

Request Concerning Life-Prolonging Procedures

On this _____ day of _____, _____, I, _____, _____
Month Year Resident or Legal Guardian, as appropriate
 request the following care in the event that the attending physician determines that
 my _____'s condition (be it injury, disease or
Name of Resident, if being completed by legal guardian
 illness) is terminal, incurable and irreversible, and that death is imminent:

You must indicate Yes or No for each listed procedure.
Yes means to do procedure, No means **DO NOT** do procedure.

Cardiopulmonary resuscitation (CPR)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use of respirators or ventilators	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Administration of medications other than those necessary to prevent infection, provide comfort or alleviate pain.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Transfer to an acute care hospital ☐ Yes ☐ No

Other _____

I fully understand the impact and potential consequences of this document and wish to emphasize my
 desire to have the procedures performed or withheld (as indicated above) if death is imminent.

Witness Signature _____	Date _____	Signature of Resident or Legal Guardian _____	Date _____
Witness Signature _____	Date _____	Physician Signature _____	Date _____

ATTENDING PHYSICIAN'S COMMENTS: _____

MEDICARE PART A ELIGIBILITY

TO BE ELIGIBLE TO RECEIVE MEDICARE PART A, ALL OF THE FOLLOWING REQUIREMENTS MUST BE MET.

- ____ 1. BE ENTITLED TO PART A HOSPITAL INSURANCE
 - ____ 2. MEET THE THREE NIGHT PRIOR HOSPITAL STAY REQUIREMENT
(3 MIDNIGHTS)
DATES OF HOSPITAL STAY-ADMIT:_____ DISCHARGE:_____
 - ____ 3. (A) ADMITTED TO FACILITY WITHIN 30 DAYS OF HOSPITAL STAY IN #2
OR RESUME COVERED LEVEL OF CARE WITHIN 30 DAYS OF LAST
MEDICARE COVERED DAY.
(B) IF TRANSFERRED FROM ANOTHER SNF (AS OPPOSED TO HOSPITAL)
GIVE DATE OF SERVICE AT OTHER SNF-
ADMIT:_____ DISCHARGE:_____
 - ____ 4. REQUIRED SKILLED NURSING SERVICES 7 DAYS A WEEK AND/OR
SKILLED REHABILITATION SERVICES AT LEAST 5 DAYS A WEEK
AND/OR RECEIVED IV'S IN HOSPITAL DURING LAST 14 DAYS.
 - ____ 5. BE CERTIFIED BY A PHYSICIAN AS NEEDING SKILLED CARE.
 - ____ 6. BE PLACED IN A MEDICARE CERTIFIED BED.
 - ____ 7. HAVE DAYS AVAILABLE IN THE CURRENT BENEFIT PERIOD.
VERIFY DAYS BY CALLING TRI-SPANS TOLL FREE VOICE
RESPONSE SYSTEM AT 1-877-567-3097
-

PATIENT NAME:_____ DOB:_____
MEDICARE # _____

RECORD THE FOLLOWING INFORMATION PROVIDED BY THE VRS:

DATE ELIGIBLE FOR PART A:_____

DATE ELIGIBLE FOR PART B:_____

FULL DAYS:_____

CO-INS DAYS:_____

LBD:_____

**LIABILITY FOR PAYMENT FOR DEDUCTIBLE AND
COINSURANCE**

Oak Lane Wellness & Rehabilitation Center

Date of Admission: _____

Resident Name

Medicare Number

Medicare will pay full coverage for the first 20 days of service in a skilled unit.

On the 21st day through the 100th day of your stay, a coinsurance amount of \$_____ per day is charged to you. This charge will be billed to your supplemental insurance by Oak Lane. If you have no supplemental insurance you will be responsible for payment of \$_____ per day coinsurance. We have determined from information provided by you that you have _____ days remaining of your 20 days full coverage.

Resident Statement

I acknowledge by my signature below that I understand that after the 20th day, Medicare will no longer pay full charges for my stay in the certified unit of Oak Lane and that Oak Lane will bill my supplemental insurance for the coinsurance rate, and if there is no supplemental insurance I will be responsible for payment.

Resident Signature or Responsible Party

Witness

Date

COVERED AND NON-COVERED SERVICES & CHARGES

MEDICARE

Medicare Part A Certified Section

RATE/DAY

Room and Board Routine Nursing Care Routine Supplies and Equipment \$____/day

Medicare covers charges for the following ancillary services when approved:

Pharmacy	Physical Therapy	Radiology
Speech/Language Pathology	Laboratory	
Medical Supplies, Chargeable	Occupational Therapy	

Medicare does not cover charges for the following personal needs, items or services:

Personal Laundry	Transportation	Massage Therapy
Equipment Rental	Private Room	Television/Cable Hook-up
Private Duty Nurse	Beauty/Barber Shop	Telephone

If the beneficiary meets the qualifying conditions, Medicare will pay 100% of the daily room rate plus all covered ancillary charges for the first twenty (20) days. You (beneficiary) are required to pay a portion of the charge for the 21st through the 100th day of coverage for each benefit period. That portion is called coinsurance. The coinsurance amount is established by the Federal government and presently is \$____per day. Medicare pays the remaining portion. Some supplemental insurance may cover the coinsurance amount.

Medicare will not pay for personal items or services. You will be charged for personal items and services.

When the beneficiary, meeting qualifying conditions is no longer covered for Medicare Part A inpatient services, Medicare Part B **may** pay 80% of the following ancillary services and you (the beneficiary) will be billed 20% coinsurance:

Occupational Therapy	Physical Therapy	Speech/Language Pathology
Surgical Dressings	Tube Feedings	Radiology
Prosthetic Devices	Laboratory	

Facility Representative

Beneficiary/Responsible Party

Date

Date

ASSIGNMENT OF BENEFITS

Resident Name: _____

Facility: Oak Lane Wellness & Rehabilitation Center

Medicare Provider #195588

ASSIGNMENT OF MEDICARE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I agree to the organization furnishing the services or authorize such organization to submit to Medicare for payment to me.

Executed this _____ day of _____, 20____.

Resident/Guardian Signature

Responsible Party Signature

Witness Signature

Date

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of the services received or to be received, I assign to Oak Lane Wellness & Rehabilitation Center any third party payment due to me or that may become due to me under all insurance policies held by me or for my benefit for services rendered in the course of this admission or a related admission. I do hereby authorize and direct that all insurance benefit payments be made directly to Oak Lane Wellness & Rehabilitation Center. I recognize that if payment is made directly to me by said insurance company, the amount received up to the amount of billed charges for services rendered is the property of Oak Lane Wellness & Rehabilitation Center and should be paid to Oak Lane Wellness & Rehabilitation Center. A copy of this assignment shall be valid as the original.

Resident/Responsible Party Signature

Date

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name _____ MRN # _____

Please read and respond to each of the following:

(Part I)

1. Are you receiving Black Lung Benefits? ☐ Yes ☐ No
 2. Are the services to be paid by a government research program? ☐ Yes ☐ No
 3. Are you entitled to benefits through the Department of Veterans Affairs (DVA)? ☐ Yes ☐ No
-

(Part II)

4. Is your illness/injury due to any of the following: ☐ Yes ☐ No
 - ☐ Work-Related ☐ Automobile Accident
 - ☐ Accident on Property (other than your own)
5. If Medicare coverage is due to age or disability, do you have group insurance coverage through your or another family member's current employer? ☐ Yes ☐ No
6. Are you entitled to Medicare due to End Stage Renal Disease and age or ESRD and disability?
☐ Yes ☐ No
7. Do you have any benefits through TriCare (formerly Champus)? ☐ Yes ☐ No

If you answered yes to questions 4, 5 or 6 there is a second form to be filled out.

Patient's Signature _____

Date _____

Thank You

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name _____ MRN # _____

If you answered yes to questions 4 or 5 on the MSP Questionnaire the following questions will need to be completed:

(Question 4)

Was your illness/injury due to any of the following?

☐ Work-Related Accident

☐ Automobile Accident

Date: _____

Date: _____

☐ Accident on Property (other than your own) Accident Date: _____

Please give details of the accident: _____

(Part III)

1. Do you intend to file a liability claim or lawsuit in connection with this injury or illness?

☐ Yes ☐ No

Please provide the name, address and contact information of the liability insurance:

Insurance Name: _____

Address: _____

City, State & Zip: _____

Phone: _____

Contact: _____

Claim Number: _____

Note: Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing Medicare and appreciate your cooperation

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

(Question 5, 6)

1. Are you currently employed? ☐ Yes ☐ No If applicable, date of retirement: _____

2. Do you have a spouse who is currently employed? ☐ Yes ☐ No

3. If you have GHP coverage based on your own or your spouse's current employment; does that employer sponsor or contribute to the GHP employ 20 or more employees? ☐ Yes ☐ No

More than 100 employees? ☐ Yes ☐ No

Insurance Name: _____

Address: _____

City, State & Zip: _____

Phone: _____

Employer: _____

Insured's Name: _____

Subscriber ID# : _____ Group number: _____

(Question 6)

1. Have you received a kidney transplant? ☐ Yes ☐ No If yes, date of transplant: _____

2. Have you received maintenance dialysis treatments? ☐ Yes ☐ No Date dialysis began: _____

3. Have you participated in a self-dialysis training program? ☐ Yes ☐ No

Date training started: _____

4. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

Patient signature: _____ Date _____

Thank you for your cooperation!

Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)

Date of Notice: _____

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

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

Items or Services:

Because:

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

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$ _____**), in case you have to pay for them yourself or through other insurance you may have.
Your other insurance is: _____
- If in 90 days you have not gotten a decision on your claim, contact the Medicare contractor
at: Address: _____
or at: Telephone: _____ TTY/TDD: _____
- If you receive these items or services, we will submit your claim for them to Medicare.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. DATE & SIGN THIS NOTICE.

☐ **Option 1. YES. I want to receive these items or services.** I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision.

☐ **Option 2. NO. I will not receive these items or services.** I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I understand that, in the case of any physician-ordered items or services, should notify my doctor who ordered them that I did not receive them.

Patient's Name: _____ Patient Identification #: _____

Date _____

Signature of the patient or of the authorized representative _____

Oak Lane Wellness and Rehabilitation Center

1400 W. Magnolia Street, Eunice, LA 70535 Ph. (337) 550-7200

Notice of Medicare Non-Coverage

Patient name:

Patient number:

The Effective Date Coverage of Your Current **Skill**
Services Will End:

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

Your Right to Appeal This Decision

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

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: **Kepro 1-844-430-9504** to appeal, or if you have questions.

See page 2 of this notice for more information.

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

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information _____

Additional Information (Optional):

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

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

Signature of Patient or Representative

Date _____

SOCIAL HISTORY & INITIAL ASSESSMENT

Resident's Name _____ Attending Physician _____

Admission Date _____ Resident Number _____ Room Number _____

Date of Birth _____ Age _____ Sex _____ Birthplace _____

Social Security No. _____ Social Security Benefits _____

Medicare # _____ Medicaid # _____ Medicaid Benefits _____

Marital Status _____ Former Occupation _____

Religious Faith _____ Church Membership _____

Name of Minister _____ Phone Number _____ Date Notified of Admission _____

Education Level _____ Special Training/Skills _____

Culture/Ethnic Background _____ Military Branch of Service _____

Living Arrangements & Address Prior to Admission _____

Reason for Admission _____

Name (s) of Interested Family or Friends and Relationships

Name	Relationship	Address	Telephone

Who will Handle Resident's Personal Fund? _____

What Organizations/Clubs does Resident Belong To? _____

Is Resident still active in these? _____ Primary Language? _____

Is Resident able to write letters and sign documents? _____

Is Resident able to read/understand his/her mail? _____ Use Phone? _____

Resident's Attitude towards placement _____

Family's Attitude towards placement _____

Affect _____

Can Resident: Walk? _____ With Help? _____ In Wheelchair? _____ Bedridden? _____

SPEECH: Good _____ Understandable _____ Slurred _____ Mumbles _____ Grunts _____

VISION: Good _____ Good with Glasses _____ Poor _____ Nearly Blind _____ Blind _____

HEARING: Good _____ Poor _____ Undetermined _____ Has Hearing Aid _____ Uses Hearing Aid _____

What is Resident's Legal Status? _____

Name/Address of Responsible Party _____

Information obtained from _____

Date _____ Social Worker _____



Oak Lane

Wellness & Rehabilitation Center



1400 W. Magnolia St. - P. O. Box 1480
Eunice, Louisiana 70535

Ph: (337) 550-7200
Fax: (337) 550-1143

Name of Resident

Date of Admission

ACKNOWLEDGMENT OF COPIES RECEIVED

The following items listed below were given to me on admission:

- *PROCEDURES FOR FAMILIES AND VISITORS**
- *RESIDENT'S RIGHTS**
- *THE FACILITY BED HOLD POLICY**
- *ARTICLES ALLOWED AND NOT ALLOWED IN RESIDENT'S ROOM**
- *POLICY REGARDING ROOM DÉCOR**
- *RESIDENT'S RIGHT TO VOICE GRIEVANCES**
- *ALCOHOL FREE CAMPUS**

I hereby acknowledge that I have been given the copies listed above.

Resident's Signature or Responsible Party

**Frequently Asked Questions for
Residents applying for Medicaid
Medicaid Pending**

●How do we apply for Medicaid for the resident entering the nursing home?

Upon admission to the nursing home, the business office will electronically submit a form to Louisiana Medicaid informing them of the resident's admission and request to apply for Medicaid. Medicaid will mail the Medicaid application and a printout of requested documents to the Responsible party that was listed upon admission.

●What questions are on the Medicaid application?

The Medicaid application consists mostly of financial questions related to the applicant and/or spouse, applicant insurance policies, burial policies, property owned, and all other assets of the applicant.

●How long do I have to complete the Medicaid application?

It is recommended that the completed application and requested documentation be returned to Medicaid within 60 days. If additional verifications are requested by Medicaid, Medicaid will mail a letter stating requested documents and a due date for the response. It is important to respond timely to avoid disqualification. Medicaid will process and reach a determination within 4-6 weeks.

●What do we do while waiting to hear from Medicaid?

The resident's monthly income will be used to pay for room and board costs each month. All monies the resident receives during this waiting period should not be spent, as it will become due to the nursing home. Even though it may take Medicaid 4-6 weeks to reach a determination, Medicaid will retro the approval back to the date of admission.

●Do we have to pay while Medicaid pending

Yes, the last page of this document will be used to calculate an estimated PLI (patient liability income). Medicaid will allow the resident to keep \$38.00 per month for personal spending and will also allow for a monthly insurance premium if applicable. All other income is due to the nursing home once Medicaid approved. The estimated monthly PLI will be due upon admission and each month continuing until a determination is reached by Medicaid.

This is an estimated cost, once approved for Medicaid the cost may differ from the estimated cost that was calculated. The resident/family may owe a difference, or the facility may have a credit for the resident.

●If the resident is now approved for Medicaid, why does he/she have to pay?

Being approved for Medicaid means that Medicaid will now pay the facility the portion of the Medicaid rate that is not covered by the resident's income. The resident is responsible for their portion of the Medicaid rate (their PLI determined by Medicaid).

(See following 4 pages for other Frequently Asked Questions-per LA Dept. of Health & Hospitals)



DEPARTMENT OF HEALTH

Frequently Asked Questions

Who qualifies for Louisiana Medicaid Long Term Care?

To qualify for coverage, an individual must:

- Live (or plan to live) in a participating long-term care nursing facility, a state developmental center, or a group or residential home for individuals with developmental disabilities.
- Already receive SSI or FITAP cash assistance OR meet the following criteria:
 1. Reside in Louisiana
 2. Have or apply for a social security number
 3. Have countable monthly income below 3 times the monthly SSI benefit rate (FBR)
 4. Have countable resources of less than \$2,000 for an individual or \$3,000 for a couple, minus allowable excursions;
 5. Be a U.S. citizen or an alien legally admitted for permanent residence;

and be:

1. Pregnant, or
 2. Under age 18, or
 3. At least 65, or
 4. Blind (with corrected vision of 20/200 or less), or
 5. Disabled (as established by receipt of SS Disability benefits or a BHSF Medical Eligibility Determination Team decision).
- Meet the "level of care" requirement for appropriate placement as determined by the agency's Health Standards Section based on medical data furnished by the admitting physician and facility or provider.

Can an individual receive the necessary care at home or in the community?

Individuals who need the type of medical care usually available in facilities but who can be treated successfully and cost-effectively in other settings may be allowed to receive the necessary care at home or in the community. The Medicaid Program provides this coverage for a limited number of persons who are otherwise eligible for and would require facility placement. Current Home and Community-Based (Waiver) Services include:

- Community Choices Waiver
- Adult Day Health Care



DEPARTMENT OF HEALTH

- Children's
- New Opportunity Waiver
- Supports Waiver
- Residential Options Waiver (ROW)

Choice

Requirements for these programs are the same as for nursing facility care with some additional requirements added. Space for new participants is limited. Interested persons should contact the Office of Aging and Adult Services at 1.866.783.5553 for specific program information and requirements.

Individuals who are Medicaid eligible can now receive personal care services in their homes even without being in one of the waiver service programs.

How do I get Medicaid?

To get Medicaid, you must answer all of the questions on the application form and give needed proof so we can see if the person who needs long-term care is eligible. When we get the application, we will see if the income and resource limits and other non-financial requirements are met. We must also decide if long-term care is medically necessary and if the provider chosen can supply the care that is needed. This decision is based on medical information given by his or her doctor(s).

How do I begin the application process?

To begin the application process for long-term facility care OR for information about Home and Community-Based Services, call us toll free at 1.877.456.1146 (TDD 1-877-456-1172) Monday through Friday between 6:30 a.m. and 4:30 p.m. Central Time.

If my parent is not able to complete the application process on their own, can I act as their representative?

Yes, with the appropriate documentation that gives you permission to act on behalf of your parent.

What are the income limits?

Effective January 1, 2015 (and continuing through 2016), the income limits are \$2,199 for an individual and \$4,398 for a couple (if both spouses need long-term care). These limits usually increase each year in January. People with income above these limits may still qualify for long-term care services through the Medically Needy Spend-Down Program. For more information, please call 1-800-230-0690.

How does the Medically Needy Spend-Down Program work?

Medically Needy provides Medicaid eligibility to qualified individuals and families who may have too much income to qualify for regular Medicaid programs. Individuals and families who meet all Medicaid program requirements, except that their income is above those program limits, can spend-down or reduce their income to Medicaid eligibility levels using incurred medical expenses.

What is countable income?

Countable income consists of:



DEPARTMENT OF HEALTH

- Unearned income, which includes money received from SSA, pensions, retirement, veteran's benefits, interest income, cash from friends and relatives, and
- Earned income, which is money received from working.

Whose income is counted?

We use only the income of the person who needs long-term care to decide if he or she is eligible. We determine how much a person who is eligible for facility care must pay toward the cost of this care. We must use GROSS monthly income and deduct \$38.00 for personal needs, the amount paid for some medical services that are not covered by Medicaid, and certain contributions made to a spouse or dependents. Any remaining income must be paid toward the cost of facility care.

May a person who qualifies give some of his or her income to a spouse and/or children?

Under Spousal Impoverishment rules, a person who qualifies for Medicaid for facility care may give some of his or her income to a legal spouse who lives at home and/or to any children under age 18. There are limits for how much can be given to these dependents. To decide how much can be contributed, we need income information about the spouse and/or children.

How is resource eligibility determined?

Countable resources cannot be worth more than \$2,000 for an individual or \$3,000 for a couple who needs long-term care. Under Spousal Impoverishment rules, a couple can have up to \$113,640 in countable resources, as long as there is a spouse at home who does not get long-term care. Resources owned separately, by either spouse, and all resources owned jointly by the couple are used to determine countable couple assets. Resources owned jointly by the couple, and those in excess of the \$2,000 allowed for the long-term care spouse must be transferred to the at-home spouse before the first review of eligibility. The Spousal Impoverishment resource limit increases each year BUT the limit that applies is the one that was in effect at the time of the most recent admission.

Resources include money plus certain items that are owned by the person who needs long-term care, the legal spouse, or those that are jointly owned. Resources include cash, financial assets, stocks, savings bonds, land, life insurance, vehicles, and anything else which could be changed to cash.

Financial assets include checking, savings, and credit union accounts; stocks, bonds, certificates of deposit, money market accounts, promissory notes, and safety deposit boxes. We look at account ownership to determine who has access to the money. We use the balance as of the first moment of the first day of a month as the value of the asset and to determine asset eligibility for the entire month. Income that is deposited on or for the first day of the month is not counted as part of the account value for that month. Funds to cover outstanding checks that have not cleared the bank by close of business on the last day of a month are considered "available" and are used to determine resource eligibility.

Some things usually do not count toward the resource limit, no matter how much they are worth. Examples of such things are a home and the land it is on, one car, life insurance policies with a combined face value of \$10,000 or less, burial plots or spaces, and irrecoverable burial arrangements.



DEPARTMENT OF HEALTH

A burial fund is an asset set aside to pay for burial expenses. In some cases, up to \$10,000 of this money will not count as a resource. Some or all of the money in a burial fund may count toward the resource limit if the person owns life insurance policies or has other burial arrangements.

We must look at any transfer of resources which occurred within the 60 months (60 months for trust situations) before or at any time after application. Transfers for less than fair market value are presumed to have been done to qualify for Medicaid, unless the applicant provides convincing evidence that the transfer was done exclusively for another purpose. If we determine that resources were transferred to qualify for Medicaid, the person who needs long-term care will not be eligible for facility payment for a specified period. We use the uncompensated value of the transferred item to determine how long the person will be ineligible.

What happens when a long-term care recipient dies?

When a long-term care recipient dies, Estate Recovery provisions require that we take steps to recover the cost of certain Medicaid payments from his or her estate. These costs include the total amount of payments for facility services, hospital care, and prescription drugs the person received at age 55 or older.

How long does an eligibility decision take?

In most cases, we will make an eligibility decision and notify you of our finds within 45 days. If we must make a disability decision, it may take up to 90 days. Coverage can start as early as three months before the month of application if all eligibility factors for Medicaid were met.

What if there are changes?

Changes must be reported to us within 10 days if the person who gets Medicaid or his/her legal spouse:

- Has a change in income or resources, including inheritances;
- Has a change in health insurance coverage or premiums; or
- Has a change in residence or mailing address.

What if I think a decision you make is unfair, incorrect, or made too late?

You or the person who needs long-term care has the right to ask for a Fair Hearing. You can do this by calling or writing to the local Medicaid office. You may also write directly to Louisiana Department of Health, Bureau of Appeals at P.O. Box 4183, Baton Rouge, LA 70821-4183.

Nursing Home Compare allows consumers to compare information about nursing homes. It contains quality of care information on every Medicare- and Medicaid-certified nursing home in the country, including over 15,000 nationwide.

Note: Nursing homes aren't included on Nursing Home Compare if they aren't Medicare- or Medicaid-certified. These Nursing Homes can be licensed by the state. For information about Louisiana nursing homes not on Nursing Home Compare, or any other nursing home inquiry contact LDH-Health Standards Section, Nursing Home Program Desk, 225-342-0114, or visit the Nursing Home Internet home page.

**Medicaid Pending
Estimated Monthly Cost**

Resident Name: _____

Admission Date: _____

Incomes:	\$ _____	Social Security Check
	\$ _____	Retirement Check
+	\$ _____	Disability/Spousal Income/Other Income
	\$ _____	Total Monthly Income

Insurance Premium Allowance: \$ _____ Monthly Premium

Insurance Company: _____

Type of Insurance: _____

Total Monthly Income: _____

Insurance Allowance: _____

Personal Spending _____ 38.00 -

Estimated Monthly Cost: _____

I, _____, resident/responsible party for _____, agree to pay Assisted Living, Inc., D.B.A. Oak Lane Wellness and Rehabilitation Center, the estimated monthly PLI of \$ _____ while Medicaid pending; and also agree to continue to pay the Medicaid determined amount once approved.

Resident/Responsible Party Signature

Date

Witness

Date

Oak Lane Wellness & Rehabilitation Center
1400 W. Magnolia Street
Eunice, LA 70535

LOUISIANA MEDICAID'S LONG-TERM CARE PROGRAM

- BROCHURE WITH SERVICES PROVIDED/QUALIFICATIONS/INCOME REQUIREMENTS/CONTACT INFORMATION
- MEDICAID APPLICATION FOR LONG-TERM CARE SERVICES

I hereby acknowledge that I have been given the above information regarding long-term care services.

Resident's Signature or Responsible Party

Date



Oak Lane

Wellness & Rehabilitation Center



1400 W. Magnolia St. - P. O. Box 1480
Eunice, Louisiana 70535

Ph: (337) 550-7200
Fax: (337) 550-1143

ADMISSION AGREEMENT

NAME OF RESIDENT

NAME OF RESPONSIBLE PARTY

I hereby agree to the following arrangements provided for the medical, nursing, and personal care of the residents.

NURSING HOME AGREEMENT

To furnish room, board, linens, bedding, nursing home care, and such personal services as may be requested for the health, safety, good grooming, and well-being of the resident.

To obtain, whenever necessary the services of a licensed physician of the resident's choice, or the services of another licensed physician, if a personal physician has not been designated, as well as such medications as the physician may order.

To arrange for the transfer of the resident to the hospital of the resident's choice, when this is ordered by the attending physician, and immediately to notify the responsible party of the transfer.

AGREEMENT OF RESIDENT & RESPONSIBLE PARTY

To provide for the personal clothing and effects as needed or desired by the resident. To provide such spending money as needed by the resident.

To be responsible for hospital charges, if hospitalization of the resident becomes necessary, and transportation.

To be responsible for physician's fees, medication, and other treatments or aids ordered by the physician.

To pay basic rate agreed upon with the nursing home at specified intervals, in the event any payments required under this agreement are not paid when due, then the responsible party agrees that the resident, shall, at the sole option of the nursing home, be transported to responsible party's home, or other such place as designated and responsible party agrees to accept physical custody of the resident and pay all transportation charges as well as all past due charges to the nursing home. If the responsible party refuses to take responsibility for the resident under any instances as outline above, it is agreed that the resident will be transported to and placed in the nearest public institution for the care of the aged and inform the responsible party.

To notify the nursing home in advance of resident's contemplated discharge not due to any emergency.



Oak Lane

Wellness & Rehabilitation Center



1400 W. Magnolia St. - P. O. Box 1480
Eunice, Louisiana 70535

Ph: (337) 550-7200
Fax: (337) 550-1143

PROMISSORY NOTE

I _____, resident/responsible party for
_____, Resident, agree to pay Oak Lane
Wellness & Rehabilitation Center, the Patient Liability Income in the amount of
\$_____. If unable to pay the total amount due upon admission, monthly
installments will be accepted.

_____ Installments at \$_____ per month, until the balance
due is paid in full.

Resident/Responsible Party Signature

Date

Witness

Witness



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STANDARD ADMISSIONS WAIVER

The management of this home has agreed to exercise such reasonable care toward this person as his or her known condition may require, however, this home is in no sense and insurer of his/her safety or welfare and assumes no liability as such.

The management of this home will not be responsible for any valuables or money left in the possession of this person while he/she is a resident of this home.

FINANCIAL AGREEMENT

The resident or responsible party agrees to pay and the nursing home agrees this payment in full consideration for care and services.

THE RATE OF _____ PER DAY, OR _____ PER MONTH
STATE _____, SOCIAL SECURITY _____,
OTHER _____

If the resident receives Title XVIII or Title XIX, the rates will agree with the States determination. Also, the resident or responsible party agrees to supplement all amount up to and equal the rate per day not covered by Title XVIII or Title XIX.

Signature of Administrator

Date

Signature of Resident or Responsible Party

Date

Relationship of Responsible Party



Oak Lane

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POLICY AND PROCEDURE FOR MANAGEMENT/HANDLING OF RESIDENT FUNDS

The resident may select how he/she will manage their personal funds. If he/she chooses to deposit personal funds with the facility, the funds will be held, safe guarded and managed as follows:

1. All funds are placed in the Resident's Trust Account which is separate from the facility funds. Resident's Funds are not commingled with any other than that of the resident. All funds will be placed in an interest bearing account if the resident chooses to do so. These funds are protected by a Surety Bond to ensure that the residents' funds are safeguarded.
2. Separate records are kept of each resident in accordance with generally accepted accounting principles. The individual finance record is available to each resident, or his/her legal representative upon request.
3. The facility will notify the resident and/or the responsible party when the amount in the resident's account is within \$200.00 of the amount determined by the State Eligibility Plan and of the fact that the amount may cause the resident to lose eligibility for state funding. As per the State Eligibility Plan, a resident's account may not exceed \$2,000.00.
4. Upon death of a resident with such an account, the facility will convey promptly the resident's personal funds a final accounting of such funds to the individual administering the resident's estate or the joint owner of the account.
5. No charges are imposed against the personal funds of a resident for any item or service for which payment is made under the Medicare or Medicaid program.
6. The facility shall be responsible and liable for any loss of resident funds deposited with the facility.



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SOCIAL SECURITY, SSI, VA, RETIREMENT, PERSONAL CHECK, ETC: This money is to be recorded and deposited into the residents account. This is to be done on a daily basis. By the end of each day the deposits are posted into the computer.

MONTHLY LIABILITY (RESIDENT'S RENT): A check is to be written out of the Trust Account to pay Assisted Living at the beginning of each month.

BEAUTY SHOP: Twice a week the beautician will turn in her tickets signed by the residents. The tickets are then deducted from each account and then a check is written to the beautician out of the Trust Account.

BARBER SHOP: The barber comes to the facility at the request of the resident/responsible party and the same procedure for the beauty shop is followed.

MONTHLY BILLS: (Cable, Phone, Supplemental Insurance, Life Insurance, Etc.) A check for these bills is written out of the resident's account and then posted to the resident's account.

PETTY CASH: The petty cash box is for residents only and must always balance to \$300.00. When a resident comes to the office and wants cash from their account, each resident signs for the amount taken. The box is balanced daily according to the amount taken and is replenished as needed. Transactions are posted daily.

The bank statement is reconciled monthly and balanced with the resident funds.

****ANY CHECKS THAT ARE RECEIVED AFTER THE RESIDENT HAS EXPIRED WILL BE RETURNED TO THE SENDER.****

Resident/ Responsible Party

Date



Oak Lane

Wellness & Rehabilitation Center



1400 W. Magnolia St. - P. O. Box 1480
Eunice, Louisiana 70535

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Fax: (337) 550-1143

AUTHORIZATION TO HANDLE PERSONAL FUNDS FOR _____

Authorization is hereby granted to the facility to maintain a trust account on my behalf during my stay in this facility if I should deposit monies; and if authorized, the funds will be maintained at a local financial institution. (The facility recommends that the resident keep only a minimum of cash on his/her possession.) My responsible party, legal representative, myself, and/or the following persons listed below are the only persons allowed to withdraw money from my account or to authorize payment of any charges from my account. The facility will supply a quarterly statement and a monthly statement will be provided upon request. Interest will be credited to my account automatically and funds will not be commingled. I hereby authorize the facility to make deposits to pay legitimate expenditures from my personal account.

Resident Signature Date

Responsible Party Signature Date

The following persons are allowed to withdraw money from my account or to authorize payment of any charges from my account.

I have declined the option to have the facility maintain a personal fund account for _____. I do not wish to deposit any monies into the account or open a personal fund account.

Resident Signature

Responsible Party Signature



Oak Lane

Wellness & Rehabilitation Center



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RESIDENT PERSONAL FUND ACCOUNT AGREEMENT

I _____, am signing this account agreement acknowledging that any funds deposited into my personal fund account are jointly owned by myself and my legal representative or responsible party.

This account agreement states that:

1. funds in the account shall be jointly owned with the right of survivorship;
2. funds in the account shall be used by, for or on behalf of the resident;
3. resident or the joint owner may deposit funds into the account; and
4. resident or joint owner may endorse any check, draft, or other instrument to the order of any joint owner, for deposit into the account.

By signing this agreement, I hereby authorize Oak Lane Wellness to transfer the funds in my personal fund account to my responsible party within 30 days of my death.

This provision only applies to personal fund accounts **not** in excess of \$2,000.00, with the exception of private pay residents.

Resident Signature

Date

Responsible Party/Legal Representative

Date

If resident signs with an X, two witnesses, other than family members, are required.

Witness

Date

Witness

Date



Oak Lane

Wellness & Rehabilitation Center



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PRIVATE PAY RESIDENTS

For a Private Room (One resident in room, NO roommate), the Resident/Responsible Party agrees to pay the rate of \$1,000.00 additionally per month above the standard rate.

_____ Yes, I want a private room at \$1,000.00 per month additionally.

_____ No, I do not want a private room.

Private Pay Residents/Responsible Parties are responsible for the cost of all medicines, physician visits, hospital stays and charges, ancillary charges (Lab, X-Ray, etc.), transportation and any other charge that is not covered in the Nursing Home Agreement.

Signature of Resident

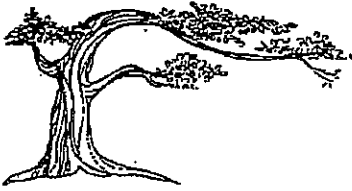
Date

Signature of Responsible Party

Date

Signature of Facility Representative

Date



Oak Lane
Wellness & Rehabilitation Center



SKILLED NURSING FACILITY BALANCE BILLING DISCLOSURE

Date of Notice: _____

PURSUANT TO LOUISIANA REVISED STATUTE 22:1880, OAK LANE WELLNESS & REHABILITATION CENTER IS DISCLOSING THAT AS OF _____ IS _____ IS NOT _____ (CHECK LINE THAT APPLIES) A PARTICIPATING PROVIDER WITH

_____ ON THE FOLLOWING DATE OF SERVICES
_____.

PATIENT (GURDIAN) INITIALS: _____

ALSO, PURSUANT TO LOUISIANA REVISED STATUTE 22:1180, OAK LANE WELLNESS & REHABILITATION CENTER IS REQUIRED TO PROVIDE THE "BALANCE BILLING DISCLOSURE NOTICE".

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

NOTICE:

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT MAY NOT BE IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT OF NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

PROFESSIONAL SERVICES RENDERED BY INDEPENDENT HEALTHCARE PROFESSIONALS ARE NOT PART OF THE SNF BILL. THESE BILLS WILL BE BILLED TO THE PATIENT SEPARATELY. PLEASE UNDERSTAND THAT PHYSICIANS OR OTHER HEALTHCARE PROFESSIONALS MAY BE CALLED UPON TO PROVIDE CARE OR SERVICES TO YOU OR ON YOUR BEHALF, BUT YOU MAY NOT

ACTUALLY SEE OR BE EXAMED BY ALL PHYSICIANS OR HEALTHCARE PROFESSIONALS PARTICIPATING IN YOUR CARE. IN MANY INSTANCES, THERE WILL BE A SEPARATE CHARGE FOR PROFESSIONAL SERVICES RENDERED BY PHYSICIANS TO YOU OR ON YOUR BEHALF, AND YOU WILL RECEIVE A BILL FOR THESE PROFESSIONAL SERVICES THAT IS SEPARATE FROM THE BILL FOR SNF SERVICES. THESE INDEPENDENT HEALTHCARE PROFESSIONALS MAY NOT PARTICIPATE IN YOUR HEALTH PLAN AND YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THE SERVICES PROVIDED BY THESE PHYSICIANS WHO HAVE PROVIDED OUT OF NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

WE ENCOURAGE YOU TO CONTACT YOUR HEALTH PLAN TO DETERMINE WHETHER THE INDEPENDENT HEALTHCARE PROFESSIONALS ARE PARTICIPATING WITH YOUR HEALTH PLAN. IN ORDER TO OBTAIN THE MOST ACCURATE AND UP-TO-DATE INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK INDEPENDENT HEALTHCARE PROFESSIONALS, PLEASE CONTACT THE CUSTOMER SERVICE NUMBER OF YOUR HEALTH PLAN OR VISIT ITS WEBSITE. YOUR HEALTH PLAN IS THE PRIMARY SOURCE OF INFORMATION ON ITS PROVIDER NETWORK AND BENEFITS. TO HELP YOU DETERMINE WHETHER THE INDEPENDENT HEALTHCARE PROFESSIONALS WHO PROVIDE SERVICES AT THIS FACILITY ARE PARTICIPATING WITH YOUR HEALTH PLAN, THIS HEALTHCARE FACILITY HAS PROVIDED YOU WITH A COMPLETE LIST OF THE NAMES AND CONTACT INFORMATION FOR EACH INDIVIDUAL OR GROUP.

PATIENT (GUARDIAN) INITIALS: _____

PURSUANT TO LOUISIANA REVISED STATUTE 22:1880, OAK LANE WELLNESS & REHABILITATION CENTER HAS PROVIDED ME WITH A LIST THAT CONTAINS THE NAME AND CONTACT INFORMATION FOR EACH INDIVIDUAL OR GROUP OF OTHER PROFESSIONALS WHO MAY PROVIDE SERVICES AT OAK LANE WELLNESS & REHABILITATION CENTER. THE RESIDENT MAY REQUEST INFORMATION FROM THEIR HEALTH INSURANCE ISSUER AS TO WHETHER THOSE PROFESSIONALS ARE CONTRACTED WITH THE HEALTH INSURANCE ISSUER AND UNDER WHAT CIRCUMSTANCES THE RESIDENT MAY BE RESPONSIBLE FOR PAYMENT OF ANY AMOUNTS NOT PAID BY THE HEALTH INSURANCE ISSUER.

PATIENT (GUARDIAN) INITIALS: _____

PHYSICIANS

BRIAN HEINEN
151 LEON STREET
EUNICE, LA 70535
NPI# 1457362899
(337) 457-8166

REGINALD SEGAR
631 W. MAPLE AVE.
EUNICE, LA 70535
NPI# 1720057417
(337) 457-0424

ZEB STEARNS
450 MOOSA BLVD.
EUNICE, LA 70535
NPI# 1487718128
(337) 546-6646

BRENT ARDOIN
728 POINCIANA AVE.
MAMOU, LA 70554
NPI# 1265446389
(337) 468-0267

OSCAR RODRIQUEZ
1413 7TH STREET
SUITE B
MAMOU, LA 70554
NPI# 1619983780
(337) 468-3306

NICK LAHAYE
4940 VIDRINE RD.
VILLE PLATTE, LA 70586
NPI#1174594857
(337) 506-3500

JOHN MATT RAINEY
3521 HWY 190
SUITE P
EUNICE, LA 70535
NPI# 1073724514
(337) 457-8040

GREG SAVOY
1508 CAJUN DRIVE
MAMOU, LA 70554
NPI# 1851373872
(337) 468-5309

NURSE PRACTITIONERS

JESSICA CHAUMONT
N/P FOR BRIAN HEINEN
(337) 457-8166

BRITTANY LANCLOS
N/P FOR ZEB STEARNS
(337) 546-6646

DENTISTS

JEFF GUIDRY
501 MOOSA BLVD.
EUNICE, LA 70535
(337) 457-7076

FRANCIS BOUSTANY
126 WESTFIELD DRIVE
LAFAYETTE, LA 70503
(337) 993-3600

PHARMACY

BELLARD'S FAMILY PHARMACY
621 W. MAPLE AVENUE
EUNICE, LA 70535
(337) 546-6386

THERAPY

REHAB XCEL
441 MOOSA BLVD.
EUNICE, LA 70535
(337) 457-8164

PODIATRIST

SCOTT BEAIRSTO
205 BONAIRE DRIVE
LAFAYETTE, LA 70506
(504) 889-0347

AMBULANCE SERVICE

ACADIAN AMBULANCE SERVICES
130 E. KALISTE SALOOM RD.
LAFAYETTE, LA 70509
(800) 259-2222

MEDEXPRESS AMBULANCE SERVICES
P.O. BOX 527
MELVILLE, LA 71353
(337) 623-0056

ST. LANDRY EMS
P.O. BOX 2556
OPELOUSAS, LA 70571
(337) 948-8404

X-RAY

SITTIG MOBILE X-RAY
711 NORTH AVENUE K
CROWLEY, LA 70526
(337) 783-4196

LABS

ACADIAN MEDICAL CENTER CAMPUS OF MERCY REGIONAL
3501 HWY.190
EUNICE, LA 70535
(337) 580-7500

HOSPITALS

ACADIAN MEDICAL CENTER
3501 HWY. 190
EUNICE, LA 70535
(337) 580-7500

SAVOY MEDICAL CENTER
801 POINCIANA AVE.
MAMOU, LA 70554
(337) 468-5261

MERCY REGIONAL MEDICAL CENTER
800 E. MAIN STREET
VILLE PLATTE, LA 70586
(337) 363-5684

BEHAVIORAL HEALTH HOSPITALS

COMPASS-BEHAVIORAL CENTER OF LAFAYETTE
310 B YOUNGSVILLE HWY.
LAFAYETTE, LA 70507
(337) 534-4655

JENNINGS SENIOR CARE
1 HOSPITAL DRIVE # 201
JENNINGS, LA 70546
(337) 824-1558

Pursuant to Act 295 of the 2004 Regular Session of the Louisiana Legislature, I acknowledge that I have been advised of the opportunity to be provided the most recent survey conducted by the Louisiana Department of Health and Hospitals on _____ (Nursing Home).

Please initial one of the following statements and sign the bottom of this form.

_____ I requested to view and was shown a copy.

_____ I declined to view a copy.

Prospective Resident

Family Member of Prospective Resident

(A copy of this form or similar form must be made part of your admissions packet)

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ give permission to
_____ to release the medical
records for _____ to **Oak Lane Wellness
& Rehabilitation Center.**

Patient/Responsible Party

Date

Witness

Witness

**A COMPREHENSIVE FORM OF
11 AUTHORIZATIONS, CONSENTS, AND RELEASES**

Name of Facility

Name of Resident

AUTHORIZATION FOR MEDICAL TREATMENT

Authorization is hereby granted to Dr. _____ (and/or whomever he/she may designate and his/her assistant or the physician on call) to administer such treatment as necessary. I hereby certify that I have read and fully understand the above Authorization for Medical Treatment. I also certify that no guarantee or assurance has been made regarding any result that may be obtained. If a physician of the resident's choice fails to fulfill a given requirement, the facility has the right, after informing the resident, to seek alternate physician participation to ensure the provision of appropriate and adequate care and treatment.

Physician's Area of Specialty

Area Code/Telephone Number

Address

City, State, Zip Code

Witness

Date

Resident's Signature

Witness

Date

or Legal Representative's Signature

AUTHORIZATION FOR DRUG PURCHASE

Authorization is hereby granted to the facility to procure drugs from either _____ pharmacy or the facility pharmacy and that I shall be responsible for all charges not reimbursed by a third party payer. The facility will not be responsible for any errors that might be made by a pharmacy outside the facility when filling resident prescriptions. The facility retains the right to obtain emergency medications, as ordered by the attending physician.

Witness

Date

Resident's Signature

Witness

Date

or Legal Representative's Signature

AUTHORIZATION AND REQUEST TO INSPECT CLINICAL RECORDS

I understand that as a resident of this facility I may request my entire clinical record for my inspection and/or photocopying. I agree to protect its contents and not to remove any part of the record from the assigned space within this facility. I agree to allow a representative of this facility to supervise my inspection of the clinical record in order to be available to answer any questions I may have. If I require privacy, I will request copies of the contents in which I am interested.

Witness

Date

Resident's Signature

Witness

Date

or Legal Representative's Signature

AUTHORIZATION TO RECEIVE MAIL

Authorization is hereby granted_____ not granted_____ to the facility to receive, process, and file on my behalf. Communications from the Department of Health and Human Services and from the State Division of Health (i.e., Medicare and Medicaid programs), from the Veterans Administration program or from my private insurance carrier.

Witness

Date

Resident's Signature

Witness

Date

or Legal Representative's Signature

AUTHORIZATION TO RELEASE SIDE RAILS

Authorization is hereby granted to the facility to adhere to the request of the resident, or legal representative, that side rails be used_____ not used_____ on the bed of the resident. Having been informed by this facility that protective side rails should be placed on my bed and raised for my personal protection if the use of side rails is not requested, I, the resident or legal representative, release the facility, all of its employees, and my physician from any responsibility for nonuse of the bed side rails and I hereby assume all risks and liability in connection therewith from any injury or damage.

Witness

Date

Resident's Signature

Witness

Date

or Legal Representative's Signature

AUTHORIZATION FOR DENTAL CARE

Authorization is hereby granted to Dr. _____ to assume responsibility for my dental care.

Witness

Date

Resident's Signature

Witness

Date

or Legal Representative's Signature

AUTHORIZATION FOR FUNERAL HOME

Authorization is hereby granted for the facility to contact _____ Funeral Home to arrange for transfer of the resident's body in the event of death while in the facility. The legal representative further agrees to make all final arrangements and assumes all costs. Authorization is given to the facility to arrange the release of the deceased resident in the event that a specific mortician has not been designated.

Witness

Date

Resident's Signature

Witness

Date

or Legal Representative's Signature

AUTHORIZATION FOR DESIGNATED CONTACT PERSON

Authorization is hereby granted to the facility in the event of an emergency to contact:

1

Name

Address

City, State, Zip

Area Code/Telephone Number

2

Name

Address

City, State, Zip

Area Code/Telephone Number

3

Name

Address

City, State, Zip

Area Code/Telephone Number

I authorize the facility staff to share information regarding my medical status with the following persons: _____

Witness Date

Resident's Signature

Witness Date

or Legal Representative's Signature

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is hereby granted _____ not granted _____ to release in accordance with the policies of this facility such professional information as may be necessary from the medical records compiled during my stay and said facility is hereby released from all legal liability that may arise from the release of this information.

Witness Date

Resident's Signature

Witness Date

or Legal Representative's Signature

AUTHORIZATION FOR RELEASE OF RESPONSIBILITIES FOR THE RETENTION OF CASH, JEWELRY, AND VALUABLES

Authorization is hereby granted to release the facility and its personnel of all responsibility against possible loss of cash, jewelry, and valuables. I have been advised by this facility not to keep cash, jewelry, and other valuables in my possession while a resident, but not withstanding this advice, I wish to retain certain items in my possession, namely—

Witness

Date

Resident's Signature

Witness

Date

or Legal Representative's Signature

AUTHORIZATION REGARDING NONDISCRIMINATION AT ADMISSION

It is understood that no resident shall be denied any services documented in this agreement or be subject to discrimination because of age, race, color, national origin, religion, sex, handicap, physical condition or developmental disability, as designated by Federal and State civil laws and guidelines.

Witness

Date

Resident's Signature

Witness

Date

or Legal Representative's Signature

**Oak Lane Wellness
Sitter Policy
Securing and Paying a sitter is the Family's Responsibility**

- A. Family is to notify Administrator or D.O.N of sitter prior to assuming duty.**
- B. Sitters will provide a written statement from a physician stating that he/she is free of communicable disease and PPD prior to duty then annually or have one taken at facility. Background check and employment application must be completed and on file. Facility will provide name tag.**
- C. All policies and procedures of this facility will be adhered to at all times by private sitters.**
- D. Name tags must be worn at all times.**
- E. A brief orientation will be provided for you prior to your tour of duty.**
- F. All sitters/nurses must be oriented on fire safety.**
- G. You may purchase meals from Oak Lane Business Office during regular business hours.**

Responsible Party (please print)

Responsible Party Signature

Date

Sitter name (please print)

Sitter Signature

Date

Administrative Staff Signature

Date

Oak Lane Wellness & Rehabilitation Center

Smoking/Tobacco Use Policy

Policy:

It is the policy of this facility to enforce a smoke free environment within the facility. In order to promote the rights, health and safety of all residents, employees, and family members/visitors within our facility, it is sometimes necessary for us to maintain smoking paraphernalia for all residents smoking in a designated area. A significant number of occupants in health care facilities are assumed to be non-ambulatory or bedridden. Other occupants, while capable of self-movement, might have impaired judgment. Because the safety and well-being of all individuals is paramount, it is the policy of this facility that all smoking residents are evaluated utilizing a Safe Smoking/Tobacco Use Assessment (see attached) upon admission, quarterly, and when there is a significant change in the resident's ability to handle their smoking products. Smoking poses serious risks to the resident's health and safety, and is against medical advice. However, we acknowledge and respect an individual's right to smoke.

Personnel:

All staff and Residents

Precautions or Points of Emphasis:

1. Acknowledges that the resident is acting against medical advice by smoking.
2. Agrees to smoke in the designated smoking area only.

Procedure:

1. Bedfast residents are not permitted to smoke in bed under any circumstances.
2. Ambulatory and mobile residents are required to smoke in the designated smoking area only. Designated smoking areas include the following areas:
Employees: Back gazebo only
Residents: Patio area between dining room and blue day room
3. Residents who smoke will be assessed upon admit, quarterly, and when there is significant change in the resident's ability to handle their smoking products.
4. Smoking aprons will be provided for residents who are evaluated to need them by the Safe Smoking/Tobacco Use Assessment. Wearing of the apron will be

assisted by the staff and be worn during smoking times for those residents who require them.

5. Fire products (i.e., lighters, matches) will be maintained by the facility staff and issued when residents desire to smoke for those residents deemed necessary per the Safe Smoking/Tobacco use Assessment and by the Interdisciplinary Care Plan Team.
6. Un-safe residents who smoke will be supervised while smoking and have assistance with lighting their cigarettes as deemed necessary per the Safe Smoking/Tobacco Use Assessment and by the Interdisciplinary Care Plan Team.
7. This policy will be explained to the resident or the resident's representative on admission and the signed copy will be retained in the resident's file.
8. Resident's family will be asked not to give smoking products to include cigarettes or lighters to the resident when smoking paraphernalia is being maintained by the facility, but to turn them into the staff to maintain compliance of this policy.
9. This policy is explained upon hire of all new employees, in-serviced annually and when needed.
10. A signed acknowledgement of the Smoking Informed Consent and Release Form will be obtained upon admission or when necessary
11. Place on MAR: Safe Smoking Practice adhered to:
☐Yes ☐No (See Nurses Notes)

Resident/Responsible Party Signature

Date

Employee Signature

Date

*Oak Lane Wellness & Rehabilitation Center
1400 W. Magnolia Street
Eunice, LA 70535
(337) 550-7200*

New Designated Smoking Area for
Residents, Visitors, and Staff

Based on the new Federal and State Regulations (Clean Air Act), in 2009 smoke areas were changed. Effective March 1, 2011, the new designated smoking area is called The Central Smoking Area/Courtyard which is located between 100 and 200 hall.

I, _____, resident or responsible party has been informed of the Federal and State Regulations, and of the designated smoking area.

Resident

Date

Or Responsible Party

Date

Smoking Policy – Residents

Policy Statement

This facility shall establish and maintain safe resident smoking practices.

Policy Interpretation and Implementation

1. Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences.
2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Electronic cigarettes are allowed in the smoking designated areas only. Smoking is not allowed inside the facility under any circumstances.
3. Oxygen use is prohibited in smoking areas.
4. Metal containers, with self-closing cover devices, are available in smoking areas.
5. Ashtrays are emptied only into designated receptacles.
6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include:
 - a. Current level of tobacco consumption;
 - b. Method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.);
 - c. Desire to quit smoking, if a current smoker; and
 - d. Ability to smoke safely with or without supervision (per a completed *Safe Smoking Evaluation*).
7. The staff shall consult with the Attending Physician and the Director of Nursing Services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the *Safe Smoking Evaluation*.
8. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff.
9. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues.
10. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision.
11. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member or family member at all times while smoking.
12. Residents who have independent smoking privileges are permitted to keep cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles in their possession. Only disposable lighters are permitted. All other forms of lighters, including matches, are prohibited.
13. Residents are not permitted to give smoking articles to other residents.
14. Residents without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision.

continues on next page

15. Staff members and volunteer workers are not permitted to purchase and/or provide any smoking articles for residents.
16. This facility maintains the right to confiscate smoking articles found in violation of our smoking policies.
17. Confiscated resident property will be itemized and ultimately returned to the resident, or his or her legal representative. When the property is returned will be determined during a meeting with the resident or representative regarding the circumstances that led to the confiscation.

References	
OBRA Regulatory Reference Numbers	§483.10(f); §483.25(d); 483.90(i)
Survey Tag Numbers	F561; F689; F921
Other References	
Related Documents	Safe Smoking Evaluation (MP5456) Smoking Policy – Employees
Version	2.0 (H5MAPL0828)

Oak Lane Wellness & Rehabilitation Center
Smoking/Tobacco Use Policy Agreement

Policy:

It is the policy of this facility to enforce a smoke free environment within the facility. In order to promote the rights, health and safety of all residents, employees, and family members/visitors within our facility, it is sometimes necessary for us to maintain smoking paraphernalia for all residents smoking in a designated area. A significant number of occupants in health care facilities are assumed to be non-ambulatory or bedridden. Other occupants, while capable of self-movement, might have impaired judgment. Because the safety and well-being of all individuals is paramount, it is the policy of this facility that all smoking residents are evaluated utilizing a Safe Smoking/Tobacco Use Assessment upon admission, quarterly, and when there is a significant change in the resident's ability to handle their smoking products. Smoking poses serious risks to the resident's health and safety, and is against medical advice. However, we acknowledge and respect an individual's right to smoke.

Personnel:

All staff and Residents

Precautions or Points of Emphasis:

1. Acknowledges that the resident is acting against medical advice by smoking.
2. Agrees to smoke in the designated smoking area only.

Procedure:

1. Bedfast residents are not permitted to smoke in bed under any circumstances.
2. Ambulatory and mobile residents are required to smoke in the designated smoking area only. Designated smoking areas include the following areas:
Employees: Back gazebo only
Residents: Patio area between dining room and blue day room
3. Residents who smoke will be assessed upon admit, quarterly, and when there is significant change in the residents ability to handle their smoking products.
4. Smoking aprons will be provided for residents who are evaluated to need them by the Safe Smoking/Tobacco Use Assessment. Wearing of the apron will be assisted by the staff and be worn during smoking times for those residents who require them.

5. Residents who have independent smoking privileges are permitted to keep cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles in their possession. Only disposable lighters are permitted. All other forms of lighters, including matches, are prohibited. Residents are not permitted to give smoking articles to other residents.
6. Staff members and volunteer workers are not permitted to purchase and/or provide any smoking articles for residents.
7. Residents without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision.
8. Un-safe residents who smoke will be supervised while smoking and have assistance with lighting their cigarettes as deemed necessary per the Safe Smoking/Tobacco Use Assessment and by the Interdisciplinary Care Plan Team.
9. This policy will be explained to the resident or the resident's representative on admission and the signed copy will be retained in the resident's file.
10. Resident's family will be asked not to give smoking products to include cigarettes or lighters to the resident when smoking paraphernalia is being maintained by the facility, but to turn them into the staff to maintain compliance of this policy.
11. This policy is explained upon hire of all new employees, in-serviced annually and when needed.
12. A signed acknowledgement of the Smoking Informed Consent and Release Form will be obtained upon admission or when necessary.
13. This facility maintains the right to confiscate smoking articles found in violation of our smoking policies.

Resident/Responsible Party Signature

Date

Employee Signature

Date



Oak Lane

Wellness & Rehabilitation Center



1400 W. Magnolia St. - P. O. Box 1480
Eunice, Louisiana 70535

Ph: (337) 550-7200
Fax: (337) 550-1143

We give our residents the opportunity to vote in our nursing facility.

I would like to vote in the nursing facility.

I would **not** like to vote in the nursing facility.

Family/Responsible Party will transport resident to the polls.

Family/Responsible Party **will not** transport resident to polls.

Resident

Social Services

Therapeutic Leave of Absence when Medicare Skilled

The Medicare Benefit Policy indicates that residents of skilled nursing facilities can leave their facility to attend the following:

- Outside pass
- Short leave of absence
- Religious Service
- Holiday Meal
- Family Occasion
- Car Ride
- Trial Visit Home

In the event a “Skilled Resident” goes out on a therapeutic pass, the resident must sign out at the nurse’s station and sign in on return. If the resident does not return by midnight, the facility cannot bill Medicare for skill services.

Resident

Date

Or Responsible Party

Date

PHARMACY CONTRACT
BELLARD'S PHARMACY INC.

PATIENT:_____

DATE OF BIRTH:_____

WING AND ROOM:_____

STATUS: PRIVATE MEDICAID MEDICAID PENDING

RESPONSIBLE PARTY

NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE_____

As responsible party I authorize _____ to provide medications for this resident_____ may bill Medicaid, Medicare or any other insurance for any medications ordered for this patient. I will be responsible for any copays, deductibles, or uncovered medications.

RESPONSIBLE PARTY_____ DATE_____

WITNESS_____ DATE_____

PLEASE LIST ANY MEDICAID OR INSURANCE INFO HERE



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Eyeglasses – Hearing Aids – Dentures

Oak Lane Wellness and Rehabilitation Center is not responsible for the loss or misplacement of resident's, family member's or visitor's Eyeglasses, Hearing Aids, or Dentures. Upon learning of the disappearance of any of these items, Oak Lane Wellness will investigate and search for the missing item. It is the responsibility of the Resident or Responsible Party to label or engrave the identification of the resident on each of these items.

It is recommended that the Resident or Family Member purchase insurance for any of these items.

Inventory:

_____ Eyeglasses Description: _____

_____ Dentures Description: _____

_____ Hearing Aids ... Description: _____

Resident or Responsible Party

Date

Witness

Date

CONSENT FORM FOR INFLUENZA AND PNEUMONOCOCCAL VACCINES

Please discuss any questions you may have, or request for more information, with the nurses or the attending physician.

INFLUENZA VACCINE: The influenza vaccine has been shown to protect older adults from hospitalization and deaths, resulting from an influenza infection. The Advisory Committee on Immunization Practices (ACIP) recommends that influenza vaccine be provided to all residents of nursing facilities, annually, prior to the influenza season. Reactions at the site of injection may occur. Mild fever or aches may also occur. Anyone with allergies to eggs or fish are not advised to take the influenza vaccine. However, influenza vaccine will be offered to residents and to new arrivals through the end of March of the subsequent year.

INFLUENZA VACCINE:

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

____ NO-I do not wish to receive the influenza vaccine this year.

Resident's Name: _____

Resident of Responsible Party's Signature: _____

Date: _____

Date last taken: _____

PNEUMOCOCCAL VACCINE: The Pneumococcal Polysaccharide Vaccine is effective against 23 pneumococcal types which cause 90 percent of all pneumococcal pneumonia and is effective for approximately six (6) years. Anyone 65 years of age or older or having chronic health problems is considered high risk for exposure to and complications from pneumococcal infections such as pneumonia, septicemia, and meningitis. The ACIP currently recommends a single dose of the vaccine for persons 65 years and older who have not been previously vaccinated or whose vaccination status is unknown. A one-time revaccination is recommended for persons 65 years and older who have been vaccinated for the first time when they were 60 years of age or younger. Local site reactions are expected in 5-10% of vaccine recipients. Less than 1% of vaccines have reported slight elevations of body temperature but severe allergic reactions have not been documented.

PNEUMOCOCCAL VACCINE:

____ When ordered by primary doctor

Date: _____

Date last Taken: _____

Consent Form Reviewed/Revised:

By: _____

Date: 2-10-12

By: _____

Date: 2-10-12

By: _____

Date: _____

presumably, the new owner has assumed existing contractual rights and obligations, including those under the contract for submitting MDS information. All contractual agreements, regardless of their type, involving the MDS data should not violate the requirements of participation in the Medicare and/or Medicaid program, the Privacy Act of 1974 or any applicable State laws.

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS (7/14/2005)	
<i>THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.</i>	
1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN) Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.	
2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate tracking of changes in your health and functional status over time for purposes of evaluating and assuring the quality of care provided by nursing homes that participate in Medicare or Medicaid.	
3. ROUTINE USES The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose. The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: To the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefits program or to a grantee of a CMS-administered grant program, (9) to another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter, and detect fraud and abuse in those programs, (10) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program.	
4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION For Nursing Home residents residing in a certified Medicare/Medicaid nursing facility the requested information is mandatory because of the need to assess the effectiveness and quality of care given in certified facilities and to assess the appropriateness of provided services. If the requested information is not furnished the determination of beneficiary services and resultant reimbursement may not be possible. Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.	
_____ Signature of Resident or Sponsor	_____ Date

<https://www.cms.gov/MDSPrivacyActStatement.pdf>

13

AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL IDENTIFYING INFORMATION

I, [name of resident] _____, authorize [facility name] _____
to use and/or disclose my personal identifying information as identified below for the following purpose(s).

By initialing the spaces below, I specifically authorize the use or disclosure of the following personal identifying information and/or records, if such information and/or records exist

- _____ Facility photographs taken at/or during functions/activities/events for internal facility use.
- _____ Facility photographs taken at/or during functions/activities/events for external use.
- _____ Facility video filming taken at/or during functions/activities/events for internal facility use.
- _____ Facility video filming taken at/or during functions/activities/events for external use.
- _____ Name, age and birth date for internal facility use. (i.e., birthday celebrations, door decorations, facility directory, internal facility newsletter, bulletin boards, etc.)
- _____ Name, age and birth date for external facility use. (i.e., community newsletter, community newspaper, local/state radio & TV announcements/coverage of special events, resident outings, church/service club's gifts/volunteer services, pastoral/church care/support, etc.)
- _____ Other _____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to [Identify the person / entity to whom written notice of revocation must be given] _____. Unless revoked earlier, this authorization will expire one year from the date of signing or upon [insert applicable date or event of expiration] _____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment/eligibility for benefits, or participate in any facility activities/events/functions. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. Residents may or may not be compensated.

Signature of Resident or Resident's Legal Representative _____

Date _____

Print Name of Legal Representative (if applicable) _____

Relationship of Legal Representative to Resident _____

(A copy of this signed form will be provided to the resident and/or the resident's legal representative.)

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, [name of resident] _____, authorize [facility name] _____
to use and/or disclose my health information as identified below to [name and address of recipient] _____

for the following purpose(s): [describe each purpose; if requested by patient and no purpose is identified, then may state "at the request of the individual"] _____

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

- | | |
|--|---|
| <input type="checkbox"/> Please send the entire medical record (all information) to the above named recipient. | |
| <input type="checkbox"/> All hospital records (including | <input type="checkbox"/> Clinician office chart notes |
| nursing records & progress notes) | <input type="checkbox"/> Dental records |
| <input type="checkbox"/> Transcribed hospital reports | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> Medical records needed for continuity of care | <input type="checkbox"/> Pathology reports |
| <input type="checkbox"/> Most recent five-year history | <input type="checkbox"/> Diagnostic imaging reports |
| <input type="checkbox"/> Emergency and urgent care records | <input type="checkbox"/> Billing statements |
| <input type="checkbox"/> Other _____ | |

* The following items must be initialed to be included in the use or disclosure of other health information:

☐ *HIV / AIDS related health information and/or records

☐ *Mental health information and/or records

☐ *Genetic testing information and/or records

☐ *Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.) _____

☐ *Psychotherapy notes (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.) _____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to [identify the person / entity to whom written notice of revocation must be given] _____. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon [insert applicable date or event of expiration] _____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Signature of Resident or Resident's Legal Representative

Date

Print Name of Legal Representative (if applicable)

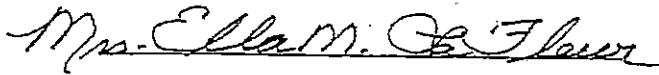
Relationship of Legal Representative to Resident

(A copy of this signed form will be provided to the resident and/or the resident's legal representative.)

must keep a
copy for 6
yrs.

Alcohol Free Campus

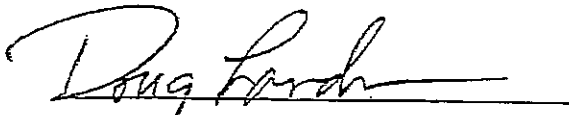
It is the Policy of Oaklane Wellness and Rehabilitation Center that our campus is an Alcohol free facility.



CEO: Mrs. Ella M. LaFleur



Medical Director: Reginald Segar, MD



Administrator-Oaklane Wellness &
RN Rehabilitation Center



Director of Nurses: Mary Estes, RN

Dated

October, 2013



Oak Lane

Wellness & Rehabilitation Center



1400 W. Magnolia St. - P. O. Box 1480
Eunice, Louisiana 70535

Ph: (337) 550-7200
Fax: (337) 550-1143

Resident's Right to Voice Grievances

Each resident has the right to voice grievances with respect to treatment or care that is, or fails to be furnished, without discrimination or reprisal for voicing the grievances. Each resident complaint will be followed by prompt efforts to resolve grievances the resident may have, including those with respect to the behavior of other residents.

Oak Lane Wellness & Rehabilitation Center
1400 W. Magnolia Street
Eunice, LA 70535

I hereby acknowledge that I have been given a copy of the
Resident's Right to Voice Grievances.

Resident's or Responsible Party Signature

Date

Social Services

Date

SERVICES AND SUPPLIES

The families are to be informed that the standards for payment, according to the Department of Health and Hospitals, **does not** require a nursing home to use ATTENDS, or any other disposable diaper or under pads. OAKLANE WELLNESS AND REHABILITATION CENTER, in an effort to minimize odor in the facility and also enhance the care of our residents, has elected to set forth in our policies and procedures the use of disposable diapers.

However, once the monthly allotment for the facility is utilized we will convert to the cloth diapers.

The nursing facility shall be responsible for providing the following services, supplies, and equipment to Medicaid residents.

1. Room, board, and therapeutic diets
2. Food supplements or food replacements, including at least one brand of each type (i.e., regular, high fiber, diabetic, high nitrogen)

Note: This does not include enteral/parental nutrients, accessories and/or supplies.

3. General Services as listed below:
 - A. Professional nursing services
 - B. An activity program with daily supervision of such activities
 - C. Medically-related social services
 - D. Other services provided by required staff in accordance with the plan of care.
4. Personal Care Needs—The facility shall provide personal hygiene items and services when needed by residents to include:

- | | |
|--|-------------------------------------|
| •hair hygiene supplies | •comb |
| •brush | •bath soap |
| •disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infections | |
| •razors | •shaving cream |
| •toothbrush | •toothpaste |
| •denture adhesive | •denture cleaner |
| •dental floss | •moisturizing lotion |
| •tissues | •cotton balls |
| •cotton swabs | •deodorant |
| •incontinence supplies | •sanitary napkins/ related supplies |
| •towels | •washcloths |
| •hospital gowns | •hair and nail hygiene services |

- bathing
- incontinence care

- basic personal laundry

Note: Special hair cuts, permanent waves, and other such services, which are provided by a licensed barber or beautician at the request of the resident shall be paid directly by residents from their personal funds, or by their legal representatives or sponsors, unless provided as a free service by the facility.

6. Drugs

Over the counter drugs are part of pharmaceutical services that the nursing facility is responsible for providing when it is specified in the resident's plan of care. If the prescribing physician does not specify a particular brand in the written order, a generic equivalent is acceptable. If the physician specifies a particular brand, the nursing facility would have to incur the cost of providing that drug. If the physician does not specify a particular brand, but the resident insists on receiving a particular brand, the nursing facility is not required to provide the requested drug. However, if the facility honors the resident's request, it may, after giving appropriate notice, make a charge to the resident's funds for the difference between the cost of the requested item and the cost for the generic item.

I fully understand the services and supplies provided by the facility, however, I may, at any given time, regarding any particular item, may choose to purchase supplies and items of my preference.

Resident Signature **Date**

Responsible Party Signature **Date**

and/or Legal Representative Signature **Date**

SITTIG MOBILE X-RAY & CARDIOLOGY, INC.

337-783-4196

771 N. AVE. K

CROWLEY, LA 70526

1-800-255-5416

* SIGNATURE ON FILE *

PATIENT'S NAME _____

DATE OF ADMISSION _____

I hereby authorize the use of my legal signature below on any and all insurance forms. I authorize payment directly to Sittig Mobile X-Ray & Cardiology, Inc., on any insurance of Medicare benefits. I authorize Medical information to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Sign Here _____

Patient's Signature

Witness's Signature

OAK LANE WELLNESS & REHABILITATION CENTER

POLICY ON ROOM DÉCOR

The facility's policy states that if a resident upon admission or after a room change has a television or a refrigerator he/she must have a table or stand to place such items on. **DO NOT PLACE** those items on the facility's furniture to avoid damage or warping of dresser tops. Refrigerators are not to be placed directly on the floor/carpet. Moisture will damage the floor.

Personal pictures can stand on the dresser top, but hanging frames must be placed by the Maintenance Department to avoid punching holes in the walls and to prevent accidents to residents caused by falling objects.

Resident or Responsible Party

Social Services

PHYSICAL RESTRAINT CONSENT

In order to protect our residents from harm or to promote them to a higher level of independence, it is sometimes necessary for us to use a physical restraint.

Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that cannot be removed easily and that restricts freedom of movement or normal access to the resident's body. Examples include leg restraints, arm restraints, hand mitts, soft ties, vest restraints, lap buddies, lap trays, wheelchair safety bars and geri chairs. These devices are NEVER used as a disciplinary action or for the convenience of the facility to control behavior.

Restraints are initiated only after less restrictive measures, such as positioning pillows, pads, wedges, removeable lap trays coupled with appropriate exercises, or other "enabling" equipment, have been demonstrated to be insufficient. The least restrictive device would be then implemented following a consultation with an appropriate health professional (i.e., physical or occupational therapist), and with a specific doctor's order.

Side rails sometimes restrain residents. The use of side rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. As with other restraints, for residents who are restrained by side rails, it is expected that the process facilities employ to reduce the use of side rails as restraints is systematic and gradual to ensure the resident's safety while treating the medical symptoms.

The following less restrictive, alternative non-restraint approaches have proven to be INEFFECTIVE:

RESTRAINT INTERVENTION RECOMMENDED

Therefore, I understand my physician has ordered the following restraint(s) for the specific target behaviors and/or medical symptoms listed.

Restraint Type, Frequency	Specific Target Behaviors	Medical Symptoms
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

STATEMENT OF CONSENT

☐ I DO ☐ I DO NOT consent to the use of restraints if the appropriate healthcare professionals have assessed the need for such and a restraining device is indicated as part of my recommended plan of care.

☐ I DO ☐ I DO NOT consent to the use of restraints on a temporary basis for treatment of emergency medical symptoms.

☐ I defer judgment regarding restraints until the appropriate healthcare professionals have assessed the need.

NAME-Last

First

Middle

Attending Physician

Record No.

Room/Bed

PHYSICAL RESTRAINT CONSENT

NAME-Last

First

Middle

Attending Physician

Record No.

Room/Bed

UNDERSTANDING RESTRAINT USE

The following is a comparison of potential BENEFITS and RISKS of restraint use:

POTENTIAL BENEFITS

- Prevention of falls which might result in injury
- Protection from other accidents or injuries
- Medical treatment allowed to proceed without resident interference
- Protection of other residents/staff from physical harm
- Increased feeling of safety and security
- _____
- _____

POTENTIAL RISKS

- Accidental injury from the restraint
- Increase incidence of falls or head trauma
- Chronic constipation
- Incontinence
- Pressure sores
- Loss of muscle tone
- Loss of balance
- Reduced appetite, dehydration
- Loss of or decline in independent mobility or ability to ambulate
- Increased agitation or delirium
- Loss of autonomy, dignity and self-respect
- Symptoms of depression, withdrawal
- Contractures
- Reduced social contact
- Increased incidence of infections
- _____
- _____

Your signature validates that the potential benefits and risks associated with restraint use have been explained to and discussed with you. It also validates the fact that neither the facility nor your physician will be held liable for adverse outcomes related to your decision.

ACKNOWLEDGMENT SIGNATURES

I have been informed of how the use of restraints would treat the medical symptoms, the potential benefits and risks of restraint use and hereby assume full liability for any adverse outcomes related to my decision.

I understand that I have the right to alter my decisions concerning restraints at any time and that any change must be indicated in writing.

Resident or Resident Representative ☒ _____ Date ____/____/____
Signature

If Signed by Resident Representative Complete the Following:

Print Name _____ Relationship _____

Staff Member Completing This Form _____ Date ____/____/____
Signature and Title

PHYSICAL RESTRAINT CONSENT



Oak Lane

Wellness & Rehabilitation Center



1400 W. Magnolia St. - P. O. Box 1480
Eunice, Louisiana 70535

Ph: (337) 550-7200
Fax: (337) 550-1143

RESIDENT'S NAME _____

IN THE EVENT OF AN EMERGENCY WHICH NECESSITATES THE
EVACUATION OF **OAK LANE WELLNESS AND REHABILITATION**
CENTER, I _____ AGREE TO RECOVER
AND/OR TRANSPORT _____ WHEN CALLED.

RESPONSIBLE PARTY/FAMILY MEMBER

DATE

RELATIONSHIP TO PATIENT



Oak Lane

Wellness & Rehabilitation Center



1400 W. Magnolia St. - P. O. Box 1480
Eunice, Louisiana 70535

Ph: (337) 550-7200
Fax: (337) 550-1143

TRANSFER FORM

In the event of an emergency, which necessitates the evacuation of
Oak Lane Wellness Center I, _____
(Name of Resident/Patient's Physician)

hereby authorize the Medical Director or his designee at the
receiving/ host hospital the right to order the continuation of care for

(Name of Patient)

provided the host hospital has the physical and staffing capability to
admit the evacuated nursing home patient.

Resident/Patient's Physician

Date

Medical Director of Nursing Facility

Date

Resident/Patient or Responsible Party
Or Legal Representative

Date

Social Security /SSI Report of Change

Report to:

SSA Office
5097 I49 S. Service Rd.
Opelousas, LA 70570
Fax: 337-942-1220

Name and Address of Reporting Facility:

Oak Lane Wellness & Rehabilitation Center
1400 W. Magnolia St.
Eunice, LA 70535
Phone: 337-550-7200 Fax: 337-550-1143

Name of Beneficiary

SSN _____

DOB _____

Type of Benefits: (Check each that applies)Social Security [☐]SSI [☐]**Report of Event**

Admission Date: _____ New Phone Number: () _____

Please change beneficiary's address to: _____
_____**Does the beneficiary wish to continue receiving benefits by direct deposit?**Yes [☐] No [☐] Not applicable [☐] Change to Direct Deposit [☐]Checking [☒] Savings [☐]Bank Routing Number 065204579 Account Number 0106887Is the beneficiary capable of directing the use of their own benefits? Yes [☐] No [☐]

If No, who would be the best payee? _____

Admitted from a: Facility [☐] Residence [☐] Hospital [☐] Discharge Date: _____

Facility Name: _____

Hospital Name: _____

Facility/Hospital or Residence Address: _____

Discharge Date: _____ **Discharged to :** _____

Address: _____

Date of Death: _____ **Funeral Home:** _____If the beneficiary receives SSI and this is a new admission, is Medicaid expected to pay more than 50% of the cost of care for all months? Yes [☐] No [☐]If no, list the expected source of payment and each month Medicaid will not cover 50%: _____
_____Do you expect to discharge this SSI beneficiary within the next 90 days? Yes [☐] No [☐]**Facility Representative**

Name/Title (Print): _____

Signature: _____

Date: _____

Beneficiary (Capable beneficiaries must also sign)

Name (Print): _____

Signature: _____

Date: _____