FRANCISCAN VILLA

Post Acute Care • Long Term Care • Assisted Living

Welcome to ***Franciscan Villa,***

At ***Franciscan Villa***, our mission is to enrich the lives of those we serve with compassion, respect, excellence, and integrity – giving care from the heart. Our community and the entire SkyBlue Health Care organization are committed to listening to our customers and putting the needs of our residents first while celebrating life each and every day.

Franciscan Villa is a personable place where people truly care for each other. Being responsive to your needs is a top priority. Your executive director and community staff are available and will communicate openly in order to better understand your needs and meet your expectations. We ask that you do your part to continuously help maintain a warm, friendly atmosphere. Please familiarize yourself with the Residents Rights and Responsibilities included in this packet.

On behalf of the entire ***Franciscan Villa*** family, we welcome you and yours. Please let us know if there is anything we can do to make your experience more enjoyable.

Sincerely,

Franciscan Villa

Executive Director

INFORMATION SHEET

Facility Name: Franciscan Villa 17110 E 51st Broken Arrow, OK 74012					Telephone: 918-355-1596
Primary Payor:		Secondary:			Res. Number
Resident:					
First Name	M.I.	Last Name	Race	Sex	Religion
Address		Suite/Apt	City	State	Zip
County	Citizenship	Phone number	Age	DOB	Marital Status M S D W Sep
Birthplace	Date Admitted	Time Admitted	Room No.	Previous Adm. Date	Previous Adm. No.
Spouse: Last Name	M.I.	First Name	Phone Number	Occupation	

Responsible Party	Relationship		**Next of Kin**	Relationship	
Address	Apt/Suite		Address	Apt/Suite	
City	State	Zip	City	State	Zip
Home Phone	Cell Phone		Home Phone	Cell Phone	
Work Phone	E-mail		Work Phone	E-mail	

Physician Dr. Joseph Moore	E-mail		**Alternate Physician**	E-mail	
Address 17110 E 51st	Apt/Suite		Address	Apt/Suite	
City Broken Arrow	State OK	Zip 74012	City	State	Zip
Work Phone 918-276-0521	Cell Phone		Work Phone	Cell Phone	

Dentist	E-mail		Podiatrist	E-mail	
Address		Apt/Suite	Address		Apt/Suite
City	State	Zip	City	State	Zip
Work Phone	Cell Phone		Work Phone	Cell Phone	

Church	E-mail		Mortuary	E-mail	
Address		Apt/Suite	Address		Apt/Suite
City	State	Zip	City	State	Zip
Work Phone	Cell Phone		Work Phone	Cell Phone	

Pharmacy	E-mail		Medicare #
Address		Apt/Suite	Medicare Part B
City	State	Zip	Medicaid #
Work Phone	Cell Phone		Social Security #

Hospital			Other SNF Stay		
Name	Phone		Name	Phone	
Admitted	Discharged		Admitted	Discharged	
Address			Address		
City	State	Zip	City	State	Zip

Other Health Insurance Company Information							
Resident				**Spouse**			
Address			Apt/Suite	Address			Apt/Suite
City	State	Zip		City	State	Zip	
Plan	Group	Certificate		Plan	Group	Certificate	
Company	Phone			Company	Phone		

Discharged to			Other information	
Name	Phone		Allergies	Allergies
Discharge Date	Discharge Time		Allergies	Allergies
Address			Primary Diagnosis	Other Diagnosis
City	State	Zip	Other Diagnosis	Other Diagnosis

Please check if YES (a copy should be provided)			
Advanced Directives	Medical Power of Attorney	Consent/Treatment	OOHDNR
Legal Guardianship	Directions to Physician	Mental Health Declaration	Financial Power of Attorney
Organ Donor	Full Code		

Appointment of Representative

Name of Party		
First Name	M.I.	Last Name

Medicare Number (beneficiary as party) or National Provider Identifier Number (provider as party)	

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider, or the supplier):

I appoint this individual _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Section 2: Acceptance of Appointment

To be completed by the representative:

Signature of Party Seeking Representation		Date
Address		Phone Number
City	State	Zip

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of DHHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a) (2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of DHHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of DHHS (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination, or decision if you are requesting an initial determination or decision. If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227). TTY users please call 1-877-486-2048.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: **AltFormatRequest@cms.hhs.gov**.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

STATEMENT OF RESIDENT RIGHTS

You, the resident, do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Any violation of these rights is against the law. It is against the law for any nursing facility employee to threaten, coerce, intimidate, or retaliate against you for exercising your rights.

If anyone hurts you, threatens to hurt you, neglects your care, takes your property, or violates your dignity, you have the right to file a complaint with the facility administrator or with the Oklahoma Department of Human Services by calling **1-877-787-8999**

You have a right to:

1. all care necessary for you to have the highest possible level of health.
2. safe, decent, and clean conditions.
3. be free from abuse and exploitation.
4. be treated with courtesy, consideration, and respect.
5. be free from discrimination based on age, race, religion, sex, nationality, or disability and to practice your ownreligious beliefs.
6. privacy, including privacy during visits and telephone calls.
7. complain about the facility and to organize or participate in any program that presents residents' concerns to the administrator of the facility.
8. have facility information about you maintained as confidential.
9. retain the services of a physician of your choice, at your own expense or through a health care plan, and to have a physician explain to you, in language you understand, your complete medical condition, the recommended treatment, and the expected results of the treatment, including reasonably expected effects, side effects, and risks associated with psychoactive medications.
10. participate in developing a plan of care, to refuse treatment, and to refuse to participate in experimental research.
11. a written statement or admission agreement describing the services provided by the facility and the related charges.
12. manage your own finances or to delegate that responsibility to another person.
13. access money and property, you have deposited with the facility and to an accounting of your money and property that are deposited with the facility and of all financial transactions made with or on behalf of you.
14. keep and use personal property, secure from theft or loss.
15. not be relocated within the facility, except in accordance with nursing facility regulations.
16. receive visitors.
17. receive unopened mail and to receive assistance in reading or writing correspondence.
18. participate in activities inside and outside the facility.
19. wear your own clothes.
20. discharge yourself from the facility unless you have been adjudicated mentally incompetent.
21. not be discharged from the facility, except as provided in the nursing facility regulations.
22. be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat your medical symptoms.
23. receive information about prescribed psychoactive medication from the person who prescribes the medication orthat person's designee, to have any psychoactive medications prescribed and administered in a responsible manner, as mandated by the Health and Safety Code, §242.505, and to refuse to consent to the prescription of psychoactive medications; and
24. place an electronic monitoring device in your room that is owned and operated by you or provided by your guardian or legal representative.

Your rights may be restricted only to the extent necessary to protect you or another person from danger or harm or to protect a right of another resident, particularly those relating to privacy and confidentiality.

Facility Rep. Signature:	**Facility Rep Name**	**Title:** Admissions Director	**Date:**
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

Admissions & Financial Agreement

Franciscan Villa located at 17110 E Omaha St., Broken Arrow, OK 74012 is a licensed long term care facility and does enter into this Nursing Facility Admission and Financial

Agreement ("Agreement") with_____(Responsible Party/Resident)

to provide long term care for _____(Resident) under the terms and conditions set forth below.

1. Responsible Party

Resident authorizes Responsible Party to be his/her agent. Responsible Party herein is:

☐ court appointed legal guardian of Resident.

☐ attorney in fact for Resident under a durable power of attorney

☐ family member **(specify)** _____

☐ other individual authorized by Resident.

☐ Self

2. Authority

Resident authorizes Responsible Party to make (check all that apply):

☐ financial decisions

☐ medical decisions (Facility has been provided with a medical power of attorney, advance directive to physicians or another appropriate instrument)

☐ admission, care, and discharge decisions

☐ other decisions related to Resident's personal property and well-being.

Responsible Party shall be Facility's primary contact person for Resident outside Facility.

3. Nondiscrimination

Facility provides care on a non-discriminatory basis so that all residents are admitted and receive benefits and services withoutregard to race, religion, color, national origin, age, sex, disability, marital status, or source of payment.

4. Nursing Care

Facility shall provide twenty-four (24) hour nursing and personal care to Resident.

5. Room & Board

Facility shall provide room and board to Resident.

6. Physician

A. A physician shall personally approve in writing a referral order to admit Resident to Facility. A physician shall provide documentation of an initial medical evaluation, including history, physical examination, diagnoses and an estimate of discharge potential and rehabilitation potential within seventy-two (72) hours of admission. Resident shall remain under the care of a physician throughout the stay in Facility.

B. Resident/Responsible Party designates:

Physician Name:	Telephone No.
Dr. Joseph Moore	918-276-0521

to serve as Resident's Attending Physician and requests that Facility contact this physician or his/her designated alternate whenever medical services are necessary. Attending Physician shall be one who agrees to see Resident either by visitation in facility or through office visits. Resident/Responsible Party further authorizes Facility to obtain on behalf of Resident the services of any other physician licensed to practice medicine in this state, at Resident's sole expense, whenever, in Facility's discretion, medical services are required, and the Attending Physician is not available. Resident/Responsible Party is responsible for payment of physician's fees.

C. Resident shall be seen by a physician at least once every 30 days for the first ninety (90) days after admission, and at least once every sixty (60) days thereafter.

D. In case of emergency or if medical orders cannot be obtained upon admission, Facility's Medical Director may give temporary orders until Resident's Attending Physician is available.

7. Authorization

Resident/Responsible Party hereby authorize and direct Facility to provide such services are required for Resident's well-being,health and safety as Facility and Resident's physician in their discretion deem appropriate.

8. Transportation

Where alternate means of transportation are not available, Facility shall transport Medicaid Residents to the Medicaid medical provider of choice in the service area for physician ordered non-emergency medical services, including routine ambulance services involved in the certification or re-certification of Resident. If no Medicaid provider is in the service area, Facility shall provide transportation to the nearest Medicaid provider chosen by the Resident. Non- emergency ambulance transport of severely disabled Medicaid residents to and from scheduled medical appointments, who cannot be transferred by other means without endangering their health and safety, shall be billed to Medicaid upon receipt of prior authorization from the Oklahoma Department of State Health Services or its designee. Charges for emergency ambulance services for Medicaid residents shall also be billed to Medicaid.

Upon request, Facility shall transport or arrange for the transport of non-Medicaid residents to their medical and health care providers at Facility's standard rates for such services.

9. Dental Services

Facility will obtain the name of Resident's preferred dentist and record it in the clinical record. Facility will maintain a list of local dentists for residents who request dental services but have not selected a dentist. At least annually, Facility will ask Resident/Responsible Party if a dental examination is desired at Resident's expense and will make reasonable efforts to arrange for a dental examination if one is desired. Covered emergency dental services provided to Medicaid residents will be billed to Medicaid.

10. Prescription & Pharmacy Services

A. Resident/Responsible Party designates **(Pharmacy)** as Resident's pharmacy provider of choice. This pharmacy shall be duly licensed in the State of Oklahoma and qualified to provide pharmacy services consistent with applicable state and federal regulations. The pharmacy shall agree to provide services on a 24-hour basis for emergency medications, deliver medications to Facility on a timely and reasonable basis, packaged and labeled in accordance with Oklahoma State Board of Pharmacy laws and regulations. In the absence of a designated pharmacy, Facility is authorized to use a duly licensed pharmacy of its choice, including one operated by an affiliate of Facility. Resident has the right to be informed of prices before purchasing items or services from Facility except in an emergency.

B. Facility shall not charge Medicare residents for over-the-counter drugs.

C. Facility shall not charge Medicaid recipients for over-the-counter drugs, non-legend drugs (with the exception of insulin), alcoholic beverages prescribed for medicinal purposes or for legend drugs not covered by the Medicaid Vendor Drug Program. Generic name medications may be used unless otherwise ordered, in writing, by a physician, or other individual authorized to prescribe under Oklahoma law.

D. All medications must be prescribed by a licensed physician, dentist, or other individual authorized by

Oklahoma law to prescribe. All medications must be administered according to Resident's assessment. Medications shall be administered by qualified staff unless Facility's interdisciplinary team determines that practice of self-administration by Resident is safe.

11. Ancillary Services

Resident/Responsible Party shall pay for diagnostic, consultant, laboratory, therapeutic and rehabilitative services ordered by Resident's physician and received by Resident which are not covered by Medicaid, Medicare, or other third-party payment plan.

12. Medical Supplies & Equipment

A. Medical accessories and equipment prescribed by Resident's physician and required to provide treatment ordered by Resident's physician such as: cannulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids and equipment, wheelchairs, crutches, canes, walkers, trapeze bars, mattresses and hospital type beds, enteral pumps and oxygen equipment are paid by Medicaid for Medicaid residents, Resident/Responsible Party shall pay for medical equipment and accessories for non-Medicaid residents when not covered by Medicare or other third party payer.

B. Medical supplies such as band aids, cotton balls, alcohol, swabs, and tongue depressors are also included in Facility's Basic Charges. Other medical supplies will be billed to Resident/Responsible Party or, if applicable, Resident's Medicaid, Medicare, or third-party provider

C. Resident/Responsible Party shall pay for routine services, appliances, and equipment (such as eyeglasses, hearing aids and medical equipment) requested and received by or on behalf of Resident and requested for convenience rather than medical need which are not covered by Medicaid, Medicare, or other third-party payment plan.

13. Personal Items & Services

Routine personal hygiene items and services are included in Facility's Basic Charges. Resident/Responsible Party shall pay for personal items and services not covered in Facility's Basic Charges such as: specific name brand items not furnished by Facility, cosmetics and grooming items and services in excess of those covered by Medicaid or Medicare, privately hired nurses, aides, and sitters, personally used televisions, radios, telephones and reading materials, gifts, smoking materials, and other personal comfort items.

14. Passes

Resident may leave Facility for therapeutic home visits on passes with permission of Resident's Attending Physician and (if applicable) Responsible Party. Facility administration shall be notified of all passes in advance and Resident shall be signed out at the nurse's station when leaving and upon return. Resident's medication may accompany Resident with an order from Resident's Attending Physician and unused medication shall be returned to the charge nurse upon return to Facility.

15. Hospital Transfers

If a physician orders Resident transferred to a hospital, Facility shall arrange to have Resident transferred and notify Responsible Party of the transfer.

16. Bedhold Policy

Upon request, Facility shall hold Resident's bed when Resident is away from Facility for hospitalization or therapeutic home visit, as long as the applicable bedhold fee is paid. The daily bedhold fee is the current daily charge for the Resident's bed. Medicaid will pay the bedhold fee during therapeutic home visits for Medicaid residents of up to three days.

17. Guardianship

If the mental condition of Resident becomes such that Resident is unable to make or communicate responsible decisions concerning Resident's person or estate, and the Resident has no healthcare and/or financial power of attorney, persons executing this Agreement other than Resident shall petition the appropriate court to appoint a guardian of the person and/or estate. The estate and/or potential guardian shall bear the costs associated with those proceedings. Resident and any of Resident's fiduciary parties acknowledge that the Facility shall have no responsibility to undertake guardianship proceedings and shall not be responsible for any injury or loss to Resident caused by a party's failure to undertake such proceedings. In the event Resident becomes mentally incompetent and has failed to designate a financial power of attorney or other legal representative, the Facility may petition the applicable court to appoint a public guardian to ensure that Resident's financial affairs are handled independently and for Resident's best interest and shall be reimbursed by Resident or any of Resident's fiduciary parties for all such costs and attorney(s) fees incurred.

18. Advanced Directives/ Health Care Power of Attorney/ Living Will

Prior to occupancy of the Resident's room, Resident shall provide the Facility, if applicable, with a fully executed copy of a health care power of attorney for Resident, living will or other advance directive, an Oklahoma approved Do Not Resuscitate order, and/or fully executed copy of a financial power of attorney. Under Oklahoma law, an agent is liable if he/she acts under a power of attorney and breaches his/her fiduciary duty to Resident. The Facility will hold Resident's financial power of attorney liable for (i) failing to provide necessary financial information to the state of **Oklahoma** and/or the Facility to get Resident approved for Medicaid or (ii) causing a denial of Resident's Medicaid application as a result of the power of attorney's failure to respond and/or provide the requested information to Medicaid.

19. Recoupment of Fees

The parties agree that the Facility is entitled to all costs of collection of unpaid charges and any other fees incurred by Resident for the enforcement of this agreement, including but not limited to court costs, reasonable attorneys' fees, and any collection fees that the Facility incurs in collecting on delinquent accounts. The Facility is also entitled to attorneys' fees in connection with the general enforcement of this agreement.

20. Transfer & Discharge

If Resident is transferred from Facility or is on a therapeutic home leave (in excess of three days for Medicaid residents), without arranging for a bedhold, Facility shall process the discharge of Resident. If Resident desires to be readmitted after discharge, Resident shall be treated as a new applicant for purposes of admission. Medicaid residents who are medically eligible shall be re- admitted to the first available bed.

Except in an emergency, Resident shall not be transferred or discharged without prior consultation with Resident, Resident's Attending Physician and/or Responsible Party and written notification describing the reason(s) for the transfer or discharge and Resident's right to appeal the transfer or discharge. Resident may be transferred or discharged if:

A. necessary for Resident's welfare and Resident's needs cannot be met in Facility;
B. Resident no longer needs services provided by Facility;
C. Resident is endangering the safety of persons in Facility;
D. Resident is endangering the health of other individuals in Facility;
E. Resident fails, after reasonable and appropriate notice, to pay, or have paid under Medicare or Medicaid for goods and services provided by Facility;
F. Facility ceases to operate as a nursing facility and no longer provides resident care; or
G. Resident, Resident's Responsible Party or family or legal representative requests a voluntary transfer or Resident has not resided in Facility for 30 days.

Written notice will be given to Resident/Responsible Party for all planned discharges and transfers. Unless waived in writing by the Resident/Responsible Party, thirty (30) days written notice will be given for discharges and transfers planned pursuant to subsection "A", unless the resident's urgent medical needs require an immediate transfer or discharge. Unless waived by the Resident/Responsible Party, thirty (30) days written

notice will be given for discharges and transfers planned pursuant to subsection "E" and sixty days written notice will be given for transfers and discharges planed pursuant to subsection "F", above. All other discharges will be made as soon as practicable.

21. Relocation within Facility

Except in an emergency, Facility shall give Resident/Responsible Party two days advanced notice of relocation to another room. The notice will explain the reason(s) for the relocation, the effective date and the room to which Resident is being relocated.

22. Facility Charges

A. Items and services included in Facility's Basic Charges:

- nursing services
- medically related social services
- dietary services, including a dietary consultant and the provision of regular, special, and supplemental diets, including tube feedings, as ordered by the physician.
- over the counter drugs
- regular laundry service (except dry cleaning)
- room and bed, including housekeeping and maintenance services.
- basic personal hygiene items and services
- linens and bedding
- management of resident funds in a Facility-based personal account
- assistance in obtaining dental services.
- activities program.

B. Items and services that are **not** included in Facility's Basic Charges may be charged to Resident/Responsible Party if not covered by Medicaid. Medicare or another third-party payer. The following items are not included in Basic Charges:

- prescription drugs
- beautician or barber services (in excess of services covered by Daily Rate)
- therapies – physical, occupational, speech, respiratory
- medical, optometric, dental, geropsychiatric and other ancillary services
- laboratory, x-ray, and diagnostic services
- dry cleaning services outside the Facility
- hospitalization expenses (including emergency room fee)
- ambulance and other emergency medical transportation
- transportation for medical appointments or hospital stays (non-Medicaid residents)
- other (non-medical) transportation
- clothing
- telephone/television and/or radio for personal use

23. Billing Charges & Refunds

A. Facility, a Medicaid certified nursing facility, accepts applicable Medicaid payment for residents who are financially and medically eligible for Medicaid. In the event that Medicaid does not pay Basic Charges for reimbursable items and services for any reason, Resident/Responsible Party shall pay Facility the current applicable rate for Basic Charges for the non- covered days of service and any additional items and services provided to Resident.

B. Medicaid eligible residents must pay or arrange to have paid to Facility applied income, including but not limited to Social Security. Payment shall be made monthly on or before the 5th day of the month.

C. If unable to pay for goods and services provided pursuant to this Agreement, Resident/Responsible Party shall apply without delay for all available federal and/or state assistance. Responsible Party shall provide Resident and Facility with any and all assistance required to complete such application.

D. Facility assists residents in applying for Medicaid and may assist Resident in applying for any other

available public assistance. Resident/Responsible Party shall continue to pay Facility pursuant to this Agreement and applicable law while any applicationfor Medicaid is pending, and unless and until eligibility is determined and retroactive adjustment is required.

E. When Resident is not financially eligible for Medicaid, Resident/Responsible Party shall pay the rate of $275 for a semi-private room per day to cover Basic Charges associated with caring for Resident and shall pay for all other reimbursable items and services provided to Resident not covered in Facility's Basic Charges or reimbursed by a third-party payer. Resident/Responsible Party shall pay Basic Charges for the first month at the time of admission. Basic Charges and any additional amounts due for reimbursable items and services shall be billed on a monthly basis following admission and are due and payable within 30 days to the facility.

F. Facility may increase or decrease the Basic Charges rate at any time with advance written notice.

G. Upon request, Resident/Responsible Party shall receive a refund of any unearned portion of the Basic Charges to which Resident is entitled, provided all terms of this Agreement have been met. All refunds shall be made within thirty (30) days following discharge.

H. Unless other arrangements are made, accounts which are not paid by the **5th** of each month shall be charged interest at the rate of ten percent (10%) per annum until paid.

I. Resident/Responsible Party shall assign to Facility the right to receive payment for any unpaid charges for goods and services that Facility is authorized to bill to residents.

J. Resident/Responsible Party shall not take any action, including but not limited to setting up a trust, purchasing an annuity or otherwise transferring resources of Resident, that will divest Resident of assets or income or impair Resident's/Responsible Party's ability to comply with this Agreement.

24. Personal Belongings

Resident/Responsible Party shall complete, and sign Facilities written inventory form listing Resident's personal belongings at the time of admission. An original inventory shall/will be retained by Resident/Responsible Party as a receipt and a copy will be kept with Resident's records. Additions and deletions to the inventory shall be brought to the attention of Facility's Administration so that records are current. Resident/Responsible Party may ask Facility to accept Resident's personal property items for safekeeping. Facility assumes no liability for the security of personal items retained by Resident or kept in Resident's room. All articles retained by Resident, (including dentures, hearing aids, eyeglasses, jewelry, and documents) shall be the responsibility of Resident. At the time of transfer or discharge, Facility shall be accountable only for Res ident's personal property items Facility has accepted for safekeeping. All personal property must be removed within 72 hours of discharge unless alternate written arrangements are made with Facility Administration.

25. Obligations of Resident/ Responsible Party

Resident Responsible Party Shall:

A. Provide spending money for Resident on an as needed basis.

B. Provide wash and wear clothing, properly labeled, and marked in sufficient quantities for Resident to maintain a neat appearance.

C. Pay, out of Resident's funds and resources, all reimbursable items and services relating to Resident's care not covered in Facility's Basic Charge and not reimbursed by Medicaid, Medicare, or other third-party payor.

D. To the extent possible, assist in transfer and transportation of Resident.

E. Refrain from bringing into Facility items not permitted for Resident. (See list provided by Facility.)

F. Abide by Facility rules and regulations, as provided to Resident/Responsible Party upon admission and as amended from time to time.

G. Abide by rules and regulations established by licensing and contracting agencies as to charges, refunds, supplies,equipment, and medicine.

26. **Special Arrangements/Grant of Authority**

[Check appropriate box]

A. **Professional Services:** Resident/Responsible Party

☐ Authorizes

☐ Does not authorize
Visits by dentists, oral hygienists, podiatrists, physical therapists, respiratory therapists, and others deemed necessary for rendering care to Resident by physician upon written permission of Resident's Attending Physician with professional service fees billed directly to Resident's account.

B. **Medical Records:** Resident/Responsible Party

☐ Authorizes

☐ Does not authorize
Facility to release medical information when required for completing insurance claims and government benefit claims.

C. **Laundry:** Resident/Responsible Party

☐ Authorizes

☐ Does not authorize
Facility to launder the residents personal articles of clothing.

D. **Assignment of Benefits:** Resident/Responsible Party

☐ Authorizes

☐ Does not authorize
Facility to receive benefit payments directly from Medicaid, Medicare or another third-party payer.

E. **Patient Identification** Resident/Responsible Party

☐ Authorizes

☐ Does not authorize
Facility to photograph Resident for medical and identification purposes.

F. **Press Release** Resident/Responsible Party

☐ Authorizes

☐ Does not authorize
Facility to use name and photograph and or video recording of Resident in Facility publications in print, video, and/or in any digital form.

MISCELLANEOUS

A. Acknowledgment of Rights and Responsibilities of Resident.

Resident/Responsible Party acknowledges receipt of Facility's admission policies, rules and regulations and statement of Resident Rights. Facility reserves the right to revise the policies and statement of rights as required from time to time in order to comply with applicable laws and regulations.

By signature below, the Resident/Responsible Party acknowledges that Facility has informed Resident/Responsible Party orally or in writing of:

- Resident's rights and all rules and regulations governing resident conduct and responsibilities,
- The rights and responsibilities contained in the Oklahoma Human Resources Code, Title 6, Chapter 102, and the Social Security Act;
- The services available through the Department of Aging and Disability Services Office of the state long term care ombudsman.
- Oklahoma Department on Aging and Facility's resident care policies and statement of Resident Rights;
- Information regarding advance directives and Resident's right to make decisions about medical care;
- Department of Aging and Disability Services rules and Facility policies for the use of restraints and involuntary seclusion;
- Facility's policy for drug testing of employees who have direct contact with residents;
- Facility's policy for criminal history checks of employees and applicants;
- Protection of Resident Funds policy; and Facility's Private Practices

B. Contributions, Donations and Gifts.

Contributions, donations and/or gifts made to Facility by a governmentally assisted resident, his or her Responsible Party or family are given solely at their discretion, and in no way affect the eligibility for admission or availability of or access to the normal services provided to all residents. Facility does not solicit or in any way require such contributions, donations and/or gifts.

C. Termination.

This Agreement may be terminated by Resident/Responsible Party or by Facility upon appropriate written notice, pursuant to the transfer and discharge provisions in this Agreement, or by mutual agreement.

D. Liability.

Facility shall exercise such reasonable care toward Resident as his/her known condition(s) may require,however, Facility shall not be liable for injuries or damages sustained by Resident of any kind unless caused by the willful act or negligence of Facility or its staff. Facility is not an insurer of the health and safety of Resident and assumes no liability as such. Facility shall not be responsible for Resident when Resident is on leave from Facility.

E. Governing Law

This Agreement shall be interpreted, construed, and governed under the laws of the State of Oklahoma and is performable in Tulsa, Oklahoma.

F. Notices

Any and all notices required or permitted to be given under this Agreement shall be sufficient if furnished in writing, sent by email, or certified mail addressed as follows or at such other address as a party may, from time-to-time, notify the other in writing.

To Facility: Franciscan Villa C/O Administrator 17110 E Omaha St., Broken Arrow, OK 74012		
To Resident/Responsible Party: Address	Apt/Suite	Email
City	State	Zip

G. Entirety of This Agreement

Except as provided herein, this Agreement, and all attachments, supersedes all other agreements, either oral or in writing, between the parties, and contains all of the covenants and agreements between the parties. Each party to this Agreement acknowledges that no representations, inducements, promises, or agreements, orally or otherwise, have been made by any party or anyone acting on behalf of any party, that are not embodied in this Agreement and, except as provided herein,that no other agreement, statement, or promise shall be valid or binding. This Agreement may be amended only by mutualagreement, reduced to writing and signed by both parties.

H. Amendment Due to Reimbursement Changes

If the governmental agencies who administer Medicare or Medicaid, or any other payor, or any other federal, state or local government or agency adopts any law, rule, regulation, standard or interpretation at any time while this Agreement is in effect which affects the method or amounts of reimbursement or payment for services rendered under this agreement, or which otherwise materially affects the obligations of Facility, Facility may give Resident/Responsible Party notice of its intent to amend this Agreement or, if applicable, increase charges in a fashion that is equitable and reasonable in order to comply with the change in government law, rule, regulation, or standard or interpretation.

I. Savings Clause

In case any one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal,or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other part of the Agreement and this Agreement shall be construed as if such invalidity or unenforceable provision has never been contained herein.

By my signature below,
I have read and agree to abide by Admissions & Financial Agreement as explained to me and provided above, as well as all federal and applicable state laws.

Facility Rep. Signature:	**Facility Rep Name**	**Title:** Admissions Director	**Date:**
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

ARBITRATION AGREEMENT BETWEEN FACILITY AND RESIDENT

This agreement ("Arbitration Agreement") is made on this _____**Date** between **Franciscan Villa** (**"the Facility"**), and _____ (the **"Resident"**). As appropriate,the term "Resident" includes the resident's guardian, attorney in fact, or any person acting as the resident's authorized legal representative. The term "Facility" includes the facility where the Resident resides, its parents, affiliates, and subsidiary companies, owners, officers, directors, medical directors, employees, successors, assigns, agents, attorneys, and insurers. This agreement shall apply to any and all residencies of the Resident as of the beginning of the Resident's residency.

RECITALS

(A) This Arbitration Agreement shall constitute an integral part of Resident's underlying admission and/or continued residency at the Facility;

(B) This Arbitration Agreement is not a condition to the rendering of health care services by any party;

(C) Resident acknowledges that he/she has read this Arbitration Agreement, has been provided with adequate time to review this Arbitration Agreement, and understands the terms of Arbitration Agreement;

(D) This Arbitration Agreement was executed by and/or on behalf of Resident as the recipient of health care services at theinception of or during the term of provision of services for a specific cause by a nursing home;

(E) Except as stated herein, this Arbitration Agreement does not and will not limit, impair, or waive any substantive rights or defenses of any party, including the statute of limitations;

(F) This Arbitration Agreement does not and will not limit, impair, or waive the procedural rights of any party to be heard, to present material evidence, to cross-examine witnesses, and to be represented by an attorney, or other procedural rights of due process of any party;

(G) This Arbitration Agreement shall constitute a mutual promise to arbitrate, binding on both the Facility and the Resident, and requiring the Parties to arbitrate any and all claims falling within the scope of this agreement; and

(H) This Arbitration Agreement shall not require the parties to compel arbitration at a specific time and the parties' right to compel arbitration shall not be considered waived unless the parties agree in writing to such waiver.

(I) This Arbitration Agreement shall allow a selection of meeting venue that is convenient to both parties.

SECTION ONE. SUBMISSION OF CLAIM TO BINDING ARBITRATION

In the event of any claim arising out of (1) any dispute between the Facility and the Resident; (2) any dispute relating to services rendered for any condition; (3) injuries alleged to have been received by patient; (3) death of patient due to negligence or other wrongful act, but not including intentional torts; (4) services rendered for any condition and arising out ofthe diagnosis, treatment or care of patient; and (5) collection proceedings in excess of $50,000.00 (hereinafter referred to as "Covered Claim"), the claim will be submitted to mandatory mediation and binding arbitration pursuant to the provisions ofthis Arbitration Agreement.

This Arbitration Agreement shall bind claims arising out of the above referenced claims and brought pursuant to a survival claim or claim brought pursuant to a survival act of any State and shall be submitted to mandatory mediation and binding arbitration pursuant to the provisions of this Arbitration Agreement.

A written notice of demand for arbitration must be accompanied by a statement of the claim and cause of action, which must be substantially similar in the form to a complaint filed in a court of competent jurisdiction for such a claim. Service of the notice and statement may be by any method authorized for service of complaints in the State of Oklahoma, or by mail, to the defendant, or, if a corporation, the registered agent of the defendant.

This agreement does not apply to the following legal actions: (1) collection proceedings for values under $50,000.00, (2) involuntary discharge proceedings, (3) the establishment and administration of a probate estate (including both disabled estates and decedent estates), (4) petitions for guardianship, and (5) health care liens.

SECTION TWO. MANDATORY MEDIATION

Any Covered Claim for which a demand for arbitration has been made shall first be subject to mandatory non-binding mediation. Within thirty (30) days after a party to this Arbitration Agreement has given written notice of demand for arbitration to all other parties of this agreement of a claim for damages arising out of a Covered Claim, the parties will jointly select a mediator. If the parties cannot agree on the selection of a mediator within thirty (30) days, any party may apply to acourt of competent jurisdiction for the selection of a mediator. The mediator will conduct, and the parties will participate in, a non-binding mediation session within a reasonable amount of time from the date of selection of the mediator. Any claim or controversy that remains unresolved after the conclusion or termination of the mediation shall be settled by binding arbitration in accordance with this Arbitration Agreement.

SECTION THREE. SELECTION OF ARBITRATOR

If any unresolved matter remains after the conclusion of the mandatory non-binding mediation, the parties will select a single,neutral, arbitrator within thirty (30) days after the conclusion of the non-binding mediation. Nothing shall bar the parties from selecting the mediator to proceed over the arbitration. The selection of the arbitrator shall be confirmed in writing by the parties.

If the parties cannot agree on the selection of a neutral arbitrator within thirty (30) days after termination of the non-binding mediation, any party may apply to a court of competent jurisdiction for the selection of a neutral arbitrator. The arbitrator will hold a hearing within a reasonable time from the date of notice of selection of the arbitrator.

The parties hereby agree to be bound by any such decision rendered in connection with any matter decided by arbitration, and expressly waive their rights to initiate legal proceedings in any other matter, and further agree that arbitration shall be their sole and exclusive remedy. The parties agree and acknowledge that they are waiving their right to a trial by jury and to have their case heard in a court of law. Any award of the arbitrator may be entered as a judgment in any court having jurisdiction.

SECTION FOUR. EXPENSES OF MEDIATION AND ARBITRATION

In consideration for the execution of this Arbitration Agreement, the Facility agrees to pay up to $5,000.00 of the Resident's mediation and arbitration costs and out-of-pocket expenses relating to mediation and arbitration. The Resident further waives any and all right to the collection of applicable Statutory attorney's fees and/or punitive damages pursuant to any applicable jurisdiction. All remaining expenses of mediation and arbitration shall be apportioned equally among the Parties and all remaining costs and fees associated with prosecuting and defending any claims herein shall be borne by each party.

SECTION FIVE. RIGHT OF CANCELLATION

This Arbitration Agreement may be cancelled by any signatory within thirty (30) calendar days of its execution. Said cancellation must be delivered to the other party in writing.

SECTION SIX. ADDITIONAL PARTIES

By consent of all parties to an arbitration proceeding commenced under the provisions of this agreement, a person, corporation, or entity not a signatory to this agreement may be invited to participate in and be bound by this Arbitration Agreement or may be accepted into this Arbitration Agreement upon an offer to participate and be bound. If an invitation or acceptance is made pursuant to consent of the parties, no signatory may refuse to arbitrate because of the participation of this additional party. An additional participant shall execute a written agreement to be bound by the arbitration proceedings and this Arbitration Agreement or will sign this Arbitration Agreement and will then be treated as a party to this Arbitration Agreement.

SECTION SEVEN. EMPLOYEES

The Facility's employees, agents, servants, officers, directors, managers, members, and shareholders are deemed to be parties to this Arbitration Agreement. No action at law may be brought by any party to this agreement against the Facility on the grounds of respondent superior for the negligence or other wrongful act of any employee of the Facility reasonably alleged to have caused the injuries on which the Resident's claim is based.

SECTION EIGHT. BINDING ADDITIONAL INDIVIDUALS

This agreement binds all parties, including, without limitation, any spouse or heirs of the Resident, any children, born or unborn, at the time of the occurrence giving rise to the claim, whose claims arise out of (1) injuries alleged to have been received by the Resident, (2) death of the Resident due to negligence or other wrongful act, but not including intentional torts, and (3) services rendered for any condition and arising out of the diagnosis, treatment or care of the Resident.

SECTION NINE. GOVERNING LAW

This Arbitration Agreement is subject to and will be governed by the Federal Arbitration Act, 9 U.S.C. §1-16 ("FAA") and the laws of the State of Oklahoma. To the extent that the FAA and laws of the State of Oklahoma are in conflict, the provisions of the FAA shall govern. All arbitration proceedings shall be conducted in the county in which the Facility is located unless otherwise agreed in writing by the parties. In rendering a decision on the merits of the claims pursuant to this Arbitration Agreement, the arbitrator shall apply the substantive and evidentiary laws of the State of Oklahoma.

It is the intent of the parties that the arbitration process be efficient and completed as quickly and inexpensively as possible while still preserving the parties' rights to a fair hearing. It is further the intent of the parties that the arbitrator may limit discovery to issues directly relating to the Resident in question and that written discovery and depositions be limited to the information necessary for a fair hearing. All claims based in whole or in part on the same incident, transaction or related course of care and services provided by facility to the Resident shall be arbitrated in one proceeding. A claim shall be waived and forever barred if it arose prior to the date upon which notice of arbitration is given to Facility or received by the Resident and is not presented in the arbitration proceeding.

SECTION TEN. GENERAL

If a court of competent jurisdiction finds any portion of this agreement void and/or unenforceable, in whole or in part, any such portion shall be deemed severed from the Arbitration Agreement and the remainder of the Arbitration Agreement shall remain in full force and effect and be binding on the parties.

The Resident understands that nothing in this agreement prevents him/her from contacting regulatory or administrative agencies in relation to services provided by the facility, and that once admitted, the Resident cannot be discharged for refusing to sign this Arbitration Agreement.

This Arbitration Agreement will continue to be valid for any stay at the Facility by the Resident, even when the Resident has been discharged and later readmitted. If an act(s) underlying a dispute is committed prior to the revocation date of this Arbitration Agreement, this Arbitration Agreement shall be binding with respect to said act(s).

Resident certifies that the Resident has read this Arbitration Agreement and has legal representation regarding thereto or has been given the right to have this Arbitration Agreement reviewed by the Resident's legal representation. The Resident has signed this Arbitration Agreement of the Resident's free will and not under duress of any nature and fully accepts the terms thereof.

By signing this Arbitration Agreement electronically, the parties agree that electronic signature is the legal equivalent of a manual/handwritten signature and consent to the legally binding terms and conditions of this Agreement. The parties agree that any signature herein or on any other document executed in connection to admission to the Facility, is as valid as if the document was signed in writing. The parties agree that no certification authority or other third-party verification is necessary to validate an electronic signature, and that the lack of such certification or third-party verification will not in any way affectthe enforceability of this Arbitration Agreement or any other document executed in connection to admission to the Facility.

The parties hereto agree and stipulate that the original of this Arbitration Agreement, including the signature page, may be scanned, and stored in a computer database or similar device, and that any printout or other output readable by sight, the reproduction of which is shown to accurately reproduce the original of this document, may be used for any purpose just as if it were the original, including proof of the content of the original writing.

SECTION ELEVEN. THE RESIDENT'S AUTHORIZED REPRESENTATIVE

If applicable, the Resident's Authorized Representative executing this document on behalf of the Resident affirms and states, under penalty of perjury under the laws of the United States of America and as provided by applicable law, that the Resident has directed, consented to and/or knowingly allowed the Resident's Authorized Representative to act on his/her behalf in executing this Arbitration Agreement, in addition to any other documents signed on behalf of the Resident for admission to the Facility, including but not limited to the Resident Admission Agreement, on the Resident's behalf.

The Resident's Authorized Representative executing this document agrees that all personal claims belonging to the Resident's Authorized Representative against the Facility, including but not limited to claims brought under a wrongful death act, shall be arbitrated in accordance to the terms set forth herein.

AGREEMENT TO ARBITRATE HEALTH CARE NEGLIGENCE CLAIMSNOTICE TO PATIENT

YOU ARE NOT REQUIRED TO SIGN THIS ARBITRATION AGREEMENT IN ORDER TO RECEIVE TREATMENT. BY SIGNING THIS AGREEMENT, YOUR RIGHT TO TRIAL BY A JURY OR A JUDGE IN A COURT WILL BE BARRED AS TO ANY DISPUTE RELATING TO INJURIES THAT MAY RESULT FROM NEGLIGENCE DURING YOUR TREATMENT OR CARE AND WILL BE REPLACED BY AN ARBITRATION PROCEDURE.

THIS ARBITRATION AGREEMENT PROVIDES THAT ANY CLAIMS WHICH MAY ARISE OUT OF YOUR HEALTH CARE WILL BE SUBMITTED TO AN ARBITRATOR, RATHER THAN TO A COURT FOR DETERMINATION. THIS ARBITRATION AGREEMENT REQUIRES ALL PARTIES SIGNING IT TO ABIDE BY THE DECISION OF THE ARBITRATOR.

Resident's Representative:

By signing this document, the Resident's Representative confirms, in that capacity as well as individually, that the he/she has read this Arbitration Agreement and had it explained, is signing this Arbitration Agreement on behalf of the Resident as well as on his/her own behalf, and that the Resident's Representative has authority to act on behalf of the Resident pursuant to a power of attorney, conservatorship, or guardianship, and has provided legal documents to the Facility supporting the Resident's Representative's authority to sign this Arbitration Agreement on behalf of the Resident.

IN WITNESS WHEREOF, the parties have executed this agreement as of the date indicated above.

Facility Rep. Signature:	**Facility Rep Name**	**Title:** Admissions Director	**Date:**
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

Indicate the relationship between the Resident's Representative and the Resident and provide copies of relevant documentation:

	Relationship		**Relationship**	**Specify Relationship**
	Conservator/Guardian		Relative	
	Surrogate Decision Maker		Other	
	Medical or Health Care Power of Attorney			

BEDHOLD AND READMISSION POLICY

After placement in the nursing home, it frequently becomes necessary for the resident to go out of the facility for brief periods of hospitalization or therapeutic home visits. It is the policy of this facility to hold beds and readmit residents as follows:

1. Private pay residents may come and go from the facility as often and for as many days as desired at any time. The room rate remains at $275 for a semi-private room as long as the bill is paid in full, the room will be held, and the resident may be readmitted to that room.

2. For Medicaid residents:
   a. On therapeutic visits the state plan allows each resident to leave the facility for up to 72 consecutive hours at any one time. The days are counted in 24-hour periods from midnight to midnight. There is no limit on the number of therapeutic visits, which can be taken by the Medicaid resident; however, these must be broken by a return to the facility for an overnight stay.
   b. When the Medicaid resident is admitted to the hospital for a period in excess of 24 hours, the Medicaid portion of the resident's bill must be paid by the resident and/or his responsible party and/or his legal representative.

The resident's bed will be reserved for him/her for as long as the bedhold charges are paid and he/she is out of the facility. Bedhold charges may be discontinued at any time if the resident, his or her responsible party and/or his or her legal representative notifies the business office and removes all personal belongings from the room.

For residents who do not hold their bed during hospitalization periods, the resident is readmitted to the facility immediately upon the first available bed in a semi-private room in the Medicaid area of the facility.

I have read and acknowledge this bedhold policy and hereby request this facility to:

__ Hold the bed for _____**(Resident)** during any stay at the facility. I agree to pay the same private rate or the Medicaid portion for each day that the resident remains out of the facility.

__ I do **not** wish to pay the bedhold charges while _____**(Resident)** is away from the facility. I am removing all personal belongings and releasing any claim to this room. I realize on readmission that it will be necessary to wait for the next available bed in the section for which the above resident requests placement.

Facility Rep. Signature:	**Facility Rep Name**	**Title:** Admissions Director	**Date:**
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

ADMISSIONS CONTRACT ADDENDUM

U.S. Medicare Beneficiary

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

Covered Services. The Medicare Program will reimburse the Facility for certain skilled services such as nursing services and certain therapies ordered by a physician. Reimbursable routine services include dietary services, activities programs, room and bed maintenance services; and customary hygiene items and services as required to meet the needs of Resident, including, but not limited to, hair hygiene supplies, comb, brush, bath soap or specialized cleansing agents when indicated to treat specials skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services (other than Beauty Shop fees), bathing and basic personal laundry.

Non-Covered Services. Resident will be required to pay certain other "Allowable Charges" which include, but are not limited to, the following:

- Fees for certain products and services not covered under the Medicare program. Such fees are identical to the fees charges to private pay Resident of the Facility for the same products and services.
- Fees for certain products and services that are more expensive than the products and services covered under the Medicare program (e.g., a private room), as requested by a Resident or Responsible Party, are not fully covered under Medicare. The fees for these more expensive products and services will be based on the difference between the Facility's fees for the products or services charges to private pay Resident and customary charges for the products and services covered under the Medicare program. The Facility will inform the individual requesting the additional or more expensive products or services that there will be a specified change for the products or services.
- Certain deductible and co-insurance amounts under the Medicare Program.

Assignment of Benefits. In consideration of services rendered and to be rendered by the Facility, Resident hereby assigns to the Facility his or her rights to reimbursement from Medicare for services rendered by the Facility and authorizes Facility to receive payments from Medicare pursuant to this assignment. Resident acknowledges that, to the extent that Medicare refuses to pay for any services rendered to him or her at the Facility, Resident shall remain personally liable for payment for these services to the extent permitted by applicable law. Resident agrees to cooperate with the Facility in collecting all proceeds due from Medicare. Resident understands that he or she is not required to assign his or her benefits to the Facility. If Resident does not wish to assign his or her benefits to the Facility now or in the future Resident can provide notice to Facility of his or her election and thereafter this section will be of no further force and effect useless Resident again elects to assign his or her benefits to the Facility.

Benefits Disallowance. If the Resident's third-party eligibility or coverage is denied or terminated for any reason, Resident and Responsible party shall pay, from Resident's assets, any and all unpaid charges for care previously rendered to the extent permitted by law.

NO CERTIFIED FACILITY MAY REQUIRE AS A CONDITION OF ADMISSION, EITHER IN ITS CONTRACT OF ADMISSION OR BY ORAL PROMISE PRIOR TO SIGNING THE CONTRACT, THAT RESIDENTS REMAIN IN PRIVATE PAY STATUS FOR A SPECIFIED PERIOD OF TIME.

THE UNDERSIGNED ACKNOWLEDGE THAT EACH OF THEM HAS READ AND UNDERSTOOD THIS ADDENDUM, AND THAT EACH OF THE VOLUNTARILY CONSENTS TO ALL OF ITS TERMS.

Facility Rep. Signature:	**Facility Rep Name**	**Title:** Admissions Director	**Date:**
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

ADMISSIONS CONTRACT ADDENDUM

U.S. Private Pay/Insurance

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

Routine Services. The Resident will reimburse the Facility for routine services ("Routine Services") which include routine nursing services, routine dietary services, routine activities program, and routine room and bed maintenance services. Beauty shop fees are not included in the daily rate. The Resident shall pay a deposit of two months' basic room and board prior to admission. Each subsequent monthly payment is due on or before the 10th day of the month.

Ancillary Services. The Resident may purchase from the Facility services and products that are not included in Routine Services. An itemized list of fees for these additional services and products is provided to the Resident and/or the Responsible Party upon request during normal business hours of the Admission Office. The Resident shall pay for ancillary services at the end of the month in which such services are rendered.

Assignment of Benefits. In consideration of services rendered and to be rendered by the Facility, Resident hereby assigns to the Facility his or her right to reimbursement from any insurance company paying benefits to him or her for services rendered by the Facility and authorizes the Facility to receive payments from such insurance company pursuant to this assignment. Resident acknowledges that, to the extent such insurance company refuses to pay for any services rendered to him or her at the Facility, Resident shall remain personally liable for payment for these services to the extent permitted by applicable law. Resident agrees to cooperate with the Facility in collecting all proceeds due from such insurance company.

Benefit Disallowance. If the Resident's insurance coverage is denied or terminated for any reason, Resident and Responsible party shall pay, from Resident's assets, any and all unpaid charges for care previously rendered to the extent permitted by law.

NO CERTIFIED FACILITY MAY REQUIRE AS A CONDITION OF ADMISSION, EITHER IN ITS CONTRACT OF ADMISSION OR BY ORAL PROMSE PRIOR TO SIGNING THE CONTRACT, THAT RESIDENTS REMAIN IN PRIVATE PAY STATUS FOR A SPECIFIED PERIOD OF TIME.

THE UNDERSIGNED ACKNOWLEDGE THAT EACH OF THEM HAS READ AND UNDERSTOOD THIS ADDENDUM, AND THAT EACH OF THE VOLUNTARILY CONSENTS TO ALL OF ITS TERMS.

Facility Rep. Signature:	**Facility Rep Name**	**Title:** Admissions Director	**Date:**
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

SMOKING POLICY

It is the policy of the facility to provide a smoke-free environment for residents and staff.

Smoking occurs in designated areas that are environmentally separate from all resident care areas. These designated locations may be outdoors. Staff maintain/keep all smoking materials (e.g., cigarettes, pipes, matches, lighters, lighter fluid) and distribute the materials to residents at smoking times. The smoking schedule is posted.

A safe smoking assessment will be conducted on all residents who smoke.

Smoking Infraction

The first infraction of the smoking policy results in a warning. This warning may be verbal.
The warning is given to both the resident and their family member of contact. A safe smoking reassessment of that resident is performed.

The second infraction of the smoking policy may result in notice of discharge. The reason for discharge would be endangerment to the health and safety of residents.

I have read, understand, and will abide by the facility's Smoking Policy.

Facility Rep. Signature:	Facility Rep Name	Title: Admissions Director	Date:
Resident/Representative Signature	Resident/Representative Name		Date:

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Franciscan Villa ("Facility") and my physicians will create and keep a written record of my care. The record will include my health history, diagnoses, evaluations, and test results. medications. treatments. care plans and objectives, and advance directives, if any. The record is for use in documenting care and treatment provided, planning care, communication among care givers, a source of information for billing and collection of health care services provided and for assessing the quality of care and services provided.

I have been provided with a Notice of Privacy Practices that describes the uses and disclosures of health information. I have been given the opportunity to review the notice prior to signing this acknowledgement. The Facility may change thenotice and its practices, and if it does so, it will post the new notice on its bulletin board.

I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and understand that the Facility may not be required to agree to the restrictions requested. If the Facility agrees to any restrictions, then it is bound by those restrictions.

I have read, and understand, the notice of the privacy practice.

Facility Rep. Signature:	Facility Rep Name	Title: Admissions Director	Date:
Resident/Representative Signature	Resident/Representative Name		Date:

Health Information Disclosure and Use of Photograph/Videotape Authorization Form

I, _____**[resident/Resident Representative]**, authorize **Franciscan Villa** ("Facility"), to use my name, information related to my specific health condition listed below, and any photographs or audio/visual recordings of myself for display, publication, marketing, or broadcast with no form of compensation. The photographs or recordings may be taken of me by the Facility, employees, or third parties for use in the Facility and/or in the public media and/or materials used by the Facility or its subsidiary. These materials might include printed or electronic publications, websites, or other electronic communications. I hereby authorize the Facility to use the following information related to my health condition for marketing purposes:

I understand that my refusal will in no way affect the medical or nursing care I will receive. I understand that when the photographs or audio/visual recordings of myself are used or disclosed pursuant to this authorization, they may be subject to re-disclosure and may no longer be protected by State or federal privacy regulations.

I understand that I may revoke this disclosure and authorization at any time in writing addressed to the Facility. Unless revoked earlier, this authorization shall expire upon the termination of my admission agreement. However, such revocation or expiration shall not require the Facility to remove my name or any photographs or audio/visual recordings of myself included in, but not limited to, printed or electronic publications, websites or other electronic communications that were displayed, published, or broadcast in reliance upon this authorization. All revocations and questions regarding this authorization should be directed to the Administrator.

By signing this form, I confirm that its content has been explained to me in terms I understand.

Facility Rep. Signature:	**Facility Rep Name**	**Title:** Admissions Director	**Date:**
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

STATEMENT OF CHARGES

The facility sets forth the financial arrangement for providing care to the resident. The signature below indicates that the Resident and/or Legal Representative understands and acknowledges the financial terms and conditions identified from the Admission and Financial Agreement:

1. **OBLIGATIONS OF RESIDENT AND RESPONSIBLE PARTY:**
   A. To be responsible for co-pay amounts as applicable
   B. To pay the basic rate, co-pay, or vendor payment on or before the 10th of each month
   C. To notify the facility at least thirty (30) days in advance of discharge
   D. Upon Discharge Resident and/or Responsible Party agrees to pay outstanding amounts related to the Residents care during their care and treatment or completes a payment schedule for the payment of the outstanding balance.
   E. The Resident is and remains obligated to pay Facility for services and supplies not covered by Medicaid or the Medicare programs.
   F. If Resident chooses to have services which his/her insurance refuses to pre-authorize, Resident shall pay Facility for those services.
   G. Resident shall notify Facility immediately of any change in Resident's Insurance status or coverage.
   H. Upon admission, the Resident agrees to pay, in advance, a sum equal to a prorated one-month's stay.
2. **ESTIMATED CHARGES RELATED TO CARE AND TREATMENT:**
   A. Residents expected length of stay and care and expected Payor source(s):

_____

_____

_____

   B. Residents calculated monthly charges are listed and explained so as to make sure that the Resident and/or Responsible Party are aware of the monthly costs of the facilities care and treatment to the Resident:

_____

_____

_____

I have read, and understand, the notice of the STATEMENT OF CHARGES

Facility Rep. Signature:	**Facility Rep Name**	**Title:** Admissions Director	**Date:**
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

	Medicare Secondary Payer Questionnaire		YES	NO	Date
1	Are you currently a patient in a skilled nursing facility such as a nursing home?				
2	Are you receiving benefits from any of the following programs?	Black Lung			
		Research Grant			
		Veterans Affairs			
3	Was the illness injury due to a work-related accident/condition?				
4	Was illness/injury due to a non-work-related accident?				
	What type of accident caused the illness/injury?	Automobile			
		Non-Automobile			
5	Are you currently employed?				
6	Is your spouse currently employed?				
7	Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?				
8	Does the employer that sponsors your GHP employ 20 or more employees?				
9	Are you entitled to Medicare based on?	Disability			
		Age			
		End Stage renal Cancer			

I confirm that the above information is correct.

Facility Rep. Signature:	**Facility Rep Name**	**Title:** Admissions Director	**Date:**
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

DESIGNATION OF PHARMACY

Pharmacy Name			
PharMerica			
Address		Apt/Suite	Phone Number
207 W 1st St			855-444-5387
City	State	Zip	Email
Sand Springs	OK	74063	

is designated to serve as Resident's Pharmacy. If the designated Pharmacy are not available, Facility is authorized to obtain on behalf of Resident the services of any other Pharmacy licensed in the State of Oklahoma. Resident/Responsible Party are responsible for the payment of all physician fees. This authorization supersedes any previous designations.

Facility Rep. Signature:	**Facility Rep Name**	**Title:**	**Date:**
		Admissions Director	
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

AUTHORIZATION OF SELF ADMINISTRATION OF DRUGS

Each resident has a right to self-administer drugs if the interdisciplinary team, as defined by 42 § CFR 483.20(d) has determined for each Resident that the practice is safe.

Every resident has the right to self-administer medications as long as this practice does not pose a danger to the Resident or to other residents in the Facility. This form is for documenting the Resident's desire to participate in the Facility's self-administration of medication program, after the program has been explained to the Resident.

__ **YES,** I would like to exercise my right to self-administer medications. I understand that this right is subject to the assessment of my rehabilitation factors of behavioral function, health status, medication history, sensory/perceptual functioning, mobility functioning, and cognitive functioning.

__ **NO,** I do not want to exercise my right to self-administer medications.

Facility Rep. Signature:	**Facility Rep Name**	**Title:**	**Date:**
		Admissions Director	
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

MEDICAL INSURANCE AUTHORIZATION OF BENEFITS

Medicare Part A			Medicare Part B		
Health Insurance Company Information					
Medigap Insurance			**Other Insurance**		
Company Name			Company Name		
Name of Insured		Relationship	Name of Insured		Relationship
Address		Apt/Suite	Address		Apt/Suite
City	State	Zip	City	State	Zip
Phone number	Email		Phone number	Email	
Policy #	Group		Policy #	Group	
Effective Date	Coverage Period		Effective Date	Coverage Period	

AUTHORIZATION OF BENEFITS

I authorize the release of all information necessary to process this claim and request that payment of all benefits payable under my coverage be made directly to **Franciscan Villa.**

Facility Rep. Signature:	**Facility Rep Name**	**Title:** Admissions Director	**Date:**
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

AUTHORIZATIONS, CONSENTS & ACKNOWLEDGMENTS

Please Read Review and acknowledge each the following.

Treatment/Health Care Professionals:

Authorization for Treatment

__ I hereby authorize Facility's professional staff to administer nursing procedures, procedures, therapies, skin scrapings, nonsurgical dental procedures, and laboratory and x-ray procedures on me. I understand that I may withdraw this consent at any time by notifying Facility in writing. I further understand that an additional consent will be required for any surgical treatment or for any treatment requiring the use of general anesthesia.

Medical Treatment

__ It is understood and agreed that Resident is under the control of his/her elected physician and/or his/her designee and that Facility Is not liable for any act or omission as a result of following instructions of said physician(s)/designee(s). Resident consents to diagnostic imaging procedures, laboratory procedures, or medical treatment rendered to Resident under the general and special instructions of Resident's physician or physician's designee.

General Duty Nursing

__ Facility provides general duty nursing care. Under this system, nurses are called to the resident's bedside by a signal system. If Resident is in such condition as to need continuous or special duty nursing care, it Is agreed that Resident, Resident's legal representative or Resident's physician(s) will make the necessary arrangements for such care. It is understood and agreed that Facility shall not, in any way, be responsible for the failure to provide such care and is hereby released from any and all liability arising from the fact Resident is not provided with such care.

Independent Status of Health Care Provider and their Agents/Designees

__ Resident and/or Resident's legal representative acknowledges that any and all health care providers and their agents/designees are not agents or employees of Facility. Resident and/or Resident's legal representative understands and agrees that each health care provider or their agent/designee who renders services to Resident will independently bill and collect fees for these services. Resident and/or Resident's legal representative agrees and understands that the health care provider's bills will be separate and apart from Facility's selection of Medical Professionals:

You have the right to use your personal health care providers during your stay. In the event you do not have a current provider, the facility has a list of independent providers who are available to provide on-site care. If you have difficulty contracting any of these Professionals, please notify our staff. Please indicate your choice of health care providers below, including the provider's phone number.

Physician's Name	Phone	Email
Dr. Joseph Moore	918-276-0521	

Facility Rep. Signature:	Facility Rep Name	Title:	Date:
		Admissions Director	
Resident/Representative Signature	**Resident/Representative Name**		**Date:**

Residents Name	Payer Type

Copies of the following should be placed in the admissions folders as applicable:

1. Social Security Card
2. Medicare Card
3. Insurance Card(s)
4. Medicaid Card or Application

The following Items should be signed with a copy placed in the admissions Folder:

1. Face Sheet/Resident Information Sheet
2. Appointment of Representative
3. Resident Rights
4. Admission Agreement
5. Arbitration Agreement
6. Bedhold Policy
7. Smoking Policy
8. Privacy Practices
9. Resident Authorization of Benefits & Release of Information
10. Statement of Charges
11. Medicare Secondary Payer Questionnaire
12. Designation of Pharmacy
13. Authorization of Self Administration of Drugs
14. Medical Determination upon Admissions
15. Admissions Paperwork Checklist

16. *Payer Addendum*
17. *Trust Account Authorization*
18. *Business Office Admission Form*
19. *Designation of Attending Physician*
20. *Release of Medical and Hospital Records*
21. *Photographic Consent (see 9 above)*
22. *Consent for Pneumococcal Vaccine and InfluenzaVaccine/Immunization Record*
23. *Advanced Directives Acknowledgement*
24. *Binding Arbitration Agreement*
25. *Authorized Electronic Monitoring*
26. *Financial Agreement (residents not eligible for Medicaid)*
27. *MSP Screening Form*
28. *Acknowledgement of receipt of notice of privacypractice*
29. *Out of Hospital DNR*
30. *Consent for Use /Disclosure of Health Information-Treatment Payment or Healthcare operations.*

An Admission Handbook containing the following information was given to the resident and/or Responsible Party.

1. Admission Policy General Facility Information Ombudsman Information
2. Bed Hold Policy Advanced Directive Policies Facility Policy for Physical Restraints
3. Grievance Procedures Privacy Notices Involuntary Seclusion
4. State/Federal Resources Resident Rights (State and Federal) Department of Aging and Disability Services
5. Rights of the Elderly Policy on Protection of Resident Funds Rules for Physical Restraints and Involuntary Resident Responsibilities Smoking Policy Seclusion
6. Advance Care Planning Drug-Free Workplace Background/Investigation Check Policy
7. Family Council Information Leadership Team Member &Titles Facility Recommended Specialist List

In addition, a list of Physicians that currently visit the facility, and a list of local Government resources were also given to the resident and/or Responsible Party. A copy of the ancillary price list is kept in the business office and is available from 9am-5pm on regular business days.

Facility Rep. Signature:	Facility Rep Name	Title: Admissions Director	Date:
Resident/Representative Signature	**Resident/Representative Name**		**Date:**