permitted only during breaks, including meal breaks.
4. The smoking area will be kept clean and uncluttered at all times. Ashtrays will be cleaned daily.
5. A large communal receptacle will be provided for used tobacco products. The receptacle will be used by all those who use the smoking area.
6. Employees using any other area, either inside the building or in an area other than the designated area, will be warned/counseled once verbally, once in writing, and then may be dismissed from their positions for infractions.
7. Visitors and family members will be reminded by staff and asked to go to the designated smoking areas when any non-adherence to this policy is observed.
8. The smoking policy will be explained to all employees when hired.
9. The smoking policy for residents will be explained to residents and family members upon admission.
10. Areas designated for smoking will be wheelchair accessible.
11. Any restrictions will be noted in the resident's record.
12. Smoking privileges will be addressed in the Care Plan.
13. Residents must be accompanied by staff, family, or properly trained volunteers while smoking unless assessed as able to smoke independently.
14. Smoking materials will be kept in a designated area accessible only by staff.
15. Residents assessed as likely to drop ashes on their clothing or self will wear a smoking apron provided by the Center.
16. Smoking near hazardous or flammable materials is STRICTLY PROHIBITED.
17. Smoking near or with oxygen equipment is STRICTLY PROHIBITED.
18. Smoking materials will be completely extinguished before exiting the designated smoking area.
19. Staff members are STRICTLY PROHIBITED from furnishing personal smoking materials to residents; residents electing to smoke must provide their own smoking materials.
20. Vapor and E-cigarettes may be used inside the facility by RESIDENTS ONLY. Employees must smoke outside.

Signature

06/27/23

Date

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient/Resident Name: _____ _____ _____ **D.O.B.** _____

Legal Representative Name: STEVE _____ _____ BROGDON _____

Company Name: _____

I. *I, the Patient/Resident or legal representative of the Patient/Resident named above, authorize: the use or disclosure by Company of the health information checked below:*

☐ Problem list/Diagnosis list

☐ Most recent discharge summary/transfer record

☐ Entire clinical record
(*Excluding Items in Section II)

☐ Comprehensive care plan

☐ Medication list

☐ Other: specifically identify:
_____
_____
_____

☐ Physician orders

☐ Most recent History/physical

For the purpose of: _____

To: _____
Name *Address* *City* *State* *Zip*

I understand this release is valid through the expiration date(s) stated below or, if left blank, until six months from the Date of Signature. I have the right to revoke this authorization in writing at any time. If I revoke this authorization, I must present my written revocation to Company's Privacy Officer or Designee. Such revocation will not apply to information that has already been released in response to this authorization, or to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand the Company may not restrict my access to health care treatment due to my authorizing or not authorizing the use or disclosure of the information identified above unless specified here.

_____ 06/27/23
Signature of Resident or Authorized Representative Date

II. *I further authorize the individual(s) or organization(s) listed above to release information pertaining to records privileged by federal law, as checked here:*

☐ Sexually transmitted diseases, HIV infection, active Tuberculosis, or infectious leprosy

☐ Behavioral or mental health services (not including psychotherapy notes)

☐ Treatment for substance abuse

_____ 06/27/23
Signature of Resident or Authorized Representative Date

Expiration Date: _____ Witness (if applicable) _____

Name: _____ _____ _____ **Record #** _____

ADMISSION AGREEMENT

This Agreement is entered into on this date of 06/27/23*, by and between* _____

(hereinafter referred to as "The Center") and _____ ___ _____,

(hereinafter referred to as "Resident") and such Additional Parties as may appear on the signatory page as Guardian, Conservator, Financial Representative, Guarantor, or Responsible Party for the obligations created hereunder on behalf of the Resident.

I. OBLIGATIONS OF THE CENTER

A. The Center agrees to:

1. Provide the Resident with nursing care and treatment, room and board (including therapeutic diets), laundry services, bedding and such personal care services in a manner and setting appropriate to the needs of the Resident from the date of admission to the date of discharge.

2. Arrange for the services of a licensed physician of the Resident's choice and other health care services whenever necessary, or the services of another licensed physician or a personal physician if one has not been designated or is not available, as well as administer such medications and treatments as the physician may order.

3. Arrange for transfer of the Resident to the hospital of the Resident's choice, or an alternate when one is not designated, when ordered by the attending physician, and notify the Responsible Party or other designated party of such transfer, in advance, except in case of emergency.

B. The Center:

1. Will not manage the Resident's finances, except personal needs funds and other trust funds for those residents who are unable or do not desire to manage those funds themselves.

2. Will exercise reasonable diligence in preserving the confidentiality of the Resident's medical record in accordance with applicable law. The medical record itself is the property of The Center.

3. May select and assign to the Resident such accommodations as it may determine to be compatible with the Resident's condition and/or that of other residents, subject to a Resident's right to share a room with his or her spouse. This Agreement creates only a license to reside at The Center and shall not create a tenancy.

II. OBLIGATIONS OF THE RESIDENT AND/OR ADDITIONAL PARTIES

A. In consideration for the foregoing, the Resident and/or Additional Parties to this agreement agree to:

1. Pay all costs, charges and expenses of The Center of every kind and description as hereinafter provided.

2. Deliver to The Center a current medical and physical history of the Resident and make arrangements with the attending physician to complete the same within forty-eight (48) hours of admission or as otherwise required by state law.

3. Provide such personal clothing and effects as needed or desired by the Resident, subject to space available. The Resident agrees to take reasonable precautions to safekeep this property by indelibly marking personal belongings at or before the time of admission and using nametags on all clothing. The

Resident shall be responsible for providing any desired insurance protection covering loss of property. All foodstuffs, medications, and personal effects brought with any resident at admission or subsequent thereto, must be brought to the nurses' station and checked with the charge nurse before delivery to the Resident.

4. Provide such spending money as needed by the Resident for personal items. It is recommended that the Resident limit cash on hand to $5.00 - $10.00 at all times.

5. Be responsible for hospital charges and transportation, if hospitalization of the resident becomes necessary, and for making transportation arrangements for the Resident to and from doctor's office visits or other specialized treatment facilities.

6. Be responsible for the physician's fees, medications and other treatments, therapies, series, equipment or any item/services which are ordered by the attending physician and are not included in the per diem rate.

7. Arrange for the services of an attending physician and a designated alternate to be contacted in the event the attending physician is unavailable. The arrangements will include a commitment to see the Resident either by visitation in this Center or through office visits on a schedule which conforms to government regulations.

8. Accept that either the Resident or one authorized person make decisions concerning the admission, care not involving medical treatment, or discharge of this Resident. However, Resident shall make his/her own medical treatment decisions unless Resident lacks decisional capacity, in which event his/her attorney-in-fact, guardian, or a proxy decision-maker selected in accordance with applicable state laws shall make medical treatment decisions.

9. Refrain from bringing in items not allowed by Center rules and regulations.

10. Comply with all reasonable rules promulgated by The Center for the health, safety, and well-being of the residents of The Center. The Center's rules, policies, and procedures shall not be construed as contractual obligations of The Center, and are subject to change.

B. Discharge:

1. In the event the Resident is discharged from The Center other than to another health care center, The Center shall discharge the Resident to the care of any authorized representative (guardian or attorney-in-fact), Responsible Party, or entity, at the Resident's expense. The Center may transport the Resident via taxi, ambulance, or other means of transportation to the Resident's home or designated residence and the attorney-in-fact, Responsible Party, or Guardian agrees to accept personal responsibility for the Resident upon the Resident's discharge.

2. In the case of a voluntary, non-emergency transfer, Resident and/or authorized person described in paragraph A.8 of this section agree to give The Center thirty (30) days written notice of such intent whenever possible. Private pay residents and/or guarantors will be responsible for all charges up to and including the day of discharge and/or through such day that all personal belongings of the Resident have been removed from The Center.

III. PAYMENT PROVISIONS

A. Basic Rate:

1. The basic rate for private pay residents is set by The Center; for Medicare residents, it is established by a formula under the Federal Medicare Program; and for Medicaid residents, it is established by a reimbursement formula under the state Medicaid program. On or before the first day of each month, the Resident and/or Additional Parties, as applicable, agree to pay The Center, in advance, the basic rate for private pay residents, the "patient liability" as described in paragraph III.C.3 herein for Medicaid

residents; or the co-insurance payment as described in paragraph III.C.6 herein for Medicare residents for room, board and basic items and services as specified in Exhibits A-1 and A-2, which are attached hereto and incorporated herein. The first month's charges shall be prorated based upon the number of days remaining in the month. The Center is not obligated to bill an insurance company directly for third-party insurance.

2. The basic rate referred to above as the private pay rate may be changed upon thirty (30) days written notice to the Resident or as otherwise required by state law. In the event the Resident later qualifies for receipt of Medicaid benefits on a retroactive basis, private pay resident payments in excess of the Medicaid patient payment will be refunded to the Resident within 30 days of the date of notification of Medicaid approval.

3. Private pay residents shall be charged for the day of admission and the day of discharge.

4. Resident agrees to assign to The Center any insurance or other third-party benefits available for health care services provided. Resident authorizes The Center to submit claims to insurance companies, and to make refunds to insurance companies, on Resident's behalf. The Center has the right to accept or decline assignment of such benefits. If for any reason such benefits are not assigned to The Center, the Resident agrees to forfeit to Center all insurance and other third-party payments for health care services immediately upon receipt thereof.

B. Additional Charges:

1. The Resident understands that there may be additional charges for items or services not included in the basic rate. All such charges will be billed at the end of the month and shall be due and payable with the basic rate charges for the following month. A list of additional items and services which are available to residents and the current charges for same which are not covered by the private pay rate (and may not be covered by Medicare or Medicaid) has been provided to the Resident and/or Additional Party.

2. Costs resulting from any willful destruction of Center property will be charged to the Resident by separate billing.

3. Room reservation charges: The charge to hold a bed for a hospitalized or otherwise absent private-pay resident will be the same as the basic room rate. Medicaid residents on medical leave or who have exceeded the Medicaid allowance for non-medical leave will be charged a daily bed hold charge in accordance with state and federal law, as described in information provided in the Admission Packet. The Resident and/or Additional Party must request a room reservation in writing and authorize and agree to pay the basic room rate, if applicable, before a bed will be held.

C. Medicaid/Medicare:

1. This Agreement does not pertain to payment of the charges which are reimbursed by Title XVIII (Medicare) or Title XIX (Medicaid) programs.

2. A resident seeking admission who has not yet been determined to be Medicaid eligible should plan a minimum of sixty (60) days from the date of application to the date of approval. Therefore, unless otherwise prohibited by state law, a Medicaid applicant is expected to pay for his/her stay each month, in advance, after the date of application to Medicaid, until the Medicaid application is approved. The Resident and Additional Party (s) agree to complete and furnish all forms and documents as required by the county or entity of application and to make all reasonable efforts to complete the Resident's Medicaid application as soon as possible. The Resident and/or Guarantor, if applicable, will be liable for all charges incurred up to the date of Medicaid approval. Refunds will be made in accordance with paragraph III.A.2 if the Resident is determined to be Medicaid eligible.

3. The Medicaid program determines the available monthly income of all persons receiving Medicaid assistance and requires that out of that income, the Medicaid beneficiary bear a reasonable share of the

cost of services rendered. Medicaid eligible residents must provide monthly payment equal to the Resident's "patient liability" determined by the Medicaid program. This amount shall be paid on the day of admission. It is understood by the Resident and/or Additional Party (s) that if eligibility for participation in the Medicaid program is established, the monthly amount to be paid to The Center as directed by the Medicaid program may be adjusted at any time based on the Resident's financial status. The Resident and/or Additional Party(s) agree that whenever such an adjustment is made, this agreement will then be automatically revised so that the resident is responsible for the adjusted monthly amount due The Center as it becomes effective. The Center may request direct mailing of such income, which will be managed in accordance with applicable state and federal law.

4. If Medicaid is denied, the Resident and/or Additional Party shall pay all past due charges within ten (10) days of denial. Thereafter, the charges and payment provisions of the Agreement applicable to private-pay residents shall be effective.

5. It is understood that if the Resident is applying for, or is now receiving, public assistance from a state or federal agency, initial or continued eligibility for such financial assistance cannot be guaranteed. If the Resident is denied eligibility for nursing center payments by the agency for medical or financial reasons, the Resident and/or Additional Party agree to pay a basic rate equal to the current private pay rate beginning with the date of admission or denial until the date of discharge. The Resident and/or Additional Party further agree that if, following denial, the financial obligation to The Center cannot be met, the Resident will leave The Center, by his/her own arrangement and expense, within a reasonable time from the date the Resident and/or Additional Party is notified of that denial, as provided by law.

6. Medicare coverage is established by federal guidelines and is limited both as to the level of care covered and the duration of coverage. Medicare eligible residents are not required to make an advance payment but must pay the assigned co-insurance amount as it becomes due. The Center shall send a statement of the amount due to the Resident and/or Additional Party and payment of such amount shall be due withing ten (10) days of billing. Charges for regular or non-covered services, I any, and for additional supplies or services shall be due and payable in accordance with the terms of Paragraph III.A.1 and III.B.1 hereof.

7. The Center cannot assure that Medicare will cover the services provided. Therefore, evidence that the Resident is able to pay for services in the absence of Medicare coverage, as either a private pay resident or otherwise, must be provided prior to admission to The Center. If the Resident intends to be discharged from The Center upon termination of Medicare benefits, Resident must notify Center in writing at the time of admission. Once Medicare coverage is terminated, the charges and payment provisions of this Agreement for private-pay or Medicaid residents, as applicable, shall be effective.

8. The Resident certifies that the information given in applying for payment under the Title XVIII or Title XIX of the Social Security Act is tru and correct to the best of his/her knowledge and belief, and hereby authorizes release of any information needed by the administering agencies to determine present and future qualifications for such benefits. The Resident further authorizes the paying agency to pay Medicare or Medicaid benefits for the benefit of the Resident directly to The Center. The Resident or his/her legal representative hereby appoints The Center as Resident's agent for the purpose of challenging Medicare/Medicaid decisions which render the Resident ineligible for such benefits while the Resident resides in The Center. This appointment may be exercised at The Center's discretion.

D. Default:

1. Private-Pay Residents:

   a. If charges are not paid by the tenth (10^{th}) day of the month, the Resident and/or Guarantor shall be deemed in default under the terms of this Agreement and the Resident shall be subject to discharge. The Center does not extend credit for services and does not accept payment terms or installment payments. The Center may impose an interest charge of one percent (1%) per month, twelve percent (12%) per annum (or, if less, the maximum amount permitted by law) on all private-pay accounts

which are more than thirty (30) days overdue. Imposition of such charge shall not be deemed a waiver of the right of The Center to demand payment in full when payments are due. If it becomes necessary for The Center to refer the Resident's account for collection, the Resident and/or Guarantor shall be obligated for payment of the Center's reasonable costs of collection and court costs, including attorneys' fees, unless prohibited by state law.

b. The Resident has the right to manage his/her own financial affairs. However, the Resident also has the right to assign his/her entitlement to monthly income to The Center or to make The Center the payee for income benefits and Social Security benefits. If the Resident's account becomes in default for failure to make payments as provided, The Center, as a condition to the Resident's continued stay in The Center may require the Resident or his/her attorney-in-fact, Conservator, or Guardian to execute such documents as may be required to cause the Resident's income sources, including Social Security benefits, to be paid directly to The Center, unless otherwise prohibited by state law.

2. Medicaid Residents:

Medicaid residents who fail to pay the required "patient liability" by the tenth (10^{th}) day of each month will be deemed in default under the terms of this Agreement and the Resident shall be subject to discharge to the extent permitted by law. In the event of default, the Resident, or his/her attorney-in-fact, Conservator, or Guardian agrees to execute such documents as may be required in order to cause the Resident's income sources, including Social Security benefits, to be paid directly to The Center, unless otherwise prohibited by state law. If it becomes necessary for The Center to refer the Resident's account for collection, the Resident and/or Financial Representative, if any, shall be obligated for payment of The Center's reasonable costs of collection and court costs, including attorney fees, unless prohibited by state law.

3. Medicare Residents:

Medicare residents shall be deemed in default if non-Medicare charges billed are not paid within ten (10) days of billing. Residents who fail to pay for charges not covered by Medicare, other than co-insurance or deductible amounts, shall be subject to discharge. In the event of default, the Resident and/or his/her attorney-in-fact, Conservator, or Guardian agree to execute such documents as may be required in order to cause the Resident's income sources, including Social Security benefits, to be paid directly to The Center, unless otherwise prohibited by state law. If it becomes necessary for The Center to refer the Resident's account for collection, the Resident and Guarantor or Financial Representative, if any, shall be obligated for payment of The Center's reasonable costs of collection and court costs, including attorney fees, unless prohibited by state law.

IV. WAIVERS, RELEASES, DISCLAIMERS

A. Resident's Physician:

The Resident and/or Additional Party(s) understand that the Resident's care in The Center is under the control and direction of the Resident's physician, and that The Center provides only general and special nursing care and does not have the services of a physician available through its staff. The Resident and/or Additional Party(s) hereby release The Center from any and all liability arising from the fact that such physician's care is not provided by The Center.

B. Safety:

The Resident and/or Additional Party(s) understand that The Center will exercise reasonable care for the benefit of the Resident based upon the Resident's physical and mental condition; however, The Center cannot ensure the absolute safety of the Resident and the Resident and/or Additional Party(s) hereby release The Center from any liability for the Resident's health, safety or general welfare except for matters involving negligence of The Center or its employees.

C. Personal Property:

The Center may provide safekeeping services for money and valuables of small size but The Center shall not be liable for loss or damage to any money, jewelry, glasses, dentures, hearing aids, documents or other articles of value. The Center reserves the right to refuse to provide safekeeping services for any item or personal property at any time and shall not be responsible for loss or damage to Resident's laundry.

D. Activities:

The Resident and/or Additional Party(s) hereby acknowledge that certain activities are furnished by The Center for the enjoyment and therapeutic benefit of the Resident. While such activities are designed to be safe and therapeutic, the resident hereby assumes the risks associated with any such participations. The Resident may refuse to participate in any activities.

E. Temporary Leave:

The Resident and/or Additional Party(s) hereby release The Center from liability for the Resident's care during the times the Resident is absent from The Center during temporary leave, either alone or in the company of a friend or family member.

V. ADDITIONAL PARTIES

A. Guardian/Conservator:

The person who executes this Agreement as a Guardian or Conservator shall be obligated under this Agreement in that legal capacity only. The Resident hereby agrees that in the event it becomes necessary (in the opinion of The Center) for a Guardian of the Resident or a Conservator of the property of the Resident to be appointed, The Center may act as a petitioner for the appointment of such legal representative for the Resident if authorized to do so by state law and, in the absence of other designation, the Resident does hereby nominate and appoint the Responsible Party listed hereafter, if any, as the Resident's choice for such legal representative. The Resident agrees that if the court having jurisdiction appoints a guardian or conservator, The Center shall be reimbursed for its actual costs and expenses, including attorney fees incurred in the process of having such legal representative appointed for the benefit of the Resident if permitted by state law.

B. Responsible Party:

The Responsible Party, who may also be the Resident's Guardian, Conservator, or other legal representative, shall be a person designated for The Center to contact for instructions with regard to the non-medical care and treatment of the Resident, and shall furnish assistance to the Resident, arrange for spending money as needed by the resident and arrange for discharge and transfer of the Resident if it becomes necessary. If discharge of the Resident becomes necessary and the Resident has no residence to be discharged to, the Responsible Party agrees to make arrangements for transfer and agree to accept physical custody of the Resident at the time of transfer. Nothing herein shall obligate The Center to be bound by directions of the responsible Party in matters where only the Resident, his/her attorney-in-fact, Guardian, Conservator, or health care proxy decision maker may have legal authority to act.

C. Financial Guarantor for Resident Admitted as a Private Pay Resident:

In consideration for The Center providing services to the Resident, the Guarantor hereby unconditionally guarantees payment of all sums due The Center by the Resident. The liability of the guarantor shall include, but is not limited to, a guarantee of sums due The Center in the event third-party payments from an insurance company, Medicaid or Medicare are later refused or terminated. The Guarantor shall be liable to The Center for sums due The Center as long as the Resident remains in The Center. The liability of the guarantor shall include the liability for payment of interest, costs of collection and court costs, including attorney fees, unless prohibited by state law, if the accounts of the Resident are not paid when due.

D. Financial Representative for Resident Admitted as a Medicare or Medicaid-Eligible Resident:

For purposes of a Resident admitted as Medicare or Medicaid eligible only, the Financial Representative is a person with legal access to the Resident's income or resources available to pay the patient payment or co-insurance portion of such Medicare/Medicaid Resident's payment. The Financial Representative guarantees such payment from that income or those resources, as well as payment for services and/or charges requested on behalf of the Resident not included in the basic Medicare/Medicaid rate, to the extent of the Resident's available income or resources. Financial Representative agrees to assist in the preparation, completion, and submission, if applicable, of Resident's application for Medicaid benefits. Failure to assist timely in the Medicaid application process may result in discharge of the Resident for non-payment.

E. Potential Personal Liability:

Guarantors, Guardians, Conservators, Financial Representatives and attorneys-in-fact shall be obligated to pay to The Center from their own resources as liquidated damages an amount equivalent to any payments or funds of the Resident which are available to pay for the Resident's care, which the guarantor, Guardian, Conservator, Financial Representative or attorney-in-fact withholds, misappropriates for personal use or otherwise does not turn over to The Center for payment of Resident's financial obligations under this Agreement, or an amount equivalent to revenue lost by The Center caused by failure to cooperate in the Medicaid eligibility or redetermination process.

VI. NOTICES

Any notices or disclosures required by this agreement or by law to be given to the Resident shall be given directly to the Resident and to the following resident representative by regular U.S. Mail.

VII. ENTIRE AGREEMENT; SEVERABILITY

A. The Resident and/or Additional Party(s) agree that the foregoing contains the entire agreement between the parties and that no further or different representations were made to them on behalf of The Center. Statements or comments made by Center representatives are not part of this Admission Agreement unless such statements are also in writing. Resident and Additional Parties acknowledge that they have not relied on any oral statements or comments made by Center representatives that are not included in this written Admission Agreement.

B. Full Force and Effect:

Should any portion of this Agreement be determined to be void or unenforceable, the remainder shall remain in full force and effect and not be affected by such determination.

C. Certification:

The parties certify that they have read and received a copy of this Agreement, which shall be effective on the date appearing on Page 1, and that this document shall constitute the entire contract between the Resident, the Resident's Responsible Party, Guarantor, Financial Representative, Guardian or conservator (if applicable) and The Center. This Agreement shall be binding on the Center and its assigns, the Resident and the Resident's heirs, executors, and administrators, and on the Additional Parties hereto.

D. Governing Law:

This Agreement shall be interpreted, construed and governed under the laws of the United States of America and the state in which Center is located without reference to such state's choice of laws provisions.

RESIDENT:

Date: 06/27/23 Signed: _____ Printed Name: _____

Address: _____

RESPONSIBLE PARTY:

Date: 06/27/23 Signed: _____ Printed Name: STEVE BROGDON

Address: _____

FINANCIAL REPRESENTATIVE/GUARANTOR:

By signature hereunder, Financial Representative of a Resident admitted as a Medicare/Medicaid Resident assumes responsibility for and agrees to pay for services and/or charges to the extent of the Resident's available income or resources.

By signature hereunder, Guarantor of a Resident admitted as a private pay Resident voluntarily assumes full responsibility for and agrees to pay all costs, charges and expenses of The Center as hereinabove set forth.

Date: _____ Signed: _____ Printed Name: _____

Address: _____

GUARDIAN:

Date: _____ Signed: _____ Printed Name: _____

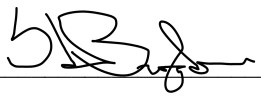
Address: _____

CONSERVATOR:

Date: _____ Signed: _____ Printed Name: _____

Address: _____

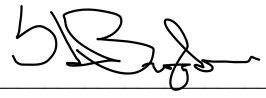
CENTER:

Date: 06/27/23 Signed:  Printed Name: Steve Brogdon

Title: Admissions Coordinator

If the resident is unable to consent to sign the foregoing because of disability, incompetence, or any other reason, complete the following item: Resident is unable to consent or sign the foregoing because:

_____

Date: 06/27/23 Signed:  Printed Name: Steve Brogdon

Title: Admissions Coordinator

OKLAHOMA STATE RIDER

If the Resident dies or is compelled by a change in physical or mental health to leave the Center, this agreement and all obligations under it shall terminate immediately. All charges shall be prorated as of the date on which the agreement terminates and, if any payments have been made in advance, the excess shall be returned to the Resident.

WAIVER OF ADMISSION CONTRACT

I, _____ _____ _____ of

Name

_____, _____,

Address State

_____ _____being to the resident as

Telephone

Son/daughter, conservator, legal guardian do hereby verify that

_____

(Center)

did offer to contract with me for nursing care for

_____

Resident

I further verify that I do not wish to sign said contract. I further verify that by the signing of this document, I acknowledge the receipt of a full copy of the "Residents Rights" and "Residents Responsibilities", and if applicable the written statement explaining the Resident's right regarding personal funds and that the Resident or his/her responsible personal representative understand the Resident's right and responsibilities as set forth therein, and have been afforded the opportunity to ask and have answered all questions which I might have.

Date:_____

_____

Resident or Representative

_____

Facility Representative

_____

Witness

OKLAHOMA LONG-TERM CARE ARBITRATION AGREEMENT

ARBITRATION AGREEMENT ("AGREEMENT")

THIS AGREEMENT GOVERNS IMPORTANT LEGAL RIGHTS. PLEASE READ IT CAREFULLY AND IN ITS ENTIRETY BEFORE SIGNING IT.

This agreement, made on 06/27/23 (date) by and between the parties, Resident _____ and Resident's Legal Representative STEVE BROGDON (collectively referred to as "Resident"), and the Facility _____, is an Agreement intended to require that Disputes be resolved by arbitration. The Resident's Legal Representative agrees that he/she is executing this agreement as a party, both in his/her representative and individual capacity.

A. WHAT IS ARBITRATION? Arbitration is a cost-effective and time-saving method of resolving disputes without involving the courts. In using arbitration proceedings, the disputes are heard and decided by a private individual called an arbitrator. The dispute will not be heard or decided by a judge or jury.

B. AGREEMENT TO ARBITRATE "DISPUTES": Any and all claims or controversies arising out of or in any way relating to this Agreement, the Admission Agreement or any of the resident's stays at this Facility, whether or not related to medical malpractice, including but not limited to disputes regarding the making, execution, validity, enforceability, voidability, unconscionability, severability, scope, interpretation, preemption, waiver, or any other defense to enforceability of this Agreement or the Admission Agreement, whether arising out of State or Federal law, whether existing now or arising in the future, whether for statutory, compensatory or punitive damages and whether sounding in breach of contract, tort or breach of statutory duties (including, without limitation except as indicated in this Agreement or any other agreement signed between these parties, any claim based on Residents' Rights or a claim for unpaid facility charges), irrespective of the basis for the duty or of the legal theories upon which the claim is asserted, shall be submitted to binding arbitration.

C. ARBITRATION PROCESS

1. **Administrator:** The Parties shall agree upon an independent entity regularly engaged in providing arbitration services to serve as the Administrator, unless the parties mutually agree to forego an Administrator
2. **Demand for Arbitration** shall be made by the claimant in writing and served on the other party to this Agreement via certified mail, return receipt requested.
3. **Mediation:** Either party may request that a mediation be held prior to the arbitration hearing, however, such mediation is not mandatory.
4. **FAA:** The parties hereby expressly agree that this Agreement, the Admission Agreement and the Resident's stay at the Facility substantially involve interstate commerce, and stipulate that the Federal Arbitration Act ("FAA") shall apply to this Agreement, and shall preempt any inconsistent State law and shall not be reverse preempted by the McCarran-Ferguson Act; United States Code Title 15, Chapter 20, or other law.

5. **One Arbitrator:** The arbitration panel shall be composed of one (1) arbitrator (the "Arbitrator"). If the parties cannot reach an agreement on selection of the Arbitrator within 20 days after the demand then, on the 21st day, each party shall select one arbitrator (the "Selected Arbitrators"). The Selected Arbitrators shall choose the final arbitrator (the "Final Arbitrator"), and the Final Arbitrator shall serve as the sole Arbitrator for this dispute.

6. **Procedural Rules and Substantive Law:** The Arbitrator shall apply NAF's Code of Procedure (in effect as of May 1, 2006) unless otherwise stated in this Agreement. The parties' selection of the NAF Code of Procedure to govern the arbitration proceedings is not tantamount to the selection of NAF as the administrator of the arbitration. A copy of NAF's Code of Procedure may be obtained from the Facility's Administrator or from NAF, (877) 655-7755, www arbitration-forum.com. The parties hereby opt-out of NAF Rules (45 regarding indigents and 43 regarding appeals and judicial review). The Arbitrator shall apply the Federal Rules of Evidence except where otherwise stated in this Agreement. Also, the Arbitrator shall apply, and the arbitration award shall be consistent with, the State substantive law for the State in which the Facility is located, except as otherwise stated in this Agreement or the parties' underlying Admission Agreement, or where preempted by the FAA.

7. **Arbitrator is Sole Decision Maker:** The Arbitrator is empowered to, and shall, resolve all disputes, including without limitation, any disputes about the making, validity, enforceability, scope, interpretation, voidability, unconscionability, preemption and/or waiver of this Agreement or the Admission Agreement, as well as resolve the parties' underlying disputes, as it is the parties' intent to completely avoid involving the court system.

8. **Refusal to Arbitrate:** To the extent permitted by applicable law, any party who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite their absence at the arbitration hearing.

9. **Final with Limited Rights to Review (Appeal):** The Arbitrator's decision binds the parties, and the parties have a limited right of review for only the express reasons as allowed by the FAA, 9 U.S.C.A. § 10 (a) (l)- (2).

10. **Waiver of Claim:** Any claim shall be waived and forever barred if it arose prior to the arbitration hearing and is not presented in the arbitration hearing. A claim that is not served and filed within the statute of limitations period that would apply to the same claim in a court of law sitting in the State wherein the Facility is located shall be waived and forever barred.

11. **Award:** The arbitration award shall be served no later than five (5) working days following the conclusion of the arbitration hearing. The award shall set forth in detail the arbitrator's findings of fact and conclusions of law and shall be marked "confidential."

D. DISCOVERY: Pre-Arbitration discovery shall be governed by NAF's Code of Procedure. However, discovery shall be limited as follows:

1. Within 30 days after service of the demand, each party must comply with Fed. R. Civ. P., Rule 26(a)(l) and thereafter must comply with Rule 26(e) regarding supplementation of disclosures and responses.
2. Each party may serve upon the other party a maximum of 30 interrogatories, 30 requests to produce and 30 requests for admissions: inclusive of subparts.
3. The following disclosures shall be served no later than one hundred fifty (150) days before the arbitration hearing by the Claimant, and one hundred twenty (120) days before the arbitration hearing by the Respondent: (a) list of witnesses to be called at the Hearing (full name, title, address and phone number, if known) and an outline of each witnesses' intended testimony; (b) list of documents to be relied upon at Hearing; except documents to be used solely for

impeachment purposes. (c) any sworn recorded statements to be relied upon at Hearing and included therewith the full name, title, address and phone number of the statement's declarant. The parties shall have a duty to supplement these disclosures per Fed. R. Civ. P., Rule 26 (e).

4. Each party is limited to no more than four (4) experts and no more than twelve (12) lay witnesses for its witness list, as well as for the Hearing. Depositions of witnesses shall be limited to those people listed on the parties' witness lists or in the parties Rule 26 disclosures or discovery responses but under no circumstances will a party be allowed to take in excess of 20 depositions and depositions shall be limited to a maximum of six hours per witness. A written report summarizing each expert's opinions and the basis for each opinion, and a list of all records contained in the expert's file, must be exchanged no later than thirty (30) days before the date of the expert's deposition.
5. Discovery shall be completed 45 days before the Hearing. The Hearing shall begin no later than 365 days after Demand for Arbitration is served, shall last in duration no longer than five (5) working days, and the hearing time allowed shall be split on a pro rata basis subject to the arbitrator's discretion.
6. Any of the discovery terms or deadlines may be modified by joint stipulation of the parties.

E. RIGHT TO CHANGE YOUR MIND: This Agreement may be cancelled by written notice sent certified mail to the Facility's Administrator from you within thirty (30) calendar days of the Resident's date of admission. If alleged acts underlying the dispute are committed prior to the cancellation date, this Agreement shall be binding with respect to said alleged acts. If not cancelled, this Agreement shall be binding on the Resident for this and all of the Resident's other admissions to the Facility without any need for further renewal.

F. OTHER PROVISIONS:

1. **No CAPS/Limits on Damages:** There are no caps or limits on the amount of damages the Arbitrator can award other than those already imposed by the law of the State wherein the facility is located.
2. **Opportunity to Review:** The Resident acknowledges that the Resident has received a copy of this Agreement, and that Resident has had an opportunity to read it and ask questions about this Agreement before signing.
3. **Right to Consult with Attorney:** Please read this Agreement very carefully and ask any questions that you may have before signing this Agreement. Feel free to consult with an attorney of your choice before signing this Agreement. Other facilities may or may not request a Resident to execute such an Agreement, and you have a choice as to which facility you desire to live in.
4. **Waiver of Trial by Judge or Jury:** By entering into this Agreement, the parties are giving up and waiving their right to have any dispute decided in a court of law before a judge and/or jury.
5. **Waiver of this Agreement:** Either party may file its dispute in a court of competent jurisdiction subject to the other party's approval, which approval shall be established by such party filing a response to the Complaint without moving in a timely manner, as prescribed by applicable rules of court, to enforce this agreement.
6. **Binding on Parties and Others:** It is the intention of the Resident and the Facility that this Agreement shall inure to the direct benefit of and bind the Facility, its parent, affiliates, and subsidiary companies, management companies, executive directors, owners, officers, partners, shareholders, representatives, directors, medical directors, employees, successors, assigns, agents, attorneys, insurers and any entity or person that provided any services, supplies or equipment related to the Resident's stay at the Facility, and shall inure to the direct benefit of and bind the Resident (as defined herein), his/her successors, spouses, children, next of kin, guardians, administrators, legal representatives, responsible parties, assigns, agents, attorneys,

health care proxies, health care surrogates, third party beneficiaries, insurers, heirs, trustees and representatives, including the personal representatives or executors of his/her estate, any person whose claim is derived through or on behalf of the Resident or relates in any way to the Resident's stays at this Facility, or any person who previously assumed responsibility for providing Resident with necessary services such as food, shelter, clothing, or medicine, and any person who executed this Agreement or the Admission Agreement. The parties agree that all aspects of one party's controversy with the other shall be included and exclusively adjudicated through the Arbitration process set forth in this Agreement except as otherwise specified herein. This provision shall apply to all covered affirmative claims a party may have against another, including cross-claims and counterclaims.

7. **Fees and Costs:** The mediator's (if any) and the Arbitrator's fees and costs and NAF's administrative fees shall be divided equally among the parties. The parties shall bear their own attorney fees and costs in relation to all preparation and attendance at the mediation and arbitration hearing, unless the Arbitrator concludes that the law provides otherwise. To the extent permitted by law, any party who opposes arbitrating the parties' dispute and/or opposes enforcement of the terms of this Agreement and unsuccessfully defends against its enforcement shall be required to pay the successful parties' reasonable attorney fees and costs incurred to enforce such contracts (i.e., Motion to Compel Arbitration or for any other means reasonably undertaken to enforce this Agreement).
8. **Confidentiality:** The mediation, if any, and arbitration proceedings shall remain confidential in all respects, including all filings, deposition transcripts, documents produced or obtained in discovery, or other materials provided by and exchanged between the parties and the arbitrator's award, including findings of fact and conclusions of law. In addition, following receipt of the arbitrator's award, each party agrees to return to the producing party within 30 days the original and all copies of documents exchanged in discovery and at the arbitration hearing.
9. **Severability Provision:** Any term, phrase or provision contained in this Arbitration Agreement is severable, and in the event any of them shall be held to be void, invalid or unenforceable for any reason, this Agreement shall be interpreted as if such term, phrase or provision were not contained herein, and the remaining provisions of this Agreement shall not be affected by such determination and shall remain in full force and effect. Under no circumstances may the voidability or enforceability of any term or terms taint the enforceability or validity of the remaining terms. No part of the Agreement will be construed against any party because that party wrote the Agreement.
10. **Integration Clause:** This Agreement controls the parties' entire agreement regarding disputes and it may only be modified in writing signed by all parties.
11. **Grievances/Discharges:** Nothing in this Agreement prevents the Resident from filing a grievance or complaint with the Facility or appropriate governmental agency; from requesting an inspection of the Facility from such agency; or from seeking a review under any applicable federal, state or local law of any decision to involuntarily discharge or transfer of the resident.

BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY DISPUTE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. NOTE THAT PROCEEDINGS PURSUANT TO 42 U.S.C. §§ 1396r(c)(2), (f)(3) and 42 C.F.R. § 431.245 WILL NOT BE SUBJECT TO ARBITRATION IF SO PROVIDED BY STATE LAW.

THE UNDERSIGNED ACKNOWLEDGE THAT EACH OF THEM HAS READ ALL PAGES OF THIS AGREEMENT AND UNDERSTANDS THAT BY SIGNING THIS AGREEMENT EACH HAS WAIVED HIS/HER OR ITS RIGHTS TO A TRIAL, BEFORE A JUDGE AND/OR A JURY, AND THAT EACH OF THEM VOLUNTARILY CONSENTS TO ALL OF THE TERMS OF THIS AGREEMENT.

RESIDENT:

06/27/23

Printed Name (Date)

Signature of Resident

RESIDENT'S LEGAL REPRESENTATIVE:

STEVE BROGDON 06/27/23

Printed Name (Date)

Signature of Resident's Legal Representative in his/her Individual and Representative Capacity

Witness to Resident Designating or Authorizing Legal Representative to Sign on Resident's Behalf (1)

FACILITY REPRESENTATIVE:

STEPHEN BROGDON 06/27/23

Printed Name (Date)

Signature of Facility Representative (2)

(1) By signing above, the witness hereby attests that the Resident, in an alert and oriented state of mind, designated and/or authorized, in the witness' presence, the above-named legal representative to sign this agreement on behalf of the Resident. The person serving as a witness cannot be the designee/authorized agent, but he/she can be another family member or friend or the Resident.

(2) This individual is authorized to sign this agreement on behalf of the facility

EXTERNAL MEDICATIONS

SUBJECT: External Medications (medications brought in by outside sources, such as family, and non-licensed medical personnel etc.

POLICY: All medications brought to the facility must immediately be given to the charge nurse on duty. All medications brought to the facility must be checked in and counted by the facility charge nurse and an order in place before the medication can be used for a resident of the facility.

RESPONSIBILITY:
Director of Nursing, all licensed nursing personnel, Administrator, Admission coordinator.

PROCEDURE:
When a patient admits or returns the facility, all medications brought with the person will be turned over to the charge nurse immediately. All medication will be counted and placed in a med cart behind lock and key. An order for each medication will be obtained by the charge nurse from the physican before use within the facility.

- No medications will be given without and order from the physician.
- Any medications unlabeled, expired, or a medication the patients does not have an order for or mixed with other meds will be accepted.
- No medications can be left with the patient, in a patient's room, or brought in by an unlicensed person and gave to the patient.
- If an unlicensed person brings in medications to a patient without following the policy they will be asked to leave the facility, and a report will be made to all needed places including OSDH, APS, Local sheriff station, etc.

Notifications:
All residents, legal guardians, other medical personnel for the patient and families will be notified over the medication policy upon admission.

Resident Signature/Date:_____

Responsible Party Signature/Date:_____

Facility representative: ___Casey Williams COO_____-

History: **H.9**

(A) JLO 3/20; 5/20 (B) P&P Committee

Resident Marijuana Policy and Procedure

Marijuana use and/or use of products developed with the marijuana (THC).

_____(Facility Name) is committed to providing a safe environment for all of its residents and employees, as well as to comply with all applicable federal and state laws and regulations. _____(Facility Name) acknowledges that Oklahoma law allows for the controlled use of medical marijuana and products made with marijuana. However, marijuana remains an illegal, Schedule I Drug under Federal law.

To maintain safe environment and in compliance with Federal law, the Facility prohibits the possession, consumption and use, even for medical purposes, of any marijuana and/or marijuana products developed with THC on its premises.

_____(Facility Name) residents and/or visitors are prohibited from possessing or consuming marijuana and/or marijuana products developed with THC, even for medical purposes on the facility premises. Any resident who violates this policy shall be subject to transfer or discharge in accordance with the facility's transfer and discharge policies.

_____(Facility Name) will not distribute, or assist in the distribution of, medical marijuana and/or marijuana products developed with THC to patients, through prescription or otherwise. _____(Facility Name) staff and volunteers are strictly prohibited from distributing medical marijuana and/or marijuana products developed with THC to patients, through obtaining prescriptions for medical marijuana or otherwise engaging in activities that assist the distribution of medical marijuana.

If a resident receives a prescription for medical marijuana from his or her physician, the facility will inform the prescribing physician of the facility's policy prohibiting medical marijuana and will consult with the physician to find an alternative treatment or medication to treat the resident's symptoms.

If any resident requests to receive medical marijuana, the facility will assist the resident to find placement in a facility that can accommodate the resident's request.

In the event marijuana or products developed by THC are suspected of being brought into the facility by staff or residents, the facility has the right to enforce the no marijuana/THC developed products policy and search of the facility can be completed by facility staff, and/or the local police or sheriff station, including but not limited to the use of drug dogs.

_____(facility Name) expressly reserves the right to amend this Policy, as necessary to conform to state and federal guidance concerning the controlled use of medical marijuana within long term care and skilled nursing facilities and in the event any provision herein is determined to be inconsistent with requirements of state or federal law, the policy shall be read to comply with such provisions.

I have read and understand the above policy.

_____ 06/27/23

Resident/Resident legal Representative Signature Date

_____Facility Representative Signature

An Act

ENROLLED SENATE
BILL NO. 587

By: Justice, Johnson (Constance), Fields, Coates and Allen of the Senate

and

Wright, Pittman, Sherrer, Hoskin, Shelton, McDaniel (Jeannie), Hamilton and Morrissette of the House

An Act relating to public health; providing definitions; authorizing noncompulsory electronic recording of residents of nursing facilities; requiring written notice; prohibiting certain restrictions on residents; requiring certain posting; prohibiting tampering with electronic recording devices; providing penalties for violations; requiring resident permission for disclosure of certain information; permitting certain information to be used for legal proceedings; requiring certain notification; requiring consent form; providing who may give consent; providing rights of other resident of a room; providing for additional information in form; requiring certain compliance; providing for codification; and providing an effective date.

SUBJECT: Electronic monitoring in nursing facilities

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-1953.1 of Title 63, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Authorized electronic monitoring" means the placement of electronic monitoring devices in the common areas or room of a resident of a nursing facility and the tapes or recordings from such devices pursuant to the provisions of this act;

2. "Authorized electronic monitoring devices" means:

a. video surveillance cameras installed in the common areas or resident's room under the provisions of this act, or

b. audio devices installed in the room of a resident under the provisions of this act that are designed to acquire communications or other sounds occurring in the room;

3. "Nursing facility" means the term as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes;

4. "Representative of a resident" means the term as is defined in Section 1-1902 of Title 63 of the Oklahoma Statutes;

5. "Resident" means the term as is defined in Section 1-1902 of Title 63 of the Oklahoma Statutes; and

6. "Unauthorized electronic monitoring" means electronic, mechanical, or other devices that do not meet the provisions of this act and that are specifically used for the nonconsensual interception of wire or electronic communications.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-1953.2 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A nursing facility shall provide written notice to each resident, or to the representative of a resident, that authorized electronic monitoring of a resident's room conducted under the provisions of this act is not compulsory and shall only be conducted with the written consent of the resident or the representative of the resident.

B. A nursing facility shall not refuse to admit an individual to residency in the facility and shall not remove a resident from a facility because of authorized electronic monitoring of a resident's room.

C. A nursing facility shall post at or near its main entrances a sign that clearly states that electronic monitoring and audio devices may be in use in the facility.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-1953.3 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. No person or entity shall intentionally hamper, obstruct, tamper with, or destroy an electronic monitoring device installed in a nursing facility.

B. Any person or entity that intentionally hampers, obstructs, tampers with, or destroys a recording or an electronic monitoring device installed in a nursing facility shall be subject to the penalties prescribed in Section 1993 of Title 21 of the Oklahoma Statutes.

C. No person or entity shall intercept a communication or disclose or use an intercepted communication of an electronic monitoring device placed or installed in a common area of a nursing facility without the express written consent of the facility, or, for an electronic monitoring device installed in a resident's room, the express written consent of the resident or the representative of the resident.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-1953.4 of Title 63, unless there is created a duplication in numbering, reads as follows:

Subject to the provisions of law, a tape or recording created through the use of authorized electronic monitoring pursuant to this act may be admitted into evidence in a civil or criminal court action or administrative proceeding.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-1953.5 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A resident or the representative of a resident may conduct authorized electronic monitoring of the resident's room through the use of authorized electronic monitoring devices placed in the room pursuant to the provisions of this act at the expense of such person or representative of the resident and with the written consent of any other resident living in the room.

B. A resident who conducts authorized electronic monitoring or the representative of the resident may post and maintain a notice at the entrance to the resident's room stating that the room is being monitored by an electronic monitoring device.

C. Nothing in this act shall be construed to prevent a resident or the representative of the resident from placing an electronic monitoring device in the resident's room at the expense of such person; however, if such resident is sharing a room with any other resident, the resident or the representative of the resident shall obtain written consent from such other resident or the representative of the resident living in the room and such consent shall be on a form prescribed by the State Department of Health and shall be placed on file with the administrator of the facility.

D. If a resident residing in a shared room, or the representative of a resident residing in a shared room, desires to utilize an authorized electronic monitoring device and another resident living in such shared room refuses to consent to the use of an authorized electronic monitoring device, the nursing facility shall accommodate the resident or the representative of the resident desiring to utilize an authorized electronic monitoring device to move to another room if the resident or resident's representative requests such a room change within a reasonable amount of time.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-1953.6 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A resident or representative of a resident who wishes to conduct authorized electronic monitoring shall be required to notify

the nursing facility on the consent form prescribed by the State Department of Health.

B. The consent form prescribed by the Department shall require the resident or the representative of a resident to obtain the consent of any other resident in the room or the representative of a resident, using the consent form prescribed for this purpose by the Department, if the resident resides in a room with another resident.

C. Consent may be given only:

1. By the resident or any other resident in the room; or

2. By the representative of the resident or representative of any other resident in the room.

D. Another resident in the room may:

1. When the proposed electronic monitoring device is a video surveillance camera, condition consent on the camera being pointed away from the consenting resident; and

2. Condition consent on the use of an audio electronic monitoring device being limited or prohibited.

E. Except as provided for in Section 7 of this act, authorized electronic monitoring may begin only after the required consent forms specified in this act have been completed and returned to the nursing facility and placed on file with the administrator of such facility.

F. If authorized electronic monitoring is being conducted in the room of a resident, another resident may not be moved into the room unless the resident or representative of the resident has consented to the use of existing electronic monitoring, in accordance with this act.

G. The Department may include other information that it considers to be appropriate on any form it is required to prescribe under the provisions of this act.

H. The Department shall prescribe the forms required by this act no later than November 1, 2013, and shall make such forms available on its website.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-1953.7 of Title 63, unless there is created a duplication in numbering, reads as follows:

Any resident or the representative of the resident utilizing existing electronic monitoring devices prior to November 1, 2013, shall comply with all written consent and disclosure provisions of this act no later than January 1, 2014.

SECTION 8. This act shall become effective November 1, 2013.

Oklahoma State Department of Health
Creating a State of Health

Consent By Roommate For Authorized Electronic Monitoring

I,_____, OR
(name of resident)

I, STEVE BROGDON, on behalf of _____,
(name of resident representative) (name of resident)

Consent to allow authorized electronic monitoring by the other residing resident or their representative of room number/location_____, in accordance with Oklahoma Statutes, Section 1-1953.6 of Title 63 Chapter 675.

Condition consent:

1) When the proposed electronic monitoring device is a video surveillance camera, condition consent on the camera being pointed away from the consenting resident.

Yes, I want the camera pointed away from my side of the room_____ ☐

No, I have no condition on placement_____ ☐

2) Condition consent on the use of an audio electronic monitoring device being limited or prohibited.

Yes, I want limitations noted here_____

Yes, I want to prohibit audio surveillance in my room _____(Initial here)

This form may be signed only by the resident or the guardian or legal representative of the resident, as provided in 1-1902 of Title 63, Chapter 675 of the Oklahoma Statutes.

✖ _____ 06/27/23

Signature –If applicable - Any Resident also residing in the room/ Date
Guardian of Resident/Legal Representative of Resident (circle appropriate title)

06/27/23

Signature/Facility Representative Date

*Note – If the resident does not want to give consent, the resident requesting electronic monitoring may request another room.

Oklahoma State Department of Health
Creating a State of Health

Consent Form
Notice to Facility for Authorized Electronic Monitoring

I,_____ , OR
(name of resident)

I, STEVE BROGDON , on behalf of _____ ,
(name of resident representative) (name of resident)

wish to conduct authorized electronic monitoring in room number/location_____,
in accordance with Oklahoma Statutes, Section 1-1953.6 of Title 63 Chapter 675 .

Is the monitoring device a video surveillance camera? ☐ Yes ☐ No

Does the monitoring device include audio recording? ☐ Yes ☐ No

This form may be signed only by the resident or the guardian or legal representative of the resident, as provided in 1-1902 of Title 63, Chapter 675 of the Oklahoma Statutes.

✖ _____ 06/27/23
Signature–Resident/Guardian of Resident/Legal Representative of Resident (circle appropriate title) Date

_____
Facility Name/Address

_____ 06/27/23
Signature-Facility Representative Date

The purpose of this form is to:
1). Notify the facility whenever video surveillance will be used by a resident in his/her room; and
2). To provide notice to a resident residing in a semi-private room of the presence of video surveillance.

ADVANCE DIRECTIVE DEFINITIONS

1. **Living Will** – A document that specifies a resident's preferences about measures that are used to prolong life when there is no terminal prognosis.

2. **Do Not Resuscitate** – Indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, or representative have directed that no cardiopulmonary resuscitation (CPR) or other "life saving" methods are to be used.

3. **Do Not Hospitalize** – Indicates that the resident is not to be hospitalized, even if he or she has a medical condition that would usually require hospitalization.

4. **Organ Donation** – Indicates that the resident wishes his or her organs to be available for transplantation upon his or her death.

5. **Autopsy Request** – Indicates that the resident, legal guardian, or representative has requested an autopsy be performed upon the death of the resident.

6. **Feeding Restrictions** – Indicates that the resident, legal guardian, or representative does not wish for the resident to be fed by artificial means (e.g., tube, intravenous nutrition, etc.)

7. **Medication Restrictions** – Indicates that the resident, legal guardian, or representative does not wish for the resident to receive life-sustaining medications (e.g., antibiotics, chemotherapy, etc.)

8. **Other Treatment Restrictions** -- Indicates that the resident, legal guardian, or representative does not wish for the resident to receive certain medical treatments. Examples include, but are restricted to, blood transfusions, tracheotomy, respiratory intubation, etc.

This signature verifies that I received and read this form

06/27/23

Signature of Resident/Responsible Party

06/27/23

Signature of Witness

Policy Number:	
Department Owner:	**Revised Date: 6/27/2023**
Date Approved:	**Page:**

SUBJECT: **NOVEL CORONAVIRUS COVID-19**

POLICY:

The facility will conduct education, surveillance and infection control prevention strategies to reduce the risk of transmission of the novel Coronavirus (2019-nCoV). The facility will rely on CDC recommendations including Identification, Isolation, & informing Health Department, DHSS, & CDC of any suspected cases of COVID-19. The facility will screen Residents by completing daily for Signs/Symptoms of Acute Respiratory Illness.

RESPONSIBILITY:

All Licensed Nursing Personnel, Infection Preventionist, Department Heads, LNHA & Monitored by the Director of Nursing.

PROCEDURE:

Identification & Assessment COVID-19:

1. Charge Nurse should complete Respiratory screenings on residents daily, unless positive covid has been identified within the facility. If Covid is identified within the facility, screenings need to be completed on all patients per shift, and continue until outbreak testing has concluded.
    - Obtain V/S (Temperature, Pulse, Respirations, Oxygen Saturation) and Notify Physician/Physician Extender of Abnormal Findings. Including: Signs/Symptoms of Respiratory Infection.

    Typical Signs/Symptoms:
        - Elevated Temperature ≥100.4
        - New Onset Cough or Worsening Chronic Cough
        - New Onset SOB
        - Loss of Sense of Smell/Taste

    Atypical Signs & Symptoms:
        - Diarrhea, Nausea, or Vomiting
        - Decreased Mental Status or Increased Confusion
        - Chest Pain
        - Sore Throat or Running Nose
        - Muscle Aches or Headache
        - Generalized Weakness or Chills
        - New Onset of Rash (e.g. Metatarsal Phalanges).

Implementation COVID-19:

2. **Initiate Transmission-Based Precautions with Droplet Isolation Precautions:**
    - Apply Appropriate PPE
        - Gloves, Gown, Isolation Mask, & Eye Protection.
    - Place Facemask on the Resident.
    - Isolate the Resident in a Private Room with Door Closed & Pull Privacy Curtain.
    - Implement Droplet Precautions with Signage Posted for **STOP SIGN** Droplet Isolation Precautions.
    - Post Signage Donning/Doffing PPE Inside/Outside Resident Room.
    - Complete Staff Education on Proper Fitting N95 Mask & Droplet Isolation Precautions.
    - Close Fire Doors to Affected Unit, if applicable.
    - Limit Entry to Resident's Room.
    - Equipment should remain in the room when possible e.g. Stethoscope, Thermometer, B/P Cuff & Disinfected after each use.

- Ensure All Staff working with COVID19 positive patients Utilize Full PPE/N95-Conventional Use; Follow CDC Guidelines on optimizing PPE during a shortage. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.
- +COVID Units-Staff will Utilize Full PPE/N95-Entire shift.

3. **Transfer to Hospital: Covid 19 positive**
   - If Resident requires to be sent to the hospital, complete the following:
     - Dispatch EMS for Acute Care Transfer.
     - Alert EMS/Hospital Resident is PUI/+COVID Transfer.
     - Charge Nurse complete COVID SBAR.
     - Charge Nurse will complete COVID Communication Tool and send a copy with the Resident.
     - Resident Transfer with Isolation Mask in place.
4. **Environmental Services: Covid 19 Positive isolation rooms**
   - Housekeeping to complete Disinfectant Schedule on Common Surfaces twice a day.
   - Resident Discharge/Room Move:
     - Close Resident Room Door for 4-6 hours and then initiate terminal room cleaning with EPA approved disinfectant.
     - Housekeeping Staff should utilize PPE when completing terminal room clean.
5. **Notifications:**
   - LNHA, DON, BOM and SS will notify Residents families of +COVID.
   - DON will inform Local Health Department & follow recommendations.
   - LNHA will notify DHSS of PUI/+COVID and complete State Specific Reporting Form.
   - LNHA/DON will notify the following of +COVID in the facility:
     - MD/NP/RD
     - Laboratory
     - Radiology
     - Pharmacy
     - Hospice
     - Dialysis
6. **Preventative Measures:**
   - *Residents*
     Do not require quarantine unless the patient has tested positive for COVD-19.

     All new admitted patients vaccinated or unvaccinated will require a covid test before admission to facility unless the individual has had a covid positive test in last 90 days.
   -
     - New Admits & Re-Admits that were out of the facility greater than 24 Hours.
       - New/Readmits who are Resolved COVID do not require to Quarantine.
   - *Initiate Droplet Precautions for the following Residents:*
     - Continuous Oxygen
     - CPAP/BiPAP
     - Tracheostomy

Evaluation COVID-19:

7. **Infection Control Logs/ COVID Tracker:**
   - NHSN-CDC Portal update weekly and submit to CDC per CMS Requirement.
   - Employee Illness Log update daily and document employee symptoms.

Staff & Resident Testing: (Antibody tests <u>DO NOT</u> meet the requirements under this regulation)

8. *All staff defined as:*
   - Employees regardless of job title
   - Contractors (will be tested on entry to facility if facility is in outbreak testing. Day 1,3,5)
   - Consultants (will be tested on entry of facility if facility is in outbreak testing. Day 1,3,5)
   - Volunteers (will be tested on entry of facility if facility is in outbreak testing. Day 1,3,5)

9. *All Residents defined as:*
- All residents

10. Routine Testing: is not required unless the home is in outbreak testing or based on the county positivity rate.
-During outbreak staff and residents will be tested on day 1,3,and day 5.
- Routine testing of asymptomatic residents is not recommended nor required.
    - Residents who test positive must be placed on quarantine precautions, they can ONLY roommate with someone who tested positive **on the same date**, positive residents must quarantine for a minimum of 10 days, can return to the common area of the facility on day 11 if they have gone 24 hours without fever and are symptom free.
- Individuals who tested positive do NOT need to repeat testing for 90 days.
- Staff can be tested elsewhere, if it is completed in the same timeframe and results are documented.
  *Presumes availability of Point of Care testing onsite or offsite texting with turnaround time <48 hours. If testing is not available, facility must call local/state public health department and document efforts to obtain testing.
  - **Symptomatic Testing:**
    - Test anyone who has signs or symptoms of COVID-19
  - **Outbreak Testing:** Test **all staff and residents** when an outbreak occurs:
    - Defined as any single new infection in staff or resident who tests positive after admission.
    - Continue to test **all staff and residents** who tested negative:
      - Test day 1, day 3, and day 5 if no other positive test, if other positive test occur continue testing based on last positive test date. Day 1, day 3 and day 5. Continue until no other positive test occur threw day 5.

11. *Documentation Requirements*:
- Physician orders required for Staff and Residents
    - Standing orders allowed
- Must document in medical or employee record.
- Keep separate file for contractors and volunteers
- Documentation varies for testing reasons
    - Symptomatic
        1. Date and time of identification of signs or symptoms
        2. Date of test and date results obtained.
        3. Results and actions taken
    - Outbreak
        1. Date first case was identified
        2. Dates and results of initial testing and retesting for all residents & staff
    - Routine (staff testing)
      On hire
      If having signs or symptoms
      During outbreak

- Refusal of Tests:
    - **Staff Refusal – Documentation must be completed for staff refusing tests and how facility will address those cases.**
        1. Outbreak testing: restricted from building until procedures for outbreak testing completed
        2. Routine testing: follow Occupational health and local jurisdiction policies.
    - **Resident Refusal – Documentation must be completed for residents refusing tests and how facility will address those cases**
        1. Residents with signs or symptoms of COVID-19 who refuse testing will be placed on TBP until criteria for discontinuing are met.
- Point of Care testing: Machine sent to facilities
    - Must have CLIA certificate for POC testing
    - Report negative and positive test results to public health agencies

12. Covid-19 Education

History: **H.9**

(A) JLO 3/20; 5/20 (B) P&P Committee

- All residents will be in-serviced educated over the COVID-19 vaccine, benefits, risks and potential side effects on admission/Hire and twice yearly.
- All residents will be offered a COVID-19 vaccine and booster shots when needed.
- All staff will be in-serviced over the facility COVID-19 policies on hire and twice yearly or as needed to ensure the facility is meeting CMS/CDC regulations.

13. Penalties for Not Testing:
- (F886) Citation for noncompliance testing requirements
- CMP (Civil Money Penalties) based on scope and severity
- If facility has documentation of attempts to comply, surveyors instructed to **NOT** cite for noncompliance
    - Document attempts to get more tests or labs to do tests
    - Call local and state health department if tests not available or results taking longer than 48 hours.

14. Mitigating the transmission and spread of COVID-19, for staff not fully vaccinated. (Including staff that with medical and religious exemptions)

Mask

- All staff vaccinated and not fully vaccinated are required to wear mask during a COVID outbreak.
- If Covid is present in the facility all staff are required to wear N-95 or K N-95 mask and full PPE, while working with a covid positive patient. All staff are required to wear surgical mask within all other areas of facility if Covid is present within the facility. Must continue to wear mask until out of outbreak testing.
- All staff not fully vaccinated should take all precautions to protect from the spread of covid-19.

15. Vaccine status
- All staff and residents vaccine status (including vaccine received, booster shots dates of each dose) will be tracked within the facility.
- Vaccines are not required for staff or residents within the facility; however, all staff and residents will be in-serviced over the COVID 19 Vaccine benefits, risks and potential side effects.
- All staff and residents will be offered the vaccine and booster shots.
- Residents and staff have the right refuse or change their mind at any time regarding taking or not taking the vaccine shots.
- All staff and residents' vaccine shots will be recorded and reported to NHSN.

16. Return to Work Criteria for HCP with SARS-CoV-2 Infection

The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immunocompromising conditions. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.

HCP with mild to moderate illness who are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:

- At least 7 days have passed *since symptoms first appeared* if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and**
- Symptoms (e.g., cough, shortness of breath) have improved.

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

HCP who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:

- At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

HCP with severe to critical illness who are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:

- At least 10 days and up to 20 days have passed *since symptoms first appeared,* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and**
- Symptoms (e.g., cough, shortness of breath) have improved.
- The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction.

The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific HCP. For a summary of the literature, refer to Ending Isolation and Precautions for People with COVID-19: Interim Guidance (cdc.gov)

HCP who are moderately to severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy (as described below) and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work.

Test-based strategy

HCP who are symptomatic could return to work after the following criteria are met:

- Resolution of fever without the use of fever-reducing medications, **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

HCP who are not symptomatic could return to work after the following criteria are met:

- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

17. Patients with Positive Covid Test Isolation timelines

Patients with mild to moderate illness who are *not* moderately to severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Patients who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:

- At least 10 days have passed since the date of their first positive viral test.

Patients with severe to critical illness and who are *not* moderately to severely immunocompromised:

- At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- The test-based strategy as described for moderately to severely immunocompromised patients below can be used to inform the duration of isolation.

The exact criteria that determine which patients will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific patients.

18. Emergency Staffing

- In the event of an outbreak of COVID within the facility, causing multiple staff to be unable to work, the facility will implement emergency staffing when needed.
- This includes having non affected staff work extra shifts if able, utilizing sister facilities to fill open shifts, and the use of agency staffing.

19. Follow CDC Updates and Guidance regarding the Novel Coronavirus (COVID-19).

I HAVE BEEN PROVIDED WITH A COPY OF THE THE FACILITY COVID POLICIES:

STEVE BROGDON

NAME OF RESIDENT OR RESPONSIBLE PARTY

SIGNATURE

06/27/23

DATE

OKLAHOMA DEPARTMENT OF HUMAN SERVICES

ELIGIBILITY REQUIREMENTS FOR LONG-TERM CARE PROGRAMS

Categorical relationship. For the AD*vantage* Waiver, the applicant must be 65 years of age or older, disabled, or blind according to the Social Security Administration rules.

Citizenship. The applicant must be a U.S. citizen or lawful permanent resident for five years or more. Proof of citizenship/alien status as well as identity is required.

Residency. The applicant must reside in the State of Oklahoma with intent to remain in Oklahoma at the time medical services are received.

Income.

- **Nursing facility care –** The income standard is $2,130 per month based on 300% of the Supplemental Security Income (SSI) Federal Benefit Rate. When income is between $2,130 and $4,365, a Medicaid Income Pension Trust must be established prior to the applicant being determined financially eligible. If the potentially eligible person is married, income may be deemed to bring the spouse's countable income up to a maximum of $2,898 when determining a vendor payment. Contact the local OKDHS office for additional information.
- **AD*vantage* Waiver** – The income standard is based on the nursing facility standard of $2,130 per month. When income is between $2,130 and $4,365, a Medicaid Income Pension Trust must be established prior to the applicant being determined financially eligible. The cost of AD*vantage* services may not exceed the annual SoonerCare (Medicaid) cost of nursing facility care. There is no vendor payment for the AD*vantage* program. Contact the local OKDHS office for additional information.
- **Personal Care** - Income standard is $958 per month for an individual and $1,293 for a married couple.

Resources.

- **Nursing facility care –** The resource standard is $2,000. Spousal impoverishment standards apply. A married couple's total resources are combined and then halved. A minimum of $25,000 to maximum of $115,920 in assets may be protected for the community spouse remaining in the home. Contact the local OKDHS office for additional information.
- **AD*vantage* Waiver –** The resource standard is the same as that for nursing facility care.
- **Personal Care** - The resource standard is $7,080 for an individual or $10,620 for a married couple residing in the same home.

INFORMATION ON APPLYING FOR SKILLED OR NURSING HOMECARE

Adult and Family Services

THE INFORMATION LISTED BELOW IS TO BE USED AS A GUIDELINE AND IS SUBJECT TO CHANGE AS POLICY CHANGES OCCUR. This list is not all inclusive and you may be required to provide additional verification.

The Department of Human Services provides payment for nursing care within the scope of the Medicaid program, on behalf of persons who meet both the financial and medical eligibility requirements for Title XIX.

Web page for information on nursing homes: www.medicare.gov

SKILLED CARE ELIGIBILITY

If you have been out of the home less than 30 days, the following income and resource standards are used to determine eligibility for skilled care. (The 30-day count includes days of hospital care immediately prior to admission to the skilled care unit.)

- Income must be equal to or less than **$973.**
- Resources must be equal to or less than **$7,160** for an individual or **$10,750** for a couple.

Once you have been out of the home more than 30 days, the same income and resource criteria as nursing home eligibility (below) is used, even you remain in the skilled care unit.

NURSING HOME ELIGIBILITY:

You must be a resident of Oklahoma, require professional nursing supervision and need maximum amount of non- professional nursing care and meet one of the following criteria:

1. Over 65 years of age, or
2. Disabled or blind as determined by SSA, or
3. Parent with a minor child in the home, or
4. Under 19 years of age

RESOURCES/ASSETS		INCOME
$2,000	for nursing home patient	**$2,163** for nursing home patient
$25,000	Minimum available to protect for Community Spouse (spouse in the (home)	**NOTE:** If patient's gross income is more than $2,163 but less than $4,365, please contact the office immediately regarding a Medicaid Income Pension Trust (MIPT).
$117,240	Maximum that can be protected for Community Spouse (spouse in the home)	

APPLICATION PROCESS

It is not necessary to make application for Medicaid prior to placement. You can be placed in the nursing home of your choice as long as they accept Medicaid. Upon placement, inform the nursing home that you wish to apply for Medicaid. The nursing home is to send an admit form (ABCDM-83 & 96) and Title XIX Nursing Assessment to our office. If you meets both financial and medical eligibility on the date of admittance, Medicaid can start payment as of that date. The application process can take up to 45 days to complete. In order to speed the process, you need to bring current documentation on all income, resources, property deeds, etc. to the face-to-face interview. We can only go back ninety (90) days from date of application to start payment so it is imperative that the information is provided the first time so you will not lose any coverage.

If the application is denied due to not providing all the necessary verification and the requested verification is provided within 30 days of the denial notice, the original application date will be used. If the application is denied and verification is not provided within 30 days from the date of the denial notice, a new application must be completed and the above process must be repeated.

Please bring the following information with you at the interview:

1. **Income:** All sources of gross income are counted. Please provide a copy of current check stubs or award letter. This includes: Social Security, SSI, Railroad Retirement, VA, Civil Service, pensions, annuities, dividends, contributions, rental income, etc. **NOTE:** If you or your spouse served in the military, you must contact Veterans Administration to apply for Aid & Attendance. (1-800-827-1000)
2. **Your full name**.
3. **Social Security number**.
4. **Medicare card**.
5. **Bank statements** on all accounts at any financial institution (checking, savings, CD's, stocks, bonds, annuities, investments, etc.) **We will need the last sixty (60) months of statements on all accounts held in the past 60 months.** If any asset have been sold, traded, or given away within the last 60 months prior to entry into the nursing home and application for Medicaid, we will require documentation of the transfer. Statement of any bank accounts, CD's, stocks, bonds, etc. closed in the prior 60 months must also be provided.
6. **Property** - Address, legal description and value of all property that has been sold, deeded, or transferred in the last five (5) years and property currently owned by patient or co-owned. If there is a **contract for deed** or **promissory note** on any property, provide a copy.
7. **Trust** - copy of Trust with all schedules attached and other list of items in Trust and their value.
8. **Insurance Policies** - provide a copy of all policies (medical, life, burial, etc.).
    A. Burial - Is this a revocable or irrevocable contract? If not irrevocable, we can only exempt up to $1500 for burial plans. If irrevocable, we can exempt up to $10,000 but we must evaluate the face value of burial policies in conjunction with other life insurance policies owned by you. There is a thirty (30) day grace period before the irrevocable contract goes into effect. **The irrevocable contract is an extra form that must be signed.**
    B. Medical - Provide copy of insurance card and verification of monthly premium - ie: copy of bill, letter or cancelled check.
    C. Life Insurance - **Provide current letter from insurance company verifying face value and cash value of all policies.** Life insurance policies can be assigned as part of the burial however both this **assignment and the burial policy must be irrevocable.** Life insurance policies are the main reason your resources might exceed standards. It is extremely important that this issue be resolved as quickly as possible. If you need further guidance, please feel free to contact our office.
9. **Life Estate** - Copy of deed reflecting life estate. Life Estates have value and must be considered as a resource.
10. **Power of Attorney** or **Guardianship** papers.
11. Copy of all **car, truck, motorcycle, boat**, etc. titles and proof of amount owed on each.
12. Name, address and phone number of person(s) we can **contact** to assist with your application.

Request for Benefits

Date _____
Case name _____
Case # _____
County # _____
Supervisor # _____ Worker # _____

For use with Forms 08MP002E, Eligibility Information for Benefits, and 08MP003E, Rights, Responsibilities, and Signature for Benefits.

What You Need to Get Started

Read the following descriptions and check all of the programs for which you would like to apply. Fill out this form or have someone else fill it out for you.

Supplemental Nutrition Assistance Program (SNAP)

☐ Helps buy food. (Formerly known as the Food Stamp Program)

Child Care Subsidy

☐ Helps pay for care for your child so you can work, go to school, or attend training.

Health Care Coverage - SoonerCare (Medicaid)

☐ Helps pay for medical costs for people who are elderly or disabled.

☒ Helps pay for nursing care in your home (AD*vantage*) or in a nursing home.

☐ Helps pay Medicare Part A and B premiums.

☐ State Supplemental Payment (SSP) - gives a small cash payment to low-income people who are disabled, blind, 65 years of age or older, or receive Supplemental Security Income (SSI) or Social Security disability income.

☐ Helps pay for medical costs for pregnant women and families with children. You may apply for this program online at www.mysoonercare.org.

☐ SoonerPlan helps pay for birth control and family planning services for adults. You may apply for this program online at www.mysoonercare.org.

Temporary Assistance for Needy Families (TANF)

☐ Helps low income families with minor children by providing temporary cash and services.

When You Ask for Help From DHS, You Have a Right To

- file an incomplete application by filling out the contact information below under 'How can we contact you?', signing your name on the signature line, and submitting the information to DHS;
- have SNAP food benefits, TANF, or SSP cash assistance benefits start from the date of application, if eligible;
- have child care benefits start from the date you complete an interview and provide all necessary proof, if eligible;
- receive help from DHS in completing the application or in getting the proof you need to be approved;
- have your application processed timely or receive notice explaining the reason for delay;
- have information you give to DHS kept confidential;
- receive equal treatment regardless of race, color, age, sex, disability, religious creed, political belief, or national origin and to file a civil rights complaint if you think you were discriminated against; and
- ask for a fair hearing, either orally or in writing, if you disagree with any action taken on your case. Any person you choose may represent you at the hearing.

How Can We Contact You?

If you are completing this form for someone else, list contact information for the person who needs benefits.

First name | M.I. | Last name

Mailing address, street or PO Box | City | State | ZIP code

Street address or directions to your home, if different than mailing address

Phone number where you can be reached | Apartment or lot number | Email address

Do you need an interpreter? ☐ Yes ☐ No

If yes, what language do you speak? _____

Read This Information and Sign Below

I give DHS permission to check the information I give on this form to make sure it is true.

I understand the names and Social Security numbers I give will be used to obtain information from other state and federal agencies.

I give DHS permission to share information with other agencies.

Signature | Date

Schedule My Interview

We will set up your interview. During your interview, we will:

- help you complete the rest of the application and tell you which benefits you may be eligible to receive;
- provide you with a form that shows what proof you must provide before your application can be completed; and
- tell you the processing time frame for your application.

What You Will Need to Bring to Your Interview

- proof of identity, such as driver license or school identification;
- Social Security number or card for everyone who wants benefits. If you are only applying for child care benefits, Social Security numbers are not required;
- proof of citizenship for everyone who wants benefits;
- proof of legal status for anyone who is not a U.S. citizen and wants benefits;
- proof of income for everyone living with you, such as pay stubs or award letters;
- proof of all resources, such as bank accounts, car titles, or land; and
- proof of your need for child care, such as your work or school schedule, and the name of the place you want to use to care for your child.

Please put an X in the table for the days and times you are available for your interview:

Time of day	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					
Afternoon					

What Happens After You Give Us This Form

You may be asked to give more information after your interview. You have the right to refuse to give any or all information. However, if you do not give us the information we need, we may not be able to help you.

Authorized Representative Information

Food Benefits

Complete the information below if you want to authorize someone to apply for or renew food benefits on your behalf and/or be issued his or her own electronic benefit transfer (EBT) card in order to buy groceries for you. You are responsible for any action taken by your authorized representative on your behalf. We will contact the person below for any additional information.

Name _____ Phone number _____ Relationship to you _____

Mailing address, street or PO Box _____ City _____ State _____ ZIP code _____

Do you want this person to apply for or renew food benefits on your behalf? ☐ Yes ☐ No

Do you want this person to be issued an EBT card in order to buy groceries for you? ☐ Yes ☐ No

Child Care Subsidy

Complete the information below if you want to authorize someone to apply for child care on your behalf or be issued his or her own EBT card to record attendance for your child(ren). **This person cannot work at the child care facility you choose.** You are responsible for any action taken by your authorized representative on your behalf.

Name | Phone number | Relationship to you

Mailing address, street or PO Box | City | State | ZIP code

Do you want this person to apply for or renew child care benefits on your behalf? ☐ Yes ☐ No

Do you want this person to be issued an EBT card in order to record your child's attendance at the child care facility for you? ☐ Yes ☐ No

By signing below, you give permission for the person(s) you listed to act as your authorized representative(s).

Signature | Date

Tell Us About Everyone Who Lives in the Home Starting With the Adult Head of Household

The head of household is an adult living in the home. When there are children in the home, it is best to choose the children's parent or the adult who has parental control over the children. This person will be the payee. You must check yes or no in the U.S. citizen block and fill in the Social Security number for each person who wants benefits. If there are more than six persons in your household, attach another sheet of paper showing their information. Providing race and ethnic background information is voluntary and does not affect your eligibility or benefit amount. Reporting this information assures that program benefits are distributed without regard to race, color, or national origin. The U.S. Department of Agriculture (USDA) requires us to answer these questions for you if you do not provide this information.

Person One (Head of Household)

Self, name of adult head of household | Date of birth | Marital status | Gender ☐ M ☐ F

U.S. Citizen? ☐ Yes ☐ No | Social Security number | Alien registration number | Hispanic or Latino? ☐ Yes ☐ No

Race - check all that apply:

☐ American Indian or Alaska Native; when checked, tribe:

☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Name on birth certificate | State of birth | County of birth

Mother's maiden name as listed on this person's birth certificate: First name | M.I. | Last name

Person Two

Name | Date of birth | Marital status | Gender ☐ M ☐ F

U.S. Citizen? ☐ Yes ☐ No | Social Security number | Alien registration number | Hispanic or Latino? ☐ Yes ☐ No

Relationship to head of household | Relationship to spouse of head of household

Race - check all that apply:
☐ American Indian or Alaska Native; when checked, tribe:
☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Name on birth certificate | State of birth | County of birth

Mother's maiden name as listed on this person's birth certificate: First name | M.I. | Last name

Person Three

Name | Date of birth | Marital status | Gender ☐ M ☐ F

U.S. Citizen? ☐ Yes ☐ No | Social Security number | Alien registration number | Hispanic or Latino? ☐ Yes ☐ No

Relationship to head of household | Relationship to spouse of head of household

Race - check all that apply:
☐ American Indian or Alaska Native; when checked, tribe:
☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Name on birth certificate | State of birth | County of birth

Mother's maiden name as listed on this person's birth certificate: First name | M.I. | Last name

Person Four

Name | Date of birth | Marital status | Gender ☐ M ☐ F

U.S. Citizen? ☐ Yes ☐ No | Social Security number | Alien registration number | Hispanic or Latino? ☐ Yes ☐ No

Relationship to head of household | Relationship to spouse of head of household

Race - check all that apply:

☐ American Indian or Alaska Native; when checked, tribe: _____

☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Name on birth certificate | State of birth | County of birth

Mother's maiden name as listed on this person's birth certificate: First name | M.I. | Last name

Person Five

Name | Date of birth | Marital status | Gender ☐ M ☐ F

U.S. Citizen? ☐ Yes ☐ No | Social Security number | Alien registration number | Hispanic or Latino? ☐ Yes ☐ No

Relationship to head of household | Relationship to spouse of head of household

Race - check all that apply:

☐ American Indian or Alaska Native; when checked, tribe: _____

☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Name on birth certificate | State of birth | County of birth

Mother's maiden name as listed on this person's birth certificate: First name | M.I. | Last name

Person Six

Name | Date of birth | Marital status | Gender ☐ M ☐ F

U.S. Citizen? ☐ Yes ☐ No | Social Security number | Alien registration number | Hispanic or Latino? ☐ Yes ☐ No

Relationship to spouse of head of household | Relationship to head of household

Race - check all that apply:

☐ American Indian or Alaska Native; when checked, tribe: _____

☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Name on birth certificate | State of birth | County of birth

Mother's maiden name as listed on this person's birth certificate: First name | M.I. | Last name

If You Need Child Care

Are you in danger of losing a job due to a lack of child care? ☐ Yes ☐ No

Have you made payment arrangements with the child care provider until a decision can be made on your child care application? ☐ Yes ☐ No

Are you starting a new job? ☐ Yes ☐ No If yes, starting date _____

Please fill in the name of each parent/caretaker, the reason you need child care, and the days and hours for the reason checked:

Parent/caretaker 1

Parent/caretaker name: _____

Reason:

☐ Work ☐ School ☐ Training ☐ Protective/preventive ☐ TANF Work

☐ Other: _____

Days and hours:

☐ Monday from ____ to ____ ☐ Friday from ____ to ____

☐ Tuesday from ____ to ____ ☐ Saturday from ____ to ____

☐ Wednesday from ____ to ____ ☐ Sunday from ____ to ____

☐ Thursday from ____ to ____

Parent/caretaker 2

Parent/caretaker name: _____

Reason:

☐ Work ☐ School ☐ Training ☐ Protective/preventive ☐ TANF Work

☐ Other: _____

Days and hours:

☐ Monday from ____ to ____ ☐ Friday from ____ to ____

☐ Tuesday from ____ to ____ ☐ Saturday from ____ to ____

☐ Wednesday from ____ to ____ ☐ Sunday from ____ to ____

☐ Thursday from ____ to ____

For Child Care Subsidy, you must complete an interview and provide all necessary proof, including the name of the child care provider you want to use. If determined eligible, the earliest date you can get help with child care is the date you bring all needed information to your local DHS office.

If You Need Food Benefits

Answer these questions to see if you can get them within seven calendar days:

How much money did you get or will you get this month from working (total amount before taxes?)	$ _____
How much other money did you get or will you get from all other sources this month (total amount)?	$ _____
How much cash do you have?	$ _____
How much money do you have in bank accounts?	$ _____
How much do you pay for your rent or mortgage?	$ _____
Do you pay the heating or cooling bill where you live?	☐ Yes ☐ No
Are you a seasonal or migrant farm worker?	☐ Yes ☐ No
Does anyone in your household receive tribal food commodities?	☐ Yes ☐ No

Households entitled to a decision within seven calendar days regarding their food benefit application are:

- households with less than $150 gross monthly income and liquid resources less then $100;
- households with monthly rent or mortgage and/or utilities which cost more than the combined monthly gross income and liquid resources; and
- destitute migrant or seasonal farm worker households with liquid resources less than $100.

If this describes your household, please stay for an interview or to get an appointment date and time.

Application Processing Time Limits

Applications must be processed within program specific time frames. The time frames are:

- TANF – 30-calendar days;
- *SNAP – 30-calendar days unless you are eligible for expedited services. Expedited services is 7-calendar days;*
- *Child Care Subsidy – 2-business days from the date the interview is completed and required proof is provided;*
- SSP – 30-calendar days for Aid to the Aged and 60-calendar days for Aid to the Blind or Disabled; and
- SoonerCare (Medicaid) for the aged, blind, or disabled – 30-calendar days for Aid to the Aged and 60-calendar days for Aid to the Blind or Disabled.

Non-Discrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The USDA also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information such as Braille, large print, audiotape, or American Sign Language can contact the Agency, State or

local, where they applied for benefits. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 977-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027), found online at http://www.ascr.usda.gov/complaint_filing_cust.html and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, S.W.,
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442 or

(3) email: Program.intake@usda.gov

For any other information dealing with SNAP issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-G, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

Please give this form to the receptionist or fax or mail it to your local DHS office.

DHS use only:

Is the household eligible for expedited food benefits? ☐ Yes ☐ No

Date received: _____

Date screened: _____ Screened by: _____

Interview date: _____ Interviewed by: _____

Routing

The original is imaged or filed in the case record. Upon request, a copy is given to the client.

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 shall remain confidential unless otherwise indicated by the complainant.

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

5. A written report shall 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 shall 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 shall be available to the public.

Complaint contact information: Long-Term Care Intake and Incident Division

Mailing address:

Oklahoma State Department of Health
Protective Health Services – 0501
1000 NE 10TH Street
Oklahoma City, OK 73117-1299

Email: LTCComplaints@health.ok.gov

Telephone: 800-747-8419 or 405-271-6868

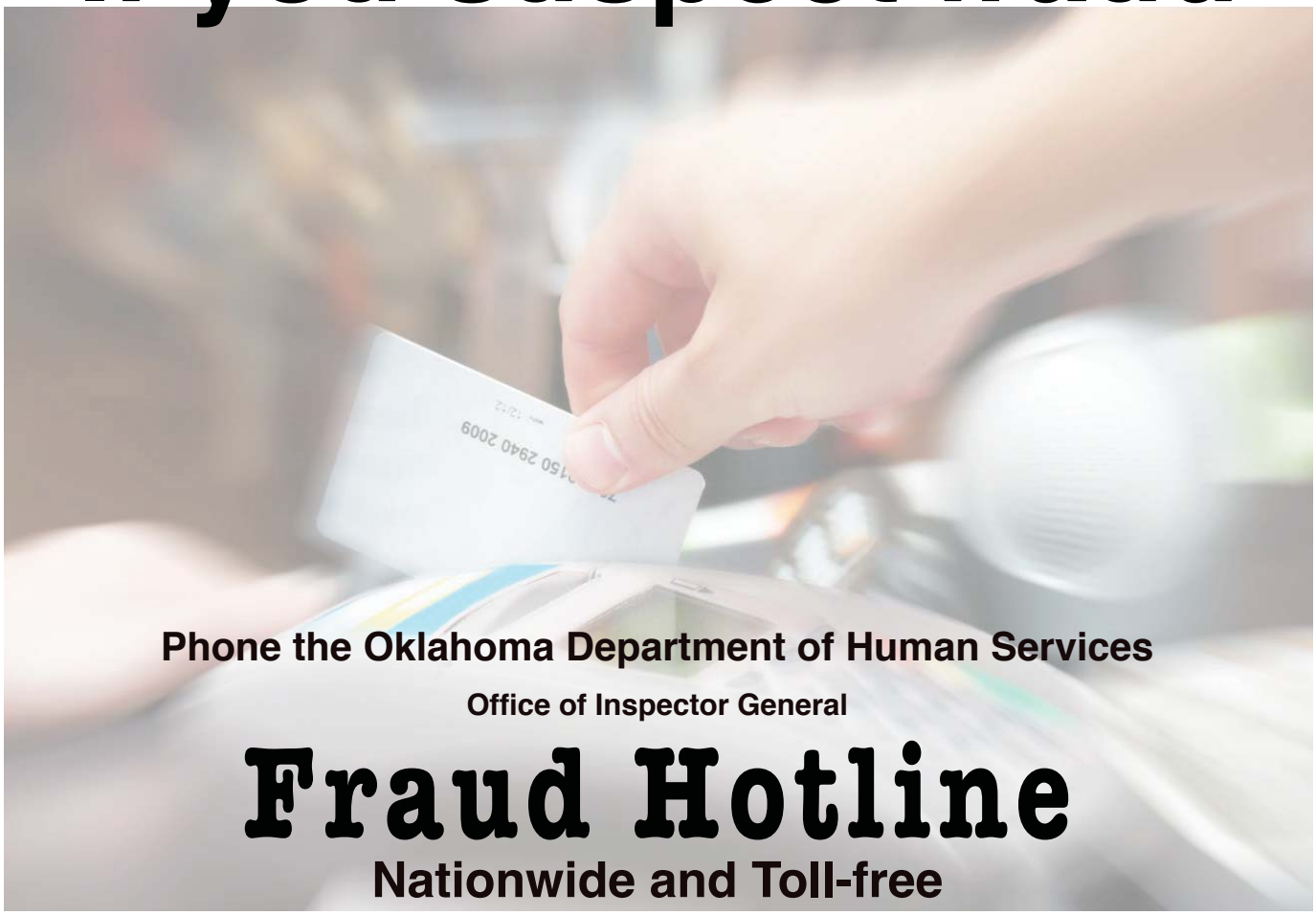
Fax: 866-239-7553 or 405-271-4172

Authorized by: Terry Cline, Ph.D.

Commissioner, Secretary of Health and Human Services

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)

If you suspect fraud



Phone the Oklahoma Department of Human Services

Office of Inspector General

Fraud Hotline

Nationwide and Toll-free

1-800-784-5887

Report

individuals who have obtained public assistance such as SNAP food benefits, TANF money payments, SoonerCare (Medicaid) or other services through fraudulent means or who have used public assistance in a manner not consistent with its intended use.

Be prepared to tell investigators the person's name and address and why you believe fraud is being committed.

All reports to the fraud hotline may be filed anonymously by persons suspecting fraudulent activity.

OKLAHOMA OKDHS EXCELLENCE
OKLAHOMA DEPARTMENT OF HUMAN SERVICES

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ITEMS AND SERVICES INCLUDED IN BASIC RATE FOR PRIVATE PAY RESIDENTS

The following list of items are included in and covered by the basic rate:
Basic Rate (in effect on the date of the agreement)

Private Room $ 215.00 Semi-Private Room $ 195.00

The items and services included in this rate are:

- **Nursing Services**
- **Dietary Services**
- **Activities Program**
- **Medically related Social Services**
- **Linen, Housekeeping and Maintenance services**
- **Basic personal laundry**
- **Routine personal hygiene items and services**

ITEMS AND SERVICES INCLUDED IN BASIC RATE FOR MEDICARE/MEDICAID RESIDENTS

The list indicates the services included and covered by Medicare or Medicaid:

1. Rooms: Semi-private or ward accommodations and bed maintenance services
2. Nursing Services (24-hour)
3. Dietary Services (Meals/Snacks)
4. Activities Program
5. Medically related Social Services
6. Linen, housekeeping, and maintenance services
7. Routine, over-the-counter drugs and supplies ordered by the attending physician not otherwise covered by a governmental program
8. Basic personal laundry
9. Routine personal hygiene items and services, including:

    a. Hair hygiene supplies (comb, brush, shampoo)
    b. Bath soap
    c. Disinfecting soaps or specialized cleaning agents, when indicated, to treat special skin problems or to fight infection
    d. Razon
    e. Shaving cream
    f. Toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss
    g. Moisturizing lotion
    h. Tissues
    i. Cotton balls, cotton swabs
    j. Deodorant
    k. Sanitary napkins and related supplies
    l. Towels, washcloths
    m. Hospital gown
    n. Nail hygiene
    o. Bathing services

ITEMS AND SERVICES *NOT* INCLUDED IN BASIC RATE

This list indicates the extra services available in The Center which are NOT covered by the basic rate. This list is subject to periodic update. Current charges for these services are available upon request, and are also subject to change.

1. Personal telephone
2. Television/radio for personal use
3. Personal comfort items, including smoking materials, notions and novelties, and confections
4. Cosmetics and grooming items and services in excess of those for which payment is made under Medicaid and/or Medicare
5. Personal clothing
6. Personal reading matter
7. Gifts purchased on behalf of a resident
8. Flowers and plants
9. Social events and entertainment offered outside the scope of the activities program
10. Non-covered special care services, such as privately hired nurses and/or aides
11. Private room, except when therapeutically required (for example, isolation for infection control).
12. Specially prepared or alternative food requests in place of the food generally prepared by the facility, except as required by physician's order
13. Beautician and barber services as requested by Resident or Resident's family
14. Dental services as requested by Resident or Resident's family
15. Hearing aids and batteries
16. Dry cleaning
17. Eye examinations, eyeglasses and repair
18. Routine podiatry care
19. Medical supplies (except under Medicare B, which covers 80% of all ancillary items. The Resident is required to pay for the remaining 20%)
20. Oxygen cylinder and concentrators
21. Physician services
22. Prescription medications (except under Medicare Part A)
23. Equipment rental
24. Skilled therapy services (except under Medicare Part A or Part B)
25. X-Ray and laboratory (except under Medicare Part A or Part B)
26. Incontinence care supplies
27. Snacks from vending machines

ABUSE POLICY

POLICY: It is the policy of this facility to maintain an abuse free environment.

ABUSE is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

ABUSE also includes the deprivation by an individual, (including a caretaker), of goods of services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in coma, cause physical harm or pain or mental anguish.

VERBAL ABUSE is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms aimed to residents or their families, or said within their hearing distance, regardless of their age, ability to comprehend or disability. Examples of verbal abuse include but are not limited to: threats of harm: saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

PHYSICAL ABUSE includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

MENTAL ABUSE includes but is not limited to humiliation, harassment, and threats of punishment of deprivation. Each resident has the right to be free from all types of abuse including metal abuse. Mental abuse includes but is not limited to abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s) including distributing or posting the photographs or information on social media.

SEXUAL ABUSE includes any gesture, verbal or physical that is threatening, degrading, lewd or lascivious in nature.

MISAPPROPRIATON OF RESIDENT'S PROPERY refers to the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

POLICIES AND PROCEDURES:

This facility has developed and implements policies and procedures regarding abuse that include seven components including screening, training, prevention, identification, investigation, protection and reporting/response.

1. SCREENING: Potential employees will be screened by background checks through the OSBI for criminal background/history especially history involving abuse, neglect or mistreatment of residents. The facility will not employ individuals who have been found guilty by a court of law of abuse, neglect or mistreatment of residents. Reference checks will be completed with previous and/or current employers to check for nay history of abuse, neglect or mistreatment of residents. CNA will be checked through the state nurse aid registry on-line to verify registration and to check for any finings entered for abuse, neglect, mistreatment, or misappropriation of property of residents. Licensed nurse will be check online with the OSBN (Oklahoma State Board of Nursing) for current active license.

2. TRAINING: All employees will be trained through orientation and yearly in-service as to what constitutes abuse, neglect, and misappropriation of resident property and how to report their knowledge related to allegations of abuse or neglect without fear of reprisal. Additionally, such topics will be presented in orientation and annually in abuse in-service.
    a. Understanding the resident's abusive actions
    b. Cultural, religious, and ethnic difference and how they can lead to conflict
    c. Resolving conflict
    d. Recognizing signs and symptoms of abuse
    e. Stress reduction and burnout
    f. Dealing with aggressive or catastrophic Resident behavior/reactions
    g. Other techniques that may be helpful in preventing Resident abuse

3. PREVENTION: Residents and families will be made aware of how and to whom they may report concerns, incidents, and grievances without fear of retribution. On admission, Residents and families are given a copy of the complaint procedure, which has a toll-free number and state hotline where they may report any concerns or grievances.

    Staff will be taught to be vigilant to the features of the physical environment that may make abuse and/or neglect more likely to occur, such as secluded areas of the facility. The facility will make sure there will be staff on each shift in sufficient numbers to meet the needs of the Residents, and to assure the staff assigned has knowledge of the individual's care needs.

    Staff will be monitored by the charge nurse, so that he/she will be able to identify inappropriate behaviors, such as using derogatory language, rough handling, ignoring Residents while giving care, or directing Residents who need toileting assistance to urinate or defecate in their beds.

Residents will be assessed, monitored, and a care plan will be established to direct care for Residents with needs and behaviors which might lead to conflict or neglect, such as Residents with a history of aggressive behaviors, Residents who have behaviors such as entering other Residents' rooms, Residents with self-injurious behavior, Residents with communication disorders, or those who require heavy nursing care and/or are totally dependent on staff for care.

4. **IDENTIFICATION**: Staff will be trained to identify potential signs of abuse and to report same to the charge nurse. These signs may include such things as suspicious bruising of Residents, scratches, new fear of staff or of receiving care, unusual occurrences, patterns and trends of incidents. Methods for identifying the aforementioned signs include the use of skin assessments, daily observation during bathing and dressing or care, and through the completion, tracking, and trending of incident reports, watching for repeat suspicious injuries with the same Resident.

5. **INVESTIGATION**: Any allegation of abuse will be investigated by the Administrator and the Director of Nursing. The Administrator and Director of Nursing will, as a minimum:

    a. Review the Resident's medical record, looking for events leading up to the incident
    b. Interview the person(s) reporting the incident
    c. Interview any witnesses to the incident
    d. Interview the Resident (if cognitive ability permits)
    e. Interview staff members (on all shifts) who have had contact with the Resident during the period of the alleged incident, if necessary
    f. Interview the Resident's roommate, family members, and visitors as able and necessary
    g. Interview other Residents to who the accused employee provides care or services, and
    h. Review all events leading up to the incident.

    Each interview will be conducted separately and in a private location. The purpose and confidentiality of the interview findings will be explained thoroughly to each person involved in the interview process

    Should a person disclose information that may be self-incriminating, that the individual will be informed of his/her rights to terminate the interview until such time as he/she may obtain legal representation.

    Witness reports will be reduced to writing with the witness signing and dating the report on the "Witness Report" form. The witness will write his/her own report.

    While the investigation is being conducted, accused individuals NOT employed by the facility (such as family members or visitors) will be denied unsupervised access to Residents. Visits may only be made in designated areas approved by the Administrator.

A written report will be completed that identifies the person responsible for reporting the incident. The Administrator will notify the Oklahoma State Department of Health by faxing "Incident Report Form" (283) to 405-271-4172 or toll-free fax 866-239-7553 and the Department of Human Services/Adult Protective Services at 580-310-7062 or 7094 within 24 hours of the incident.

6. **PROTECTION**: Residents who are alleged to have been abused will be protected from harm during the investigation. Employees of this facility who have been accused of Resident abuse will be suspended from duty. This action will remain in effect until the investigation has been completed.

7. **REPORTING/RESPONSE**: All alleged violations and all substantial incidents will be reported to the Oklahoma State Department of Health as described in number 5 above. Any CAN who has been found unfit for service by a court of law will be reported to the State Nurse Aid Registry. Any licensed nurse found unfit for service by a court of law will be reported to the Oklahoma Board of Nursing.

    All occurrences of abuse will be analyzed by the Quality and Assurance Committee during the next scheduled meeting or in a called meeting to determine changes that are needed, if any in-facility practices and policies and procedures will be amended or developed to prevent further occurrences.

    Residents identified by their past or present behavior, diagnoses, medical history, or through the Minimum Data Set as having a potential for abuse will have a care plan developed for behavior modification, which will be reviewed and/or updated at least quarterly and with a significant change. Residents may be referred to a geriatric mental health facility for behaviors that the facility is unable to control.

ABUSE BY RESIDENT

All forms of abuse, including resident-to-resident abuse, resident to family/visitor, or staff must be reported to the charge nurse who then must report to the Director of Nursing and the Administrator.

1. Facility staff will monitor Residents for aggressive/inappropriate behavior toward other Residents, family members, visitors, or toward the staff. Occurrences of such incidents must be promptly reported to the charge nurse, who will fill out an incident report and he/she will report the incident to the Director of Nursing and the Administrator.

2. Should a Resident be observed/accused of abusing another Resident, family or visitor, or staff, our Facility will implement the following actions:

    a. Remove the aggressor from the situation, if the aggressor is still in the area in which the incident occurred, unless in his/her own room.

    b. Temporarily separate the Resident from other Residents as a therapeutic intervention to help lower the agitation and calm the Resident until the interdisciplinary team can identify causes and develop a plan of care to meet the needs of the Resident.

    c. Interview and evaluate the Resident to gather information about the cause of the behavior, including circumstances/events leading up to the incident. Notify each Resident's responsible party and attending physician of the incident.

    d. Develop a care plan that includes interventions to prevent the recurrence of such incidents, including the appropriate management of any underlying conditions such as acute psychosis that may have caused or contributed to the problem.

    e. Inform all staff involved in the care of the Resident of the new care plan and to promptly report behavioral changes to the charge nurse.

    f. Document in the clinical record all interventions and their effectiveness.

    g. Consult psychiatric services as needed for assistance in assessing the Resident, identifying causes, and developing a plan for intervention and management as necessary for transfer to a geri-psych facility for treatment.

    h. Complete an incident report and document the incident, findings, and any corrective measures taken in the Resident's medical/clinical record.

    i. Report incidents, findings, and corrective actions to appropriate state agencies as in #7: Reporting/Response.

HOSPICE PROGRAM

Our facility contracts for hospice services for residents who wish to participate in such programs.

POLICY:

1. Our facility has entered into a contractual arrangement for hospice services to ensure that residents who wish to participate in a hospice program may do so.
2. When a resident has been diagnosed as terminally ill, the Director of Nursing will contact the hospice agency and request that a visit/interview with the resident/family be conducted to determine the resident's wishes relative to participation in the hospice program.
3. When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status.
4. The hospice agency retains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions which include:
    a. Designation of a Hospice Registered Nurse to coordinate the implementation of the plan of care
    b. Provision of substantially all core services (e.g. physician, nursing, medical social work, and counseling services) that must be routinely provided directly by the hospice employees, and cannot be delegated to the facility as outlined in current hospice regulations at Section 418.112.
    c. Provision of drugs and medical supplies as needed for palliation and management of the terminal illness and related conditions,
    d. The facility and hospice will identify the specific services that will be provided by each entity and this information will be communicated in the plan of care.
    e. The hospice and facility will communicate with each other when any changes are indicated or made to the plan of care.
5. All hospice services are provided under contractual arrangement. Complete details outlining the responsibilities of the facility and the hospice agency are contained in the agreement. A copy of this agreement is on file in the facility and the hospice agency.
6. This policy provides complete disclosure to the resident of the facility's relationship with Halo Hospice and that the parent company holds greater than a 5% ownership in said hospice company as required by State regulation.
7. The Social Services Director or designee will provide a list of available hospice companies to all residents at the time of admission and at the time of identified need for hospice services (see Facility list).

PROVISION OF DENTURES AND EYEGLASSES

POLICY: It is the policy of this Center to provide eyeglasses and dentures to Medicaid residents as determined by the quarterly assessments of each resident. Eyeglasses must be medically necessary. If the resident, family or guardian wishes to upgrade their frames or lenses from the standard $100, the resident's family or guardian must assume the added costs.

_____(Optometrist) _____(Dentist)

will see our residents either in their office or at the facility, if deemed necessary. The assessment will be documented on the dental and vision plan of care. All new residents will be assessed upon admission, then annually.

POLICY FOR LOST AND/OR STOLEN ITEMS

Due to the open visitation rights extended to all residents, we cannot assume the expense of loss by theft of any items brought in the facility. We will, in all cases, be happy to assist the family in locating missing items and in aiding law enforcement officers in recovering stolen property. If the loss was reported by someone other than the family, we contact the family to assure that the item was not removed by them. Notation of the loss and the efforts to recover same shall be documented in the nurse's notes in the resident record. Due to this policy, we recommend that items of large value NOT be included in the resident's possession. We will not assume responsibility for lost or stolen goods. When an item is reported missing, the Administrator will be contacted and efforts to locate the item will be implemented. If the lost item is not recovered after an in-facility search, we will assist the family in reporting the loss to the proper law enforcement agency should the family desire to pursue this option.

PERSONAL PROPERTY

POLICY: It is the policy of this Center that any medication brought into this facility for a resident must be checked in with the licensed nurse. Federal regulations prohibit any medication, prescription and/or over the counter, to be in a resident's room without an order written by the physician. It is our policy that resident may self-administer medication if they request to do so. The physician's order must be obtained, and an assessment must be done by the Interdisciplinary Care Planning Team to determine that the resident is capable of safely administering their own medication. These medications include but are not limited to: Vicks, salve, mentholatum, hemorrhoid medication, Ben Gay, aspirin, Tylenol, etc.

DESTRUCTION OF MEDICATIONS

POLICY: It is the policy of this Center that all discontinued medication or medication left after the death of a resident will be destroyed by the Consulting Pharmacist and a registered nurse. If a resident is transferred home or to another facility, the medication will be transferred with that resident.

REFUNDS

POLICY: It is the policy of this Center that, when a resident is discharged from the facility, any money refunded to the resident or responsible party will be refundable within thirty days of discharge.

NON-DISCRIMINATION POLICY

POLICY: In accordance with Title VI of the Civil Rights Act of 1964 and its implementing regulation, this facility will not directly or through contractual arrangements, discriminate on the basis of race, color, or national origin in its provision of services and benefits, including assignments or transfers or referrals to or from the facility. Staff privileges are granted without regard to race, color, or national origin.

In accordance with Section 504 of the Rehabilitation Act of 1973 and its implementing regulation, this facility will not directly or through contractual arrangements, discriminate of the basis of disability in admissions, access to treatment or employment.

In accordance with the Age Discrimination Act of 1975 and its implementing regulations, this facility will not, directly or through contractual arrangements, discriminate on the basis of age in the provision of services, unless age is a factor necessary to normal operations or the achievement of any statutory objective.

BED HOLD POLICY

POLICY: It is the policy of this facility that if a resident is admitted to the hospital or leaves the facility for longer than a 24-hour period on therapeutic leave, the Department of Human Services allows and will be responsible for seven (7) therapeutic leave days, but no hospital days.

1. It is the policy of this facility to continue to charge for the bed, unless the family has notified the facility that they wish to give up the bed.
2. At the time the bed is released, the resident's personal belongings will be removed from the facility.
3. In the event the bed is released, there is no guarantee that a bed will be available upon the resident's discharge from the hospital.
4. Medicaid residents are responsible for their monthly payments on the 1st of each month, whether they are out to the hospital or out on therapeutic leave during the month.
5. Private pay residents must pay for hospital days unless the nursing facility is instructed NOT to hold the bed.

OKLAHOMA DO-NOT-RESUSCITATE (DNR) CONSENT FORM

I, _____, request limited health care as described in this document. If my heart stops beating or if I stop breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider including, but not limited to, emergency medical services (EMS) personnel.

I understand that this decision will not prevent me from receiving other health care such as the Heimlich maneuver or oxygen and other comfort care measures.

I understand that I may revoke this consent at any time in one of the following ways:

1. If I am under the care of a health care agency, by making an oral, written, or other act of communication to a physician or other health care provider of a health care agency;

2. If I am not under the care of a health care agency, by destroying my do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation;

3. If I am incapacitated and under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by written notification of a physician or other health care provider of the health care agency or by oral notification of my attending physician; or

4. If I am incapacitated and not under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by destroying the do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation.

I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers. I hereby state that I am making an informed decision and agree to a do-not-resuscitate order.

_____OR_____

Signature of Person Signature of Representative

(Limited to an attorney-in-fact for health care decisions acting under the Durable Power of Attorney Act, a health care proxy acting under the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act.)

This DNR consent form was signed in my presence.

_____	_____	_____
Date	Signature of Witness	Address
	_____	_____
	Signature of Witness	Address

CERTIFICATION OF PHYSICIAN

(This form is to be used by an attending physician only to certify that an incapacitated person without a representative would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. An attending physician of an incapacitated person without a representative must know by clear and convincing evidence that the incapacitated person, when competent, decided on the basis of information sufficient to constitute informed consent that such person would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Clear and convincing evidence for this purpose shall include oral, written, or other acts of communication between the patient, when competent, and family members, health care providers, or others close to the patient with knowledge of the patient's desires.)

I hereby certify, based on clear and convincing evidence presented to me, that I believe that would not have consented to the Name of Incapacitated Person adminstration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Therefore, in the event of cardiac or respiratory arrest, no chest compressions, artificial ventilation, intubations, defibrillation, or emergency cardiac medications are to be initiated.

_____ _____

Physician's Signature/Date Physician's Name (PRINT)

_____

Physician's Address/Phone

Witnesses must be individuals who are eighteen (18) years of age or older who are not legatees, devisees or heirs at law.

It is the intention of the Legislature that the preferred, but not required, do-not-resuscitate form in Oklahoma shall be the form set out in subsection B of this section.

State of Oklahoma

Advance Directive for Health Care

This form is available in English, Spanish and Vietnamese at okdhs.org/programsandservices/aging/legal.

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

I. Living Will

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below:

1. If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

(Initial one option only)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

_____ See my more specific instructions in paragraph four (4).

2. If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

(Initial one option only)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

_____ See my more specific instructions in paragraph four (4).

3. If I have an end-stage condition, that is, 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:

(Initial one option only)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

_____ See my more specific instructions in paragraph four (4).

4. Other.
Here you may: (a) describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn; (b) give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition; or (c) do both of these.

_____

_____

_____

_____

_____

_____

_____

_____

_____

II. My Appointment of My Health Care Proxy

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of:

_____, whom I appoint as my health care proxy.

If my health care proxy is or becomes unable or unwilling to serve, I appoint:

_____ as my alternate health care proxy with the same authority.

My health care proxy is authorized to make whatever health care decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I have indicated in the foregoing sections.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

III. Anatomical Gifts

Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of:

(Initial all that apply)

_____ transplantation therapy
_____ advancement of medical science, research or education
_____ advancement of dental science, research or education

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. I specifically donate:

(Initial all that apply)

_____ My entire body; or

The following body organs or parts:

_____ lungs	_____ liver	_____ arteries
_____ pancreas	_____ heart	_____ glands
_____ kidneys	_____ brain	_____ tissue
_____ skin	_____ bones/marrow	_____ eyes/cornea/lens
_____ bloods/fluids	_____ tissue	_____ other

IV. General Provisions

a. I understand that I must be eighteen (18) years of age or older to execute this form.
b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.
c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my 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.
d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.

Continued on next page

e. This advance directive shall be in effect until it is revoked.

f. I understand that I may revoke this advance directive at any time.

g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.

h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.

i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

Signed this _____ day of_____, 2_____.

_____

Signature

_____ _____

Residence (City, county and state) Date of birth (Optional)

This advance directive was signed in my presence.

_____ _____

Signature of Witness Signature of Witness

_____ _____

Address Address

_____ _____

City/State City/State

For assistance in filling out this form call (405) 522-3069.

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