CONTRACT BETWEEN RESIDENT AND
MASON CITY AREA NURSING HOME ASSOCIATION, INC
(d/b/a MASON CITY AREA NURSING HOME)

CONTRACT dated _____ between

Resident:_____ and "Facility".

IN CONSIDERATION OF THE MUTUAL PROMISES CONTAINED IN THIS CONTRACT, THE PARTIES AGREE AS FOLLOWS:

I. DEFINITIONS

A. FACILITY. **MASON CITY AREA NURSING HOME ASSOCIATION, INC** is a Medicare and Medicaid Certified skilled nursing facility located at **520 N. Price Avenue Mason City, IL 62664.**

B. RESIDENT. Resident will reside at Facility and receive nursing and support services.

C. RESPONSIBLE PARTY. Responsible Party is an individual who has control and/or access to the Resident's funds and/or assets. The Responsible Party who executes this contract agrees to act on the Resident's behalf, and agrees to cause payment of fees and charges incurred by or on Resident's behalf from Resident's funds, assets or estate. The Responsible Party agrees to provide an accounting of the Resident's funds, assets and estate upon request including providing documentation to verify accounts. A Responsible Party who uses due care in executing his/her duties will not be held personally liable for the payment of Resident's rates and charges. Failure to cause payment of fees and charges incurred by or on the Resident's behalf from the Resident's funds, assets or estate shall constitute a failure to exercise due care and will subject the Responsible Party to personal liability for the charges incurred by the Resident. The Responsible Party also agrees to act promptly and expeditiously to establish and maintain eligibility for Medicaid assistance, including but not limited to taking any and all necessary action to ensure that the Resident's assets are appropriately used and to maintain such assets within allowable limits for maintaining the Resident's eligibility. The Resident and Responsible Party agree that failure to do so may result in financial harm to the Facility; and that they shall be responsible for any damages arising out of such failure. The Responsible Party may act in more than one capacity and agree to other applicable terms and conditions of this Contract. Failure to appropriately use the Resident's funds and assets for the Resident's care at Facility may constitute abuse and/or financial exploitation of the Resident in violation of state law. Inappropriate use of the Resident's funds and assets will be reported to the state and may result in criminal liability. Facility waives all liability for the improper use of the Resident's funds by the Resident's Responsible Party(s) or others.

D. RESIDENT REPRESENTATIVE. The Resident Representative is the individual who has the legal authority to make decisions on the Resident's behalf regarding health care. By signing this Contract as the Resident Representative, the individual represents that he/she has the legal authority to made health care decisions on behalf of the Resident. The Resident

Representative agrees to provide Facility a copy of all documentation relating to his/her status as the legal decision maker (e.g., health care power of attorney, letters of guardianship). The Resident Representative further agrees to inform Facility of any changes in his/her status or the legal decision maker for health care.

II. NURSING CARE

Facility agrees to provide nursing care to Resident and accept Resident for the contract term under the terms and conditions stated below. Resident agrees to reside at Facility and comply with the policies and rules of Facility.

III. TERM (MONTH TO MONTH)

This contract shall commence on _____, 20_____ and shall continue on a month-month basis until the Resident signs a new agreement, or until the Resident discharges. If the Resident returns from a discharge in which a bed hold was not utilized, a new contract will be signed.

IV. GENERAL TERMS

A. PAYMENT SOURCE. The skilled nursing facility accepts Private Pay, Medicare and Medicaid Residents. The provisions of Section V apply to Private Pay Residents. The provisions of Section VI apply to Medicare Residents. The provisions of Section VII apply to Medicaid Residents. The parties understand that the provisions corresponding to Resident's source of payment will apply. If the Resident's source of payment changes, this agreement remains in place, as it will not be required to execute a new agreement. The parties hereby agree that if the Resident's source of payment changes, the applicable payment provisions will apply effective on the date of the change of payment source. The parties understand that the Resident will be considered a Private Pay Resident unless and until the Resident has been deemed a covered beneficiary by a federal health care program.

B. CHANGE IN RATES AND CHARGES. The "Basic Daily Rate," as outlined in Attachment A may change from time to time. Products and services may also be curtailed or eliminated completely, consistent with applicable law. Current information about such charges shall be made available to the Resident by Facility. Thirty (30) days written notice shall be given to the Resident/Responsible Party(s) of any changes to the existing "Basic Daily Rate."

C. STATEMENTS. The billing office shall send statements for the current month's room and board and previous month's ancillary products and services. Statements are processed and mailed at the beginning of each month to the Responsible Party(s) or any other party required by law. Payment is due by the tenth day of the month in which an itemized statement is issued. The billing office shall prepare and mail a revised statement of pre-billed services following the discharge or transfer of a resident.

D. LATE PAYMENT FEE. All payments are due by the tenth day of the month. Facility may in its discretion charge a fee equal to one and one-half percent (1 ½ %) per month, or such higher amount allowed by law, of all fees and charges outstanding for more than thirty (30) days as of the last day of the month. These fees shall be paid by the Parties liable for payment.

E. EXHAUSTION OF FUNDS. If the Resident has insufficient assets and/or income to meet his/her obligations, the Resident/Responsible Party(s) shall take the necessary steps to obtain financial assistance from any appropriate governmental or private programs for which the Resident is eligible and from which Facility accepts payment or reimbursement. The Resident/ Responsible Party(s) agrees to advise Facility in advance of depletion of the Resident's funds, and Facility may assist in the application process for governmental or private funding when such request is made. The Resident/Responsible Party(s) agree to notify Facility when the Resident's assets fall below $50,000. This notification will allow sufficient time to plan for properly meeting the Resident's needs. The Resident/Responsible Party(s) further agree to notify Facility when the Resident's assets fall below $20,000. This notification will ensure appropriate measures can be taken to ensure continued care for the Resident. By signing this Contract the Resident/Responsible Party(s) grant Facility the right to confirm the financial information provided regarding the Resident's financial status including granting Facility the right to request and review documentation from banks or other entities to confirm the Resident's financial information.

V. PRIVATE PAY RESIDENTS: RATES AND PAYMENTS

A. BASIC DAILY RATE. The "Basic Daily Rate" for services to Residents at Facility is established according to the room type in which the Resident resides. The "Basic Daily Rate" applicable to the Residents is outlined in the Attachment A and incorporated herein. Resident/Responsible Party(s) agree to pay the pre-billed "Basic Daily Rate" from the Resident's assets on or before the tenth day of the pre-billed month.

B. PREPAYMENT OF SERVICES. On or before admission, Resident shall prepay for services for the remainder of the current month and the entire subsequent month. In the event the Resident does not receive services for the entire period of time covered by the prepayment of services, the unused balance will be refunded to the Resident/Responsible Party(s) within thirty (30) days of the Resident's account being deemed current.

C. OTHER CHARGES. The Resident may purchase from Facility certain miscellaneous products and services that are not covered by the "Basic Daily Rate." The Resident/Responsible Party(s) agree to pay from Resident's funds and assets for such extra products or services purchased from Facility upon receipt of a bill for such extra products or services.

D. MEDICAID PENDING. A Resident who applies for Medicaid but who has not yet been approved for Medicaid Long Term Care benefits shall be considered a Private Pay Resident. The Resident/Responsible Party(s) shall remain responsible for the full Private Pay rate until the Resident is covered for Long Term Care benefits at this Facility. The Facility may accept the Resident's monthly income as partial payment during the period that the Resident's application is pending; however the Resident/Responsible Party shall remain responsible for any portion not paid by Medicaid.

VI. MEDICARE RESIDENTS: RATES AND PAYMENTS

A. MEDICARE. Medicare Residents must meet the technical and medical requirements for Medicare and be periodically certified by their physicians as needing such care. Facility's present participation in the Medicare Program does not in any way guarantee that the Resident

will qualify for Medicare or that Facility will always be a participating provider in the Medicare Program. The Resident/Responsible Party(s) is responsible for paying the prevailing co-insurance payment and deductible applicable for any day of the Resident's stay in Facility that is not fully covered by Medicare. If Medicare coverage is exhausted then the Resident will be deemed to be a Private Pay Resident unless and until another funding source is elected and the Resident has been deemed covered.

B. ALLOWABLE CHARGES. Resident/Responsible Party(s) will be required to pay certain other "Allowable Charges" which include, but are not limited to, fees for certain products and services not covered under the Medicare Program. The Resident/Responsible Party(s) agree to pay Allowable Charges from the Resident's assets on or before the last day of the month following receipt of a bill for such Allowable Charges.

C. BENEFIT DISALLOWANCE. If Medicare eligibility is exhausted, denied, or terminated for any reason, Resident/Responsible Party(s) agrees to pay from Resident's funds and assets all unpaid charges for care previously rendered to the extent permitted by law.

D. OTHER CHARGES. The Resident/Responsible Party(s) agree to pay from Resident's funds and assets for such extra products or services purchased from Facility upon receipt of a bill for such extra products or services.

VII. MEDICAID RESIDENTS: RATES AND PAYMENTS

A. MEDICAID. Facility serves persons who qualify for public assistance under the Medicaid Program. Facility's present participation in the Medicaid Program does not in any way guarantee that the Resident will qualify for Medicaid or that Facility will always be a participating provider in the Medicaid Program. Facility is not required to admit an individual who is qualified or eligible for Medicaid.

B. MEDICAID PENDING. Facility may in its sole discretion accept persons applying for Medicaid. Facility is not required to admit an individual who is qualified or eligible for Medicaid. Until an individual qualifies and becomes eligible for Medicaid Long Term Care benefits he/she shall be deemed a Private Pay Resident.

C. PERSONAL ALLOWANCE. Pursuant to state and federal law Medicaid beneficiaries are allowed to retain $60 of their monthly income for personal expenses. The balance of the Resident's income must be applied to the cost of the Resident's care as the Resident's portion. To the extent permitted by law, the Resident's monthly income (which includes but is not limited to Social Security and pensions) minus the $60.00 allowance retained by Resident (or other allowance as set by law), shall be paid to Facility. The Resident/Responsible Party(s) agree to turn over the Resident's monthly income less the personal allowance to Facility. Failure to properly allocate the Resident's funds and assets for the payment of the Resident's care may constitute abuse and/or financial exploitation of the Resident. Any individual found to have improperly used the Resident's funds shall be reported to the appropriate authority and may be criminally liable. Facility waives all liability for the improper use of funds by the Resident's Responsible Party(s) or others.

D. BENEFITS DISALLOWANCE. If Medicaid eligibility is denied or terminated for any reason to the extent permitted by law, Resident/Responsible Party(s) agree to pay from Resident's

funds and assets all unpaid charges based on the Private Pay rate for the time period not covered by Medicaid.

E. OTHER CHARGES. The Resident may purchase from Facility certain miscellaneous products and services that are not covered by the "Basic Daily Rate." The Resident/Responsible Party(s) agree to pay from Resident's funds and assets for such extra products or services purchased from Facility upon receipt of a bill for such extra products or services.

VIII. RESIDENT'S RESPONSIBILITIES

A. SELECTION OF HEALTH CARE PROFESSIONALS. Resident may select, or have selected on his/her behalf, qualified health care professionals who conform to Facility's policies, rules, applicable laws, and regulations. Resident must have, select, or have chosen on his/her behalf a personal physician who will be available, or whose agent will be available, at all times for notification of significant changes in the Resident's clinical condition. Resident agrees that if Resident's personal physician is not available for consultation in a medical emergency or as otherwise needed, as determined by Facility staff, Facility's Medical Director or his authorized agent may be contacted. If the Resident's attending physician or any other health care provider retained by the Resident fails or refuses to fulfill a statutory or regulatory requirement (including a Medicaid and/or Medicare requirement) as applicable, then Facility retains the right, after informing the Resident, to seek an alternate physician and/or other health care provider to assure the provision of appropriate and adequate care and treatment as required by applicable law and Facility policy. The Resident's refusal to consent to treatment by an alternate physician or other health care provider under these circumstances shall constitute grounds for involuntary discharge of the Resident for medical reasons, for the Resident's physical safety and for the physical safety of other Residents, Facility staff and visitors under applicable involuntary discharge laws.

B. NOT AGENT OF FACILITY. Resident's personal physician and other health care professionals described above shall be retained solely by and at the election of the Resident. It is expressly acknowledged by all parties that no physician or other health care professional is the employee or agent of Facility with respect to personal services rendered to Residents. Facility expressly disclaims any responsibility for any actions of such persons acting in such capacity and that no action or statement by employees of Facility may be interpreted to change this policy.

C. RESPONSIBILITY FOR PERSONAL ITEMS. Resident shall provide all items for his/her personal use, including, but not limited to clothing, toiletry equipment and supplies.

D. PERSONAL POSSESSIONS. All items of furniture or miscellaneous articles the Resident brings with him must be clearly and permanently marked with the Resident's name. All clothing items must be labeled prior to the Resident entering Facility. Articles subsequently acquired by the Resident must also be labeled. Personal items may not be used if they threaten the health, safety, or welfare of other Residents or if they in any way infringe on the rights of other Residents.

E. PERSONAL VALUABLES: Should the resident wish to keep personal funds at the facility, we provide a Resident Trust Fund. Please see our Resident Trust Fund Policy listed later in

this handbook for more information. In situations of loss of or damage to any money or valuables (eyeglasses, hearing aids, dentures, cell phones, or other appliance) the facility, when notified, will promptly investigate.

F. COMPLIANCE WITH FACILITY RULES. Resident agrees to comply with all rules and regulations of Facility, as set forth in the Resident Handbook and as amended, a copy of which is attached hereto and incorporated by reference.

G. EMERGENCY MEDICAL TREATMENT. Resident authorizes Facility to provide to Resident any emergency medical treatment deemed necessary by Facility or to transfer Resident to a hospital or other facility for such purposes unless specific written instructions are documented in an advance directive.

H. PHARMACY SERVICES AND MEDICATIONS. Resident authorizes Facility to provide to the pharmacy dispensing medication with resident billing information. Resident, or Resident's insurance carrier, will be billed for medication administered on days for which the resident was not on a Medicare skilled stay.

IX. TERMINATION OR MODIFICATION OF CONTRACT

A. BY RESIDENT. Resident may terminate this agreement upon discharge. "The Basic Daily Rate" shall be prorated as of the date on which the contract terminates. If any payment has been made in advance, the excess shall be refunded to the Resident. The Resident must vacate Facility on or before the date of contract termination established under Section IX.

B. CHANGE IN RESIDENT'S HEALTH. If Resident's physical or mental condition changes and Facility, in its sole discretion, determines that it cannot provide appropriate care, Resident will be transferred to another facility for appropriate care and this Contract shall terminate after seven (7) days unless the Resident has initiated a bed hold in compliance with Section IX., C. Notice of termination is deemed given upon such transfer. This Contract shall terminate on Resident's death.

C. BED HOLDING/TEMPORARY LEAVE. If a Medicaid Resident temporarily leaves Facility and is admitted to a hospital, Facility will hold a bed available for ten (10) days, if the conditions for receiving reimbursement from the Medicaid Program for the bed hold period are satisfied. If the Medicaid Resident's leave exceeds the bed hold period as allowed by the Medicaid Program, Facility shall readmit the Resident upon availability of a bed should the Resident continue to need the services of Facility. If a Private Pay Resident temporarily leaves Facility, Facility will hold a bed available so long as the Private Pay Resident pays the applicable daily rate.

D. INVOLUNTARY TRANSFER OR DISCHARGE. Facility reserves the right to involuntarily transfer or discharge a Resident for any reason permitted by law, as amended from time to time. A Resident shall be discharged from Facility under one or more of the following conditions:

1. For medical reasons;
2. For the Resident's physical safety;

3. For the physical safety of other Residents, Facility staff, or visitors;

4. Facility is unable to meet the needs or desires of the Resident or the Resident's family;

5. Resident is an "identified offender" as that term is defined in the skilled nursing facility licensing regulations; or

6. For either late payment or nonpayment for the Resident's stay (except as prohibited by Title XVIII and XIX of the Federal Social Security Act) after reasonable notice, or due to the Resident's failure to have payment made under either the Medicare or Medicaid programs.

If Facility decides to involuntarily transfer or discharge the Resident for one or more of the reasons indicated above, Facility shall give the Resident at least thirty (30) days written notice. This Contract will terminate on the date of the involuntary transfer or discharge.

E. EMERGENCY INVOLUNTARY TRANSFER OR DISCHARGE BY FACILITY. The thirty (30) day advance notice for involuntary transfer or discharge shall not apply, however, when the transfer or discharge:

1. Is ordered by the Resident's attending physician because of the Resident's urgent medical needs; or

2. Is required to protect the health or physical safety of the Resident, other Residents, other individuals, or Facility staff, as documented in the clinical record.

F. ABANDONMENT. If the Resident is absent from the facility for more than 30 consecutive days (except for therapeutic home leave, or hospitalization) the absence shall be deemed a voluntary termination of this Contract by the Resident and shall be a basis for involuntary discharge proceedings under the Nursing Home Care Act. Notice shall be served on the Resident by mailing the notice to the Resident's last known address via certified mail.

G. REFUSAL TO EXECUTE NEW CONTRACT. If the Resident refuses to execute a new contract within seven days' notice when such execution is required it shall be deemed a voluntary termination by the Resident and shall be the basis for a voluntary discharge of the Resident under the Nursing Home Care Act.

X. MISCELLANEOUS PROVISIONS

A. ADMISSION DOCUMENTS. Resident/Responsible Party(s) acknowledge that Resident's admission is based upon the representations contained in the Resident's application, financial summary form, and other admission documents. Failure to provide accurate financial information could result in the Resident having to relocate to another facility. The Resident/Responsible Party(s) agree to pay from Resident's funds and assets for products or services purchased from Facility upon receipt of a bill for such products or services. Resident/Responsible Party(s) represent that the statements made in all admission documents are true, correct and complete. False representations and statements made in Resident's admission documents are grounds for termination of this contract.

B. FEES FOR COLLECTING OUTSTANDING BILLS. The Parties agree that Facility is entitled to all costs of collection of unpaid charges including court costs and reasonable attorneys' fees. This includes collection of estate claims not processed in a timely manner.

C. ESTATE ARRANGEMENTS. This Contract shall terminate immediately if the Resident passes away. Facility shall have no liability for financial obligations arising out of the Resident's passing. All funeral expenses shall be paid by the Resident's estate or by funds made available by law. Upon a Resident's passing, Facility may enter into a Resident's living quarters to inventory, secure, and store any property of a Resident. Facility will dispose of all Resident's un-removed property thirty (30) days after a Resident's death. The Resident/Responsible Party(s) further agrees that his/her estate shall settle any outstanding claims with the facility promptly.

D. GUARDIANSHIP. If a Resident's mental condition becomes such that Resident is unable to make or communicate responsible decisions concerning his/her person or estates, and Resident has not previously appointed a surrogate decision makers as permitted by law, a person executing this Contract other than the Resident shall petition the appropriate court to appoint a guardian of the person and estate and shall bear the costs associated with those proceedings. Resident/Responsible Party(s) acknowledge that Facility shall have no responsibility to undertake guardianship proceedings, and shall not be responsible for any injury or loss to Resident caused by any parties' failure to undertake such proceedings. A copy of the documents verifying guardianship must be attached to this Contract. The Resident shall be presumed to have the capacity to contract for admission to Facility unless he has been adjudicated a "disabled person" under the Probate Act of 1975, or if a physician determines that a person is so disabled as to be unable to consent to placement, or if the Resident is comatose or unconscious.

E. LIVING QUARTERS AND ROOMMATES. Facility reserves the right to transfer a Resident to other living quarters if required to do so by law or for efficient management, and will notify Resident/Responsible Party(s) prior to such transfer and change of room type or level of care. If in the opinion of the professional staff at Facility, a Resident's needs for care changes and a transfer to a different room or level of care is required, such transfer will be accomplished in a timely manner following notification to the Resident/Resident's Responsible Party(s) and/or guardian. The new rate reflecting the applicable charge for the new room or level of care will go into effect on the date of the transfer. The Resident/Responsible Party(s) have the right to receive notice before the Resident's room or roommate is changed. The Resident has the right to share a room with his or her spouse when married Residents live in the same facility and both spouses consent to the arrangement and Facility determines that the room is appropriate for such an arrangement and that such an arrangement will not interfere with other Residents' care or negatively affect their well- being.

F. MEDICINES. All medicines necessary or appropriate for Resident's use will be prescribed by the Resident's personal physician or attending physician, as appropriate, or Facility's Medical Director. No medications may be brought into Facility by or for Resident without prior approval by Facility's Administrator or the Director of Nursing. This restriction includes those items normally sold over- the-counter. Medications will be provided by a licensed pharmacy on a unit dose basis and monitored by a licensed pharmacist. By entering into this Contract, Resident/Responsible Party(s) expressly agree to the pharmacy service

arranged by Facility. Any nutritional supplements (e.g. vitamins, etc.) must have prior approval of the Resident's physician and Director of Nursing. For health and safety reasons, any medicines brought into Facility must be approved by the Resident's personal physician or attending physician and must be labeled as to content, dated with expiration date. The safety seal of the medicine must be intact and the package must contain instructions for use and dosage. Facility reserves the right to refuse the use of and remove any unapproved medications or treatments.

Medical supplies, therapies, durable medical equipment, and other services are often billed to the Resident's Medicare Part B benefit, if applicable. Medicare Part B does not provide coverage for the room and board expense. In the event that the payer source changes during the course of service delivery or billing, the Pharmacy will adjust the daily billed party accordingly, including the billing of multiple payers during the month. It is common for the Resident's Medicare Part D insurance coverage to be billed on all days, unless the Resident is not receiving skilled nursing services under their Medicare Part A benefit or an equivalent Option C replacement plan. If the new payer source does not cover the total cost or if the coverage terms change, the Resident shall be responsible for paying any remaining balance after the payment from the new payer source has been applied. The Pharmacy will issue a revised invoice reflecting the updated payer source and any additional balance due. The Resident agrees to settle any outstanding balance promptly following notification of the change in payer source. The Resident further agrees that if the new payer source delays or denies payment, the Resident is liable for the full remaining balance. The Resident agrees to promptly inform the skilled nursing facility of any changes to their payer source. Both parties agree to cooperate to ensure accurate billing.

G. FOODS BROUGHT INTO FACILITY: No food or liquids may be brought into Facility by or for a Resident without prior approval by Facility's Administrator or nursing staff. In the event that such consent is obtained, a single serving of food can be brought in and given to the Resident to eat immediately. Any uneaten food must be taken by the visitor or discarded. If a Resident goes out of the Facility for a meal, leftovers cannot be brought back into the Facility. Food brought into the Facility cannot be stored or kept in the Facility due to sanitation concerns. Alcoholic beverage must be approved by the Resident's attending physician, be kept in the locked cabinet, and be dispensed by the nursing staff.

H. RESTRICTION OF ACCESS. Facility reserves the right to restrict or bar visitation access to anyone who endangers the health or safety of any Resident, Facility staff, or other visitor who disrupts or interferes with any Resident's care, the operation of Facility or the duties of its staff.

I. ADVANCE DIRECTIVE. The Resident has received written information regarding Facility's policy on Life Sustaining Treatment. The Resident has been given the opportunity to execute a Living Will in accordance with the Living Will Act (Ill. Rev. Stats. 1991, ch. 110-1/2, pars. 703 et. seq); or Power of Attorney for Health Care in accordance with the Powers of Attorney for Health Care Law (Ill. Rev. 1991, ch. 110-1/2, pars. 804-1 et seq.); or has been provided the opportunity to decline consent to any of all of the life sustaining treatments available at Facility. Unless a copy of a properly executed written document that conforms with the Illinois Living Will Act or Powers of Attorney for Health Care Law has been provided to Facility, Resident and all other parties to this Contract represent to Facility that no agreement or understanding exists which could require the

denial or cessation of medical treatment or procedures necessary to prolong the natural life of the Resident. Unless Facility's administration receives a copy of such a document, Facility may take every step necessary to extend the natural life of Resident by whatever means are necessary. Resident and all other parties to this Contract hereby release and hold harmless Facility, its shareholders, directors, officers, employees, agents, and representatives from any and all actions taken or claims made pursuant to this Section.

J. CHANGE OF ADDRESS. Any party required to furnish an address below shall promptly inform Facility, in writing, of any change in address or telephone number.

K. NOTICES. All notices or communications which may be or are required to be given will be in writing and mailed by registered or certified mail, or delivered in person, to the last known address of such party. Notices to Facility shall be sent to: Mason City Area Nursing Home Association, Inc, skilled nursing facility, at 520 N. Price Avenue, Mason City, IL 62664.

L. INTERPRETATION OF PROVISION/SEVERABILITY. Wherever possible, each provision of this Contract should be construed so as to make it consistent with and effective under applicable law. If at any time any provision of this Contract is prohibited by or invalid under applicable law, such provision shall be severed from the Contract and the remaining provisions shall be unaffected.

M. GOVERNING LAW

This Contract between Resident and Facility shall be construed, interpreted, enforced, and governed in all respects in accordance with the laws of the State of Illinois, except as otherwise provided in the Contract.

N. COMPLETE AGREEMENT. This Contract constitutes the entire Contract between the parties, and except for the changes in the "Basic Daily Rate" and other charges for products or services provided by Facility described in Sections V., VI., and VII., this Contract may not be amended except in writing executed by the parties below or their successors.

O. WAIVER. Waiver of any of the provisions of this Contract shall not be deemed a complete waiver of the requirements and shall not excuse the Resident/Responsible Party(s) from fulfilling their responsibilities.

P. PERSONAL FUNDS. The Resident has the right to manage his/her financial affairs, and Facility will not require Resident to deposit his/her personal funds with Facility, nor will Facility be responsible for holding, safeguarding, managing, or accounting for Resident's personal funds. In the event that the Resident does wish Facility to hold his/her private funds, Resident/Responsible Party authorizes Facility to accept and hold funds not to exceed Fifty Dollars ($50.00) of Resident in a non-interest bearing petty cash fund. Such funds may be withdrawn by written request in accordance with the procedures of Facility which will ensure that Resident's funds are readily available for Resident. The balance held in this fund on behalf of Resident shall not exceed Fifty Dollars ($50.00) at any time. Any Resident funds in excess of Fifty Dollars ($50.00) will be deposited in an interest-bearing account that is separate from any of Facility's operating accounts and that credits all interest earned on Resident's account to his/her account. Facility shall purchase a surety bond to guarantee the security of Resident's funds. Facility will furnish Resident/Responsible

Party(s) a quarterly statement of Resident's account and will furnish information concerning the account at any time upon reasonable request to Resident, Resident's Representative(s), or Responsible Party(s).

Q. HOLD HARMLESS PROVISIONS. The Resident agrees to hold harmless Facility, its owners, management, all of their officers, trustees, staff, and personnel from any and all claims arising from an injury or illness incurred through natural or normal causes during his/her life at Facility.

R. INDEMNIFICATION. Resident will indemnify and hold harmless Facility from all claims, expenses, and damages arising out of property damage and/or physical injury caused by Resident or any third party hired by Resident, including repair or replacement of property of Facility, its staff, or other Residents, and injuries to Facility staff or other Residents.

S. NOT LIFE CARE. This Contract does not, and is not intended to constitute an undertaking to care for the Resident for life. (This means that Facility does not assume financial responsibility for a Resident when personal funds are exhausted.)

T. REASONABLE CARE. Facility will exercise reasonable care towards the Resident. However, Facility is not an insurer of the Resident's welfare or safety and assumes no such liability.

U. SUCCESSOR OWNERSHIP. This Contract may be assigned by Facility to any successor in ownership or operation of the Facility.

V. ACKNOWLEDGEMENT OF REVIEW. By signing below, the Resident/Responsible Party(s) acknowledges that the parties have reviewed the following documents:

1. This Contract
2. The statement of Resident's rights
3. A copy of Resident Handbook
4. Facility's policies on billing and payment

[Signature Page Follows]

Name of Resident _____

The undersigned acknowledge that each has read and understood this Contract, and that each voluntarily consents to all of its terms. I further understand that I have the ability to refuse to enter into this contract and instead, remove the Resident from the Facility's Care. INITIAL _____

RESIDENT

Print Name: _____

Signature: _____ Date: _____

Address: _____

RESIDENT REPRESENTATIVE

Print Name: _____

Signature: _____

Date: _____

Address: _____

_____

Relation to Resident (check as appropriate)

- ☐ Self
- ☐ Guardian of Person
- ☐ Guardian of Estate
- ☐ Agent under Durable Power of Attorney

RESPONSIBLE PARTY

Print Name: _____

Signature: _____

Date: _____

Address: _____

_____

Relation to Resident (check as appropriate)

- ☐ Immediate Family Member
- ☐ Other _____

Facility Admission Staff Signature: _____ **Date:** _____

Facility Administrator Signature: _____ **Date:** _____

Section 300.625 of IDPH Skilled Nursing and Intermediate Facilities Code as amended requires the following:

As a prospective Resident, I am aware of the requirement to disclose to the Facility information concerning whether I have ever been an identified offender. Please check one of the following:

☐ Yes, I have been an identified offender

☐ No, I have never been an identified offender

If yes, please explain in the space below:

The Facility reserves the right to not admit the prospective Resident offender. This decision will be based on our ability or inability to meet the needs and or provide care for the identified offender.

Signature of Resident or Resident's Representative: **Date:**

_____ _____

Relationship to Resident: **Date:**

_____ _____

Signature of Responsible Party: **Date:**

_____ _____

Administrator's Signature: **Date:**

_____ _____

ATTACHMENT A: MASON CITY AREA NURSING HOME
MASON CITY, ILLINOIS

Effective: December 1, 2024 for new admissions
January 1, 2025 for current residents

NUMBER 4 - BASE RATE (per person):

Semi-Private or Two-Bed Room	$290.00
Small Private Room	$330.00
Semi-Private Room Converted to Private Room	$580.00

The above charges include room and board and basic nursing care.

The bed-hold rate is equal to the daily base room rate.

Arrangements can be made for temporary/respite care, not to exceed 14 consecutive days. This service offers nursing care and support services when primary caregivers are unable, absent, or in need of temporary reprieve of caregiving duties. The rate is fifteen dollars ($15.00) per day added to the base rate quoted above.

NUMBER 6 - ADDITIONAL SERVICES

Nursing Supplies and Equipment: Nursing supplies are built into the cost of the base room rate *except for* oxygen, oxygen concentrators and resident specific specialized equipment which will be billed monthly.

Other Charges: Beauty shop, barber charges, transportation services, guest meals, and personal purchases are billed monthly (contact facility for services provided), as used, unless facility requires pre-payment of services. Contact facility for details. Physical therapy and/or other therapy ordered by the Doctor will be billed monthly. Doctor fees and prescription drugs are billed directly by the supplier.

Contract Rights: All the rights and responsibilities of a resident pass to the resident's guardian, next of kin or sponsoring agency or agencies if the resident is adjudicated incompetent under State law or is determined by his/her physician to be incapable of understanding his/her rights and responsibilities.

ADMISSION MASTER SHEET

Date: _____ Resident Name: _____ Phone: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (ZIP Code)

S.S.# _____ Med.Rec.# _____

Medicare #: _____ I.D.P.A. Recip.# _____

Marital Status: *M__ S__ D__ W__* Sex: *M__ F__* Race: _____ Age: ____ Birthdate: ____/____/____

Admitted from: _____ Admit Date: ____/____/____ Time: _____ *am__ pm__*

Contact: _____ Phone:(____)_____

Station: (Specify)_____ Room#: _____ Bed: _____ Room Type: _____

Hospital Stay From: ____/____/____ Through: ____/____/____

Medicare Days Used: _____ Where used: _____

PROFESSIONALS

Primary Physician: _____ Alternate Physician: _____

Dentist: _____ Opthamologist: _____

Podiatrist: _____ Other: _____

Diagnosis (if known): _____

ALLERGIES: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ P.O.A. of FINANCES: *Yes__ No__* Forward Mail: *Yes__ No__*

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

Phone: home(____)_____ work(____)_____ Relation: _____

Cell Phone: (____)_____ email: _____

CONTACTS: Emergency Contact:

Name: _____ Relation: _____

(POA of Healthcare _____ POA of Finances ____)

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

Phone: home(____)_____ work(____)_____

Cell Phone : (____)_____ email: _____

Secondary Contact:

Name: _____ Relation: _____

(POA of Healthcare _____ POA of Finances ____)

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

Phone: home(____)_____ work(____)_____

Cell Phone: (____)_____ email: _____

Other Contact:

Name: _____ Relation: _____

(POA of Healthcare _____ POA of Finances ____)

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

Phone: home(____)_____ work(____)_____

Cell Phone: (____)_____ email: _____

REVIEWED FEB 2012 admissions committee

INSURANCE INFORMATION

Medicare Effective Dates: Part A:____/____/____ Part B:____/____/____
VA#_____ Effective Date:____/____/____
PA Case#_____ Effective Date:____/____/____
Insurance Policy #1:
Company:_____ Policy#_____
Type: *supplemental* ____ *nursing home*____ Group#_____
Date of Verification:____/____/____ Confirmed by:_____
Insurance Policy #2:
Company:_____ Policy#_____
Type: *supplemental* ____ *nursing home*____ Group#_____
Date of Verification:____/____/____ Confirmed by:_____

FINANCIAL INFORMATION

Payor Type:

*Medicare*____ *Private Pay*____ *Insurance* ____ *Public Aid*____ *Hospice*____ Room Type:_____
Medicare co-payor:_____

Other:_____

Sufficient Funds for Min. of 60 days? *Yes*___ *No* ___

2448 Physician Certification done? *Yes*___ *No*___ (include copy)

Pre-Screening Done? *Yes*___ *No*___ Date of Prescreening:____/____/____

Pre-screener's Name:_____

Length of Stay: *Permanent* _____ *Temporary* _____ (If temporary, include copy of physician's approval)

DEMOGRAPHICS

Birthplace:_____ _____ _____
City: State: Country:
Citizenship:_____ Primary Language:_____
Mother's Maiden Name: (first, last)_____ _____
Father's Name: (first, last)_____ _____
Branch of military service:_____ Current Status:_____ Enlist Date:____/____/____
Discharge date:____/____/____
Lifetime Occupation:_____ Education Level:_____
Religious Denomination:_____ Church:_____
Hospital Preference:_____ Funeral Home:_____
Ambulance Preference: _____
Laundry done by: *family*____ *staff* ____ Prepaid Funeral: *Yes*____ *No*____

REVIEWED FEB 2012 admissions committee

Facility Name: MASON CITY AREA NURSING HOME

MSP SCREENING QUESTIONNAIRE

Resident Name:_____ Date: _____

Medicare Number:_____ Medical Record Number:_____

Ask all four questions of each Medicare Resident. If the Resident responds "Yes" to any questions, continue to Section Two. The Resident or Representative must sign the form. It is important to ask all the questions and document all the answers on this form. A provider may be held liable if an overpayment occurs and Medicare finds that the provider furnished erroneous information or failed to disclose facts it knew were relevant to payment.

SECTION 1

1. **Is the resident covered by the Veterans Administration, the Black Lung Program or Worker's Compensation?**
   No _____ Proceed to Question #2
   Yes _____ Bill the other insurer prior to Medicare

2. **Is the illness or injury due to any type of accident?**
   No _____ Proceed to Question #3 and #4
   Yes _____ Date of accident _____/_____/_____ Complete next section & continue below:
   Question #3 if 65 or older; Question #4 if under 65

3. **Is the Resident 65 or over employed, or is the spouse employed at time of service?**
   No _____ Retirement date of Resident: _____/_____/_____ Spouse: _____/_____/_____
   Yes _____ Complete next section – Medicare may be primary

4. **Is the Resident under 65 and covered under any Employer Group Health Plan or Large Group Plan?**
   No _____ See Note
   Yes _____ Complete next section-Medicare may not be primary.

NOTE: If the answer to all questions is "NO," bill Medicare primary.
If any response is "YES" continue to the next section, Medicare may not be primary.

SECTION 2

5. **ILLNESS/INJURY CAUSED BY ACCIDENT:**

A. Motor Vehicle
Name of Resident's Automobile Insurer:_____
If another party was responsible for accident
Name and address of Liable Insurer: _____

B. Work Related
Name of Workman's compensation Insurer: _____

C. Other Accident – Explain where accident occurred: _____
If fall other than resident's home, has the resident filed or intends to file suit?
No _____ Bill Medicare Yes _____ Name and address of Liability Insurer and Attorney:
_____
Bill other Insurer prior to Medicare; submit documentation to Medicare if conditional payment requested.

6. EMPLOYER GROUP COVERAGE FOR THOSE 65 AND OVER

A. If resident employed at time of service, give name of employer:_____

Does employer employ 20 or more employees? Yes_____ No_____

Does the resident have an Employer Group Health Plan (EGHP) with current employer? Yes_____ No_____

If yes, name of Employer Group Health Plan _____

7. EMPLOYER GROUP COVERAGE FOR THOSE YOUNGER THAN 65

A. Resident is entitled to Medicare solely due to End Stage Renal Disease and in first 18 months of Medicare entitlement.

Date of first Dialysis treatment: _____/_____/_____ OR Date of Kidney transplant:_____/_____/_____

Does resident have coverage through his/her, or spouse's; a parent or a guardian's Employer Group Health Plan?

No _____ Medicare Primary

Yes _____ Give name of Employer:_____

B. Resident is entitled to Medicare solely because of disability. (Does not have/has not had ESRD)

Does resident have coverage through his/her, spouse's, a parent or a guardian's Employer Group Health Plan?

No _____ Bill Medicare

Yes _____ Continue below

Does employer employ 100 or more employees?

No _____ Bill Medicare

Yes _____ Give the name of each insured whose policy covers resident:

Employer:_____ EGHP: _____

Employer:_____ EGHP: _____

8. HMO/MEDICARE ADVANTAGE

Is the resident enrolled in an HMO that has Medicare benefits assigned or a Medicare Advantage Plan?

No _____ Continue

Yes _____ Name of HMO/Medicare Advantage Plan:_____

Policy#:_____

If yes, IMPORTANT: contact HMO/Medicare Advantage Plan to obtain authorization and copy of card. HMO/Medicare Advantage Plan is primary, "Informational" claim only submitted to Medicare.

9. MEDICAID/MEDICARE MANAGED PLANS

Is the resident enrolled in a Medicaid/Medicare Managed Plan?

No _____ Continue

Yes _____ Name of Insurance Plan:_____

Policy#:_____

I hereby certify that, to the best of my knowledge, the above information is true.

Resident /Representative Signature: _____ Date: _____

RELEASE OF INSURANCE & MEDICARE

Facility: MASON CITY AREA NURSING HOME

Name of Resident: _____ Birth Date: _____ MR# _____

Resident's Address: _____ _____ _____ _____
Street City State Zip Code

Type of Insurance Policy:

Medicare Supplement	☐ YES	***OR***	☐ NO	
Group Insurance/HMO	☐ YES	***OR***	☐ NO	
Medicare Replacement (Option C)	☐ YES	***OR***	☐ NO	
Dual Eligible Medicare/Medicaid Program (MMP)	☐ YES	***OR***	☐ NO	
Integrated Care Program (ICP) – Medicaid	☐ YES	***OR***	☐ NO	
LTC/Nursing Home Policy	☐ YES	***OR***	☐ NO	

All insurance companies must be called and asked specific questions about pre-cert, coverage and co-pays. Please note it is the responsibility of the guarantor to understand the benefits of each particular plan.

Pre-authorization IS NOT A GUARANTEE of payment to the facility.

Attach a copy of all cards *(front and back)*:

Authorization to Release Information: The undersigned hereby authorizes the above facility to release information requested on this form.

Assignment of Insurance Benefits: The undersigned hereby assigns payment directly to the above named Nursing Home facility of the Medical Benefits herein specified and otherwise payable to me but not to exceed the facility's regular charges for this period of treatment. I understand I am financially responsible to the facility for charges not covered by this assignment. It is further agreed that any credit balance resulting from payment of the insurance or other sources may be applied on any other account owed the said facility by the insured or his family.

Medicare Release Authorization: I hereby certify that the information given to me in applying for payment under title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

Signed: _____ Date: _____

RESIDENT TRUST FUND AGREEMENT

EXPLANATION:

Mason City Area Nursing Home offers a "Resident Trust Fund" in which each resident may participate. Money deposited into the Trust Fund by the resident is used for services listed below. The Resident Trust Fund is managed by the employees for the benefit of the participating residents. Participants will be provided with a quarterly statement, and an inspection of a resident's account record is available to the resident or their representative. Participation in the Resident Trust Fund is voluntary. Money deposited into the Trust Fund by the resident is used for:

Hair Care Services as needed
Cable TV if Applicable
Shopping Trips
Personal Purchases; gifts
Insurance Premiums if any Policy Number: _____

AUTHORIZATION:

Name of Resident: _____

☐ **NO** - I DO NOT wish to participate in the Resident Trust Fund

_____ _____
Signature of Resident or Resident's Representative Date

☐ **YES** – I DO wish to participate in the Resident Trust Fund

The undersigned hereby wishes to participate in our Resident Trust Fund. The above mentioned facility is given permission to manage the personal funds deposited in the Resident Trust Fund. This includes the collection, depositing, and disbursement of said funds on behalf of the residents' health, welfare, and personal needs.

The above mentioned facility agrees to manage the funds in a prudent manner and shall retain all receipts of all expenditures and maintain a record of all income.

_____ _____
Signature of Resident or Resident's Representative Date

_____ _____
Signature of Witness **(Not an agent of facility)** Date

You can speak with…

I, (name of resident) _____ give Heritage Operations Group, permission to speak with, the below named individuals, regarding the status of my health. This form does not give permission to release the medical record to those listed below, only general inquiries regarding my health. In the event my medical record is requested to be released, a release of information form must be signed.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

In the event that someone calls to check on me that is not listed above please have them contact my healthcare Power of Attorney (POA) / Personal Representative.

POA/ Representative Legal Name: (Printed) _____

Contact Phone Number: ( ) _____

Email Address: (Printed) _____

Resident or POA/ Representative Signature: _____

Date:_____

State of Illinois
Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients: *Use of this form is completely voluntary. If desired, have someone you trust with you when discussing a POLST form with a health care professional.* ***For health care providers:*** *Complete this form only after a conversation with the patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. With significant change in condition, new orders may need to be written.*

PATIENT INFORMATION. *For patients: Use of this form is completely voluntary.*		
Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yyyy)	Address (street/city/state/ZIP code)	

A *Required to Select One*

ORDERS FOR PATIENT IN CARDIAC ARREST. Follow if patient has NO pulse.

- ☐ **YES CPR: Attempt cardiopulmonary resuscitation (CPR).** Utilize all indicated modalities per standard medical protocol. (Requires choosing **Full Treatment** in Section B.)
- ☐ **NO CPR: Do Not Attempt Resuscitation (DNAR).**

B *Section may be Left Blank*

ORDERS FOR PATIENT NOT IN CARDIAC ARREST. Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)

- ☐ **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.
- ☐ **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.
- ☐ **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death.** Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

C *Section may be Left Blank*

Additional Orders or Instructions. These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

D *Section may be Left Blank*

ORDERS FOR MEDICALLY ADMINISTERED NUTRITION. Offer food by mouth if tolerated. (When no selection made, provide standard of care.)

- ☐ Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.
- ☐ Trial period for artificial nutrition and hydration but NO surgically-placed tubes.
- ☐ No artificial nutrition or hydration desired.

E *Required*

Signature of Patient or Legal Representative. *(eSigned documents are valid.)*

X Printed Name ***(required)*** | Date

Signature ***(required)*** *I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient's preferences.*

X

Relationship of Signee to Patient:
☐ Patient
☐ Parent of minor
☐ Agent under Power of Attorney for Health Care
☐ Health care surrogate decision maker (See Page 2 for priority list)

F *Required*

Qualified Health Care Practitioner. Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)

X Printed Authorized Practitioner Name ***(required)*** | Phone

Signature of Authorized Practitioner ***(required)*** *To the best of my knowledge and belief, these orders are consistent with the patient's medical condition and preferences.*

X

Date ***(required)***

THIS PAGE IS OPTIONAL – use for informational purposes		
Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records a patient's wishes for medical treatment in their current state of health. The patient or patient representative and a health care provider should reassess and discuss interventions regularly to ensure treatments are meeting patient's care goals. This form can be changed to reflect new wishes at any time.
No form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows a person to document, in detail, future health care instructions and name a Legal Representative to speak on their behalf if they are unable to speak for themselves.

Advance Directives available for patient at time of this form completion			
☐ Power of Attorney for Health Care	☐ Living Will Declaration	☐ Declaration for Mental Health Treatment	☐ None Available

Health Care Professional Information	
Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated, and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone consent by the patient or legal representative are acceptable.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of the original form is encouraged. Digital copies and photocopies, including faxes, on ANY COLOR paper are legal and valid.
- Forms with eSignatures are legal and valid.
- A qualified health care practitioner may be licensed in Illinois or the state where the patient is being treated.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g., ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying, or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid.
- Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult children
4. Parents
5. Adult siblings
6. Adult grandchildren
7. A close friend of the patient
8. The patient's guardian of the estate
9. The patient's temporary custodian appointed under subsection (2) of Section 2-10 of the Juvenile Court Act of 1987 if the court has entered an order granting such authority pursuant to subsection (12) of Section 2-10 of the Juvenile Court Act of 1987.

For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996)
PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

HERITAGE OPERATIONS GROUP

Notice of Privacy Practices

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.*

This information pertains to facilities and services managed by Heritage.

Understanding Your Health Record/Information

Each time you are admitted to a nursing facility, a record of your stay is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or electronic or paper medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials who oversee the delivery of health care in the United States
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcome we achieve

Understanding what is in your record and how your protected health information (PHI) is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Our Responsibilities

Our nursing facility is required to:

- maintain the privacy and security of your protected health information (PHI)
- provide you with a notice as to our legal duties, privacy and security practices with respect to information we collected and maintain about you
- abide by the terms of this notice.
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- notify you promptly if a breach occurs that may have compromised the privacy or security of your health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a copy of the current Notice, which will identify its effective date, in our facilities and on our website at www.heritageofcare.com.

We will not use or disclose your health information without your authorization, except as described in this notice.

How We Will Use or Disclose Your Health Information

(1) Treatment. We will use your health information for treatment. For example, information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you during your course of treatment and once you're discharged from our nursing facility. Copies of original documents may be made for internal use.

(2) Payment. We will use your health information for payment. For example, a bill may be sent to you or a third-party payer, including Medicare or Medicaid. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

(3) Health care operations. We will use your health information for regular health care operations. For example, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

(4) Business associates. There are some services provided in our organization through contacts with business associates. Examples include our accountants, consultants and attorneys. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

(5) Directory. Unless you notify us that you object, we may use your name, location in the facility, general condition, and religious affiliation for directory purposes. The directory is often posted near the front door of our facilities. This information may also be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. We may also use your name on a nameplate next to or on your door in order to identify your room, unless you notify us that you object.

(6) Notification. We may use or disclose information to notify or to assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided us, e.g., on an answering machine.

(7) Communication with family. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care, unless you notify us that you object to any person or person(s) by name.

(8) Research. We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

(9) Funeral directors. We may disclose health information to funeral directors and coroners to carry out their duties consistent with applicable law.

(10) Organ procurement organizations. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

(11) Marketing. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you, unless you object to participate in marketing activity.

(12) Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

(13) Workers compensation. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

(14) Public health. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

(15) Law enforcement. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Similarly, should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

(16) Reports. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

(17) Incidental disclosures. Unless you notify us that you object, your name and likeness may be used in our building, newsletters, and other publications, which report on birthdays, celebrations, community activities and other events and occasions involving our facility.

(18) Health Information Exchange(s). We may disclose to participating providers of Health Information Exchanges(s), health information relative to provide accurate patient care. It is the responsibility of the individual to notify the provider of any restriction.

(19) Accountable Care Organizations (ACOs). We may disclose your health information to healthcare organizations, practitioners and their contractors for care coordination and quality improvement purposes.

Your Health Information Rights and Choices

Although your health record is the physical property of the nursing facility, the information in your health record belongs to you. You have the following rights:

- You may request that we not use or disclose your health information for a particular reason related to treatment, payment, the Facility's general health care operations, and/or to a particular family member other relative or close personal friend. We ask that such requests be made in writing on a form provided by our facility. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it. For more information about this right, see 45 Code of Federal Regulations (C.F.R.) § 164.522(a).

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. For more information about this right, see 45 C.F.R. § 164.522.
- If you are dissatisfied with the manner in which or the location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such a request must be made in writing, and submitted to the facility Administrator. We will attempt to accommodate all reasonable requests. For more information about this right, see 45 C.F.R. § 164.522(b).

- You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. If you request copies, we will charge you a reasonable fee. For more information about this right, see 45 C.F.R. § 164.524(b).

- If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment. We ask that you use the form provided by our facility to make such requests. For a request form, please contact the Administrator, Director of Nursing, or Social Services Director at your facility. For more information about this right, see 45 C.F.R. § 164.526.

- You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed 6 years, and commencing April 14, 2003). We ask that such requests be made in writing on a form provided by our facility. Please note that an accounting will not apply to any of the following types of disclosures: disclosures made for reasons of treatment, payment or health care operations; disclosures made to you or your legal representative, or any other individual involved with your care; disclosures to correctional institutions or law enforcement officials; and disclosures for national security purposes. You will not be charged for your first accounting request in any 12 month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee. For more information about this right, see 45 C.F.R. § 164.528.

- You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

- You may choose someone to act for you. If you have given someone medical Power of Attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. For more information about this right, see 45 C.F.R. § 164.514(h); 45 C.F.R. § 164.530(c).

- You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious or imminent threat to health or safety.

- You have the right and the choice to share information with your family, close friends, or others involved in your care.

- You have the right and the choice to share information in a disaster relief situation.

- You have the right and the choice to include information in a directory.

Certain uses and disclosures will be made only with the individual written authorization and you may revoke such authorization as provided by 45 C.F.R. § 164.508(b)(5). In these cases we never share your information unless you give us written permission for:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising we may contact you for fundraising efforts; you can tell us if you prefer to opt out of fundraising communication.

Breach Notification

A "breach" means the acquisition, access, use or disclosure of protected health information (PHI) in a manner not permitted under subpart E of this part which compromises the privacy or security of the PHI. The breach poses a significant risk of financial, reputational, or other harm to individual. For more information about breach notification, see 45 C.F.R. § 164.402.

Unsecured protected health information means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under HITECH section 13402(h)(2) of Public Law 111-5.

Notification to individuals will comply with 45 C.F.R. § 164.404; 45 C.F.R. § 164.406 and 45 C.F.R. § 164.408 as applicable.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Heritage Operations Group Privacy Officer at (309) 828-4361.

If you believe that your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing on a form provided by our facility. The complaint form may be obtained from the Administrator, Director of Nursing, or Social Services Director, and when completed should be returned to your facility Administrator. There will be no retaliation for filing a complaint.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by:

Sending a letter to:
U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201

Calling: 1-877-696-6775

Or visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/

Effective Date: September 23, 2013
Revised Date: July 16, 2019

Please sign and return the
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(attached) to your facility.

HERITAGE OPERATIONS GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, [print name of resident] _____, acknowledge and agree that I have received a copy of Heritage Operations Group Notice of Privacy Practices.

_____ _____
Resident Signature Date

_____ _____
Resident's Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to Resident

FOR FACILITY USE ONLY:

If resident or Legal Representative refuses to sign, please complete the following:

Facility Name: Mason City Area Nursing Home made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]

Consent Form

Facility: Mason City

Resident's Name: _____

INSTRUCTIONS: The resident or the resident representative's signature is REQUIRED at the end of this form. Each article should be read by the resident or the representative, and an explanation should be provided, if necessary or requested.

1. **Acknowledgment of Advance Directives**. The above-named resident has been provided with written information about rights under state law to make decisions about his or her medical care. Included in this information was an explanation of the right to accept or refuse care through the formulation of advanced directives, such as Do-Not-Resuscitate Orders (DNR)/Practitioners Orders for Life Sustaining Treatment (POLST), Power of Attorney (POA) for Health Care, and Living Wills. Furthermore, an explanation was given on the policies of the facility in implementing these rights. Please refer to the resident handbook and contract for information regarding advanced directives.

2. **Acknowledgment of Bed Hold Policy**. The above named resident has been informed of the right to request a bed-hold during a leave from the facility. I acknowledge that if a bed is held, the resident will be responsible for paying a daily charge at the prevailing room rate. Unless notified by the resident or POA, the facility will automatically begin charging for the bed to be held. If the resident elects not to have the bed held, it is understood that he or she has given up the right to that bed, and it may be filled by another resident. If this occurs, the resident's name will go onto a waiting list and will be offered the first available bed, if appropriate care can be provided. For more details regarding the bed-hold policy, please refer to the resident handbook.

3. **Explanation of Medicare and Medicaid.** Upon or before admission, the resident or POA was given an explanation of the payor sources accepted by the facility. Verbal and written information was given regarding the Medicare and Medicaid programs. The Medicare and Medicaid rights information is provided in the admission packet, and a description of these programs are also described in the resident handbook. The resident or POA was given the opportunity to ask questions regarding this information.

4. **Resident Rights.** The above-named resident has received an oral and written explanation of the rights and responsibilities as a resident of the facility. All questions have been answered and the resident acknowledges there will be an annual review of these rights.

5. **Release of Laundry.** This is to certify the undersigned consents to have laundry services arranged by the facility. I understand that all clothes are machine washed and dried by commercial equipment. In the event that shrinkage, fading or stretching should occur, I will not hold the facility responsible.

6. **Personal Valuables**. The above-named resident acknowledges that should he or she wish to keep personal funds at the facility, we provide a Resident Trust Fund. Please see our Resident Trust Fund Policy listed later in this handbook for more information. In situations of loss of or damage to any money or valuables (eyeglasses, hearing aids, dentures, cell phones, or other appliance) the facility, when notified, will promptly investigate.

7. **Care Plan Conference.** The above named resident and their family members were encouraged to attend the Care Plan Conference. It is understood that notification will be made prior to the conference so plans may be made to attend and give input.

8. **Resident Council**. The above named resident has received an explanation of the facility's Resident Council. It is understood that the resident will be notified prior to the meeting so plans may be made to attend and give input.

9. **Off Campus Outing**. The above named resident hereby gives permission to the facility to take them from the nursing home by the activity director, or other the facility personnel, for the purpose of entertainment, rides, shopping, visiting local places of interest, doctor visits, or any planned activities.

10. **Release of Responsibility for Audio and Photographic Materials.** I hereby give my permission to Heritage Enterprises, Inc. or any of their owned, managed or affiliated facilities to use my likeness (photo and/or voice) and my story to promote the agency/organization. I understand that my likeness may be used in print (newspaper, magazine, company collateral), websites (company websites, social media outlets), or broadcast (radio, television) advertising. Further, I understand that I will receive no financial compensation for the use of my likeness in promoting the agency/organization.

11. Release of Responsibility for Audio and Photographic Materials. I hereby give my permission to Heritage Enterprises, Inc. or any of their owned, managed or affiliated facilities to use my likeness (photo and/or voice) and my story to promote the agency/organization. I understand that my likeness may be used in print (newspaper, magazine, company collateral), websites (company websites, social media outlets), or broadcast (radio, television) advertising. Further, I understand that I will receive no financial compensation for the use of my likeness in promoting the agency/organization.

12. Photography and Social Media. Photography of residents or employees by anyone is prohibited without their explicit consent, or consent of the responsible party. This includes photos taken of your loved one in part of a group setting and/or with other residents, and those photos may not be shared on any social medial platform.

13. Identification and Documentation. The above named resident gives consent to the facility and its staff to use photographs taken of the resident for the purpose of identification of the resident.

14. Medical Support, Community Support and Pastoral Services. The resident or their representative acknowledges that they have received information regarding community medical services. Furthermore, they have been informed about local community support and pastoral services that are available through the Social Services Director. If requested, the resident's church will be notified upon admission.

15. Safety Devices. The resident or their representative acknowledges that an explanation of the facility's safety devices philosophy has been provided, as outlined in the resident handbook.

16. MDS Electronic Transmission Standard. The Centers for Medicare and Medicaid (CMS) requires nursing facilities to transmit medical information from the Minimum Data Set (MDS) of each resident to the State of Illinois. Submission of this data is required of the nursing facility by CMS for participation in the Medicare and Medicaid programs. The resident or their representative acknowledges that an explanation of the Healthcare Records Privacy Act was provided and explained to them.

17. Resident Handbook. The key points of the "Resident Handbook" were explained to the resident or their representative and a Resident Handbook was issued to them.

18. I have been given a copy of the **Notice of Privacy Practices.**

_____ _____

Resident or Resident Representative's Signature: Date:

_____ _____

Facility Representative's Signature: Date:

Alternative Dispute Resolution
Voluntary Mediation/Voluntary Arbitration Agreement

This is voluntary, agreeing to this dispute resolution is in no way a condition of admission or requirement to continue receiving care at this facility.

Mediation

All claims, disputes, and controversies arising out of or in relation to the performance, interpretation, application, or enforcement of this Contract, including but not limited to breach thereof, or relating to care and treatment or any other dispute relating to the Resident's residency, shall be referred to mediation before, and as a condition precedent to, the initiation of any adjudicative action or proceeding. The parties agree to pursue mediation in good faith. A mediator will be chosen by mutual agreement of the parties. In the event the parties are unable to agree on a mediator after the exchange of 2 proposals (1 each), mediation services shall be provided by a mediator chosen by Facility. Mediation fees, if any, shall be divided equally among the parties involved. Mediation shall take place at a venue convenient to both parties. The party defending against a claim may make a written offer to the opposing party to allow judgment on specified terms, with the costs then incurred. If, within 7 days after receiving the written offer, the opposing party may either serve written notice of acceptance, or rejection. If the offer is accepted via written notice, either party may seek to enter judgment per the terms of the offer. In the event the offer is rejected, the offer is considered withdrawn, but does not preclude a later offer. Evidence of an unaccepted offer is not admissible in a proceeding except to determine costs. If the judgment that the offeree finally obtains, exclusive of any award for attorney's fees, is not more favorable than the unaccepted offer, the offeree must pay the costs incurred after the offer was made. The Resident, Power of Attorney, Responsible Party, Resident Representative, or other signatory, by initialing this Section expressly consents, acknowledges, authorizes and binds the Resident, Power of Attorney, Responsible Party, Resident Representative, other signatory, heirs, or agents to the Mediation Section of this Contract.

Arbitration

Should the parties fail to reach a resolution of the claim, dispute or controversy by way of mediation, the dispute shall be arbitrated in accordance with the American Arbitration Association (AAA) "Commercial Dispute Resolution Procedures," which are available at the AAA website (www.ADR.org). The arbitrator shall be selected using the AAA selection procedure or the procedure established by another mutually agreeable service. The place of the arbitration shall be at a venue convenient to both parties. This Agreement for binding arbitration shall be governed by and interpreted in accordance with the Federal Arbitration Act, 9 U.S.C. Sections 1-16. By agreeing to arbitration of all disputes, the Resident, Power of Attorney, Responsible Party, Resident Representative, or other signatory, and the Facility, are waiving a jury trial for all claims, disputes and controversies referenced in this paragraph. The Parties agree that this Agreement to Arbitrate shall survive and not otherwise be revoked by the death or incompetency of the Resident. The award of costs of the arbitration shall be determined by the arbitrator in accordance with state law. The administrative fee and arbitrators 'compensation shall be allocated on the ratio of the final award to each party over the total award in the final Arbitration Order. No

part of this Agreement shall be **construed as prohibiting or discouraging the Resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman, in accordance with 42 CFR 483.10(k).**

The undersigned acknowledges that the facility's alternative dispute resolution "voluntary arbitration" agreement was explained in a method, manner, and language that I understand, and I voluntarily consent to all its terms. I further understand that I have the right to rescind my consent to participate in this alternative dispute resolution method within 30 days of signing the Agreement.

Resident:

_____ _____

Resident Signature Date

Responsible Party:

_____ _____

Signature & Relationship to Resident Date

_____ _____

Signature & Relationship to Resident Date

Dispute resolution consent rescinded: _____

Date

Facility Representative:

_____ _____

Signature Date

Patient Consent for Telehealth

Patient Name: _____

Patient Address: _____

Date of Birth: Discipline: ☐ PT ☐ OT ☐ ST

Purpose: The purpose of this form is to obtain your consent to participate in Telehealth Evaluation and/or Treatment Sessions for Occupational, Physical, and/or Speech Therapy. These services will be provided as appropriate based on your medical condition and individualized treatment plan.

1. During the telehealth sessions, the following may be discussed/performed:
   a. Details of your medical history, examinations, x-rays, and tests may be discussed using interactive video, audio, and/or telecommunication technology. All technologies are HIPAA compliant.
   b. A physical examination may take place.
   c. Another clinician may be present with you to aid in the video transmission.
   d. Although we do not record the entire session, it is possible video, audio, and/or photo recording may be taken during the procedure(s) or service(s). IF so, we will ask your permission each time before recording and storing this information.
2. We have made all reasonable efforts to protect your data before, during, and after the tele visit. This includes meeting all existing confidentially protections under state and federal law.
3. You have the right to withhold or withdraw your consent to the telehealth sessions at any time without affecting your right to future care or treatment.
4. You have been advised of all the potential risks, consequences and benefits of telehealth. Your health care provider has discussed the information provided above.

I agree to participate in telehealth services.

Signature: _____ Date:

If signed by someone other than the patient, indicate the relationship: _____

Witness Signature: _____ Date:

Witness Name in Print: _____

Resident Portal Authorization

Access to PointClickCare Connected Care Center

How the Connected Care Center Works:
We offer a secure, online, easy to use, mobile friendly **resident portal** providing you access to your healthcare information – anytime and anywhere! We use industry-standard security measures to protect your data. Only authorized individuals will have access to your information and once you are logged into the Connected Care Center, you will have access to only your records.

The resident portal will allow you to view:

1. Allergies and Intolerances (Allergy tab)
2. Care Plan (Care Plan tab)
3. Practitioners (Medical Professionals – Profile tab)
4. Clinical Notes (Prog Notes tab)
5. Diagnoses/Conditions (Diag tab)
6. Immunizations (Immun tab)
7. Lab/Rad tests and results (Results tab)
8. Medications
9. Resident Information (Demographics)
10. Vital signs (Wts & Vitals tab)

You will have the ability to download and send records instantly, safely, and securely.

Participation in Connected Care Center Resident Portal:
One log-in will be provided to either the resident or their legal representative/proxy. Once this form is signed and approved, you will receive an invitation to set up your username and password via the email address you provide.

Protecting Your Health Information and Risks:
This method of communicating and viewing prevents unauthorized parties from being able to access your private health information. However, keeping health information secure depends on two important factors: 1) You need to make sure we have your correct email address, and you must inform us if it ever changes. We strongly suggest you use a personal email account rather than a work email address as this information might be available to your employer. 2) It is your responsibility to keep your password confidential. If you think your password has been compromised, you should promptly change it.

Conditions of Participation in the Resident Portal:
Our use and disclosure of medical information is described in our Notice of Privacy Practices. Access to this secure web portal is an optional service, and we may suspend or discontinue it at any time for any reason. If we do, we will notify you as promptly as possible. As a user of the Connected Care Center and by signing this form you agree NOT to:

1. Transmit any electronic information that violates the rights or privacy of any party.
2. Use the web portal in any way that would violate local, state, or federal laws.
3. Transmit materials that are obscene, defamatory, abusive, slanderous, or otherwise likely to result in harm to others.
4. Intentionally distribute software/computer viruses or take any other action that could compromise the security of our computer system.

Resident Name: _____ Resident D.O.B. _____ Resident MRN # _____

You can speak with…

I, (Name of Resident) ______________________ give Heritage Operations Group, LLC, on behalf of its associated managed facilities, permission to speak with the below named individuals, regarding the status of my health. If someone calls to check on me that is not on the list, please have them contact my healthcare Power of Attorney (POA)/Personal Representative.

Name: ___________________________________ Relationship: ____________________________

Name: ___________________________________ Relationship: ____________________________

Name: ___________________________________ Relationship: ____________________________

Authorization Access to PointClickCare Connected Care Center

I, ___________________________, permit CHOOSE FACILITY FROM DROPDOWN to release protected health/medical information through the Connected Care Center Portal, to_____________________________.

Email address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

- I understand that giving proxy access to this person will allow them to view my health information. This includes records that were created or were existing prior to signing this form.
- I understand that once information has been disclosed, there is potential for it to be re-disclosed by my proxy and will not be protected by state or federal privacy laws.
- I understand that the protected information may include, but is not limited to, testing, diagnosis and treatment related to physical and mental illness, alcohol and/or drug abuse, STDs, HIV/AIDS.
- I understand that I may revoke this proxy at any time by contacting the facility Administrator/Executive Director in writing.

Proxy Access Request – Select One:

☐ Capable Adult Resident - The resident must sign this form to provide authorization for the proxy to receive access to his/her health information Connected Care Center, the Resident Portal. Any termination of this authorization must be submitted in writing and does not apply to previously viewed/released records.

☐ Legal Representative of Adult Resident (Please check which best describes your relationship.)

☐ Legal Guardian ☐ Power of Attorney for Health Care

By signing below, I acknowledge that I have read and understand the Authorization Access to PointClickCare Connected Care Center. I agree with the terms and designate the above-named person as my Connected Care Center Proxy, allowing them access medical information. I understand that my proxy can be revoked at any time, either by the myself, or by designated representative for any reason.

Printed Name: ____

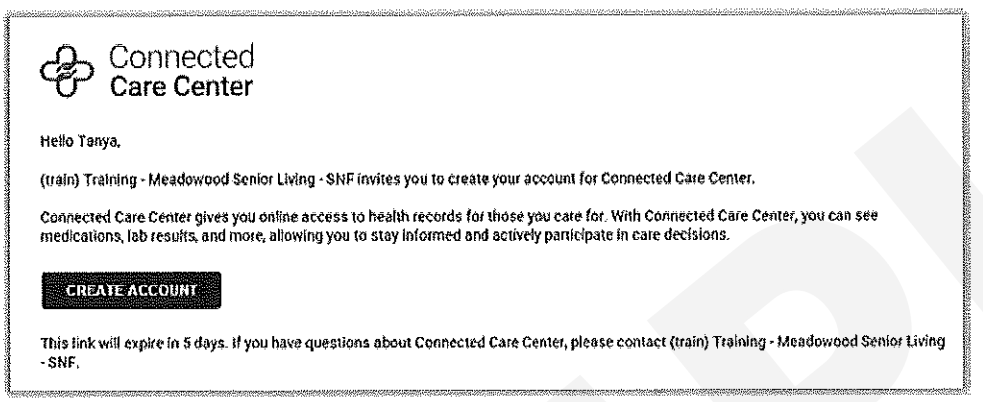
Signature: ____ Date: _______________

Resident Name: _________________________ Resident D.O.B. ____________Resident MRN # _________

Connected Care Center

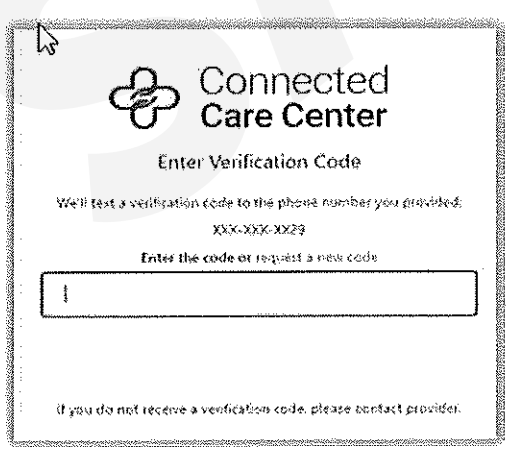
Thank you for signing up to the Heritage Operations Group's Patient Portal. After consent is received and the email and cell phone numbers are entered into the facility's Electronic Health Record, the designated individual will receive an email to create an Account. **The email link is only active for five days.** If the link has expired and needs to be resent, please contact the facility.

Example below:



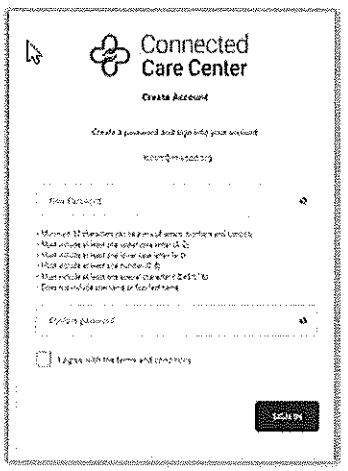
When you click on the "Create account", it will ask you to verify your cell phone number. This will send you a code via text message.

You must enter the verification code sent to your cell phone.

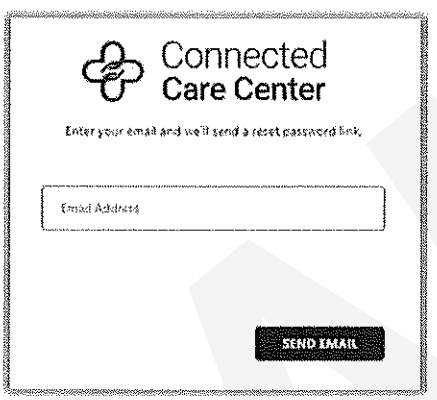


Connected Care Center

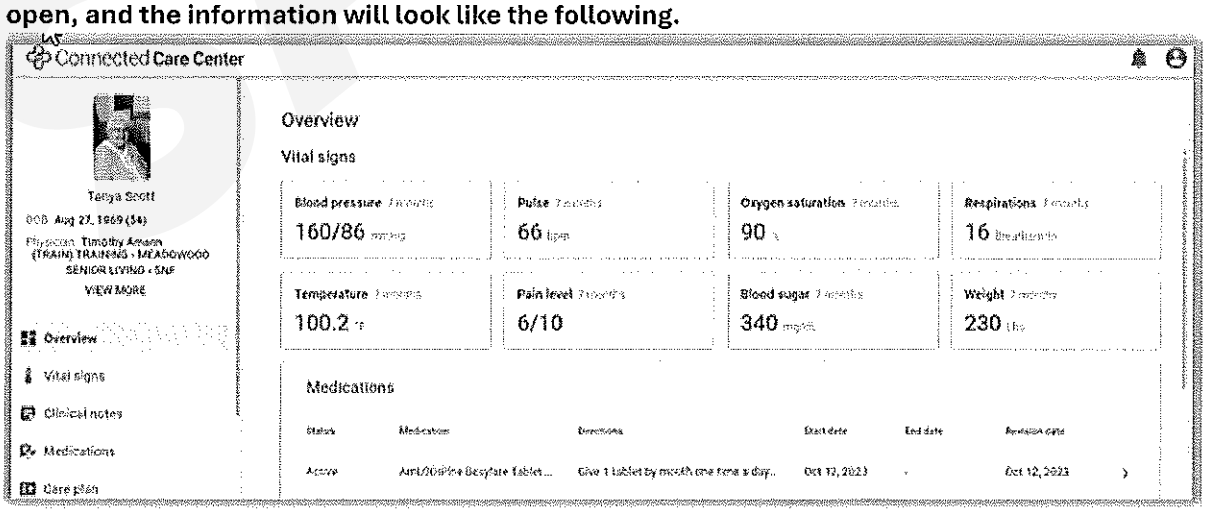
Once you enter the Verification Code, you will be prompted to create a password and confirm the password.



Heritage Operations Group employees do not know your password, nor can they reset the password.



After you agree with the terms and conditions and click sign in, the Connected Care Center will open, and the information will look like the following.



PREFERRED PODIATRY GROUP

PODIATRY CONSENT FORM

NH-55132
MASON CITY AREA
NURSING HOME
520 N Price St, Mason City
IL, 62664-9600

I hereby request Preferred Podiatry Group (PPG) to assume responsibility for podiatry evaluation and treatment for:

_____ until I cancel service in writing.

(please print patient name)

I understand that PPG takes assignment. All bills shall be directed towards Medicare, Medigap, MMAI and insurance carriers when possible. I am responsible for the deductible and co-insurance when not covered by supplemental insurance or Medicaid. I authorize Medicare and my insurance to send payments directly to PPG. I also authorize the release of any information from any agency or carrier to PPG for purposes of administering the Medicare program. I also authorize PPG to release any required information to any agency, insurance carrier, or Medicare as needed. I acknowledge that Preferred Podiatry Group, P.C. has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can request access to this information. I understand that if I have questions or complaints, I may contact the Privacy Officer at privacy@ppgpc.com. I also understand that I will receive updates if Preferred Podiatry Group, P.C. makes material changes to its Notice of Privacy Practices.

REQUIRED: SIGNATURE AND REFERRING PRIMARY CARE PROVIDER INFORMATION

_____ _____

(signature of patient, guardian, responsible party, or capacity of signature) Date

PCP Name (Last, First)	Phone Number	Last Date Seen by PCP

Primary Care Provider Address

PLEASE COMPLETE THE FOLLOWING OR ATTACH RESIDENT'S FACESHEET WITH INSURANCE:

SOCIAL SECURITY NUMBER	PATIENT DOB	
MEDICARE NUMBER	MEDICAID NUMBER	
SECONDARY INSURANCE	ID NUMBER	GROUP NUMBER
INSURANCE ADDRESS		INSURANCE PHONE NUMBER
RESPONSIBLE PARTY NAME	PHONE NUMBER	EMAIL ADDRESS
ADDRESS	CITY AND STATE	ZIP CODE

(847) 504-5000 (844) 443-0082 168 N. Clinton St. 3rd Floor
Chicago, IL 60661

Preferred Podiatry Group, P.C.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed by Preferred Podiatry Group, P.C., Preferred Podiatry Group of Michigan, P.C., and Preferred Podiatry Group of Kansas, LLC (together, "PPG") and how you can get access to this information. Please review it carefully. Effective Date: 7/8/2022

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

COVID-19 2024 - 2025 Vaccine Consent Form

Eligibility

- ☐ I've had COVID in the last 90 days
  - ☐ Yes – Must wait at least 90 days for vaccine
  - ☐ No
- ☐ It's been at least 2 months since my last 2023 – 2024 COVID vaccine.

- ☐ I have pharmacy insurance coverage
  - ☐ Yes – please provide card (*NOTE: some insurances may require copay*)
  - ☐ No – Facility will cover vaccine cost for staff and/or uninsured.

Section 1: Information About You (PLEASE PRINT AND COMPLETE ALL FIELDS)

NAME: Last:	First:	Middle Initial:

DATE OF BIRTH: (MM/DD/YYYY)	AGE:	MOBILE PHONE NUMBER:
/ /		( )

ADDRESS:	Apt/Room #:

CITY:	STATE:	ZIP:

GENDER:	RACE:		ETHNICITY:
☐ Female	☐ American Indian or Alaska Native	☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic or Latino
☐ Male	☐ Asian	☐ Other Race	☐ Not Hispanic or Latino
☐ Other	☐ Black or African American	☐ Unknown	☐ Unknown
☐ Unknown	☐ Hispanic or latino	☐ White	
	☐ Middle Eastern or North African		

Section 2: COVID-19 Vaccine History

Vaccine Brand: ☐ *Pfizer* ☐ *Moderna* ☐ *Johnson & Johnson*

Date of LAST Booster (if applicable) _____

Section 3: Consent

I understand I will be provided an Emergency Use Authorization Fact Sheet or a Vaccine Information Statement prior to the vaccination and have the ability to revoke consent at any time.

☐ **I GIVE CONSENT** to be vaccinated with this vaccine. (If this consent form is not signed, you will not be vaccinated.)

☐ **I DO NOT GIVE CONSENT** to be vaccinated with this vaccine. (If this consent form is not signed, you will not be vaccinated.)

Signature:

_____

Date: Month: _____ Day: _____ Year: _____

Continue on back for insurance information.

COVID-19 2024 - 2025 Vaccine Consent Form

Insurance Name		
Insurance ID #		
Policy Holder's Name		
Group	Bin #	PCN #

FOR OFFICE USE ONLY
Administered By: _____
Administration Site: _____
Product Given: _____
Lot #: _____
Expiration Date: _____
Additonal Comments: _____
Patient Location:
☐ Communal Room
☐ Patient Room

Vaccination Consent
(Hepatitis B, Pneumococcal Pneumonia, Shingles & Influenza)

Resident Name: _____

Risk Assessment

Age of resident: _____

Must be over 18 to receive Hepatitis B. Shingles is recommended for 60 + years. Pneumococcal Pneumonia & Influenza are recommended for people over 65 because they are at a higher risk for these illnesses. Mark all risk factors that apply below:

_____ Chronic lung, heart or kidney disease
_____ Long Term Care admission or resident
_____ Recovering from an acute illness
_____ Diabetes
_____ Weakened immune system

- OR -

_____ None of the items listed apply. Resident is not at high risk. No further assessment is needed.

_____ Risk factors for Hepatitis B were reviewed (read 2nd column on VIS). If laboratory testing is requested to determine infection status the physician will be notified.

Contraindications

(If any of the items below are marked, physician needs to evaluate appropriateness of vaccination.)

Hepatitis B	Shingles	Pneumococcal Pneumonia	Influenza
___ Allergies ___ Acute or Chronic medical condition ___ Previously vaccinated ___ Pregnant ___ Breast feeding ___ Other (Please explain) *Vaccine is given in 3 doses. 1st dose at elected date 2nd dose 1 month later 3rd dose 6 months after the first dose *Titers may be drawn if ordered by physician.*	___ Allergy to gelatin or Neomycin ___ Weakened immune system due to current: • AIDS • Radiation • Chemotherapy • Prolonged use of High dose steroids • Cancer • Acute illness • Temperature of 101.3F or higher ___ Previously vaccinated ___ Other (Please explain)	___ History of Sickle Cell Anemia ___ History of previous Allergic reaction to Pneumococcal Pneumonia vaccination ___ Previously vaccinated (List date and location below.) _____ ___ Other (Please explain) PCV13: Date: _____ Location: _____ PPSV23: Date: _____ Location: _____ PREVNAR 20: Date: _____ Location: _____	___ History of Guillain Barre Syndrome ___ History of previous Allergic reaction to Influenza vaccination ___ Previously vaccinated ___ Other (Please explain) *See reverse side of form for annual education and consent documentation.*

_____ Vaccine Information Statements (VIS) have been given to resident/POA on Hepatitis B, Pneumococcal Pneumonia, Shingles & Influenza.

Hepatitis B:
_____ I have been educated on the risks & benefits of receiving the Hepatitis B series & I DO want to be vaccinated.
_____ I have been educated on the risks & benefits of receiving the Hepatitis B series & I DO NOT want to be vaccinated.

Pneumococcal Pneumonia:
_____ I have been educated on the risks & benefits of receiving the Pneumococcal Pneumonia vaccines & I DO want to be vaccinated.
_____ I have been educated on the risks & benefits of receiving the Pneumococcal Pneumonia vaccines & I DO NOT want to be vaccinated.

Shingles:
_____ I have been educated on the risks & benefits of receiving the Shingles vaccine & I DO want to be vaccinated.
_____ I have been educated on the risks & benefits of receiving the Shingles vaccine & I DO NOT want to be vaccinated

Influenza:
_____ I have been educated on the risks & benefits of receiving the Influenza vaccine & I DO want to be vaccinated annually.
_____ I have been educated on the risks & benefits of receiving the Influenza vaccine & I DO NOT want to be vaccinated annually.

_____ Date
Signature of Resident/POA

_____ Date
Staff Members Signature

Annual Immunization review is required. Go to Immunization tab in resident's electronic health record to review past immunizations and to record decisions made annually for Hepatitis B, Shingles, Pneumococcal Pneumonia and Influenza. Document education on the risks vs. benefits of the vaccinations requested. Provide Vaccine Information Statements for each vaccination requested.

Annual Influenza, Hepatitis B, Shingles & Pneumococcal Pneumonia Education & Consent Documentation

Influenza:

____ Resident/POA has been educated on the risks & benefits of receiving the Influenza vaccine & DO want the vaccination.
____ Resident/POA has been educated on the risks & benefits of receiving the Influenza vaccine & DO NOT want the vaccination.
____ Reviewed status of Hepatitis B, Shingles and Pneumococcal Pneumonia vaccinations.

If choices have changed, please provide (Vaccination Information Statement) VIS for change requested, educate resident/POA on the risks & benefits of receiving the vaccination & contact the physician for orders.

Nurse Signature: ______________________________ Date: ______________

Influenza:

____ Resident/POA has been educated on the risks & benefits of receiving the Influenza vaccine & DO want the vaccination.
____ Resident/POA has been educated on the risks & benefits of receiving the Influenza vaccine & DO NOT want the vaccination.
____ Reviewed status of Hepatitis B, Shingles and Pneumococcal Pneumonia vaccinations.

If choices have changed, please provide (Vaccination Information Statement) VIS for change requested, educate resident/POA on the risks & benefits of receiving the vaccination & contact the physician for orders.

Nurse Signature: ______________________________ Date: ______________

Influenza:

____ Resident/POA has been educated on the risks & benefits of receiving the Influenza vaccine & DO want the vaccination.
____ Resident/POA has been educated on the risks & benefits of receiving the Influenza vaccine & DO NOT want the vaccination.
____ Reviewed status of Hepatitis B, Shingles and Pneumococcal Pneumonia vaccinations.

If choices have changed, please provide (Vaccination Information Statement) VIS for change requested, educate resident/POA on the risks & benefits of receiving the vaccination & contact the physician for orders.

Nurse Signature: ______________________________ Date: ______________

Influenza:

____ Resident/POA has been educated on the risks & benefits of receiving the Influenza vaccine & DO want the vaccination.
____ Resident/POA has been educated on the risks & benefits of receiving the Influenza vaccine & DO NOT want the vaccination.
____ Reviewed status of Hepatitis B, Shingles and Pneumococcal Pneumonia vaccinations.

If choices have changed, please provide (Vaccination Information Statement) VIS for change requested, educate resident/POA on the risks & benefits of receiving the vaccination & contact the physician for orders.

Nurse Signature: ______________________________ Date: ______________

Influenza:

____ Resident/POA has been educated on the risks & benefits of receiving the Influenza vaccine & DO want the vaccination.
____ Resident/POA has been educated on the risks & benefits of receiving the Influenza vaccine & DO NOT want the vaccination.
____ Reviewed status of Hepatitis B, Shingles and Pneumococcal Pneumonia vaccinations.

If choices have changed, please provide (Vaccination Information Statement) VIS for change requested, educate resident/POA on the risks & benefits of receiving the vaccination & contact the physician for orders.

Nurse Signature: ______________________________ Date: ______________

Measles, Mumps, and Rubella Vaccine Consent/Declination Form (MMR) Resident

Date____/____/____ Name_____

Primary Physician_____

Date of Birth_____ Age _____ Phone_____

	Yes	No
1. Are you allergic to any medications? If yes, please list	☐	☐
2. Have you felt ill or run a fever in the past 48 hours?	☐	☐
3. If female, are you or could you be pregnant at this time?	☐	☐
4. Are you allergic to latex?	☐	☐
5. Are you currently on steroids, chemotherapy, HIV positive, asplenic, or immunosuppressed for any reason?	☐	☐

Indications: MMR is indicated for immunization against measles, mumps, and rubella in persons 12 -15 months of age or older.

Contraindications: (Do not take vaccine if one or more of these conditions exist)

- People who have had allergic reactions to gelatin, neomycin, or a previous dose of MMR.
- People with cancer, with diseases or treatments that affect the immune system, with low platelet counts, or recent transfusions.
- Moderate or severe illness.
- Women who are pregnant should not receive this vaccine. Women should not get pregnant for 4 weeks following vaccine.

_____**Receive the Measles vaccine.** I understand the risks and benefits of the vaccine and consent to vaccination with the MMR vaccine. If I am a female, I certify that I am not pregnant at this time and I understand I should not become pregnant for 4 weeks following the vaccine.

_____**Decline the Measles vaccine because of presumptive evidence of immunity specified as:**

1. Written documentation of **one or more doses** of a measles-containing vaccine administered on or after the first birthday for preschool-age children and adults not considered high risk
2. Written documentation of **two doses** of measles-containing vaccine for school-age children and adults at high risk, including students at post-high school secondary educational institutions, healthcare personnel, and international travelers
3. Laboratory evidence of immunity
4. Laboratory confirmation of disease
5. Birth before 1957 (*see below for presumptive evidence of immunity criteria for health care personnel born before 1957*)

_____Decline the Measles vaccine for unspecified reasons:

- If I decide at any time during my stay at the facility that I would like to be vaccinated against Measles, the facility will notify my physician of my wishes, an order obtained if deemed appropriate, and the vaccine administered.

I have read the above information and have had an opportunity to ask questions. I have read the Vaccine Information Statement "Measles Mumps & Rubella Vaccines and What You Need to Know" by the CDC.

_____

Resident/POA Signature Date

DO NOT WRITE BELOW THIS LINE

Temp: _____ ☐ IM right Deltoid ☐ IM left Deltoid

Manufacturer/Lot No: _____ Exp. Date: _____

Nursing Signature: _____ Date: _____

Refences: https://www.nwmissouri.edu/wellness/PDF/ConsentFormMMR.pdf.

Respiratory Syncytial (RSV) Vaccine Consent

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

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

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you can get the respiratory syncytial virus (RSV) vaccine. If you answer "NO" to all the following questions, you can get the respiratory syncytial virus (RSV) vaccine. If you answer "YES" to one or more of the following questions, you may not be able to get the respiratory syncytial virus (RSV) vaccine.

Please mark YES or NO for each question	YES	NO
1. Do you have serious allergies to any component of the RSV vaccine?	†	†
2. Do you have any other serious allergies? Please list:_____	†	†

Section 3: Consent

CONSENT FOR VACCINATION:

I have read or had explained to me the 20____ - 20____ Vaccine Information Statement for the respiratory syncytial virus (RSV) vaccine and understand the risks and benefits, based on clinical shared decision making between myself and my healthcare provider.

____ I **DO** want to be vaccinated.

____ I **DO NOT** want to be vaccinated.

_____ Date

Signature of Resident/POA

_____ Date

Staff Member's Signature