Oak Lane

Wellness & Rehabilitation Center

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

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

Dear Families,

It has been brought to my attention that there are some of our residents whose clothing is labeled on the outside in view of others. In order to preserve their dignity, please remember to label all clothing items on the inside out of view of others. In addition to providing the medical care your loved ones require we also want to preserve their dignity.

Your cooperation in this matter is greatly appreciated.

Sincerely,

Director of Social Services

Oak Lane
Wellness & Rehabilitation Center

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

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PROCEDURES FOR FAMILIES AND VISITORS

This facility was planned, designed and built to provide efficient and comfortable care for its residents. Since for most of the residents this is their home. We have attempted to create the home atmosphere as much as possible and still provide excellent nursing care. Our staff and employees are selected for their intelligence, ability, character, and willingness to help other people. We feel that we have been successful in obtaining people who fill all of these requirements, in most cases.

Although the employees and staff of this facility will make every effort to give each resident the care and understanding that he or she may need to make them happy and content, it will require the help and understanding of the residents and their families. So that there will be no misunderstanding in the future, and in order to provide the best resident care possible, the following procedures are in effect for the family and visitors:

1. Designate one family member to handle business matters, requests, and complaints. Business matters should be discussed with the Administrator. Requests and/or care of the resident are to be taken up with the nurse in charge of the area.

2. On admittance, every resident must have an examination by his/her doctor and have an up-to-date chest x-ray.

3. We reserve the right to move a resident to another room when there is personality conflict or if the resident is disturbing to other residents. We will strive to have everyone in a room with someone they will be compatible with. Residents may also be moved for medical reasons.

4. The residents will normally need the following.
    A. Approximately six changes of clothing if ambulatory.
    B. Six or more gown or pajamas
    C. Two or three pairs of shoes or slippers and six pairs of socks.
    D. Personal effects, toothbrush, toothpaste, powder, lotions, etc.
    E. All items should be clearly marked with residents name.
    F. Plain drip-dry clothing can be folded and placed in drawers.

RESIDENT BILL OF RIGHTS

1. The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside this facility. He/she may exercise his/her rights as a citizen or resident of the United States.

2. The resident has the right to be free of interference, coercion, discrimination, or reprisal from this facility in exercising his/hers rights.

3. In the case of a resident adjudged in competent under the laws of this state by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.

4. The resident is informed both orally and in writing in a language that the resident understands of his/her rights and all rules and regulations governing the resident's conduct and responsibility during the stay in this facility. This notification is made upon admission and updated as changes occur during the resident's stay. All updates and amendments will be made in writing and require a written acknowledgement by the resident or legal guardian.

5. The resident may inspect and purchase photocopies of all records pertaining to his/her care upon written request and 48 hour notice to the facility.

6. The resident will be fully informed in language he/she can understand of his or her total health status including but not limited to his/her medical condition.

7. The resident may refuse treatment and refuse to participate in experimental research.

8. The resident who is entitled to Medicaid benefits is fully informed in writing at the time of the admission to the nursing facility or when he/she becomes eligible for Medicaid of all items and nursing facility services under the State plan for which he/she may not be charged: and of those services which may be charged and the amount of each charge. Changes made in rates and charges are sent to the resident 10 days in advance of change.

9. All residents will be informed at time of admission and periodically during his/her stay of services available in the facility and of charges for those services, including services not covered under Medicare or by the facility's perdiem rate.

10. Upon admission, the resident is provided a copy of the facility's Resident Fund policy.

11. The resident is informed I writing of how he/she may files a complaint with the state survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property while in the facility.

12. The resident is informed of the name specialty and way of contacting the physician responsible for his/her care during his/her stay in this facility.

13. Except in a medical emergency or when the resident is incompetent, the facility consults with the resident immediately and if known the resident's legal representative or interested family member within 24 hours when there is:

    a. An accident involving the resident which results in injury;
    b. A significant change in the resident's physical, mental, or psychosocial status;
    c. A need to alter treatment significantly; or
    d. A decision to transfer or discharge the resident from the facility; (All transfers/ discharges will be made according to policy.

e. A change in room or roommate assignment: (these changes are made in accordance with the Transfer/Discharge policy.)

f. Any change in the resident's rights under Federal or State law or regulations. The facility keeps any updated record toe the address and phone numbers of the resident's legal representative or interested family member.

14. The resident has the right to manage his or her financial affairs and the facility does not require the resident to deposit their personal funds with the facility. If the resident chooses to deposit their personal funds with the facility they are kept in an account separate from facility funds. The individual financial records are made available to the resident or his legal guardian upon request.

15. The resident may choose and retain his/her own attending physician, subject to that physician's compliance with the facility's policies for physician practice. The resident is kept informed in advance about care and treatment and of nay changes in that care or treatment that may affect his/her well being. Unless adjudged incompetent or other wise found to be incapacitated under the State laws, the resident participates in planning care and treatment or changes in care and treatment.

16. The resident's records of his/her medical and personal care will be treated with confidentiality and not discussed with others. The resident may approve or refuse the release of personal and clinical records to any individual outside the facility except in the following:

a. The resident is transferred to another health care institution: or
b. Record release is required by law or third-party payment source.

17. The resident may voice grievances with respect to treatment or care that is or fails to be furnished, without fear of reprisal or discrimination for voicing the grievance. This facility will make prompt efforts to resolve the grievance, including those with respect to the behavior of other residents.

18. Results of recent surveys are posted by this facility on the bulletin board. All residents have the right to examine these results and to review any plan of correction in effect.

19. Each resident may receive information from agencies acting as client's advocates and may contact these agencies at any time.

20. The resident is not required to perform service for the facility. Where applicable he/she may choose to participate in work activities when the following have been met:

a. The plan of care documents the need or desire for work the nature of the service performed and whether the services are voluntary or paid:
b. Compensation for paid services is at or above prevailing rates: and
c. The resident agrees to the work arrangement described in the plan of care.

21. The resident may send and receive mail promptly that is unopened: and have access to stationary, postage, and writing implements at his/her expense.

22. The resident may communicate and visit privately with persons of his choice except when these visits interfere with his/her own care or treatment or with the treatment and care of other residents. These visits and communications include the following:

a. Any representative of the Secretary:
b. Any representative of the State:
c. The resident's individual physician:
d. The State long term care ombudsman as established under section 307 (a) (12) of the Older Americans Act of 1965:
e. The agency responsible for the protection and advocacy system for developmentally disabled individual as established under part C of the Developmental Disabilities Assistance and Bill of Rights Act:
f. The agency responsible for the protection and advocacy system for mentally ill individuals as established under the Protection and Advocacy for Mentally III Individuals Act:
g. Immediate family or other relatives of the resident's choice:
h. All others who are visiting with the consent of the resident:
i. All entity and/or individual that provide social, legal, or other

services to the residents subject to his/her consent at the time.

23. The resident or his/her legal representative may grant permission to representative of the State Ombudsman to examine his/her clinical records.

24. The resident has regular access to the patient's telephone located. Assistance will be provided upon request.

25. The resident may retain and use his/her personal clothing and possessions including some furnishings as space permits unless to do so would infringe upon the rights or health and safety of other residents.

26. The resident may share a room which his/her spouse when married residents live in the same facility and both spouses consent to the arrangement.

27. The resident myself-administer drugs unless the interdisciplinary team has determined for the resident that this practice is unsafe.

28. The resident has the right to remain in the facility and not be transferred or discharged except in the following:

a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the facility.

b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

c. The safety of individuals in the facility is endangered.

d. The health of individuals in the facility would otherwise be endangered.

e. The resident has failed after reasonable and appropriate notice to pay for a stay at the facility.

f. The facility ceases to operate.

29. The resident has the right to be notified in writing 30 days before transfer or discharge except as follows:

a. The health and/or safety of individuals in the facility would be endangered.

b. The resident's health improves sufficiently to allow a more immediately transfer or discharge.

c. An immediate transfer or discharge is required by the resident's urgent medical needs.

d. The resident has not resided in the facility for 30 days.

30. The resident will be free from an physical restraints imposed or psychoactive drug administered for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

31. The resident will be free from any verbal, sexual, physical, or mental abuse corporal punishment and involuntary seclusion.

32. The resident may choose activities schedules and health care consistent with his/her interests, assessments, and plan of care: he/she may interact with members of the community both inside and outside the facility and make choices about aspects of his/her life in the facility that are significant to him/her.

33. The resident may organize and participate in resident groups which may be the Resident Council as described in the Resident Council Procedure: or may meet with the families of other residents on the facility.

34. The resident may participate in social religious and community activities which do not interfere with the rights of other residents in the facility.

35. The resident may reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

36. The resident in semi – private rooms will receive notice before the resident's room or roommate in the facility is changed.

Who pays for Nursing Home Care?

What is the difference between Medicare and Medicaid?

Medicare is your Government health insurance program for people over 65 and for those who are on Social Security disability. Medicare provides coverage for hospitalization, doctors and other types of medical expenses. Medicare is a medical insurance program, and *except for a limited short term nursing home benefit,* is not coverage for nursing home or other long-term care.

In order to get Medicare coverage for a nursing home stay, you must be in an approved skilled nursing facility, have been in the hospital for at least three days prior to entering the facility, and to be deemed by Medicare to be medically benefiting from that skilled nursing (usually undergoing therapy). Technically, there is a maximum of 100 days of nursing home benefit. Medicare will pay 100% for first 20 days and 80% for the remainder of the 100 days. Usually, resident will have a supplement or Medicaid to cover the 20%. If not, then resident is responsible for the co-pay.

Medicaid, on the other hand, which is funded jointly by the Federal Government and the individual states, is the program that provides benefits for long-term care nursing, if the individual has limited financial assets. If Medicaid approved for the nursing home, then whatever resources the resident has for example, Social security check, retirement check will become their patient liability and Medicaid will cover the remainder of the balance to the nursing home.

Example: (The following figures are only an example, not real cost)

30 days in a nursing home (not skilled) @ 125.00/day	=	$ 3,750.00
Patient gets 500.00 Social Security Check, they are allowed to keep 38.00 for personal needs and if they have supplement ins. that costs 50.00 per month.		
Patient liability would be 500.00 less 38.00 and 50.00.		-412.00
Medicaid would cover the balance of		3,338.00

Example:
Resident meets criteria for skilled nursing services.
30 days as a skilled patient, **Medicare** would pay 100% for first 20 days and 80% for remainder of days up to 100 days. Co-pay would be 148.00 per day, paid by **Supplement insurance** or **Medicaid** or **Privately**. After resident is discharged from skilled nursing services, their payer source changes to either Medicaid or Private.

A promissory note should be signed if the resident cannot pay month of entry at time of admission.

MONTH OF ENTRY COLLECTIONS

FEBRUARY 7, 2008

Upon admission to OakLane, a new resident's month of entry liability will be collected immediately on the date of admission or shortly after, within the first month. The patient liability will be estimated for month of entry, until a Form 18-LTC is received from the Medicaid Parish Office. Upon receipt of the Form 18-LTC, the month of entry payment will be adjusted, if needed, to have the correct amount posted to the resident's account.

This is how the month of entry liability payment is figured:

The resident admitted to the facility on the 7th of March. His/her income is: $ 500 per month from Social Security and $ 200 from VA/Retirement. The resident pays $ 125 per month for Medicare Supplement Insurance and he/she is allowed $ 38 for personal allowance.

Add: $ 500.00
200.00

700.00
- 38.00
- 125.00

$ 537.00

Multiply: $ 537.00
X 12

6,444.00

Divide: $ 6,444.00
: 365

17.65 daily rate

31 days in the month of March
- 7
+ 1

25

$ 17.65
x 25

$ 441.25 month of entry payment to collect

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

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

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:

- 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.

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:_____

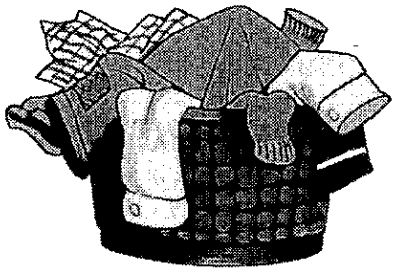
I, _____, resident/responsible party for _____, agree to pay Assisted Living, Inc., D.B.A. Oak Lane Wellness and Rehabilitation Center, the estimated monthly PLI of $_____ while Medicaid pending; and also agree to continue to pay the Medicaid determined amount once approved.

_____ _____

Resident/Responsible Party Signature Date

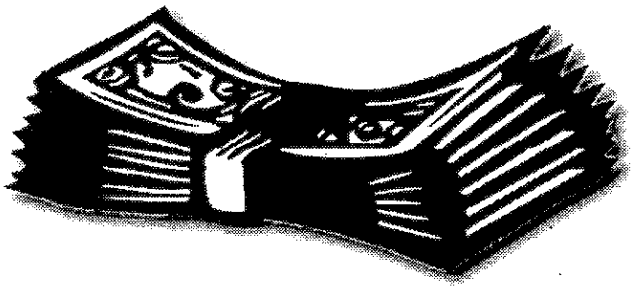
_____ _____

Witness Date



Linen

Please do not attempt to hoard supplies (bibs, sheets, towels, washcloths are to be used daily and not kept in resident drawers.) We have ample linen and your linen needs will be met on a daily basis.



FACILITY PERSONNEL

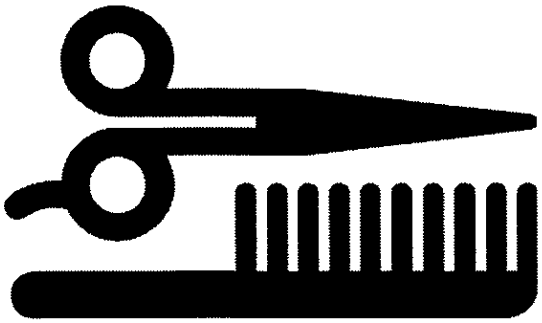
Personnel issues, such as salaries, benefits, etc. are facility concerns. Please do not meddle. Your concern is the care of your loved one, ours is operating a facility designed to meet those needs.

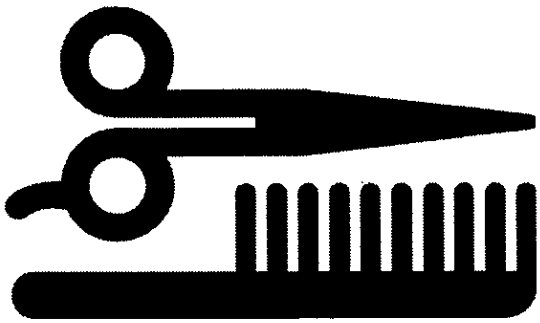
NON-EMERGENCY TRANSPORTATION FOR MEDICAL APPOINTMENTS

It is the responsibility of the nursing facility to arrange for or provide transportation to all necessary medical appointments. This includes wheelchair bound residents and those residents going to therapies and hemodialysis. Transportation will be provided to the nearest available qualified provider of routine or specialty care within reasonable proximity to the facility. Residents can be encouraged to utilize medical providers of their choice in the community in which the facility is located when they are in need of transportation services. It is also acceptable if the family or legal representative/sponsor agrees to transport the resident. In cases where residents are bedbound and cannot be transported other than by stretcher and the nursing facility is unable to provide an ambulance service. The ambulance provider will be reimbursed at the non-emergency transportation rate.

ATTENDANTS DURING TRAVEL

The facility is required when medically appropriate, to provide an attendant if the resident or the responsible party cannot arrange for an attendant. In no circumstances shall the facility require the resident or responsible party to pay for an attendant. However, if a resident is being admitted to a hospital and transportation is via ambulance, then an attendant is not necessary.





BEAUTY SHOP PRICES:

Shampoo/Set----------$10.00

Womens' Hair Cut----------$10.00

Perms (includes shampoo and set)----------$40.00

Mens' Hair Cut----------$7.00

Colors----------$15.00

at&t

LIFELINE DISCOUNT PROGRAM
APPLICATION

THINGS TO KNOW

- You must be a current AT&T Telephone customer. If you are not currently an AT&T Telephone customer, please do NOT complete this form. To establish service please contact 1-800-288-2020.
- Please select all applicable government programs or income eligibility criteria in Step 4.
- In Step 5, please ensure you submit a photocopy of the corresponding supporting documents based on your selection in Step 4.
- This application will not be processed without a signature, date of birth and last 4 digits of Social Security Number (or Tribal ID, if applicable) in Step 6 or if the One per Household is not completed, signed and dated in Step 7.

Should you have any questions or need further assistance, please call 1-855-301-0355.

Sincerely,

AT&T Lifeline Services

Enclosures

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Questions? Call 1-855-301-0355

LIFELINE TELEPHONE APPLICATION - AT&T LOUISIANA

This signed application is required in order to enroll you in the Lifeline program as approved by the Federal Communications Commission (FCC). The form is only for the purpose of certifying your eligibility for the Lifeline program and will not be used for any other purpose. **PLEASE PRINT USING BLOCK CAPITAL LETTERS** in black or blue ink only. When completed, please mail the form and copies of proof of eligibility to: **AT&T Louisiana, PO Box 5020, Charleston, IL 61920-5020** -OR- you may fax completed form and copies of proof of eligibility to: **1-800-295-7495**.

APPLICANT INFORMATION

First Name **Middle Initial** **Last Name**

Service Address (Cannot be P.O. Box)

City **State** **Zip** -

Please check if this is a **Temporary address:**

My AT&T Telephone Number: - -

Billing Address (if different from service address)

City State Zip -

IMPORTANT DISCLOSURES

- Lifeline is a government benefit that helps eligible consumers pay for eligible telecommunications services by discounting their monthly service bill. Willfully making false statements to obtain the benefit can result in fines, imprisonment, de-enrollment or being barred from the program.
- Only one Lifeline service benefit is available per household. Note: A subscriber enrolling for federal Lifeline Benefits must be verified by the FCC National Lifeline Accountability Database (NLAD) before he/she can be enrolled in Lifeline with AT&T.
- A household is defined, for purposes of the Lifeline program, as any individual or group of individuals who live together at the same address and share income and expenses.
- A household is not permitted to receive Lifeline benefits from multiple providers.
- Violation of the one-per-household limitation constitutes a violation of FCC rules and will result in the subscriber's de-enrollment from the program.
- Lifeline is a non-transferable benefit and the subscriber may not transfer his or her benefit to any other person.

STEP 1 - ACKNOWLEDGEMENT OF SERVICE

You must be a current AT&T Telephone customer. If you are not currently an AT&T Telephone customer, please do NOT complete this form. To establish service please contact 1-800-288-2020. (IF YES, PROCEED TO STEP 2.)

STEP 2 - TRANSFER CONSENT

By my initials and by signing this application, I authorize AT&T to transfer any pre-existing Lifeline benefit with another carrier to my AT&T account, subject to all terms and conditions described in this application. I acknowledge that any pre-existing Lifeline discount with another carrier will cease when this transfer becomes effective.

STEP 3 - NATIONAL LIFELINE ACCOUNTABILITY DATABASE (NLAD) DISCLOSURE AND CONSENT

The FCC has ordered the creation of a National Lifeline Accountability Database for enrollment in the federal Lifeline Program. AT&T must provide the below information about our relationship with you to the database to ensure the proper administration of the Lifeline Program:

- Your full name
- Your date of birth
- Your telephone number
- Service Type
- Your full residential address
- The amount of the discount AT&T provides
- Whether your eligibility is program or income based
- The date AT&T began providing you with Lifeline service
- The future date when your Lifeline service with AT&T ends
- The last four digits of your Social Security number (or Tribal ID)

By my initials and by signing this application, I confirm I have read and understand the disclosures provided above and hereby provide consent to AT&T to release any of my information contained in this Lifeline Application required for the administration of the Lifeline program to the FCC or its designee, including the Universal Service Administrative Company, and to any state and federal agency or its designee, as required by law. (Failure to provide consent will result in being denied Lifeline service.)

STEP 4 - ELIGIBILITY REQUIREMENTS

You may qualify for Lifeline either because (A) you participate in a qualifying government PROGRAM -OR- (B) your total annual household income is within INCOME guidelines (next page). Please complete at least one eligibility method: Section (A) or (B).

Please check which Lifeline program you qualify for:
☐ Regular Lifeline ☐ Tribal Lands Lifeline

Please initial if applicable: I am seeking to qualify for Lifeline as an eligible resident of Tribal lands and I certify, under penalty of perjury, that I live on **Tribal Lands:**

(A) PROGRAM BASED ELIGIBILITY

I certify that I, or a member of my household, participate in at least one of the following programs (please check ALL that apply):

- ☐ Medicaid (note: this is not the same as Medicare)
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Supplemental Security Income (SSI)
- ☐ Federal Public Housing Assistance
- ☐ Veterans and Survivors Pension Benefit

If you live on a tribal land/reservation (as defined in Title 47 - Code of Federal Regulations, Section 54.400(e)), you may also qualify for Lifeline if you participate in:

- ☐ Bureau of Indian Affairs General Assistance
- ☐ Food Distribution Program on Indian Reservations (FDPIR)
- ☐ Tribally Administered Temporary Assistance for Needy Families (TTANF)
- ☐ Head Start (must meet income-qualifying standard)

APPLICATION CONTINUED ON BACK

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(B) INCOME BASED ELIGIBILITY

Total number of persons in my household is ☐☐.

Total annual household income is $ ☐☐☐, ☐☐☐.

☐☐ **By my initials and by signing this application**, I certify that my total household income is at or below 135% of the Federal Poverty Guidelines. (Please refer to the chart on the right.)

2017 FEDERAL POVERTY GUIDELINES*

This chart reflects the eligibility guidelines for customers at 135% of the federal guidelines.

Persons in Household	Annual Income Limits*
1	$16,281
2	21,924
3	27,567
4	33,210
5	38,853
6	44,496
7	50,139
8	55,782
Over 8: Per each additional person	$5,643

*New guidelines are published annually by the U.S. Department of Health and Human Services (DHHS)

STEP 5 - PROOF OF ELIGIBILITY

PHOTOCOPY (original documentation will not be returned) one or more of the following acceptable proofs of your eligibility for program(s) from Step 4 and submit with this application.

(A) PROGRAM BASED ELIGIBILITY

I have attached copies of one or more of the documents listed below:

- The current or prior year's statement of benefits from the program(s) marked in Step 4.
- A notice letter of participation in the program(s) marked in Step 4.
- A program participation document from the program(s) marked in Step 4, for example, a SNAP electronic benefit transfer card including participant's name or a Medicaid participation card.
- Other official document proving your participation in the program(s) marked in Step 4.

Benefit Qualifying Person (Provide information below **only if name is different** from Applicant):

First Name ☐☐☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐ Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Household member receiving benefits Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ Last 4 digits of Social Security Number: ☐☐☐☐ Tribal ID: (If applicable) ☐☐☐☐☐☐☐☐☐☐

(B) INCOME BASED ELIGIBILITY

I have attached copies of one or more of the documents listed below.

- Prior year's federal, state or tribal Tax return
- Veteran's Administration benefits statement
- Divorce Decree/Child Support document
- Federal or Tribal General Assistance Notice Letter
- Unemployment/Workmen's Compensation statement of benefits
- Social Security statement of benefits
- Retirement/Pension statement of benefits
- Current income statement from employer
- Paycheck stubs for most recent three (3) months
- Other official document containing income information

STEP 6 - SIGN & DATE BY MY INITIALS AND BY SIGNING BELOW I CERTIFY, UNDER PENALTY OF PERJURY, THAT: (Must initial not checkmarks)

☐☐ The information contained in this application is true and correct to the best of my knowledge.

☐☐ I meet the program or income based eligibility criteria for receiving Lifeline benefits.

☐☐ The service for which I am requesting a Lifeline Benefit be applied is in my name and, to the best of my knowledge, this account will represent the only service receiving the Lifeline Benefits provided to my household, and I am aware that my household can only receive the Lifeline discount on one qualifying service

☐☐ If I move to another address, I will provide notice of that address to my carrier within 30 days.

☐☐ I acknowledge that providing false or fraudulent documentation in order to receive Lifeline benefits is punishable by law.

☐☐ I acknowledge that I may be required to re-certify my continued eligibility for Lifeline assistance at any time and that failure to do so will result in de-enrollment and termination of Lifeline benefit.

☐☐ I understand that if I fail to re-certify my eligibility and I am de-enrolled, I will be required to pay the full published monthly recurring charges for my telephone service going forward.

☐☐ If in the future I, or the qualifying member of my household, no longer participate in at least one of the federally qualifying programs or my total household income exceeds 135% of the Federal Poverty Guidelines listed in Step 4, I begin receiving benefits from another carrier, or if conditions above change, I will promptly notify my carrier within thirty (30) days that I am no longer eligible for Lifeline assistance. Annually, I will need to re-certify my participation in the Lifeline program.

☐☐ I affirm under penalty of perjury, that the foregoing representations are true. **This application will not be processed without a signature, date of birth and last 4 digits of Social Security Number (or Tribal ID, if applicable).**

Applicant's Signature:_____ **Date:**_____

Applicant's Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Last 4 digits of Social Security Number:** ☐☐☐☐ **Tribal ID (if applicable):** ☐☐☐☐☐☐☐☐☐☐

APPLICATION CONTINUED ON BACK

→ STEP 7 - AT&T LIFELINE HOUSEHOLD WORKSHEET

AT&T LIFELINE HOUSEHOLD WORKSHEET

APPLICANT INFORMATION

Name:		My AT&T Telephone Number:	
Service Address:			

Lifeline is a government program that provides a monthly discount on eligible telecommunications services. Only **ONE** Lifeline Program-supported service per household is allowed under federal law. Members of a household are not permitted to receive Lifeline service from multiple telecommunications companies.

Your **household** is everyone who lives together at your address as one economic unit (including children and people who are not related to you).

The **adults** you live with are part of your **economic unit** if they contribute to and share in the income and expenses of the household. An **adult** is any person 18 years of age or older, or an emancipated minor (a person under age 18 who is legally considered to be an adult). Household **expenses** include food, health care expenses (such as medical bills) and the cost of renting or paying a mortgage on your place of residence (a house or apartment, for example) and utilities (including water, heat and electricity). **Income** includes salary, public assistance benefits, social security payments, pensions, unemployment compensation, veteran's benefits, inheritances, alimony, child support payments, worker's compensation benefits, gifts, and lottery winnings.

Spouses and domestic partners are considered to be part of the same household. Children under the age of 18 living with their parents or guardians are considered to be part of the same household as their parents or guardians. If an adult has no income, or minimal income, and lives with someone who provides financial support to that adult, both people are considered part of the same household.

You have been asked to complete this Worksheet to confirm that no one else in your household currently receives a Lifeline-supported service at your address. Answer the questions below to determine whether there is more than one household residing at your address.

1. Does your husband, wife, or domestic partner living at your address have a Lifeline Program-discounted service? (Check NO, if you do not have a husband, wife, or domestic partner)

☐ **NO >** If you checked **NO**, please answer **question #2.**

☐ **YES >** If you checked **YES**, you may not sign up for Lifeline because someone in your household already receives Lifeline. Only ONE Lifeline discount is allowed per household.

2. Does another adult (age 18 or older, or emancipated minor) live with you AND have a Lifeline Program-discounted service? For example, parent, son, daughter, another relative (such as a sibling, aunt, cousin, grandparent, grandchild, etc.), a roommate, or another person.

☐ **NO >** If you checked **NO**, you are ELIGIBLE for the Lifeline Program because no one in your household has a Lifeline Program benefit. You do not need to answer the remaining question. Please check OPTION A below and SIGN AND DATE THIS FORM.

☐ **YES >** If you checked **YES**, please answer **question #3.**

3. Do you share expenses for bills, food, or other living expenses AND share income (salary, public assistance benefits, social security payments or other income) with the person(s) in question #2 that has a Lifeline Program-discounted service?

☐ **NO >** If you checked **NO**, then your address includes **more than one household**. Please check OPTION B below and SIGN AND DATE THIS FORM.

☐ **YES >** If you checked **YES**, then your address includes only **one household**. You may not sign up for Lifeline because someone in your household already receives Lifeline. DO NOT sign this form.

Please check the box below for the one that applies to you:

☐ **OPTION A.** No one in my household currently receives a Lifeline Program benefit.

☐ **OPTION B.** I live at an address occupied by multiple households. I certify by my signature below that I share my address with other adults who do not contribute income to my household and share in my household's expenses or benefit from my income. The other adult(s) who reside at my address who receive a Lifeline program benefit are not part of my household.

I certify that the information provided above is true. I understand that violating the one-per-household requirement is against the Federal Communications Commission's rules and I may lose my Lifeline Program benefits, and may be prosecuted by the United States government for violating the rules.

→ **Applicant's Signature:**_____ **Date:**_____

Please return the signed form to: **AT&T Louisiana, PO Box 5020, Charleston, IL 61920-5020** -OR- you may fax completed form to: **1-800-295-7495.**

at&t

02/09/2017

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SafeLink WIRELESS

LOUISIANA CERTIFICATION FORM
LIFELINE ASSISTANCE PROGRAM

Enrollment ID: _____

PromoCode: _____

Date: _____

Section 1

Please make sure that you provide correct personal information. Your information will be validated against Public Records and any discrepancies could result in delays in your approval or rejection of service.

1. PLEASE PRINT name and physical residence address of person verifying for assistance:

Legal Last Name | Legal First Name | MI | SSN (Last 4) | Birth Date (MM/DD/YYYY)

Street Address / Apt. Number (no PO BOX allowed) | City | Zip Code

Address Line 2 | State | Contact Phone Number | Email Address

Mailing Address

Mailing Address (PO Box allowed) | Mailing Address 2 | City | Zip Code | State

Complete this part ONLY if your child or dependent is the beneficiary of the qualifying program.

First Name | Last Name | Birth Date (MM/DD/YYYY) | SSN (Last 4)

Your Plan Features

If you qualify for SafeLink Wireless, you can receive a free SafeLink phone, or use your current one with our Bring Your Own Phone program (BYOP). Select which phone option you would prefer.

○

Bring Your Own Phone

350 FREE monthly minutes & unlimited texts. Receive 1GB/month of FREE data for the first 3 months of service and 500MB/month thereafter.
*Unused minutes and data will not carryover from month to month.
Only new or returning customers who have been De-enrolled for more than 90 days will receive our 1GB promotion.

You must have a T-Mobile or other Unlocked GSM compatible phone for the BYOP program.

OR

○

Free SafeLink Phone

350 FREE monthly minutes & unlimited texts with 500MB/month of FREE data.
*Unused minutes and data will not carryover from month to month.

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Section 2

I hereby certify that I participate in at least ONE of the following public assistance programs (select just ONE program):

- ☐ Medicaid
- ☐ Supplemental Nutrition Assistance Program (SNAP) Food Stamps
- ☐ Supplemental Security Income (SSI)
- ☐ Federal Public Housing Assistance (Section 8)
- ☐ Veterans and Survivors Pension Benefit
- ☐ Bureau of Indian Affairs General Assistance (BIA)
- ☐ Tribally Administered Temporary Assistance for Needy Families (Tribal TANF)
- ☐ Tribal Head Start (only those households meeting its income qualifying standard)
- ☐ Food Distribution Program on Indian Reservations (FDPIR)

You must send a COPY of any current document that proves your participation in one of the programs previously selected. All documents must have the same name and address as provided in this application.

SafeLink is a Lifeline supported service. Lifeline is a federal benefit, and only eligible subscribers may enroll. Customers who willfully make false statements in order to obtain the benefit can be punished by fine or imprisonment or can be barred from the program. Lifeline is available for only one line per household. A household is defined as any individual or group of individuals who live together at the same address and share income and expenses. A household is not permitted to receive Lifeline benefits from multiple providers. Violation of the one-per-household rule constitutes a violation of FCC rules, and will result in the Customer's de-enrollment from Lifeline. Lifeline is a non-transferable benefit, and a Customer may not transfer his or her benefit to another person.

Section 3

You MUST place a check mark (√) next to each statement, then Sign and Date below (your application cannot be approved without these items).

I certify under penalty of perjury to each of the following:

☐ 1. I participate in the above designated qualifying program.

☐ 2. I understand that I must notify SafeLink within 30 days if I no longer participate in the qualifying program, if I or another member of my household obtains Lifeline supported service from another carrier, or, for any other reason, I no longer qualify for Lifeline support.

☐ 3. I understand I may be required to recertify my continued eligibility for Lifeline at any time, and failure to do so will result in termination of my Lifeline benefits.

☐ 4. If I change my address, I will provide my new address to SafeLink within 30 days.

☐ 5. I understand that my household may receive only one Lifeline supported service. My Household does not currently receive Lifeline Service OR my household currently receives Lifeline Service from another carrier and I authorize SafeLink to transfer my Lifeline benefit to SafeLink and I understand this will terminate my Lifeline benefits with my existing carrier.

☐ 6. The information contained in this application is true and accurate to the best of my knowledge, and I acknowledge that providing false or fraudulent information to obtain Lifeline benefits is punishable by law.

☐ I authorize SafeLink Wireless or its duly appointed representative to: (1) access any records required to verify my statements herein; (2) to confirm my continued eligibility for Lifeline assistance; (3) to update my address to proper mailing address format; (4) to provide my name, telephone number, and address to the Universal Service Administrative Company (USAC) (the administrator of the program) and/or its agents for the purpose of verifying that I do not receive more than one Lifeline benefit; and (5) authorize social service agency representatives to discuss with and/or provide information to SafeLink Wireless verifying my participation in benefit programs that qualify me for Lifeline assistance.

By signing below, I separately affirm and agree to each of the above statements

Printed Name _____ Date _____

Applicant Signature _____ PromoCode _____

E-Signature _____

Referred by a Friend

Referred by a Friend

Customer's First Name _____ Customer's Last Name _____ SafeLink Phone Number _____

☐ Please check this box if you would like to receive pre-recorded special offers for SafeLink customers and promotional offers from TracFone at the home telephone number provided in the contact information.

Please Return to:

Mail Application: SafeLink Wireless
PO Box 220009
Milwaukie, OR 97269-0009

Or Fax Application: 1 (866) 902-5756

For questions concerning Lifeline, please call SafeLink Wireless business office at 1 (800) SafeLink (723-3546)

Lifeline Household Worksheet

Lifeline is a government program that provides a monthly discount on home or mobile telephone services. Only ONE Lifeline discount is allowed per household. Members of a household are not permitted to receive Lifeline service from multiple telephone companies.

Your **household** is everyone who lives together at your address as one economic unit (including children and people who are not related to you).

The **adults** you live with are part of your **economic unit** if they contribute to and share in the income and expenses of the household. An **adult** is any person 18 years of age or older, or an emancipated minor (a person under age 18 who is legally considered to be an adult). Household **expenses** include food, health care expenses (such as medical bills) and the cost of renting or paying a mortgage on your place of residence (a house or apartment, for example) and utilities (including water, heat and electricity). **Income** includes salary, public assistance benefits, social security payments, pensions, unemployment compensation, veteran's benefits, inheritances, alimony, child support payments, worker's compensation benefits, gifts, and lottery winnings.

Spouses and domestic partners are considered to be part of the same household. Children under the age of 18 living with their parents or guardians are considered to be part of the same household as their parents or guardians. If an adult has no income, or minimal income, and lives with someone who provides financial support to that adult, both people are considered part of the same household.

You have been asked to complete this Worksheet because someone else currently receives a Lifeline-supported service at your address. This other person may or may not be a part of your household. Answer the questions below to determine whether there is more than one household residing at your address.

1. Does your spouse or domestic partner (that is, someone you are married to or in a relationship with) already receive a Lifeline-discounted phone? (check no if you do not have a spouse or partner) ☐ **YES** ☐ **NO**

If you checked **YES**, you may not sign up for Lifeline because someone in your household already receives Lifeline. Only ONE Lifeline discount is allowed per household.
If you checked **NO**, please answer question #2.

2. Other than a spouse or partner, do other adults (people over the age of 18 or emancipated minors) live with you at your address?

A. A parent
☐ **YES** ☐ **NO**

B. An adult son or daughter
☐ **YES** ☐ **NO**

C. Another adult relative (such as a sibling, aunt, cousin, grandparent, grandchild, etc.)
☐ **YES** ☐ **NO**

D. An adult roommate
☐ **YES** ☐ **NO**

E. Other
_____ ☐ **YES** ☐ **NO**

If you checked **NO** for each statement above, you do not need to answer the remaining questions. Please initial line B, below, and sign and date the worksheet.

If you checked **YES**, please answer question #3.

3. Do you share living expenses (bills, food, etc.) and share income (either your income, the other person's income or both incomes together) with at least one of the adults listed above in question #2? ☐ **YES** ☐ **NO**

If you checked **NO**, then your address includes **more than one household**. Please initial lines A and B below, and sign and date the worksheet.
If you checked **YES**, then your address includes **only one household**. You may not sign up for Lifeline because someone in your household already receives Lifeline.

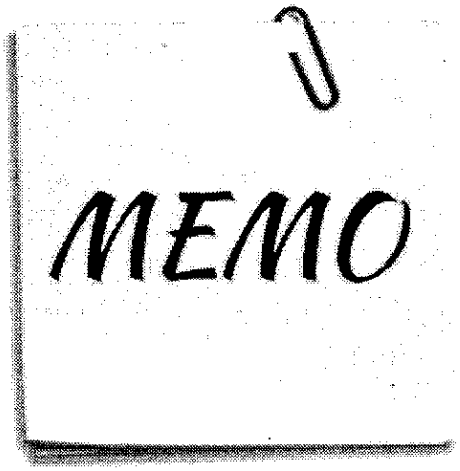
CERTIFICATION

Please initial the certifications below and sign and date this worksheet. Submit this worksheet to *SafeLink Wireless* along with your Lifeline application.

A. ☐ *I certify that I live at an address occupied by multiple households.*

B. ☐ *I understand that violation of the one-per-household requirement is against the Federal Communication Commission's rules and may result in me losing my Lifeline benefits, and potentially, prosecution by the United States government.*

Signature _____ Date _____



1. Staffing

Certain day, listed on newsletter. Time to discuss care and if any concerns. We strongly encourage family participation.

2. Problems....Concerns

Office is open and directors available 24 hours a day 7 days a week to address your concerns. Please allow facility staff to address issues. Then, and only then, if you feel we have not sufficiently resolved issue(s) you can notify the state complaint hotline. We must work as a team.

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 on 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
- basic personal laundry
- incontinence care

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 fro 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 request 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.

_____

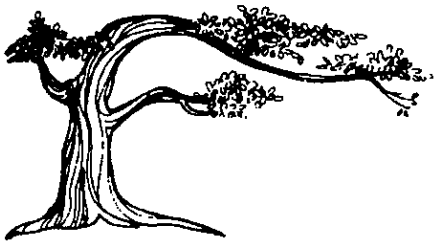
Resident Signature **Date**

_____

Responsible Party Signature **Date**

_____

and/or Legal Representative Signature **Date**



Oak Lane

Wellness & Rehabilitation Center

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

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

ARTICLES ALLOWED AND NOT ALLOWED

ARTICLES ALLOWED

- Vicks vapor tub
- Efferdent (cream or powder)
- Shaving lotion
- Electric toothbrush
- Non-aerosol products
- Shoe cream
- Body lotion
- Electric razor
- Shampoo, non-medicated
- Personal care items

ARTICLES NOT ALLOWED

Miscellaneous Items

- Ben gay
- Efferdent denture tablets
- Small electrical appliances
- Matches, lighter, cigarettes
- Extension cords, adapters
- Hair color and dyes
- Aerosols of any kind
- Asper cream
- Nail polish remover
- Hair oil
- Shoe Polish
- Alcohol
- Cleaning agents

Medications

- Pain pills
- Vitamins
- Suppositories
- Antibiotic cream
- Hemorrhoid medication
- Chloroseptic spray
- Laxatives
- Antacid
- Cough Syrup
- Corn Medications
- Eye Drops
- Nose spray or drops

****No over-the-counter meds of any kind****

Sharp Objects

- Scissors
- Nail files, etc.
- Knives
- Tools

Food

- Foods not in a sealed container
- Foods not allowed on special diets
- Foods in a sealed container must be dated.

General Rules

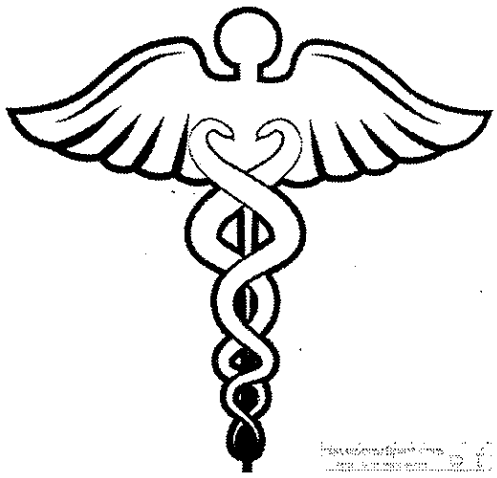
- No Smoking allowed in rooms or halls.
- Designated smoking areas are on the East and West Entrances.

Policy for Volunteers

Prior to anyone volunteering at Oak Lane, he/she must report to Administrator, Assistant Administrator, or Assistant Administrator Supervisor.

In addition to the above, the Volunteer is responsible to:

- A background being done at facility's expense
- All volunteers are to attend an orientation provided by facility prior to beginning
- A PPD or chest x-ray must be done prior to beginning
- Get familiar with facility's policy and procedures and abide by them
- Any incidents/accidents or any hazardous areas are to be reported immediately to a Supervisor
- Volunteers are allowed one free meal per shift
- Grievances are to be reported to the Nurse, Social Worker, or Administration.



PHYSICIAN SERVICES

We have two (2) physicians on staff. We encourage you to choose our staff physicians who are available on a 24/7 basis. However, you do have the right to choose your own physician who doesn't come to our facility, if so you will be called upon to assist with transportation to/from physician office.

Oak Lane

Wellness & Rehabilitation Center

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

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

POLICY AND PROCEDURES REGARDING FURNITURE, PICTURES AND ROOM CHANGES

1. All furniture coming in must be approved

2. Recliners-we will accept recliners provided they are clean, in good condition, and they do not smell offensive.

3. Pictures-please do not hang pictures yourself. If possible place them in frames that can be placed on night stands and dressers. The janitor will assist in hanging items

4. We reserve the right to move a resident as acuity of care increases.

Oak Lane

Wellness & Rehabilitation Center

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

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

POLICIES FOR ROOM CHANGES

The facility will reserve the right to move a resident to another room when there is a personality conflict or if the resident is disturbing to other residents. We will strive to have everyone comfortable, pleased, and in a room with someone they will be compatible with. We reserve the right to move a resident as acuity of care increases. We reserve the right to move a resident temporarily or indefinitely if the resident's room requires maintenance and/or improvements that may be deemed a sanitary or safety issue.

In any of the room change instances listed above, the facility will provide a minimum of 24 hours notice to the resident and/or responsible party of the change in room and/or roommate. Once 24 hour notice is given, the facility may transfer the resident prior to the 24 hours notice of change if agreed upon by the resident(s) involved.

The facility will make every effort to adhere to the procedures outlined in the Standards for Payment for Nursing Facilities.

REVISED 01/25/12

Rehabilitation Services

Rehab Xcel in partnership with Oaklane Wellness and Rehabilitation Center, is proud to offer therapy services to your loved one. We offer Physical Therapy, Occupational Therapy, and Speech Therapy. These services are offered on a daily basis, dependent upon the residents' individual needs. Therapy staff will accommodate treatment setting in either a private room setting or on a more social basis in our community gym. We offer all of the up to date equipment and techniques to help get your loved one back to his/her maximum level of function.

Oak Lane

Wellness & Rehabilitation Center

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

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

RE: EATING IN ROOMS

I would like to take this opportunity to address the issue of residents eating in their rooms. It is each resident's right to eat in their room as well as keep snacks in their room as long as it is in a sealed container. Although it is the right of the resident, it is the policy of Oak Lane to discourage residents from eating in their rooms. It is a safety hazard to have residents eating in their rooms unattended. The staff is only required to check on each resident every two hours. It also takes away an opportunity for social interaction. Although OLWRC will not interfere with a resident's right to eat in his/her room, we will continue to discourage it as an unsafe practice. Each resident and family member will be asked to sign a form stating that this policy is understood and that if the resident chooses to continue to eat in their rooms they accept the consequences of this action. Thank you for your attention to this matter.

Sincerely,

Director of Social Services