Durham Ridge Assisted Living
3420 Wake Forest Hwy
Durham, NC 27703
919-596-9464

WELCOME TO DURHAM RIDGE!

Durham Ridge Assisted Living is a 142-bed locked Memory Care facility for Residents with Alzheimer's or another form of Dementia.

Located on seven spacious acres on the outskirts of Durham, North Carolina, Durham Ridge Assisted Living is convenient to shopping, dining, hospitals, and lodging. It is only minutes away from Highway 70 and Interstate I-85.

Durham Ridge Assisted Living offers spacious bedrooms, large living rooms, beautifully appointed dining, and calm, peaceful outdoor areas complemented by the natural scenery of North Carolina.

A variety of social activities are also offered for residents to ensure the highest level of wellness for them - not only physically, but mentally and emotionally, including our very own in-house rehab department offering state of the art physical, occupational, and speech therapy and range of motion exercises.

Durham Ridge Assisted Living offers Specialized Care for Alzheimer's Residents. Durham Ridge Assisted Living has a totally secure environment that includes a self-enclosed courtyards and key pad entry system that balances safety with the comfort of friendly living areas and a beautiful outside landscape. Higher staffing levels and dedicated training programs ensure that your loved one receives the specialized care that he or she needs.

We are fully equipped to provide assistance to residents with special dietary needs. We provide three meals per day, as well as coffee, tea, and snacks. Our home-cooked meals are prepared fresh daily by experienced cooks.

Durham Ridge Assisted Living also offers a full Activities Program. Activities occur every day of the week and include Exercise, Games, Socials, Special and Holiday events, Birthday Parties, Religious and Music Groups, and much, much more.

Durham Ridge Assisted Living takes the safety of our Residents and Staff very seriously. As a result, we have put in place a very strict Infection Prevention and Control program to control the risks associated with COVID-19 and other infection control risks.

Please feel free to contact me anytime for questions, concerns or comments you may have at (919) 596-9464 or email me at pcox@drassistedliving.com.

On behalf of Durham Ridge Assisted Living, its staff, and its residents I would like to <u>Welcome You to The Durham Ridge Family</u>.

Kayla Moose, Administrator

Durham Ridge Assisted Living

3420 Wake Forest Hwy.
Durham NC 27703
(919)596-9464

RESIDENT FACT SHEET

Resident Name_______________________________
Date of Admission____________________________
Date of Birth________________________________
Social Security Number________________________
Medicaid No. ________________________________
Medicare No._________________________________
RSVP No.____________________________________ Date_______________
Responsible Party Name________________________
Responsible Party Address______________________
____

Email Address_________________________________
Responsible Party Phone number (home)____________
(cell)____________
(work)____________
Secondary contact Name________________________
Secondary contact Address______________________
____

Secondary contact phone (home) ________________
(cell)________________
(work)________________
Pay Status (circle one) Medicaid Private
Medicaid rate___________________
Private rate____________________
If Medicaid what are payment sources (circle all that apply)

Supplemental Security Income Social Security SA

Where does the SS and or SSI go
now____

Is there a representative payee yes no

If yes who? ______________________________________
If different from responsible party list name, address, and phone number
____

Admitted by _________ (initial)
FORWARD THIS FORM TO THE BUSINESS OFFICE

CUSTOMER CONSENT AND AUTHORIZATION FOR ACCESS TO FINANCIAL RECORDS

(Chap., 53B, N.C. Gen. Stat.)

I, ________ hereby authorize ________ to disclose the applicable records as described herein concerning me to the DURHAM ________ County (N.C.) Department of Social Services for the purpose of determining and/or redetermining eligibility for public assistance benefits. During the period of this consent, ________________ is authorized to provide to the Department the information requested on the reverse side of this consent, similar information concerning any other accounts that I have or may open hereafter with ________________ and updates of that information about those accounts which the Department may request from time to time.

STATEMENT OF CUSTOMER RIGHTS UNDER THE NORTH CAROLINA FINANCIAL PRIVACY ACT

None of my financial records may be disclosed by ________________ except in accordance with the terms of this consent or a duly issued judicial order or subpoena; and I understand that if the financial institution discloses any of the financial records or the government authority obtains any information about my financial records in violation of the North Carolina Financial Privacy Act (Chapter 53B, North Carolina General Statutes), I may sue for damages as provided in the Act. I further understand that:

a. I have the right not to give this consent;

b. Once given, this consent may not be revoked;

c. This consent will be valid for a period not to exceed twelve (12) months from the date set out below; and

d. Giving this consent cannot be made a condition of doing business with any financial institution.

I certify that I have read this consent or that it has been read to me, that I understand its terms, and that I voluntarily signed it on the date appearing beneath my signature.

WITNESS:

____

____
Signature of Customer

____
Date Signed

Designation of Authorized Representative

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace or the Department of Social Services in the County where you live (http://www.ncdhhs.gov/dss/local/). If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of Applicant/Beneficiary			
2. Name of Authorized Representative	Durham Ridge Assisted Living/Rhonda Schwarze		
3. Address	3420 Wake Forest Hwy		Apt/Suite #
4. City Durham	5. State NC	6. Zip code 27703	
7. Phone Number ( ) - 919-596-9464	Language Preference English		

- I understand that by signing this authorization, I am allowing the above named individual to sign my application, complete my re-enrollment/redetermination, get official information about my case status, and act for me on all future matters with this agency.
- I understand that by signing this authorization, my authorized representative may view and discuss any information contained in my case file or pertaining to my case other than information from another source specifically designated as "Confidential" or "Do Not Release").
- I understand that my authorized representative and I are responsible for any incorrect or incomplete information provided.
- I undestand that I may revoke this designation of Authorized Representative at any time.

Applicant/Beneficiary Signature	Date
Authorized Representative Signature Rhonda Schwarze	Date 10/25/21

NEED HELP WITH YOUR APPLICATION? Contact your County DSS (http://www.ncdhhs.gov/dss/local/) or call us at 1-800-662-7030. Para obtener una Copia de este formulario en Español, llame 1-800-662-7030. If you need help in a language other than English, call 1-800662-7030 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-452-2514.

Direct Deposit Enrollment Authorization Form

Special Assistance (SA) including SA In-Home, Refugee Cash Assistance (RCA) and Work First Cash Assistance (WF) benefits are issued as electronic payments. Payments will be issued as a Direct Deposit to your personal savings or checking account, or a facility collective account, provided it is an appropriately title fiduciary account. The term "fiduciary" means the payee may not seek personal benefit from managing the money of those they represent. A fiduciary title shows the payee manages the account but does not own the account. The beneficiaries own the account, but do not have access to the account.

Here's how Direct Deposit works

Each month your benefits will be electronically deposited into your checking or savings account. A separate notice is not sent to you when funds are deposited.

Bank Fees

While Direct Deposit is free, some banks charge fees for accounts. Make sure you understand the bank rules and fees that apply to your account.

Who can sign up for Direct Deposit?

Households that have a checking or savings account.

How many Direct Deposits accounts can I open?

You can choose only one account for each program payment. SA payments cannot be deposited into a facility operating account. The facility must have separate accounts for SA payments and operating expenses.

When will Direct Deposit Start?

The county social/human services agency can tell you when direct deposit will begin for your program benefit.

How to sign up for Direct Deposit

Complete Section 1. (The county agency can assist you.)

- Attach a voided or cancelled check for the checking account (starter/counter checks cannot be used).
- If you do not attach a voided check or if arranging Direct Deposit to a Savings Account, have the bank complete section 2.
- Remember to sign and date the form.
- The case payee on the Work First, RCA or the name of the person receiving SA (or the substitute payee) must be on the bank account, except for collective accounts.
- Once the form is complete, return it to your caseworker.
- Keep a copy for your record.

Stopping Direct Deposit

Contact your local department of social/human services agency to cancel your direct deposit authorization. You may be required to complete a Request to Cancel Direct Deposit form.

You must complete a new form if you change your account.

Section 1 (to be completed by Case Nominee/Payee)

Name of Case Head (last, first, middle initial)		Social Security Number (SSN)	Telephone number (919) 596-9464		
Name of Payee (if different than Case Head)		Payee's SSN	Gender	DOB	Preferred language English
Type of Account ☑Checking ☐Savings	Account Number: 001512522878	Name(s) on Account Durham Ridge Assisted Living, LLC	Bank Name First Citizens		
Nominee/Payee's Mailing Address (Street, Route No., P.O Box) 3420 Wake Forest Hwy		City/State/Zip code Durham, NC 27703	Payee's Telephone Number (919) 596-9464		

I hereby authorize the ______________________ Department of Social Services (DSS)/ Human Services Agency to make deposits to this bank account. DSS may make deposits to this account until I cancel this authorization.

Attach one of the following

☑ I have attached a voided or cancelled check with my name, routing and bank account number preprinted by the bank.

Print Name	Signature	Date
Print Name of Payee (if different than Case Head)	Signature	Date

Section 2 (to be completed by the bank if a cancelled or voided check is not attached or if depositing to a Savings Account)

Name and Address of Financial Institution	Routing Number: ______ Account Number:		
Name(s) on Account		Type of Account: ☐ Checking ☐ Savings	
Print or Type Bank Representative's Name	Signature	Telephone Number	Date

For County Use Only
Case No: ______________ CNDS No. ______________
Circle the applicable program area: WFFA SA SA In-Home RCA

SOCIAL SECURITY ADMINISTRATION USA

Social Security

Add/change Direct Deposit Information

Resident's Name ____________

Claimant Information

Name of Claimant If Different from Above: ____________

Social Security Number: ____________ Date of Birth ____________

Place of Birth City/ Town ____________

State/Foreign Country ____________

Address: ____________

____

Please answer at least one of the following

Type of Benefit (check all that apply) Retirement /Survivors/ Widow ________

Social Security /Disability ________

Supplemental Security Income ________

Mother's Maiden Name: ____________

Bank Account Information

Name of Bank First Citizens

Name on the account Durham Ridge Assisted Living

Routing Number 053100300

Account Number 001512522878

Checking X **Savings** ________ **(Please Check one)**

Pre-Admission Financial Screening

Resident Name ______________________________

Responsible Party ___________________________

Phone ______________________________________

Payment Type: Private Medicaid

Medicaid

Does Resident receive SS or SSI or Both?_______________________________

Who is the payee? ____

Where does the check go? ______________________________________

Do you want Durham Ridge to become payee? _____________________________

What is the total income including any pension or retirement payments?_____________________

If family is to remain payee, they must bring the income to the facility by the 10th of each month. If Durham Ridge is to become the payee, the family must bring the income to the facility until the change in payee is processed. Failure to do so will result in the issuance of a 30 day discharge notice. ________(initial)

Private

Total Income? ____

Source of Income? ____

Who will be responsible to make the payments to the facility? ______________________

Private Payments are due by the 10th of each month. If income is received later in the month, an awards letter must be provided to show the date of receipt of payment so the due date can be adjusted. Payments that are not received will result in the issuance of a 30 day discharge notice. ________(initial)

______________________________________ ____________________

Responsible Party Date

______________________________________ ____________________

Durham Ridge Assisted Living Date

Picture Consent Form

All Residents at Durham Ridge Assisted Living must have their picture taken for identification purposes only, including but not limited to the Resident Chart, Electronic Medication Administration Record and outside their bedroom door. Please sign below to state that you have agreed to this.

Resident/Responsible Party Signature:__________________________

Date: ____

☐ Please check the box also if you agree for Durham Ridge Assisted Living to use your picture for our website, bulletins, magazines etc.,

Durham Ridge Assisted Living Disclosure Statement

Special Care Facility

PHILOSOPHY

The philosophy of Durham Ridge Assisted Living Special Care Facility is to provide assistance and personal care tailored to the cognitively impaired resident, which allows maintenance of optimal self-function of the individual resident and keeps the resident functioning at his or her highest level of care. A structured but flexible lifestyle will be provided which includes an activity program tailored for each resident. Care plans will be developed that will stress the maintenance of each resident's abilities and family involvement will be encouraged in the development of these care plans. These care plans will also promote the highest level of physical and mental functioning through the emphasis on restorative care. Methods of behavior management will be used to preserve the dignity of the resident through design of the physical environment, physical exercise, social activity, appropriate medication administration, and proper nutrition and health maintenance. Changes in the resident's condition will be immediately to the physician, family, and other appropriate community resources.

PURPOSE:

The purpose of Durham Ridge Assisted Living Special Care Facility is to provide a safe, secure, familiar, and consistent environment for the cognitively impaired resident that promotes mobility while using the least restrictive measures to promote independence. It includes a locked door security system and a 38 camera surveillance system that prevents inappropriate or unsupervised movement into or out of the facility. Durham Ridge Assisted Living Special Care Facility provides 24-hour supervision by appropriately trained staff. Limitations to the services provided exists when a physician determines that an individual cannot be effectively cared for in this environment due to the level of skilled care required on a daily basis.

ADMISSIONS PROCEDURES & ANNUAL RESIDENT SCREENING:

Admission to the facility is dependent on the existence of an FL-2 with a diagnosis of Alzheimer's disease or a related Dementia as determined by a qualified health professional. A pre-admission screening (see attached) is completed by the facility for evaluation of the individual to ensure that the prospective resident's needs can be met in the facility and that the safety of others will be insured. If there are concerns regarding "danger to self and others" or "significant behavior problems that seriously disrupt the rights of other residents" this might create a problem for admission to the facility and will have to be evaluated by an appropriate health professional. A resident that is bed fast or unable to ambulate or able to move about on their own or with the use of assistive devices will not met the criteria for admission due to the lack of the need for supervision or risk for elopement. Other considerations regarding activities of daily living will be evaluated on an individual basis. Family members seeking admission of a resident to the facility will be provided with disclosure information and a copy of the screening form. The Admission Criteria Review will be completed prior to admission and annually to insure continued appropriateness of the individual.

DISCHARGE PROCESS:

Discharge from the facility occurs when:

1. It is necessary because the resident's needs can no longer be met in the facility as identified by the healthcare staff in conjunction with an appropriate physician.
2. The resident's health has improved so that he/she no longer needs the services provided by the facility.
3. The resident becomes a danger to him/herself and all appropriate referrals have been made and actions taken as identified by community resources and medical practitioners.
4. The health and safety of others becomes endangered.
5. The resident or responsible person has failed to pay the costs of services according to the admission contract.
6. The transfer or discharge is mandated under state law or the facility ceases operation.
7. The resident may also be discharged if they become bed fast or unable to ambulate or able to move about on their own or with the use of assistive devices due to the lack of the need for supervision or risk for elopement.

SPECIAL CARE FACILITY SERVICES

Durham Ridge Assisted Living Special Care Facility is designed to provide housekeeping services, assistance with personal care services, medication administration, and meal preparation and service for all its residents. Additionally, there will be an individualized activity program designed specifically for cognitively impaired residents, allowing for creative and intellectual expression. The resident/responsible party has the right to obtain mental health services through either the county mental health agency or the contracted mental health service provider. If the resident has intermittent skilled needs that can be obtained through a local home care agency and are ordered by the physician, such as physical therapy, occupational therapy, or skilled nursing, this will be done by allowing the resident/responsible party to choose service providers. The facility has contracted with a private primary care service for two days a week and a private therapy company to provide physical, occupational, and speech therapy five times a week to provide resident care needs.

RESIDENT ASSESSMENT AND CARE PLANNING

Within thirty days of admission to the special care facility and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes resident behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. This profile shall be developed and reviewed by all providers involved in the resident's services. The resident care plan shall be based on the resident profile and shall specify programming that is individualized to meet the resident's treatment and rehabilitative needs, and directed toward the goal of community integration to the greatest extent possible for the resident.

SAFETY MEASURES

The facility has 142 beds and is equipped with a call bell system. Part of the orientation to the facility includes a demonstration of the use of this call bell system. In the case of a healthcare emergency, the staff activates the local 911 system and the resident's physician, as well as the appropriate responsible party. Additionally, the staff will notify the Administrator/Resident Care Coordinator of the occurrence of any emergency. If a fall occurs, the resident will be assessed by staff appropriately trained in first aide and physical assessment techniques to determine if transport to a local emergency room is indicated. In the case of any display of aggressive behaviors, the residents and staff will be contained safely, and the appropriate mental health/medical professional will be accessed. Staff is trained in techniques to control

aggressive behaviors and prevention of falls. At a minimum, one staff member per shift is trained in Cardiopulmonary Resuscitation as well as the Heimlich Maneuver (anti-choking maneuver). Each facility includes a security system that prevents inappropriate or unsupervised movement into or out of the facility (wandering). Multiple fenced in courtyard is available to allow access to the outside environment for each resident. All Residents will be supervised by a staff member when in any outside environment. For safety of the residents, each resident is provided with lockable space within his/her room to store personal care and hygiene items. This is to prevent ingestion of any chemicals that may be hazardous to the resident. The key for the lockable space will be maintained by the staff.

STAFFING:

Staff will be present in the facility at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person who meets the orientation and training requirements for up to eight residents on first and second shifts and 1 hour staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident on each unit. There will be a Care Coordinator on duty in the facility at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required for facilities with 15 or fewer residents. In facilities of 16 or more residents and any facilities that are freestanding facilities, there will be a care coordinator as required above in addition to the other staff required.

STAFF TRAINING:

Prior to the establishment of a special care facility for residents with a mental health disability, the Administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care facility operated. The Administrator shall have in place a plan to train other staff assigned to the facility that identifies content, texts, sources, evaluations and schedules regarding training achievement. Within the first week of employment, each employee will be assigned to perform duties in the special care facility shall complete six hours of orientation on the nature and needs of the residents. Within six months of employment, each employee who has not previously received training as a Certified Nursing Assistant shall receive training that is comparable to the State Approved Nurse Aide 1 training unless exemptions are granted as noted in 10 NCAC 13F .0501. In addition, staff assigned to the facility shall receive at least 12 hours of continuing education annually that is specific to the needs of the residents, of which 6 shall be dementia specific. Staff who is responsible for medication administration and those who supervise the administration of medications shall have documentation of having successfully completed the clinical skills validation portion of the medication administration skills checklist. Those individuals who administer medications or supervise the administration of medications shall successfully pass the written examination prior to or within 90 days after successful completion of the clinical skills portion of a competency evaluation by a Registered Nurse. Medication Aides and staff who directly supervise the administration of medications shall complete six hours of continuing education annually related to medication administration.

PHYSICAL ENVIORNMENT AND DESIGN FEATURES

The Special Care Facility is equipped with secured doors to prevent unauthorized movement into or out of the facility. A secured courtyard allows safe and free movement into the outside environment. Each facility that has more than six beds is equipped with a call bell system. The 400 Hall is an additional secured area that is located within the locked facility to serve residents with additional needs or behaviors that need additional security and supervision. There is a staff work area and nourishment station for the preparation and provision of snacks. Medications are either secured on a medication cart and/or locked area. Living and Dining space is also provided within the facility, as well as bathing and lavatory facilities.

ACTIVITY PLANS:

Activity plans will be developed on admission and every six months thereafter to reflect personal preferences and needs of individual residents. These will be developed with input from family and significant others and will be designed to optimize independence and promote self-esteem. Opportunity will be available for both individual and group social and recreational activities sufficiently diverse to accommodate the residents' varied interest and capabilities, taking into account cultural differences. If there is a question about a resident's ability to participate in an activity, the resident's physician will be consulted to obtain a statement regarding the resident's capabilities.

FAMILY INVOLVEMENT AND SUPPORT PROGRAMS:

A part of the restorative philosophy of Durham Ridge Assisted Living Special Care Facility is to encourage and promote family involvement in the resident's care and activities. Staff training will include methods used to encourage family involvement as well as the formation of family support groups.

ADDITIONAL COSTS AND FEES

Residents, that require assistance with activities of daily living, such as ambulation, feeding, and toileting will not be assessed an additional fee, based on the extent of this need.

All client information shall be safeguarded as confidential, and no such information will be disclosed without an appropriate signed release as noted in the resident register.

By signing below the resident/responsible party acknowledges receipt and understanding of the Durham Ridge Assisted Living Special Care Facility Disclosure Statement:

Resident/Responsible Party _______________ Date _______________

Witness _______________ Date _______________

RESIDENT REGISTER

The following resident information is to be completed and signed by the Administrator or Supervisor-in-Charge/Administrator-in-Charge and the resident or his/her responsible person within 72 hours of admission and kept in the resident's record in the home. Put "NA" if the requested information is not applicable to the resident.

NAME OF HOME/FACILITY ______________________________

A. IDENTIFYING INFORMATION

1. NAME: ______________________________
   (first) (middle) (last) (what resident prefers to be called)

2. DATE OF ADMISSION: ______________________________
   (month) (day) (year)

3. FORMER ADDRESS ______________________________ COUNTY: ______________

   ADMITTED FROM: ☐ Own Residence ☐ Another's Residence

   A facility: ______________________________
   (Name) (Address)

   Other: ______________________________

4. BIRTHDATE ______________ BIRTHPLACE ______________ SS# ______________

5. MEDICARE # ______________ MEDICAID # ______________ OTHER INSURANCE #'S ______________

6. MARITAL STATUS: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

7. GENDER: ☐ Female ☐ Male

8. RACE: ☐ Caucasian ☐ African-American ☐ Native-American ☐ Hispanic ☐ Other ______________

9. FAMILY: Father ______________ Mother ______________
   (include maiden name)

   CHILDREN: ______________________________

   SIBLINGS: ______________________________

   SPOUSE/PARTNER (Address if applicable) ______________________________

10. RESPONSIBLE PERSON (if applicable) ______________________________

    Address ______________________________ Phone ( ) ______________

    Nature of Responsibility: ☐ Guardian ☐ Power of Attorney ☐ Payee

11. CONTACT PERSON (If responsible person is not designated) ______________________________

    Address: ______________________________ Phone ( ) ______________

B. RESOURCE INFORMATION

1. ATTENDING PHYSICIAN: ______________________________

   Address ______________________________ Phone ( ) ______________

2. PREVIOUS PHSYICIAN ______________________________

   Address ______________________________ Phone ( ) ______________

PLANS MADE FOR PAYMENT OF: Personal Needs____________________

Other____________________

C. PERSONAL INFORMATION

1. ASSISTANCE REQUIRED FOR: (Check all that apply)

☐ Dressing ☐ Correspondence ☐ Mouth Care
☐ Bathing ☐ Getting In/Out of Bed ☐ Feeding
☐ Nail Care ☐ Toileting ☐ Positioning/Turning
☐ Shaving ☐ Hair/Grooming ☐ Scheduling Appointments
☐ Ambulation ☐ Skin Care ☐ Orientation to Time and Place
☐ (other)____________________

If different from information contained on the FL-2, home must contact resident's physician for clarification.

2. MEMORY: ☐ Adequate ☐ Forgetful – Needs Reminders ☐ Significant Loss – Must Be Directed

3. SPECIAL AIDS: (Check all that apply)

☐ Walker ☐ Hearing Aid ☐ Wheelchair
☐ Eyeglasses ☐ Dentures (Type)________ ☐ Other________

4. PERSONAL HABITS: ☐ Smoking ☐ Alcohol ☐ Other____________________

5. **KNOWN ALLERGIES OR SUBSTANCES NOT TO BE ADMINISTERED (Drug, Food, or Otherwise):**

____

6. FOOD PREFERENCES: If special diet, please describe:____________________

____

	FAVORITE	LEAST FAVORITE
Vegetable		
Fruit		
Meats		
Meat Substitutes		
Cereals and Breads		
Milk or Buttermilk		
Other Beverages		

7. COMMUNITY INVOLVEMENT

a. FAITH COMMUNITY____________________ PASTOR____________________

Address____________________ Phone ( )__________

b. CLUB, GROUP OR ORGANIZATIONAL MEMBERSHIPS____________________

c. SPECIAL SKILLS OR TALENTS____________________

d. PAST WORK AND VOLUNTEER SERVICE____________________

e. HOBBIES____________________

f. ACTIVITY INTERESTS: (Review *Listing of Suggested Activities with resident*).

	Favorite
Games	
Music	
Exercises	
Outdoor Activity	
Crafts	
Outings	
Social Activity	
Work Type/Volunteer Activity	
Intellectual Activity	

g. ACTIVITIES STRONGLY DISLIKED OR TO BE AVOIDED:____________________

If there is a question about a resident's ability to participate in an activity, the home must obtain a statement from the resident's physician regarding the resident's capabilities.

D. **REQUEST FOR ASSISTANCE**

Below are some areas in which the home can assist a resident upon the request of the resident or his/her responsible person. The administrator or supervisor-in-charge/administrator-in-charge must explain and complete each statement with the resident or his/her responsible person. The resident or his/her responsible person may subsequently change his/her mind and make a new request in writing at any time using Section H or some other notice. An equivalent signed record can be substituted for Section D.

1. I, as resident or the resident's responsible person, request that pertinent information be secured from the facility from which I just left. Signature:____________________

2. I, as resident or the resident's Legal guardian/payee, request that the management of this home handle my personal funds. I understand that the funds are available for my use during regular office hours and that I have the right to examine my account or to withdraw this request at any time. Signature:____________________

3. I, as resident or the resident's responsible person, request the use of lockable space for the security of personal valuables. I understand that I am entitled to one key at no charge and this space is accessible only to me, the administrator or supervisor-in-charge. Signature:____________________

4. I, as resident or the resident's responsible person, request that the management of this home –
   a. Open my personal mail in my presence to read and explain the contents to me;
   b. and assist in handling my mail that pertains to my financial or medical affairs.
   Signature:____________________

E. **RECEIPT OF MATERIALS**

I, as resident or the resident's responsible person, acknowledge receipt of the following information which the management of the home reviewed with me:

Home's resident contract specifying rates for the resident services and accommodations

House Rules which include policies on refunds, smoking, alcohol consumption visitation, and reasons for discharge.

Declaration of Residents' Rights.

Home's grievance procedures for residents to present complaints and make suggestions as to the home's policies and services.

Home's willingness to comply with Title VI of Civil Rights Act.

Other:____

____

Signature____________________

F. **SIGNATURES**

The resident or his/her responsible person should be asked to sign this form only after Sections A-E have been completed. The administrator or supervisor-in-charge/administrator-in-charge is to review this form with the resident or his/her responsible person at least once a year and revise it as needed using Section H. Section G is to be completed at the time the resident is discharged or transfers from the facility.

____
(Resident or Resident's Responsible Person) (Date)

____
(Administrator or Supervisor-in-Charge/Administrator-in-Charge) (Date)

G. **DISCHARGE/TRANSFER INFORMATION**

1. NOTICE OF DISCHARGE/TRANSFER________________________
(Month) (Day) (Year)

2. INITIATED BY: ☐ Administrator ☐ Other________________
Reason(s)________________________________

3. DATE OF DISCHARGE/TRANSFER________________________
(Month) (Day) (Year)
To: ☐ Own Residence ☐ Another's Residence (Name)________________
☐ A Facility ☐ Other________________________

4. New Address____________________________ Phone ( )________

I acknowledge the above information to be complete and accurate.

____
(Resident or Resident's Responsible Person) (Date)

____
(Administrator or Supervisor-in-Charge/Administrator-in-Charge) (Date)

H. **REVIEW/REVISION**

The space below may be used to revise the information contained on the form.

Changes:____

____

____
(Resident or Resident's Responsible Person) (Date)

____
(Administrator or Supervisor-in-Charge/Administrator –in-Charge) (Date)

NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES
DECLARATION OF RESIDENTS RIGHTS

Every resident shall have the following rights:

1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.

2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

3. To receive upon admission and during his or her stay a written statement of the services provided by the facility and the charges for these services.

4. To be free of mental and physical abuse, neglect, and exploitation.

5. Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need.

6. To have his or her personal and medical records kept confidential and not disclosed without the written consent of the individual or guardian, which consent shall specify to whom the disclosure may be made, except as required by applicable state or federal statute or regulation or by third party contract. It is not the intent of this section to prohibit access to medical records by the treating physician except when the individual objects in writing. Records may also be disclosed with the written consent of the individual to agencies, institutions or individuals which are providing emergency medical services to the individual. Disclosure of information shall be limited to that which is necessary to meet the emergency.

7. To receive a reasonable response to his or her requests from the facility administrator and staff.

8. To associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own or their initiative at any reasonable hour.

9. To have access at any reasonable hour to a telephone where he or she may speak privately.

10. To send and receive mail promptly and unopened, unless the resident requests that someone open and read mail, and to have access at his or her expense to writing instruments, stationary, and postage.

11. To be encouraged to exercise his or her rights as a resident and citizen, and to be permitted to make complaints and suggestions without fear of coercion or retaliation

12. To have and use his or her own possessions where reasonable and have an accessible, lockable space provided for security or personal valuables. This space shall be accessible only to the resident, the administrator or supervisor-in-charge.

13. To manage his or her personal need funds unless such authority has been delegated to another. If authority to manage personal need funds has been delegated to the facility, the resident has the right to examine the account at any time.

14. To be notified when the facility is issued provisional license or notice of revocation of license by the North Carolina Department of Human Resources and the basis on which the provisional license or notice of revocation of license was issued. The resident's responsible family member or guardian shall also be notified.

15. To have freedom to participate by choice in accessible and community activities and in social, political, medical and religious resources and to have freedom to refuse such participation.

16. To receive upon admission to the facility a copy of this section.

17. To not be transferred or discharged from a facility except for medical reasons, the residents' welfare, nonpayment for the stay, or when the transfer is mandated under state or federal law. The resident shall be given at least 30 days advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the medical care commission, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law. The medical care commission shall adopt rules pertaining to the transfer and discharge of residents that offer the same protections to residents as state and federal rules and regulations governing the transfer or discharge of residents from nursing homes.

Home Contract

Civil Rights Statement

Durham Ridge Assisted Living has signed DSS-1464 indicating its willingness to comply with Title VI of the Civil Rights Act. If the home fails to comply, it will not be able to provide care to residents receiving State/County Special Assistance nor will it receive supportive services from Durham County Department of Social Services.

Admission Policies

Admission policies are governed by the N.C. Department of Health and Human Services. The following prerequisites are essential for admission:

1. Age 18 or older.
2. Have a current FL-2 completed, date, and signed by a physician, within 90 days prior to admission, indicating adult care home placement.
3. Have a primary diagnosis of Dementia or a related disorder.
4. Have date of chest x-ray or tuberculin test recorded on FL-2 with results in accordance with minimum rules.
5. Provide the facility with any past psychological, medical evaluation and social history.
6. Have available medications as prescribed on the FL-2 or prescriptions for these medications.
7. No resident will be admitted in need of treatment for acute mental illness.
8. No resident will be admitted in need of professional nursing care under continuous medical supervision.
9. All resident belongings must be labeled with the resident's first and last name.
10. All resident belongings must be processed through facility staff for examination and treatment if needed to prevent the spread of bed bugs for any other potential pest.

Rates, Refunds, Discharge, and Transfer Policies

1. The established rate of _____$1515__Medicaid___will be paid one month in advance. Payments should arrive in the office no later than the 10th of the month from representative payees and all other responsible parties.
2. Rates for public assistance recipients will be the maximum amount allowed and approved in budgets set forth by the North Carolina General Assembly, and implemented by the Social Services Commission, and the North Carolina Department of Health and Human Services. Residents and/or Responsible Parties will be notified of increases, which will be reflected in a signed amendment to the initial contract.
3. No gratuities in addition to the rate are permitted.
4. If the resident's adjustment to the home is not satisfactory, the home reserves the right to initiate discharge/transfer. Before doing this, however, the home will seek the assistance of the resident's responsible person and the County Department of Social Services to help the resident in adjusting.

a. The discharge of the resident will be done with prior written and oral notification to the resident, his/her family, responsible party and the County Department of Social Services, allowing 30 days for discharge/transfer. Reasons will be cited for the necessity of such action. (See Discharge Policy).
b. If the home initiates discharge, monies will be refunded equal to the cost of care for the remainder of the month from the discharge date.
c. If the resident initiates discharge/transfer, a 14 day prior written notification will be required.
d. If the resident initiates discharge, he/she will owe the facility an equal amount to the cost of care for the entire 14 days. He/she will be refunded the remainder of the advance payment following the settlement of costs.
e. The resident may appeal discharge initiated by the facility.
f. Residents that have Medicaid but are not assessed to qualify for Personal Care Services will be discharged for nonpayment as well.

5. Exceptions to the 30-day Notice: As payments are made a month in advance, the daily cost will be refunded when:
   a. The resident remaining in the facility would jeopardize the health or safety of self or other residents/staff as certified by the physician and/or approved by the County Department of Social Services.
   b. If the resident needs medical care that cannot be provided by the facility and is moved to a higher level of care.
   c. If death occurs before the end of the month, the resident's funds will be returned to the appropriate source within 30 days after the resident's death and any unused prepaid cost of care will be returned within 30 days.

<u>Services and Accommodations</u>

A comprehensive program of total care is the objective of the facility.

1. The Administrator will make appropriate arrangement for health care as needed.
2. Transportation will be provided or arranged to the nearest local medical facility, to meet the medical needs, and to necessary community resources. Families/responsible parties may provide transportation. It is necessary that the facility schedule all appointments if the facility will be doing the transportation.
3. Meals are nutritious with table and tray services provided to all residents, as needed. Meals are not served in resident rooms unless ordered by the physician and must have a medical reason.
4. Telephones are made available for use by the residents for a reasonable amount of local calls.
5. Assistance will be given for residents on an individual basis with their eating, walking, dressing, bathing, personal grooming, correspondence, scheduling of appointments and shopping when necessary.
6. Supervision is provided to residents on a 24 hour a day basis.
7. Activities of the home are designed to promote the residents' active involvement with each other, their families and the community.

8. There is at least 10 hour s of planned group activities per week plus individual activities.
9. A lockable space will be provided for each resident with a key furnished. There will be a $5 charge for replacement keys to be issued if the original key is lost.
10. Incidental or occasional medical care is provided when necessary.
11. Regular laundry services will be provided to residents without additional fees.
    a. It is not, however, the facility's obligation to pay for a resident's dry cleaning.
    b. Families, who desire, may provide laundry services for any particular resident but must provide a hamper or plastic container with a lid. Soiled clothes will need to be picked up weekly; otherwise, they will have to be sent to the facility laundry.

House Rules

Tobacco Use

1. New admission to Durham Ridge Assisted Living are not allowed to use tobacco products of any kind.
2. Residents that were admitted prior to that policy taking affect are allowed to smoke at scheduled times under staff supervision.

Medications

1. Only medications prescribed by a physician (prescription or non-prescription) will be administered to residents of this facility.
2. All procedures established by licensing rules and implemented by the facility's Pharmaceutical Policy and Procedure Manual will be followed for each resident.
3. No medication (prescription or non-prescription) will be stored in the resident's room unless prior written authorization has been obtained from the resident's physician and the resident is deemed capable of following guidelines established for self-administration.
4. Drugs for self administration must be kept secured and out of sight in the resident's room.
5. The facility reserves the right to confiscate all medication found in a resident's room unless it is authorized to be there by virtue of a physician order.
6. If the resident is absent from the facility, all medication must be in self contained packages recorded by staff and signed for by the responsible person sighing the resident in and out. The home is not responsible for any mismanagement or shortage of drugs that have been removed from the premises.
7. The facility is not liable for any medication, drug, or medical expenses.

Visitation

1. Visiting hours are from 9:00 a.m. to 9:00 p.m. Exceptions may be made by obtaining prior permission from the Administrator.

2. Any resident who desires to leave the facility must make the staff aware of his/her plans.
3. When residents are taken from the facility by family or friends for any purpose, the proper sign out procedure must be followed, relieving the facility of all responsibility and liability during the time the resident is out.

Alcoholic Beverages

Alcoholic beverages are allowed only in accordance with physician's orders. The facility is responsible for storing and giving the beverages to the authorized residents.

Illegal Drugs

No illegal drugs will be permitted on the premises. The appropriate law enforcement authorities will be contacted. The facility reserves the right to request the resident, family, responsible person or agency to arrange other placement immediately when it is believed that a delay would jeopardize the resident's or other's health or safety.

Battery

The touching of another without his/her consent for the purpose of harassment, abuse, or exploitation will not be permitted. The facility reserves the right to request the resident, family, responsible person or agency to arrange other placement immediately when it is believed that a delay would jeopardize the resident's or other's health or safety.

Firearms/Dangerous Instruments

Guns, knives, or any other dangerous instruments that can harm another will not be permitted in the facility. The facility reserves the right to confiscate dangerous instruments and to request resident, , family, responsible person or agency to arrange other placement immediately when it is believed that a delay would jeopardize the resident's or other's health or safety.

Resident's Personal Funds Policies

Personal funds will be managed according to the capabilities and desires of each resident.

1. Personal funds may be managed by the home, resident, family, or responsible party.
2. Personal funds given to the resident after payment of cost of care will be dated and signed by the resident.
3. Personal funds will be managed by the Administrator or his/her designee if no other means are provided:
    a. Written authorization of resident or responsible party.
    b. At least monthly every transaction (receipts or disbursements), records will be signed by resident.

c. All or any portion of the funds will be available to resident, legal guardian or his/her payee anytime during business hours as long as the resident is currently residing in the facility.
d. If a resident gives notification to leave the facility, the personal funds balance will be refunded as soon as possible after appropriate disbursements with the time being no longer than 14 days after the resident leaves the home.
e. Of a resident dies, the personal funds balance will be refunded within 30 days after death (10NCAC 13F.1105).

Resident's Personal Funds Agreement

I, as a resident/responsible party, indicate by (X) in the appropriate block below by which means I wish to have my personal spending funds managed.

I choose to manage personal spending funds myself with the expectation of funds required for payment of mediation and drug expense. I authorize management to deduct that portion of funds required for payment of medications and drug expense from monthly personal fund allowance.

I choose to manage all personal spending funds myself. Durham Ridge Assisted Living Facility will not be held liable for any expense incurred.

I choose to have family/responsible party__________________________ manage my personal spending funds making that person responsible for my medication and drug expense.

I authorize the management of Durham Ridge Assisted Living to manage my entire personal spending funds account following procedures outlined in accordance with licensing rules.

I authorize the management of Durham Ridge Assisted Living to pay my responsible party or me all spending monies due me on a regular monthly basis after appropriate collections and disbursements.

Resident's Mail Policies and Agreement

Staff will assist and encourage residents with correspondence as needed or requested. Outgoing mail by residents will not be censored.

Residents' incoming mail will be managed in the following manner according to their capabilities and desires.

I, as a resident/responsible party, indicate by (X) in the appropriate block below by which means I wish to have my mail managed.

I authorize Durham Ridge Assisted Living management to open mail, which contains financial, medical, or any type of information that is deemed essential for my financial responsibilities or medical necessities so as to assist me with the same.

I do not authorize Durham Ridge Assisted Living management to open any mail. I will handle all responsibilities for payment of financial and medical obligations.

General Policies

1. All residents have freedom of movement unless restricted by appropriate written orders by physician.
2. No resident is required to perform any work-related arrangements by oral or written agreement while the resident is in Durham Ridge Assisted Living. Any work-related task will be done on volunteer basis or as requested by the attending physician for work-related therapy or as a diversional activity.
3. All resident/family members/responsible parties are encouraged to contact their physician concerning any questions they may have regarding their mediation and its side effects.
4. The management has the final decision regarding room assignments, including moving residents to 400 Hall when necessary. Room changes may be effected for the purpose of compatibility or the convenience of caring for that particular resident or if rooms require renovation.
5. The family/responsible party will be notified when the resident becomes ill and requires treatment by a physician or hospitalization. If you are concerned about the condition of the resident, please talk to the responsible staff in charge or the Administrator.
6. After the resident leaves the facility, all clothing and personal items must be disposed of within 15 days of departure.

Resident/Family/Responsible Party Are Responsible For:

1. Providing, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medication, and other matters relating to his/her health.
2. Reporting unexpected changes noted in his/her condition.
3. Following instructions of staff in implementing the responsible practitioner's orders, and as they enforce the applicable facility rules and regulations.
4. His/her actions if he/she refuses treatment or does not follow the practitioner's instructions.
5. Following facility rules and regulations affecting resident care and conduct.
6. Being considerate of the rights of other residents and facility personnel.
7. Being respectful of the property of other persons and the facility.
8. Securing money or valuables maintained on his/her person or in his/her room.
9. Securing permission from the Administrator for the use of his/her personal appliance (radio, TV, stereo, recorders, razors, lamps, and furniture).

10. Having all food from outside the facility checked by staff to insure compliance with prescribed diet and health regulations. A resident who is allowed to keep food in his/her room is responsible for keeping food in air tight containers and is responsible for not giving food to other residents.
11. Cooperating with staff and the fire department concerning the required number of fire drills that are mandated by state regulations.
12. Assuming all costs of medication including co-payment for prescription drugs, non-prescription drugs, ambulance fees, hospital and physician fees, co-payment of Medicare, clothing, personal items, tobacco products, writing materials, stationary, postage, etc.
13. Cooperation with administration, staff, or outside counsel for help in adjusting to the home.
14. Hiring private sitters if desired, but the facility reserves the right to approve anyone selected.
15. Paying for all keys after the first key to the lockable space areas.
16. Paying for any damages to the facility or furnishings other than everyday wear while residing in the facility.
17. Paying for long distance calls made by the resident.
18. Provide, to the best of his/her knowledge, complete information regarding financial status such as but not limited to: SS, SSI, VA and other.

Pharmacy Policy

As a resident of Durham Ridge Assisted Living Facility, I understand that it is my right to use the pharmacy of my choice. I understand that if I choose a pharmacy other than the facility pharmacy and the facility is for any reason unable to obtain medications from the pharmacy of my choice Durham Ridge will have to get the needed medications from the facility pharmacy which could generate a bill. Durham Ridge is not responsible for payment of medications.

Cape Fear Pharmacy______________________

VA_____________________________________

Other___________________________________

Durable Medical Equipment Policy

As a resident of Durham Ridge Assisted Living, I understand that it is my right to choose a medical equipment supplier. I elect to use the following supplier:

Restorative Medical_______________________________

VA____

Neil Medical______________________________________

Other____

Durham Ridge Assisted Living, LLC
Resident Agreement

Recitals:
The Resident has applied for admission to Durham Ridge Assisted Living.
The terms of the Resident Agreement are necessary for the comfort and security of the resident and for the proper operation of the facility.

Therefore, it is hereby agreed as follows:

1. Interior of Living Unit: The resident shall be responsible for any damages to living unit in excess of ordinary wear and tear caused by the resident or guests of the resident.
2. Loss and Storage of Resident's Property: The facility shall not be responsible for the loss of any property belonging to the resident due to theft, mysterious disappearance, fire or any other cause. Upon vacancy of any living unit for more than thirty days, except as arranged with the facility, the facility shall have the right to remove all property belonging to the resident. The resident or resident's estate shall pay such storage charges and agrees to reimburse the facility for any expense so incurred.
3. Miscellaneous:
    a. Liability: The resident agrees that the facility shall not be liable to the resident for the negligent or intentional acts of other residents, guests, or visitors.
    b. Right of Entry: The resident grants duly authorized employees of the facility the right to enter the Resident's Living Unit for managerial or emergency purposes.

Durham Ridge Assisted Living, LLC
Resident Agreement Continued

1. Identification of Resident Belongings Initial________
   a. It is the responsibility of the Resident/Responsible Party to ensure that all personal items are labeled for them to be easily identifiable. Items to be labeled should include but not be limited to clothing, shoes, dentures, glasses, hearing aides, walkers, wheelchairs and their leg rests, or other medical equipment.
2. Stolen/Misplaced/Lost Items Initial________
   a. Durham Ridge Assisted Living is a very large memory care unit. As part of the symptoms of Dementia, Residents may at times wander in to the wrong room and pick up something, put something away in their room and not remember where, or other similar actions that would cause something to be misplaced.
   b. Durham Ridge will make every effort to locate lost, stolen, or misplaced items.
   c. **Durham Ridge will not be responsible for replacing lost, stolen, or misplaced items. Signature________________**
   d. If clothing items are taken to the laundry, they may not be returned the same day. Please allow 2-3 days for clothes to return from laundry before reporting them missing
3. Room Assignments Initial________
   a. Durham Ridge Assisted Living will have the final say on all Room Assignments.
   b. Every effort will be made to find roommates that are a good match.
   c. Placement on 400 Hall is at the sole discretion of the management of Durham Ridge.
4. Falls Initial________
   a. Advanced age, previous falls, muscle weakness, gait & balance problems, poor vision and chronic conditions, like Dementia, are factors that put people at greater risk of experiencing falls.
   b. Most residents of Durham Ridge are affected by all of these factors.
   c. Residents that experience falls are seen by their Primary Care Provider and referred to physical and occupational therapy as needed.
   d. Low beds, floor mats, wheelchair cushions and other durable medical equipment that can reduce the risk of falls or injury will be used when necessary.
   e. Additional supervision can be provided in the activity rooms for residents experiencing falls.

Authorization for Medical Treatment Agreement

I, ______________________________, a resident of Durham Ridge Assisted Living, hereby authorize Dr. ______________________________ (and whomever he may designate as his assistant) to administer such treatment as is necessary during my stay in above said facility.

I also consent to the performance of any diagnostic or therapeutic measures to be undertaken at ______________________________ Hospital, or any other hospital of my choice in the event of an emergency or otherwise upon the order of my attending physician or one in attendance at the hospital.

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 as to the result that may be obtained.

______________________________ Date

______________________________ Signature of Resident/Responsible Party

______________________________ Date

______________________________ Signature of Administrator/SIC

Advanced Directives

Alert competent adults are able to exercise their rights to make financial and healthcare decisions. Problems arise when an individual becomes unconscious, incompetent, or otherwise unable to make such decisions. In order to avoid such a problem may people plan ahead by creating advanced directives such as: a *durable power of attorney*, a *healthcare power of attorney*, and/or a *living will*.

- A durable power of attorney is a legal document that allows you to appoint someone as you agent to manage y our affairs should you be incompetent or incapacitated.
- A healthcare power of attorney allows you to appoint someone to act as your healthcare agent to make healthcare decisions for you should it be determined by your physician that you are no longer able to make these decisions for yourself.
- A living will is a legal document in which you can declare your desire that under certain conditions your life not be prolonged by extraordinary or artificial means. Advice and assistance with such matters for people unable to afford the services of a private attorney may be available through a Legal Aid office.

I certify by signature below that Advanced Directives have been explained and I fully understand my options.

______________________________	______________________________
Signature of Resident	Date
______________________________	______________________________
Signature of Responsible or Legal Person	Date

Statement of Policies and Procedures at Admission

Adult Care Home Residents Bill of Rights

Home's Suggestions and Grievance Procedures

Home's Civil Rights Statement

Admissions Policies

Rates, Refund, Discharge/Transfer Policies

Services and Accommodations

House Rules

Resident's Personal Funds Policies and Agreement

Resident's Mail Policies and Agreement

Authorization for Medical Treatment Agreement

General Policies

Resident/Family/Responsible Party Responsibilities

I, ______________________, as a resident/responsible party, acknowledge receipt of the above information by marking an ("X") in the block by each of the materials which management of Durham Ridge Assisted Living reviewed and gave to me.

______________________ ______________________

Signature of Resident/Responsible or Legal Person Date

______________________ ______________________

Signature of Administrator/ SIC Date

Durham Ridge Assisted Living, LLC

Grievance Policy

Each resident has the right to express grievances, complaints or suggestions without fear of reprisal, restraint, interference, coercion, or discrimination. A copy of the grievance policy is provided to each resident and/or responsible party. A signed receipt is kept in the resident's record.

1. Each resident has the right to:
    a. Complain
    b. Suggest
    c. Recommend and be heard
2. Resident comments regarding the above may be oral or written and may;
    a. Be written and signed
    b. Be written and not signed
    c. Submitted to the administrator or other appropriate staff member
    d. Submitted to the resident council
    e. Submitted to a representative of Durham Ridge Assisted Living, LLC
    f. Submitted to the Division of Facility Services or Durham County Department of Social Services
    g. Submitted to the Ombudsman

All comments shall be considered with confidentiality to insure against reprisal, interference, coercion, and discrimination.

Step 1: When a resident has a complaint, they can present it verbally to the supervisor who will review the information. Every effort will be made to arrive at a solution. If a solution satisfactory to all parties is not reached, Step 2 should be taken.

Step 2: The resident may present the complaint to the administrator who will make every effort to resolve the problem. If the resident is dissatisfied with the decision of the Administrator, the Step 3 will be utilized.

Step 3: The resident may present their complaint to the Grievance Committee. The committee is composed of the administrator, one staff member, two residents, and two family members. The committee will review the complaint and conduct any necessary investigations to resolve the complaint.

Step 4: If the decision of the Grievance Committee is unsatisfactory then the resident may contact a representative of Durham Ridge Assisted Living, LLC through the Administrator.

Durham Ridge Assisted Living is licensed by the North Carolina Department of Health and Human Services. It is monitored by Durham County Social Services. The Division of Aging Long-Term Care Ombudsman Program investigates resident rights complaints.

1. Durham County Social Services, 300 N. Duke Street, Durham, NC 27702, (919) 560-8000
2. NC Division of Facility Services, 2701 Mail Service Center, Raleigh, NC 27699, (919) 855-3765
3. Division of Aging LTC Ombudsman, 2101 Mail Service Center, Raleigh, NC 27699, (800)622-7030

I, ____________________, have received and understand y rights and the Grievance Policy and Procedure.

______________________________ ______________________________

Resident's Signature Date

I, ____________________, as the responsible party have read and understand ______________, rights and the Grievance Policy and Procedure.

______________________________ ______________________________

Responsible Party Signature Date

______________________________ ______________________________

Witness Date

DURHAM RIDGE ASSISTED LIVING

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: 05/01/2006

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE?

This notice describes DURHAM RIDGE practices at all its locations and that of:

- Any independent health care professional who treats or cares for Residents at DURHAM RIDGE and

is authorized to enter information into your medical record.

- ALL departments and units of DURHAM RIDGE.
- All employees of DURHAM RIDGE.
- Any volunteers we allow to help you while you are in DURHAM RIDGE
- All students or trainees.
- Any DURHAM RIDGE corporate office staff.
- All the above listed persons, entities, sites and locations follow the terms of this notice. In addition, these persons, entities, sites and locations may share medical information with each other for your treatment or DURHAM RIDGE operations purposes and the purposes described in this notice. The independent health care professionals, who provide care at DURHAM RIDGE and have agreed to follow the terms of this notice, are not employees or agents of DURHAM RIDGE and DURHAM RIDGE is not responsible for how they fulfill their professional responsibilities.

<u>THE MEDICAL INFORMATION TO WHICH NOTICE APPLIES:</u>

This notice applies to all of the records of your care and billing for care that are created at DURHAM RIDGE, whether made by DURHAM RIDGE personnel, your independent personal doctor or other independent health care personnel, who are responsible for their own actions. These records are the

physical property of and are owned by DURHAM RIDGE. Your personal doctor or other independent health care personnel treating you may have different policies regarding confidentiality and disclosure of your medical information that is created in their office or locations other than DURHAM RIDGE.

WHAT THIS NOTICE DOES:

This notice will tell you about the ways in which the people listed above may use and disclose medical information about you at Durham Ridge. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information at DURHAM RIDGE.

We required by law to:

- make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices at DURHAM RIDGE with respect to medical information about you; and follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you, to persons who are involved in taking care of you at DURHAM RIDGE, such as independent doctors and other independent health care professionals who are permitted to treat or care for Residents of DURHAM RIDGE, nurses, nurse's aides and other DURHAM RIDGE personnel or to students and faculty who are participating in clinical teaching experiences at DURHAM RIDGE For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of DURHAM RIDGE also may share medical information about you in order to coordinate what you need, such as therapy and activities. We also may need to disclose medical information about you to people outside DURHAM RIDGE who may be involved in your medical care before, during or after you leave DURHAM RIDGE, such as family members, or others who provide services, such as hospitals, therapists, or medical specialists that are part of your care. We may provide,

without your consent, medical information about you in connection with the provision of emergency medical services but disclosures shall be limited to that which is necessary to meet the emergency. We will otherwise only disclose medical information about you to people outside DURHAM RIDGE, who are not currently involved in your care at DURHAM RIDGE, with your consent, except for disclosures that are required or permitted by law.

- For Payment. We may need to use and disclose medical information -about you so that the treatment and services you receive at DURHAM RIDGE or as given by other providers may be billed to and payment may be collected from you, Medicare and Medicaid, an insurance company health plan, or a third party. We are permitted by law to disclose the amount of medical information necessary for us to obtain payment for the care and services provided to you pursuant to the terms of a third party contract. For example, if your insurance contract provides for the release of information. Our disclosure of medical information for the purpose of obtaining payment for the care and services provided to you may also include our giving information to your family members, who are involved in your care, insured on your policy or help pay for your care.

- For Health Care Operations. We may use and disclose medical information about you for DURHAM RIDGE operations. These uses and disclosures are necessary to run DURHAM RIDGE and make sure that all of our Residents receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the qualifications and performance of our staff in caring for you. We may also combine medical information about many DURHAM RIDGE Residents to decide what additional services DURHAM RIDGE should offer, what services are not needed, and whether improvements can be made. We may also disclose information to nurses, technicians and other_DURHAM RIDGE personnel,_independent doctors and health care professionals who are involved in treatment of Residents at DURHAM RIDGE or faculty and students who are having clinical education experiences at DURHAM RIDGE for review and learning purposes. We will only disclose, with your consent, medical information about you that identifies you to people outside DURHAM RIDGE, who are not currently involved in your care, except for disclosures that are required or permitted by law.

- Treatment Alternatives. We may use and disclose medical information to tell you about or recommend different ways to treat you.

- Health-Relate" Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- Fundraising: Activities. We will not share information about you with people or organizations that are involved in general fundraising activities. We may share information about you with people or organizations that are involved in fund-raising activities by or for the benefit of DURHAM RIDGE. We only would release contact information, such as your name and room

number. If you do not want DURHAM RIDGE to contact you for fundraising efforts, you must notify THE BUSINESS OFFICE MANAGER in writing.

- Assisted Living Facility Roster or Directory. Unless you tell us otherwise, we will include certain limited information about you in DURHAM RIDGE roster or directory while you are a Resident at DURHAM RIDGE. This information may include your name, room number and religious affiliation. This directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you in DURHAM RIDGE and generally know how you are doing. If you choose not to be listed in the directory, then we may not be able to acknowledge that you are in DURHAM RIDGE to your family, friends, clergy or delivery people. If you do not want anyone to know this information about you, if you want to limit the amount of information that is disclosed, or if you want to limit who gets this information, you must notify THE BUSINESS OFFICE MANAGER in writing or indicate your choice on DURHAM RIDGE Resident Directory Instructions Form.

- Individuals Involved in Your Care. In addition to the information furnished in connection with DURHAM RIDGE Roster or Directory, explained above, we may disclose medical information about you to a friend or family member who is involved in your medical care, unless you are able to and do object. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition; status, and location. You can object to these disclosures by telling us that you do not wish any or all individuals involved in your care to receive this information. If you cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to disclose relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort.

- Research. Under rare circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all Residents who received one medication to those who received another for the same condition. All research projects, however, will require your written consent if the researchers will know who you are. Medical information about you that has had identifying information removed may be used for research without your consent.

- As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

- To avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health

and safety of the public or another person. Any disclosure, however, would only be to someone 'able to help prevent the threat and limited to the information needed.

- SPECIAL SITUATIONS:

- Organ and Tissue Donation. We are required by law to release medical information concerning deceased patients to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary for them to' determine organ or tissue donation potential. If you are an. organ or tissue donor, we are also required by law to provide medical information about you after your death to the person or entity who receives the organ or tissue donation.

- Public Health Risks. We may disclose without your consent medical information about you for public health activities; These activities generally include the following:

1. To prevent or control disease, injury, or disability;
2. To report cancer, deaths or other items required to be reported;
3. To report suspected abuse or neglect as required by law;
4. To report reactions to medications or problems with products;
5. To notify people of recalls of products they may be using; and
6. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Surveys and Other Health Oversight Activities. We may disclose without your consent medical information to a health oversight agency when authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with applicable laws. The Department of Health and Human Services has authority to inspect DURHAM RIDGE and to review any records of the current or former Residents of when necessary to investigate any alleged violation of the resident's rights. The Department of Health and Human Services has designated the local Departments of Social Services to monitor assisted living facilities, and representatives of the Department may review records to carry out their duties. The Department of Health and Human Services may also receive information regarding your death in certain circumstances. The state

ombudsman can review your records with your consent or the consent of your legal representative. Some professional licensing boards, such as the board that governs licensing of physicians, have the right to review your records when investigating a particular physician.

- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we must disclose medical information about you in response to a court or administrative order. We also may disclose medical information about you in response to a subpoena or other lawful process from someone involved in a dispute by furnishing your medical records or information under seal to the court. The copies of your medical record under seal may only be opened by the judge, the parties to the case or their attorneys unless a judge orders otherwise.

- Law Enforcement. We may release without your consent medical information to a law enforcement official:

    - In response to a court order grand jury demand, or search warrant;
    - To report a death or injury we believe may be the result of criminal conduct; or
    - To report criminal conduct committed at DURHAM RIDGE.

- Coroners. Medical Examiners. And Funeral Directors. We may release without your consent medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about the identity of Residents at DURHAM RIDGE to funeral directors as necessary to carry out their duties.

- Behavioral Health Care. Regardless of the other parts of this Notice, any information relating to alcohol and drug treatment or other behavioral health care treatment, including psychotherapy notes will not be disclosed outside DURHAM RIDGE except as authorized by you in writing, pursuant to a court order, or as required by law. Psychotherapy notes about you will not be disclosed to personnel working within DURHAM RIDGE, other than to the person who wrote the notes, except for training purposes or to defend a legal action brought against DURHAM RIDGE, unless you have properly authorized such disclosure in writing.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you.

- Right to Inspect and Copy. You have the right to inspect and receive a copy of medical information that may be used to make decisions about your care, unless your treating physician determines that providing you with such information would be injurious to your well-being. When we deny your request to inspect and receive a copy of your medical information on this basis, you may request that the denial be reviewed. Another licensed health care professional chosen by DURHAM RIDGE ~ will review your request and the denial. The person conducting the review will not be the person who denied your request. We will do what this reviewer decides. To inspect or receive a copy of your records, you must submit your request in writing to the Business Office. If you request a copy of the information, we may charge a fee not to exceed the community standard rate for the costs of copying, mailing, or other supplies associated with your request and may collect the fee before providing the copy to you. If you agree, we may provide you with a summary of the information instead of providing you with access to it or with an explanation of the information instead of a copy. Before providing you with such a summary or explanation, we first will obtain your agreement to pay and will collect the fees, if any, for preparing the summary or explanation. .

- Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for DURHAM RIDGE.

To request an amendment, your request must be made in writing and submitted to the BUSINESS OFFICE MANGER. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment, if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was created by a provider other than DURHAM RIDGE, unless the provider who created the information is no longer available to consider or make the amendment;
  - Is not part of the medical information kept by or for DURHAM RIDGE;
  - Is not part of the information that you would be permitted to inspect and copy; or has been determined to be accurate and complete.

- Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we have made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to DURHAM RIDGE Privacy Officer. Your request must state a time period that may not be longer than six years prior to the request and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, or electronically). The first list you request within a 12-

month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We may collect the fee before providing the list to you.

- Right to Request Restrictions. Except where we are required to disclose the information by law, you have the right to request a restriction or limitation on the medical information we use or disclose about you. For example, you could ask that we not use or disclose information about a treatment you had to a family member or friend. We are not required to agree to your request to restrict use or disclosure of your information within DURHAM RIDGE except with regard to psychotherapy notes or as required by law. If we do agree, we will comply with your requested restriction unless the information is needed to provide you emergency treatment. Except as permitted or required by law, we will only disclose your confidential medical information to persons outside DURHAM RIDGE who are not currently involved in your care at DURHAM RIDGE, in accordance with your written authorization.

To request restrictions, you must make your request in writing to the BUSINESS OFFICE MANAGER. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- Right to Request Alternative Communications. You or your representative have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by speaking with you in a certain location or contacting your representative at work or at a certain mailing address. To request communications by certain means, you must make your request in writing to the BUSINESS OFFICE MANAGER and specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice or any revised notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Business Office.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice will be made only with your written permission or as required by law. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the purposes that you

had authorized in writing. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

CHANGES TO THIS NOTICE.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in DURHAM RIDGE. The notice will remain in effect for each subsequent visit unless changed. If the notice changes, a copy will be made available to you upon request

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with DURHAM RIDGE or with the Secretary of the United States Department of Health and Human Services. To file a complaint with DURHAM RIDGE, contact the Privacy Officer, at (919) 596-9464. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

RESIDENT ACKNOWLEDGMENT

I have been given a copy of DURHAM RIDGE's notice of Privacy Practices that became effective April 14, 2003.

______________________________ ____________

Signature or Resident or Representative Date

____

Print Name

____

Relationship of Representative to Resident

Please describe the Representative's authority to act on behalf of Resident:______________________

____

____

FOR DURHAM RIDGE USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the Resident or an authorized person, please explain your efforts to obtain the acknowledgment and the reasons you could not obtain it:

<u>Consent For Release of Resident Information</u>

I hereby authorize____________________________ to release specified information in my treatment record to____________________________ and to indentify other treatment centers (such as psychiatric hospitals) of which they have knowledge where other information may be obtained.

This date should include only that of the nature and to extent specified below:

Psychiatric, Psychological, Social, and Medical Information
Current Medications
History of Psychotropic Drugs Prescribed
Other Treatment Centers Identified in my chart

- ____________________________
- ____________________________
- ____________________________

I understand this information will be used only for____________________________

____

Other Information____________________________

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid for a period <u>no to exceed one year.</u> I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

____________________________ ____________________________
Signature of Resident/Responsible Person Date

____________________________ ____________________________
Signature of Witness Date

Durham Ridge Assisted Living
Primary Physician Agreement

I, ______________________________, choose EVentus/DMHC to be my Primary Care Physician and Psychiatrist/Psychologist (if necessary).

I, ______________________________, choose to have my own Primary Care Physician and Psychiatrist/Psychologist (if necessary).

Primary Care Physician's Name______________________________

Address ______________________________

____

Office Telephone Number______________________________

Office Fax Number______________________________

Psychiatrist/Psychologist's Name______________________________

Address ______________________________

____

Office Telephone Number______________________________

Office Fax Number______________________________

____
Resident/Responsible Party Signature

____
Date

eventus
WHOLE HEALTH

Southeast Assisted Living Patient Consent

Part 1: Patient Demographic Information					
Facility Name:				Date:	
Patient Last Name:		Patient First Name:		Middle Initial:	
Date of Birth:		Gender: Male ☐ Female ☐			
Is patient capable of making his/her own healthcare decisions? Yes ☐ No ☐					
If no, does patient have Surrogate Decision Maker (Healthcare POA, Legal Guardian, POA)? *Yes ☐ No ☐					
Surrogate Decision Maker Name:		Relationship to Patient:			
Phone:		Email:			
*Note: Surrogate listed here should be same as Surrogate signing on page 2.					

Part 2: Services Requested (Please check services)		
Check to approve	**Services**	**Description of Services**
☐	Primary Care	*To include all primary care services for health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses.*
☐	Mental Health	*To include psychiatry, psychotherapy and behavioral health integration services for the purposes of managing emotional, behavioral, or cognitive problems, and/or psychotropic medication management.*
☐	Podiatry/ Foot Care	*To include management of preventive foot care.*
☐	Optometry	*To include management of diagnosis, prevention, and treatment of ophthalmic diseases and visual disorders.*
☐	Audiology	*To include management of diagnosis, prevention, and treatment of auditory diseases and hearing impairment.*
☒	Chronic Care Management	*This box should be checked for all patients unless Chronic Care Management Services are declined. CCM is offered to ALL eligible patients who have been diagnosed with two (2) or more chronic conditions that are expected to last at least twelve (12) months and that place patient at significant risk of further decline.* *Initial if declined by patient:* ____________
☒	Behavioral Health Integration	*This box should be checked for all patients unless Behavioral Health Integration is declined. Behavioral Health Integration is offered to ALL eligible patients who have services provided for behavioral health disorders, who are participating in psychiatric collaborative care programs, or are receiving behavioral health integration services.* *Initial if declined by patient*______________
☒	Telehealth	*Telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by an eligible provider who isn't at patient's physical location using an interactive 2-way telecommunications system (such as real-time audio, video and telephone).* *Initial if declined by patient*______

Prior to sending to intake please make sure the following items are attached if needed. Patients will not be scheduled for services until all items are received.

Face Sheet________ **Copy of Insurance Card**___________ **Copy of POA or HCPOA**___________

[Consent and Acknowledgement Follow on Next Page]

eventus WHOLE HEALTH

Southeast Assisted Living Patient Consent

Patient Last Name:		Patient First Name:		Middle Initial:	
Date of Birth:					

Part 3: Patient Consent and Acknowledgement

By signing below:

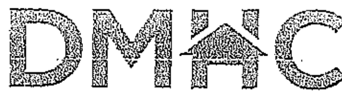
- I request and consent for the healthcare services indicated on page 1 to be provided to me by Eventus WholeHealth, PLLC.
- I authorize the release of any medical or other information necessary to determine available health care benefits and to remit and process third party payment claims for services rendered on my behalf.
- I understand that my insurance company may assign a portion of a bill for services as patient responsibility.
- I understand that my records will be kept on file at the facility where services are provided and securely in an Electronic Medical Record.
- I authorize the release of information to my Attending Physician and/or facility as applicable.
- I agree that my responsible party (financial agent) may be informed that I am receiving services for billing purposes unless I request otherwise.
- I acknowledge I have received Eventus's Patient Rights and Grievance Policies.
- I acknowledge that I may request a copy of Eventus's Notice of Privacy Practices or find a copy on Eventus's company website (www.eventuswholehealth.com).
- I acknowledge I have received Eventus's CCM and/or BHI Patient Information sheets.

Patient Signature: (If patient is able to sign, no other signatures are required)		**Surrogate Decision Maker Signature:**	
Printed Name:		**Printed Name:**	
Date:		**Date:**	
☐ ****Check if Verbal Consent** **Patient or Surrogate Decision Maker spoken to:** _______________ ***Verbal consents require 2 witness signatures below*		****Surrogate's Designation:** ***If a legally appointed surrogate, please include copy of documents verifying relationship / legal capacity.*	☐ **POA** ☐ **Legal Guardian** ☐ **Healthcare POA**

Incapacity to Sign: ***Patient consents to the terms set forth herein, but was unable to sign this Consent and Acknowledgement Form due to (please be specific and include two Witness Signatures (one of which may be the healthcare provider):***
State Reason:

1st Witness Signature:		**2nd Witness Signature:**	
Date:		**Date:**	

When complete, please send to:
Eventus WholeHealth Intake Department:
Fax: (855) 827-1740
Email: seintake@eventuswh.com
Please include facility facesheet, insurance cards, AND legal documentation of Surrogate Decision Maker. Patient cannot be seen until all documentation is received.



DOCTORS MAKING HOUSECALLS

2511 Old Cornwallis Road, Suite 200, Durham, NC 27713 | newpatient@doctorsmakinghousecalls.com | Phone: 919.932.5700 | Fax: 919.724.4951

Patient: ______________________________ DOB: ____/____/____
(Please Print Patient's Name)

Authorization

1) I authorize the release of my medical records to *Doctors Making Housecalls* upon its request for dates of treatment going back 2 years from the date below, including all discharge summaries, progress notes, consults, laboratory tests and imaging studies, for the purpose of continuity and coordination of care.
2) I authorize payment of my medical benefits to *Doctors Making Housecalls* for services rendered, and for *Doctors Making Housecalls* to give my insurance company any information about services rendered to me as necessary to process claims.
3) I understand and agree that I am financially responsible for all charges for services rendered to me, including what is not covered by my insurance and balances owed, after insurance payments, and authorize the use of my credit card or my checking account for these charges.
4) I acknowledge that I have been provided with Doctors Making Housecalls' Notice of Privacy Practices. A copy of the Notice is available on our website; www.doctorsmakinghousecalls.com.

For the purposes of this authorization "Doctors Making Housecalls" means: (a) Doctors Making Housecalls- Family Medicine, P.A., Doctors Making Housecalls- Geriatric Medicine, P.A., Doctors Making Housecalls- Internal Medicine, P.A., Doctors Making Housecalls- Psychiatric Medicine, P.A., and/or any of their respective contracted partners (collectively, the "DMHC Parties"), and (b) any individual or entity which acquires any DMHC Party or its business or any material portion of its assets.

➤ ____
Date (Signature of Patient or Patient's Power of Attorney)

Advanced Beneficiary Notice- Required for patients to be seen for urgent visits

As you know, Medicare does not pay for all your medical expenses, even some services that you or your physician have good reason to think you need. Medicare does not pay for the services listed below, which means you are responsible for payment at the time of service.

SERVICES	COST	REASON
Trip Fee – ***Waived in senior communities on scheduled visit days***		
Weekdays	$105	Not a covered benefit
Weekends	$130	Not a covered benefit
Out-of-Area Surcharge	$25-$50	Not a covered benefit
One time visit to transfer to hospice or out of state	$250	Not a covered benefit

NOTE: Approval will be automatic for urgent care visits requested by assisted living facilities (ALFs) in an effort to avoid an unnecessary trip to the emergency room; for non- urgent visits to ALFs, approval will be sought for each charge.

➤ ____
Date (Signature of Patient or Patient's Power of Attorney)

Vaccination Services

Please check the box if you would like to receive the following vaccinations or mark if you have already received them.

- ☐ Yearly Flu Shot — Received on-------
- ☐ Pneumovax 23 — Received on-------
- ☐ T-dap Not covered by Medicare — Received on-------
- ☐ Prevnar 13 — Received on-------

Additional On-Site Services

Please check the box if you would like to receive the following On-Site services when available in your area:

- ☐ Cardiology
- ☐ Mental Health
- ☐ Nephrology
- ☐ Dermatology
- ☐ Neurology
- ☐ Urology
- ☐ Orthopedic
- ☐ Podiatry
- ☒ Chronic Care Management
- ☒ Behavioral Health Integration
- ☒ Telehealth

➤ ____
Date (Signature of Patient or Patient's Power of Attorney)

HIPAA: I have been offered or read the complete HIPAA Form on the Doctors Making Housecalls website at: http://bit.ly/dmhchipaa

➤ ____
Date (Signature of Patient or Patient's Power of Attorney)

Patient Information: Every Field Needs to be Filled

Last Name ______ First Name ______ MI ______

Sex: M / F DOB ____/____/____ Soc. Sec. # ______-______-______

Community name if not at home Durham Ridge Assisted Living Apt or Room # ______

Address 3420 Wake Forest Hwy City Durham State NC Zip 27703

Phone: Home (919) 596 - 9464 Cell (____) ____-______ E-mail ______

Emergency Contact Person (Responsible party? Yes / No)

Last Name ______ First Name ______ Relationship to patient ______

Address ______ City ______ State ______ Zip ______

Phone: Home (____) ____-______ Cell (____) ____-______ Work (____) ____-______ Ext ______

E-mail Address ______ POA? Y / N (attach copy)

Secondary Emergency Contact Person (Not Residing with Patient)

Last Name ______ First Name ______ Relationship to patient ______

Address ______ City ______ State ______ Zip ______

Phone: Home (____) ____-______ Cell (____) ____-______ Work (____) ____-______ Ext ______

E-mail Address ______ POA? Y / N (attach copy)

Form of Payment Needed for Deductibles, Co-Insurance, and Trip Charges: Please Check One

☐ Credit Card

Credit Card Type ______ # ______ Exp ____/____

Card Holder's Name ______ CVC2 (3 digit code, Amex is 4 digits) ______

Cardholder's Address ______

☐ Bank Checking Account

Bank Name ______ Name on Account ______

Routing # ______ Checking Account # ______

☐ Deposit of $250.-$500.00 is Included

Primary Insurance Policy - Name of Insurance ______

Policy, Subscriber, etc. # ______ Grp # ______

Claims Address (not needed for Medicare) ______

City ______ State ______ Zip ______

Secondary Insurance Policy/Medicare Supplement - Name of Insurance ______

Policy, Subscriber, etc. # ______ Grp # ______

Claims Address (not needed for Medicare) ______

City ______ State ______ Zip ______

Preferred Pharmacy ______ **Preferred Hospital** ______

Prior PCP, Specialists, Hospital Visits ______

Allergies ______

Medications (attach or list with dose and frequency) ______

Medical Records- Please Attach.

Patient: ______________________________ DOB: ____/____/______
(Please Print Patient's Name)

☐ **Check if Verbal Consent**

Patient or Surrogate Decision Maker spoken to:

____
*****Verbal consents require 2 witness signatures below***

***Incapacity to Sign:** Patient consents to the terms set forth herein, but was unable to sign this Consent and Acknowledgement Form due to (please be specific and include two Witness Signatures (one of which may be the healthcare provider):*
State Reason:

1st Witness Signature:		2nd Witness Signature:	
Date:		Date:	

Services	Description of Services
Mental Health	*To include psychiatry, psychotherapy and behavioral health integration services for the purposes of managing emotional, behavioral, or cognitive problems, and/or psychotropic medication management.*
Chronic Care Management	*This box should be checked for all patients unless Chronic Care Management Services are declined. CCM is offered to ALL eligible patients who have been diagnosed with two (2) or more chronic conditions that are expected to last at least twelve (12) months and that place patient at significant risk of further decline.* *Initial if declined by patient:* __________
Behavioral Health Integration	*This box should be checked for all patients unless Behavioral Health Integration is declined. Behavioral Health Integration is offered to ALL eligible patients who have services provided for behavioral health disorders, who are participating in psychiatric collaborative care programs, or are receiving behavioral health integration services.* *Initial if declined by patient*__________
Telehealth	*Telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by an eligible provider who isn't at patient's physical location using an interactive 2-way telecommunications system (such as real-time audio, video and telephone).* *Initial if declined by patient*_______

2511 Old Cornwallis Road, Suite 200, Durham, NC 27713 | newpatient@doctorsmakinghousecalls.com | Phone: 844.932.5700 | Fax: 919.933.6881

CAPE FEAR
LONG TERM CARE

Dear residents and family members,

We at Cape Fear Long Term Care Pharmacy are excited to work with you and Durham Ridge Assisted Living to make certain that you and/or your family member receives the best care possible. Below are a few of the services we provide to ensure the well-being of our patients - your loved ones:

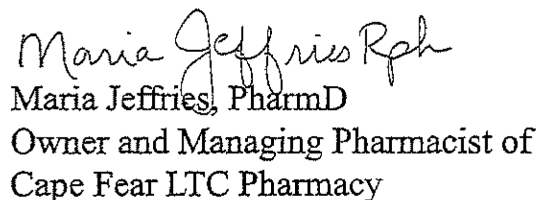
- On-call pharmacist available 24 hours a day, 7 days a week.
- Medication deliveries arrive the same day by bedtime.
- Special medication packaging that promotes safety and prevents errors.
- All routine medications are automatically filled and delivered every 30 days.
- A 30-dose supply of the most commonly used over-the-counter medications are **only 95¢**!
- On-site flu shots and other vaccines.
- We can provide other convenience items such as first aid supplies, denture care products, adult diapers, nutritional supplements and much more.

We pride ourselves in our devotion to our patients and are always happy to help. If you have any questions or concerns, please let us know. We continuously search for ways to improve our services.

You may reach me by calling the pharmacy at (910)893-2986 or email at maria@capefearltc.com. Please visit our website at http://www.capefearltc.com.

Thank you for allowing us to serve you.

Sincerely,



Maria Jeffries, PharmD
Owner and Managing Pharmacist of
Cape Fear LTC Pharmacy

CAPE FEAR
LONG TERM CARE

Phone: (910) 893-2986 | Fax: (866) 375-9070

New Resident Admission Information

Resident Name: ____________________

Date of Birth: ____________________ Room/Hall/Cart: ____________________

Primary Care Provider: ____________________

Allergies: ____________________

Social Security Number: ____________________

Insurance Information: ____________________

Medicare Number: ____________________

Medicaid Number: ____________________

****Please provide a copy of all applicable insurance cards.****

Responsible Party (where the monthly statement will be sent):

Name: ____________________

Address: ____________________

Phone Number: ____________________

Email Address: ____________________

By signing below, I hereby agree to guarantee and be liable for payment of all pharmacy related charges for the resident stated above. I also acknowledge that I have received the Notice of Privacy Practices of Cape Fear Long Term Care Pharmacy.

Signature: ____________________

Please forward a copy of the most recent FL-2 & current MAR if applicable.

Thank You,

Maria Jeffries, RPh

CAPE FEAR
LONG TERM CARE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Cape Fear Long Term Care Pharmacy LLC will ask you to sign an Acknowledgement that you have received this Notice of Privacy Practices (Notice). This Notice describes how **Cape Fear Long Term Care Pharmacy LLC** may use or disclosure you protected health information in accordance with the HIPPA Privacy Rule. It also describes your rights and **Cape Fear Long Term Care Pharmacy LLC's** duties with respect to protected health information about you.

Section A: Uses and Disclosures of Protected Health Information

1. Treatment, Payment and Health Care Operations
    a. We will use your health information to provide treatment. This may involve receiving or sharing information with other health care providers such as your physician. This information may be written, verbal, electronic or via facsimile. This will include receiving prescription orders so that we may dispense prescription medications.
    b. We will use your health information to obtain payment. This will include sending claims for payment to your insurance or third party payer.
    c. We will use your health information for our heath care operations necessary to run the pharmacy. This may include monitoring the quality of care our employees provide to you and for training purposes.

2. Permitted or Required Uses and Disclosures
    a. Our pharmacists, using their professional judgment may disclosure your protected health information to a family member, other relative, close personal friend or other person you identify as being involved in your health care. This includes allowing such a person to pick up filled prescriptions, medical supplies or medical records on your behalf.
    b. We also have contracts with entities called Business Associates that perform some services for us that require access to your protected heath information. We require our Business Associates to safeguard any protected health information appropriately.
    c. Under certain circumstances Cape Fear Long Term Care Pharmacy LLC may be required to disclosure health information as required or permitted by federal or state laws.

3. Authorized Use and Disclosure
    a. Use or disclosure other than those permitted or required by law, will not be made unless we obtain your written Authorization in advance. You may revoke any such Authorization in written at any time. Upon receipt of a revocation, we will cease using or disclosing protected health information about you unless we have already taken action based on your Authorization.

Section B: Patient's Rights

1. Restriction Requests
    a. You have a right to request a restriction be placed on the use and disclosure of your protected health information for purposes of carrying out treatment, payment or heath care operations. Restrictions may include requests for not submitting claims to your insurance or third party payer or limitations on which persons may be considered personal representatives.
    b. Cape Fear Long Term Care Pharmacy LLC is not required to accept restrictions other than payment related uses not required by law that have been paid in full by individual or representative other than health plan.
    c. If we do agree to requested restrictions, they shall be binding until you request that they be terminated.

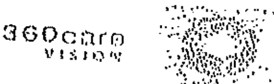
For Internal use

- ☐ Akron
- ☐ Louisville
- ☐ Pittsburgh
- ☐ Perrysburg
- ☐ Rocky Mnt
- ☐ Russellville

Facility Name: Durham Ridge Assisted Living Patient Name: ____________

Residents *WITH* Medicaid

Services will be provided under the signed order of your Primary Care Physician with no additional out-of-pocket expense. Insurance payments will be made directly to the 360care affiliated provider for covered services.

360care VISION 

Vision services may include items such as:

- Eye health exams
- Vision tests
- Eyeglass dispensing

Any service not covered by insurance can be covered through the Offset process.

☐ I DECLINE Vision

360care PODIATRY

Podiatry services may include items such as:

- Foot care that is medically necessary

☐ I DECLINE Podiatry

Signature of Responsible Party: ____________ Relationship: ____________ Date: ________

(Your signature is your request and consent to any service not checked as declined.)

Residents *WITHOUT* Medicaid

The Responsible Party listed below assumes responsibility for all allowable charges (deductibles and/or coinsurance) not reimbursed by the insurance carrier and authorizes payment be made directly to the 360care affiliated provider for covered services.

360care VISION

- Certain vision services may be covered by your insurance, including Medicare.
- If not covered by your insurance, the cost of the vision test, eyeglasses and fitting is $187. Prepayment of $187 is required prior to ordering glasses.

☐ I CONSENT to covered Vision services
☐ I CONSENT to non-covered eye health exam, vision test, eyeglasses & fitting for $187
☐ I DECLINE Vision

360care PODIATRY

- Certain podiatry services may be covered by your insurance, including Medicare.

☐ I CONSENT to covered Podiatry services
☐ I DECLINE Podiatry

Signature of Responsible Party: ____________ Relationship: ____________ Date: ________

360care provides an easy to use patient portal for patients to access portions of their medical records online from any computer or tablet with internet access. To set up or ask questions about a patient portal account, please email patientportal@360care.com. We will reply to your request within 2 business days.

FACILITY NAME: Durham Ridge Assisted Living, LLC

RESIDENT NAME: ______________________________

DATE: ______________________________

Dental Treatment Authorization

I hereby authorize Senior Dental Connection and its Dentists and Dental Hygienists to deliver medically necessary dental treatment, including x-rays and cleanings as recommended by the Dentist. I understand that there are risks, including potential side effects, associated with any examinations and/or treatment. I acknowledge that no guarantee or assurance has been made by anyone regarding results of examinations or treatments which I am to receive.

____

Signature or Resident or Responsible Party Date

Confirmation of Authorization
(If needed)

Though this Resident cannot sign his/her name, I hereby sign as a witness that this Resident is competent to make his/her own medical decisions, and consents to the above-described terms.

____

Signature Date

____

Print Name Title

Patient Questionnaire

Please fill out this form. The information you provide will be used to create materials and activities to individualize speech/occupational therapy sessions for your family member.

Name: ______________________________

Family:

Names	Relation	State of Residence	Extra Information (optional)

Close Friends:

Name	State of Residence

Pets:

____

____

Favorite job or most recent job before retirement:

____

____

Significant life events:

Hobbies:

Favorite foods:

Special talents, awards or recognition in life?

Significant places patient has traveled to for vacations, anniversaries, etc:

Where did the patient grow up?

How long has the patient been married:

How and where did patient meet his/her spouse?

Important information about patient's spouse (occupation, hobbies, etc):

____

____

Any extra information that you would like to share regarding your family member:

____

____

What else would be helpful to know or practice in therapy? Please leave your ideas below:

____

____

INFORMED CONSENT FOR PHYSICAL THERAPY

Therapy involves the use of many different types of physical evaluation and treatment. At Elevation Rehab, LLC, we use a variety of procedures and modalities to help us to try to improve your function. As with all forms of medical treatment, there are benefits and risks involved with therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your responses to a certain therapy modality or procedure. We are not able to guarantee precisely what your reactions to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them. I acknowledged that my treatment program has been explained by Elevation Rehab, LLC, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Elevation Rehab, LLC as outlined to me, and I wish to proceed.

______________________________ ______________________________

Patient Name Patient Signature

______________________________ ______________________________

Responsible Party Signature Date

FINANCIAL AUTHORIZATIONS AND ACKNOWLEDGEMENTS

AUTHORIZATION FOR FINANCIAL CONTACT: You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Elevation Rehab, LLC may also contact you by sending text messages or emails, using an email address you provide. Methods of contact may include using pre-recorded or artificial voice messages and/or the use of an automatic dialing device.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY: I, the undersigned, whether acting as an agent or patient, agree that in consideration for the services rendered or to be rendered, do hereby assign payment directly to Elevation Rehab, LLC for services provided by Elevation Rehab, LLC. I authorize Elevation Rehab, LLC to submit a claim for payment for benefits. I hereby agree to pay any and all charges that exceed or that are not covered by my insurance coverage. **This assignment is irrevocable.** I further understand that I am financially responsible for any charges not covered by this assignment of benefits and have been provided a copy of Elevation Rehab's Financial Responsibility Policy.

ACKNOWLEDGEMENT OF ESTIMATION OF BENEFITS: I understand that Elevation Rehab, LLC will provide me an Estimation of Benefits prior to the start of service. I acknowledge that this is only an estimate and that my insurance benefits are determined solely by my insurance company. I further understand that I have the right to terminate services or seek financial advocacy based on this estimate.

RELEASE OF FINANCIAL INFORMATION AUTHORIZATION: I authorize Elevation Rehab, LLC to release any or all of my medical or financial records to any person or corporation which is or may be liable under contract for all or part of the medical charges. I also authorize the entity to release any additional information needed for payment and healthcare operation purposes to entities that are part of the payment process while I am a patient at Elevation Rehab, LLC.

I authorize Elevation Rehab, LLC to release my billing information to the following individuals:

1) Name: ______________________ Relationship: ______________

2) Name: ______________________ Relationship: ______________

I, the undersigned, acknowledge that I have read and understand each section of this document.

Patient Name (Print): ______________________________

Financially Responsible Party Name (Print): ______________________________

Patient/Financially Responsible Party Signature: ______________________________

Date: ____________ Social Security #: ______________ Date of Birth: ____________

MEDICAL AUTHORIZATIONS AND ACKNOWLEDGEMENTS

AUTHORIZATION FOR TREATMENT: I consent and authorize Elevation Rehab, LLC to provide physical/occupational/speech therapy as per written from my medical referral source. I further consent to examinations and procedures deemed advisable or necessary in diagnosis and treatment at the discretion of the professional staff. I understand that no promise, guarantee, or warranty has been made regarding the result of medical treatment or examination. The risks and hazards of treatment and procedures have been explained to me.

AUTHORIZATION FOR MEDICAL CONTACT: I agree, in order to provide continued care, Elevation Rehab, LLC may contact me by telephone at any telephone number associated with the patient, including wireless telephone numbers, which could result in charges to me. Elevation Rehab, LLC may also contact me by sending text messages or emails, using an email address I provide. Methods of contact may include using pre-recorded or artificial voice messages and/or the use of an automatic dialing device.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I have been given a copy of Elevation Rehab's, LLC Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Elevation Rehab, LLC has the right to change this Notice at any time. I may obtain a current copy by contacting Elevation Rehab's, LLC Privacy Officer. This can be done by calling (919)-823-1606, ext. 1016.

RELEASE OF MEDICAL INFORMATION AUTHORIZATION: I authorize Elevation Rehab, LLC to release any or all of my medical information to any person or entity needed for treatment to physicians, or entities that provide direct or indirect medical services to me while I am a patient of Elevation Rehab, LLC.

I authorize Elevation Rehab, LLC to release my medical information to the following individuals:

1) Name: ______________________ Relationship: ______________

2) Name: ______________________ Relationship: ______________

I, the undersigned, acknowledge that I have read and understand each section of this document.

Patient Name (Print): ______________________________

Medical Power of Attorney Name (Print): ______________________________

Patient/Medical Power of Attorney Signature: ______________________________

Date: ______________

If correspondence has been received from the Insurance Verification department indicating Medicare is the secondary payer due to an open case & the case should be CLOSED, the patient/POA must contact Medicare at 855-798-2627 to close the case.

Date Case Closed with Medicare: ____________________ Name of Patient/POA: ____________________________________

Signature of Patient/POA: ____

If correspondence has been received from the Insurance Verification department indicating Medicare is the secondary payer due to an open case and the case is still OPEN, please provide detailed information:

Who is the case open for? Self or spouse ____ DOB: _______________

Name of Primary Payer: __________________________________ Telephone Number: _______________________________

Policy No. ____

Medicare Secondary Payer Questionnaire

Patient's Name: ______________________ Date of Birth: __________ Today's Date: ____________

1) Is Patient employed currently? YES or NO *If NO, skip to question 3
2) Does Patient's present or former employer offer health insurance? YES or NO *If NO, skip to question 3

Patient Occupation: ______________________ Employer Name: ______________________

Employer Address: ____

Group Health Plan: ________________ Address: ______________________________

Policy #: ______________________ Group ID: ______________________

3) Do you have group health plan (GHP) coverage based on your spouse's or parent's current or former employment? YES or NO

*If YES, does the employer that sponsors your spouse's or parent's GHP employ 20 or more employees? YES or NO

*If YES, GHP is Primary:

Group Health Plan: ______________________ Insured Name: ____________________

Address: ______________________ Relationship to Patient: ________________

Group ID No. : ______________________

4) Was your illness/injury due to a work-related accident/condition? YES or NO If yes, Date of Injury/Illness: __________

*If YES, Name & address of Workers Compensation Plan: ______________________________

______________________ Policy or ID Number: ____________________

Name & Address of Employer: ______________________________________

5) Was your illness/injury due to a non-work-related accident? YES or NO

*If YES, date of accident: ________________ State in which accident occurred: ____________

6) What type of accident caused the illness/injury? ____Automobile ____Non-automotive

Name & Address of no-fault or liability insurer: ______________________________________

____

Insurance Claim No.: ________________ No-Fault insurer is primary payroll only for those claims related to accident

7) Are you entitled to Medicare based on disability? YES or NO *Unless otherwise indicated, Medicare is primary.

8) Are you receiving Black Lung (BL) Benefits? YES or NO If YES, date benefits began: __________ *claims related to BL only

9) Have you received a kidney transplant? YES or NO *If YES, date of transplant: ____________________

10) Have you received maintenance dialysis treatments for End State Renal Disease (ESRD)? YES or NO

If YES, date dialysis began: ____________________

11) Are you within the 30-month coordination period for ESRD Medicare Benefits? YES or NO