PERSONAL CARE HOME
ADMISSION AGREEMENT

The Management of Corinth Road Personal Care Home (Personal Care Home) hereby agrees to provide the following services for _____ (Resident).

BASIC SERVICES: included in the basic monthly fee are a semi-private or private room (see criteria for retaining a private room), 24 hour access to staff with all Workforce Training including Medication Management and Infection Control procedures, supervision of nutrition, laundry facilities, towels, toilet tissue, soap, light bulbs, bedding and supplies – minimally 2 sets, emergency transportation, referral for appropriate services when needed, insure resident safety and security, continuous assessment of needs and personal services, 24 hour a day lodging, 3 balanced meals per day and 2 snacks, information to surrogate, relative or representative regarding changes in resident's condition.

The services listed above will be provided at a rate of $_____ per _____.

The following services shall be the responsibility of either the management or the resident, as indicated by the appropriate signature in the designated column. If provided by the management, any additional fee is so designate.

SERVICE	PARTY RESPONSIBLE FOR SERVICE	FEE
Purchase clothing and personal hygiene supplies as needed.	Family / Personal Representative	
Acquire medication refills and/or obtain new medication.	Corinth Rd PCH / Family / PR	
Transportation to/from medical appointments	Corinth Rd PCH / Family / PR	
Transportation to/from other activities.	Corinth Rd PCH / Family / PR	
Personal laundry.	Corinth Rd PCH	
Arrange for transfer and/or discharge when necessary.	Family / Personal Representative	

Receipt of Information: I acknowledge that I have received a copy of and agree to comply with:

a. This home does not claim to be practicing nursing.
b. Nursing visits are completed by outside agencies are not staff members of the home.
c. That he/she has received information relative to advance medical directives.
d. The House Rules
e. This home DOES OR DOES NOT require multi-dose packaging of medications.
f. This home DOES OR DOES NOT offer the use of proxy caregivers
g. The home does not use unsupervised volunteers as staff members of the home.
h. Has the right to voice complaints/concerns with management at any time in accordance with the Remedies for Residents of Personal Care Homes Act and the right to file a complaint with the Healthcare Facility Regulation Division.
i. He/she will not be required to perform services for the home except as provided in this agreement or in subsequent written agreement, and then only if the resident volunteers or is compensated at or above prevailing rates.

PERSONAL CARE HOME
ADMISSION AGREEMENT

Emergency/Disaster: In the unlikely event that the home must be temporarily closed due to some disaster, management will make every effort to find appropriate placement for residents. During any interim, the resident's family and/or sponsor will be expected to house the resident.

Both the management and the resident understand that this agreement may be terminated by either party, only with a thirty (30)day written notice. **EXCEPTION**: No notice is required if the resident develops a communicable disease or a change in condition that requires continued nursing care.

Management further agrees to provide a sixty-day written notice prior to a change in fees. This agreement has been read by and/or fully explained to the resident/surrogate.

By signing below, all parties to this agreement acknowledge that they understand and will abide by the conditions outlined in this document.

Signed: _____ Date: _____
(Manager)

Signed: _____ Date: _____
(Resident)

Signed: _____ Date: _____
(Surrogate)

I am _____ am not _____ resident's legal guardian.

EMERGENCY PROCEDURE/CONSENT FOR EMERGENCY TREATMENT

EMERGENCY PHONE NUMBERS

Ambulance: **911** Poison Control: **911** Fire: **911** Police: **911**

IDENTIFYING INFORMATION

Resident's name: _____ DOB: _____

Address: _____ Phone: _____

City: _____ County _____ State _____ Zip: _____

Age: _____ Sex _____ Race _____ Religious preference/church: _____

MEDICAL INFORMATION

Does resident have a Living Will or Durable Power of Attorney for Health Care? Yes No If Yes, See attached copy.

M'caid # _____ M'care# _____ VA Status _____ SS# _____

Other insurance: _____

Physician name: _____ Address: _____ Phone: _____

City _____ State _____ Zip _____ Fax: _____

Hospital choice: _____ Address: _____ Phone: _____

City _____ State _____ Zip _____ Fax: _____

Known Diagnoses

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

10. _____ 11. _____ 12. _____

Pharmacy: _____ Address: _____ Phone: _____

Known drug allergies: _____

FAMILY/RESPONSIBLE PARTY INFORMATION

Resp. party: _____ Phone(H) _____

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

Relationship: _____ Employment: _____ Phone(W) _____

#2 contact: _____ Phone(H) _____

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

Relationship: _____ Employment: _____ Phone(W) _____

CONSENT FOR EMERGENCY TREATMENT

IN THE EVENT THAT NEITHER FAMILY/RESP. PARTY IS AVAILABLE, Corinth Road Personal Care Home and/or its employees are hereby given full authority to seek or administer care/medication for the resident, named above, and to secure or provide transportation. I AGREE TO ASSUME FULL RESPONSIBILITY FOR ALL EXPENSES incurred in securing prompt medical care.

Signature: _____ Witness: _____ Date: _____

Advance Directive Checklist

Please read the following three statements. After reading the statements, please write your initials at the end of **each** statement.

1. I have been given written materials on my rights to accept or refuse medical treatment and/or services and on my rights to formulate Advance Directives.

   _____ (Resident's Initials)

2. I understand that I am not required to have an Advance Directive in order to receive services or medical treatment at

   Corinth Road Personal Care Home
   (Name of Healthcare Facility/Service)

   _____ (Resident's Initials)

3. I desire that the terms of any Advance Directive that I execute will be followed by

   Corinth Road Personal Care Home
   (Name of Healthcare Facility/Service)

   _____ (Resident's Initials)

Please read the following statements. After reading the statements, please check **ONE** of the following statements:

1. _____ I have executed an Advance Directive and will provide a copy to the Healthcare Facility providing services. I understand that the staff and physicians of

   Corinth Road Personal Care Home
   (Name of Healthcare Facility/Service)
   will not be able to follow the terms of my Advance Directives until I provide a copy of it to the staff.

2. _____ I have not executed an Advance Directive and do not wish to discuss Advance Directives at this time.

3. _____ I have not executed an Advance Directive but would like to obtain additional information about Advance Directives.

_____ _____
Resident's Signature Date

_____ _____
Witness' Signature Date

PERSONAL CARE HOME Corinth Road Personal Care Home
RESIDENT _____

WRITTEN CONSENTS

(1) Medical Information

I, _____ (resident), give permission for _____ (manager) to receive any necessary medical information concerning my care. This will remain in effect as long as I am a resident of this personal care home or until revoked in writing.

Resident or Sponsor/Guardian _____ Date _____ Manager _____ Date _____

(2) Financial Assistance

I DO _____ DO NOT _____, request the assistance of _____ (manager) in managing my monthly checks and other financial matters. I understand a quarterly accounting of my money will be provided to me.

Resident or Sponsor/Guardian _____ Date _____ Manager _____ Date _____

(3) Personal Needs Allowance

I DO _____ DO NOT _____ wish to receive the $20.00 per week personal needs allowance. (I understand that if I elect to receive it, I will be billed for it.)

Resident or Sponsor/Guardian _____ Date _____

(4) Relation to Personal Care Home Owner

Date _____ Owner Ann Cowan

I, _____, being admitted today to the above named Personal Care Home, acknowledge that I am in no way related to the above named Owner of said home, or to any member of the staff to the best of my knowledge.

Signature, Resident _____ Signature, PCH Representative _____

Designating a Representative

I, _____ ,authorize
(Resident's name)

_____ as my representative
(Representative's Name)

_____
(Representative's Address)

(_____) _____
(Representative's Telephone Number)

To act on my direction in matters of:

_____ Health and Well-Being

_____ Access to any records pertaining to me or my care

_____ Receiving information and notices pertaining to my care and condition

Signed: _____ Date _____

I choose not to designate a representative at this time.

Signed: _____ Date _____

IN THE EVENT OF DEATH

NAME OF RESIDENT _____

SOCIAL SECURITY _____ DOB _____

LIFE INSURANCE _____ POLICY NUMBER _____

BENEFICIARY _____ PHONE _____

ADDRESS _____

DOES RESIDENT HAVE PREARRANGED FUNERAL ARRANGEMENTS? _____

NAME OF FUNERAL HOME _____

ADDRESS _____

PHONE _____

IF NO PREARRANGED FUNERAL ARRANGEMENTS

FAMILY MEMBER RESPONSIBLE _____ PHONE _____

ADDRESS _____

DESIGNATED FUNERAL HOME TO CALL _____

PHONE _____

OTHER NEXT OF KIN _____ PHONE _____

ADDRESS _____

Resident Receipt of Forms
Party Responsible for Financial Transactions

RESIDENT: _____

PCH: Corinth Road Personal Care Home

RESIDENT MOVED INTO THIS PCH ON: _____

PREVIOUS ADDRESS: _____

_____

_____

PARTY RESPONSIBLE FOR FINANCIAL TRANSACTIONS:

_____

PARTY RESPONSIBLE FOR PERSONAL NEEDS ALLOWANCE:

_____

I have received copies of the following:

* Admission Agreement
* House Rules
* Resident Rights
* Notice of Privacy Practices
* Written Consents
* Inventory List

_____

Signature of Resident/Surrogate

PERSONAL CARE HOME
Resident's Bill of Rights

AS A RESIDENT OF THIS PERSONAL CARE HOME, YOU ARE GUARANTEED OF CERTAIN RIGHTS that cannot be waived by anyone-including you, your legal surrogate, or the management of this home. *These basic rights follow:*

- You will receive care that is adequate and appropriate for your needs, and in compliance with all State and Federal laws, and without discrimination based on your age, sex, race, physical or mental status, or the source of payment for your service.
- You will not be harassed or punished by anyone in this Personal Care Home because or your efforts to enforce your rights.
- You also that the right to:
    - Exercise your constitutional rights as a citizen of this state and county, including your right to vote.
    - Choose activities and schedules that are consistent with your interests and assessments
    - Interact with other members of this community, both inside and outside the home, and to participate in the life of this community.
    - Make choices about aspects of your life in this home that are important to you.

For example:

- You have the right to privacy in your room; employees and other residents must respect your privacy by knocking on your door before entering. You may associate with and speak privately with people or groups of your choice, without fear of eavesdropping or censoring.
- If you are married and your husband or wife is also a resident in this home, you may share a room, unless you prefer not to.
- You have the right to respect and privacy when you are taking care of your personal needs such as bathing and toileting; you may use the bathrooms, in privacy, at any hour of the day or night.
- Neither the management of this home nor its employees will impose any religious belief upon you; you are free to practice your religious beliefs as you choose. You may participate in social, religious, and community activities, as long as they do not interfere with the rights of other residents.

- You are guaranteed that you will not be abused-mentally, verbally, sexually or physically-nor will you be neglected or exploited. You have the right to be free from physical or chemical restraints, and to be free from the threat of such restraints. You will not be punished by isolation from other residents, you will not be struck, and you will not be the victim of any unusual punishment, such as interference with your eating or sleeping.
- You have the right to use, keep and control your property in the living quarters, EXCEPT when the use of your property would interfere with the health or safety of other residents. You have the right to expect that reasonable safeguards exist to protect your personal property and the possessions you have brought into this home, as long as such property is registered with the Management and listed on the "Inventory of Personal Property."
- Your mail will be delivered to you, unopened, on the day that it is delivered to the home; your outgoing correspondence will not be opened or censored.
- You may have free and private access to the home's telephone, in accordance with the "House Rules." If you want a private telephone, you may have it, at your own expense.
- Your visitors are welcome, as outlined in the "House Rules;" no advance notice is necessary. However, if you do not want to see a visitor, you will not be forced to do so; you may also end a visit when you choose.
- You have the right to manager your own financial business, including the right to keep and spend your own money, unless a judge (in a legal hearing) has determined that someone else must manage

your money, neither the management of this home nor the staff will try to convince you to transfer to the home or to any individual your money, valuables, benefits, or property – or anything of value – other than payment for services rendered by this home.

- You have the right to know how much your care will cost and what portion (if any) will be paid by other sources, such as your insurance or government programs.
- You have the right to be informed of the relationship between this home and any other organization or service that you are referred to by this agency. You have a right to choose a different organization or service that you are referred to by an agency. You have a right to choose a different organization or service if you so desire.
- You have the right to a twenty dollar ($20.00) per week allowance, for your free use, to be issued by an authorized staff person:
    - This allowance will be included as a charge on your bill for services
    - If you do not want to receive the $20.00 allowance, you or your legal surrogate may sign a written statement to that effect, at any time. In such a case, you will not be billed for the allowance; however, if you or your legal surrogate do not sign such a waiver, you will receive the allowance in cash, on the same day each week.
    - You will not need to purchase such necessary goods as the home usually provides, the home will make sure that these goods – such as toilet tissue and light bulbs – are available to you.
- You have the right to receive or refuse medical care, dental care, or other services EXCEPT as required by law or regulations.
- You have the right to choose your own physician, and any other healthcare professional or service. This home will not interfere with your right to receive complete and accurate information about your condition and treatment. You (and/or your legal surrogate) have the right to be fully informed about your condition, your care and any changes in your condition or care in words that you can understand. You have the right to see the information contained in your medical records.
- You have the right to participate in planning your own care. Any discussion of your condition or care as well as consultation and examination will be confidential, and will be handled discreetly. No person who is not directly involved in your care may be present when it is rendered, without your permission.
- You have the right to expect proper identification – by – name and title – of those persons who care for you.
- You may inspect your records; you may copy your records. You also have the right to confidential treatment of personal information in your file.
- Unless you have been committed to this home by a court order – and, unless you have a legal surrogate with written authority to admit, transfer or discharge you for this home-you may discharge or transfer yourself, by notifying the home, in compliance with terms outlined in the "Admission Agreement."
- You have the right of access to the State Long-Term Care Ombudsman Program; the name, address, and telephone number of the ombudsman and county inspector assigned to the home is on the "House Rules" posted in the home's common areas.
- You and other residents have the right to form a Resident Council and have meetings in this home without Management or staff being present.
- You have the right to state your objections and to suggest changes in this home's policies and services without being afraid of discrimination. To express a problem or recommend a change, contact the State Long-Term Care Ombudsman Program.

Client signature: _____ Date: _____

Witness/Manager signature: _____ Date: _____