The Springs

Nursing Center

704 N. Taylor | Hughes Springs, TX 75656
903-639-2531 | Fax: 903-639-1763

Admission Record

Admission Date & Time _____

Name _____
Last *First* *Middle*

Permanent Address _____
Street/P.O. Box *Apt. Number*

_____
City *County/State* *Zip Code*

Date of Birth _____ Birthplace _____

Type of Payment: Medicaid Pay or Private Pay Medicaid # _____

SS # _____ Medicare # _____

Occupation before retired _____

Religion _____ Pastor _____

Veteran _____ Date of Service _____

Physician _____ Phone _____

Alternate Physician _____ Phone _____

Dentist _____ Phone _____

Pharmacy _____ Phone _____

Optometrist _____ Phone _____

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Admission Record

Preferred Name _____

Funeral Home Preference _____
In case of emergency, notify:

1. Name: _____

   Address: _____

   Phone #: _____

   Relationship: _____

2. Name: _____

   Address: _____

   Phone #: _____

   Relationship: _____

3. Name: _____

   Address: _____

   Phone #: _____

   Relationship: _____

Notes:

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Privacy Act Statement- Health Care Records

This form is not a consent to release or use health care information pertaining to you:

1. **Authority for Collection of Information Including Social Security Number (SSN)**
   Sections 1819 (f), 1919(f), 1819(b)(3)(a), 1919(b)(3)(a), and 1864 of the Social Security Act.

2. **Principal Purposes for which information is intended to be used.**
   This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate tracking of changes in your health and functional status over time for purposes of evaluating and assuring the quality of care provided by nursing homes that participate in Medicare or Medicaid.

3. **Routine Uses**
   The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose. The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: to the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefit program or to a guarantee of a CMS-administered grant program, (9) to another federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefit program funded in whole or in part by federal funds to prevent, deter, and detect fraud and abuse in these programs, (10) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program.

4. **Whether disclosure is mandatory of voluntary and effect on individual of not providing information**
   For nursing facility residents residing in a Medicare/Medicaid nursing facility, the requested information is mandatory because of the need to assess the effectiveness and quality of care given in certified facilities and to assess the appropriateness of provided services. If the requested information is not furnished the determination of beneficiary services and resultant reimbursement may not be possible.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

_____ _____

Signature of Resident/Responsible Party Date

Nursing Facility Admission and Financial Agreement

The Springs Nursing Center located at 704 N. Taylor, Hughes Springs, TX, 75656 is a licensed long term care facility and does enter into this Nursing Facility Admission and Financial 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

2. **Authority.** Resident authorizes responsible party to make

   ☐ Financial Decisions

   ☐ Medical decisions (Facility has been provided with a durable power of attorney, Advance directive or other appropriate instrument)

   ☐ Admission, care and discharge

   ☐ 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 without regard 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 and 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 evaluation, diagnosis 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 _____ 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 thirty (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 to provide such services as 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 are for physician ordered non-emergency medical services, including routine ambulance services involved in the certification or re-certification of resident. Non-emergency ambulance transport of severely disabled Medicaid residents to and from scheduled and medical appointments, who cannot be transferred by other means without endangering their health or safety, shall be billed to Medicaid upon receipt of prior authorization from the Texas Department of Health 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 records. 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 and Pharmacy Services.**
    A. Resident/responsible party designates _____ as pharmacy provider of choice. This pharmacy shall be duly licensed in the State of Texas and qualified to provide pharmacy services consistent with applicable state and federal regulations. The pharmacy shall agree to provide services on a twenty-four (24) hour basis for emergency medications, deliver medications to facility on a timely and reasonable basis, packaged and labeled in accordance with Texas 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 physician.

    D. All medications must be prescribed by a licensed physician, dentist or podiatrist or other individual authorized by Texas 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 and Equipment.** Medical accessories and equipment prescribed by resident's and required to provide treatment ordered by resident's physician such as: canulas, 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 payor.

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.

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 for convenience rather than medical need which are not covered by Medicaid, Medicare or other third-party payment.

13. **Personal Items and 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 on therapeutic pass with permission of resident's attending physician and (if applicable) responsible party. Facility admission shall be notified of all passes in advance and resident shall be signed out at the nurses' 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 the 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. **Transfer and 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 or 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 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 the resident's needs cannot be met in facility;

B. Resident no longer needs services provided by facility;

C. Resident is endangering the safety of other 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 participate in the program that pays for resident's care; or

G. Resident has not resided in facility for thirty (30) days.

Written notice will be given to resident/responsible party for all planned discharges and transfers. Unless waived by the resident/responsible party, thirty (30) days written notice will be given for discharges and transfers planned pursuant to subsections A and B above. All other discharges will be made as soon as practicable.

18. **Relocation within Facility**. Except in an emergency, facility shall give resident/responsible party five (5) days advance written notice of relocation to another room. The notice will explain the reason(s) for the relocation, the effective date and the room to which the resident is being relocated.

19. **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 charges to resident/responsible party if not covered by Medicaid, Medicare or other third party payor. 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. Podiatric, optometric, dental, geripsychiatric and other ancillary services
- Laboratory, x-ray and diagnostic services
- Dry cleaning services outside the facility
- Hospitalization expenses (including the emergency room)
- 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

20. **Billing and Refunds.**

A. Facility, a Medicaid certified nursing facility, accepts applicable Medicaid payments 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.

C. 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.

D. 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.

E. Facility assists residents in applying for Medicaid and may assist resident in applying for any other available public assistance. Responsible/responsible party shall continue to pay facility pursuant to this agreement and applicable law while any application for Medicaid is pending, and unless and until eligibility is determined and retroactive adjustment is required.

E. When resident is not eligible for Medicaid, resident/responsible party shall pay the rate of $ _____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 five (5) days at *The Springs Nursing Center, 704 N. Taylor, Hughes Springs, TX. 75656.*

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 day of each month shall be charged interest at the rate of ten (10) percent 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 residents'/responsible party's ability to comply with this agreement.

21. **Personal Belongings.** Resident/responsible party shall complete and sign facility's written inventory form listing resident's personal belongings at the time of admission. An original inventory 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 resident's personal property items facility has accepted for safekeeping. All personal property must be removed within seventy-two (72) hours of discharge unless alternate arrangements are made with facility administration.

22. **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 payer.

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.

23. **Special Arrangements/Grants of authority.** [Check appropriate space]

A. Professional Services, 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.

☐ **Authorizes** ☐ **Does not authorize**

B. Medical Records, facility to release medical information when required for completing insurance claims and government benefit claims.

☐ **Authorizes** ☐ **Does not authorize**

C. Laundry, facility to have personal laundry done for resident and to have dry cleaning provided by an outside source at the expense of resident/responsible party. Due to State regulation, laundry done within the facility will be done at 160˚F.

☐ **Authorizes** ☐ **Does not authorize**

D. Personal Services.

☐ Authorizes with direct billing of resident/responsible party by barber or beautician.

☐ **Authorizes with deduction of charges from resident's trust fund.**

☐ **Does not authorize provision of hair care by barber or beautician.**

E. Patient Identification, facility to photograph resident for medical and identification purposes.

☐ **Authorizes** ☐ **Does not authorize**

F. Press Release, facility to use name and photograph of resident in facility publications.

☐ **Authorizes** ☐ **Does not authorize**

24. **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.

Resident/responsible party acknowledges that facility has informed resident/responsible party orally and in writing of:

- Resident's rights and all rules and regulations governing resident conduct and responsibilities,
- Texas Human Resource Code, Title 6, Chapter 102, and the resident's bill of rights under the Omnibus Budget Reconciliation Act of 1987,
- The rights and responsibilities contained in the description of services available through the office of the Texas Long Term Care Ombudsman, Texas Department of 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,
- Protection of Resident funds policy.

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 assumed no liability as such. Facility shall not be responsible for resident when resident is on leave from facility.

E. Parties Bound. Resident/responsible party acknowledges that they have received and reviewed the agreement and the same shall be binding on resident, responsible party, and resident's heirs, executors and administrators.

25. **Governing Law.** This agreement shall be interpreted, construed and governed under the laws of the State of Texas and is performable in Cass, Texas.

26. **Notices.** Any and all notices required or permitted to be given under this agreement shall be sufficient if furnished in writing, sent by certified mail addressed as provided in

admission agreement or at such other address as a party may, from time-to-time, notify the other in writing.

27. **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 mutual agreement, reduced to writing and signed by both parties.

28. **Amendment Due to Reimbursement Changes.** If the governmental agencies who administer Medicare or Medicaid, or any other payer, 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.

29. **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.

_____	_____
Resident/Responsible Party (Print Name)	Facility Representative (Print Name)
_____	_____
Resident/Responsible Party (Signature)	Facility Representative (Signature)
_____	_____
Date	Date

Inventory of Personal Effects

Instructions: Upon admission, identify the residents personal belongings by indicating quantity of those items listed. Use the space allowed to write in additional items as necessary. The original copy shall be kept in the resident's chart. The copy is given to the resident or resident representative. Update as necessary throughout the resident's stay by using the space provided. Upon discharge, use the marked columns to indicate that all personal belongings are accounted

Qty.	Items	Qty.	Items
	Belts		Shirts
	Blouses		Shoes
	Coats		Shorts
	Dresses		Slacks
	Gloves		Slippers
	Handkerchiefs		Slips
	Hats		Suitcases
	Housecoats		Suits
	Jackets		Suspenders
	Nightgowns		Sweaters
	Pajamas		Ties
	Purses		Undershirts
	Hearing Aid(s): Right___ Left __		Dentures: Up ___ Low ___ Part __
	Eyewear		Cane
	Walker		Wheelchair
	Brace		Prosthesis
	Chairs		Pictures
	Clock		Radio
	Comforter/Quilt		Rings
	Dresser		Television
	Electric Razor		Wallet/Purse
	Shaving Kit		Watches

Resident/Responsible Party (Signature)

Facility Representative (Signature)

Date

Date

Nutrition and Hydration

In accordance with the Texas Natural Death Act, the owners of *The Springs Nursing Center* do not consider food and water (nutrition and hydration) supplied to a resident as medical treatments. We do however consider food and water to be necessary to provide comfort, provide care and alleviate pain. Therefore, we will take whatever steps necessary to insure that each resident in the facility is properly nourished and hydrated as required by state regulations. Should circumstances arise where the resident, the resident's physician or a family member of the resident chooses to discontinue food and water (nutrition and hydration), we will no longer serve as caregiver for the resident. The facility will assist as necessary, explaining the law and our position in regards to the law, and finding alternate placement for those individuals wishing to have food and water discontinued.

_____	_____
Resident/Responsible Party (Print Name)	Facility Representative (Print Name)
_____	_____
Resident/Responsible Party (Signature)	Facility Representative (Signature)
_____	_____
Date	Date

Consent for Release of Health Information

Name of Resident _____

Date of Birth _____ Social Security # _____

I authorize the release of health information from the medical records to

The Springs Nursing Center 704 N. Taylor Hughes Springs, Texas 75656.

In order to determine current health status for consideration of admission and/or provision of care upon admission, I have been provided with a Notice of Information Practices that describes the uses and disclosures of health information. I have been given the opportunity to review the notice prior to signing this consent. The facility may change the notice and its practices, and if it does so, it will post the new notice on its bulletin board.

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

This consent is valid until revoked. I understand that I can revoke this consent at any time for records not released. Revocation of consent does not affect information disclosed prior to written notice.

I release you from all legal responsibility or liability that might arise from this consent.

_____ _____

Resident/Responsible Party (Print Name) Relationship to Resident

_____ _____

Resident/Responsible Party (Signature) Date

Authorization for Resident's Mail

The Springs Nursing Center is authorized to handle the Resident's mail as follows:
(Check one option only)

☐ All mail given directly to resident

☐ Forward all resident's mail to:

_____

_____

_____

☐ All mail read to resident

☐ Give personal mail to resident, forward business mail to:

_____

_____

_____

Authorization to Participate in Activities

_____
Name of Resident

The Springs Nursing Center provides programs offering opportunities for social interaction, stimulation and development, recreation, educational and cultural activities. The program, based on resident's physical, mental and psychological needs and abilities, offers a variety of scheduled activities and events, individual, small and large programs, special events, out-of-facility trips. Resident may participate in activities appropriate to Resident's condition if Resident/Responsible Party has authorized participation in advance by execution of this form.

Neither the facility nor its owners; affiliates; directors; agents; employees; servants; or representatives shall be held liable for injuries or damages sustained by resident unless caused by a willful or grossly negligent act or omission on the part of Facility or its staff.

_____ may participate in on-site activities determined by the Activities Director to be within Resident's abilities and suited to Resident's preferences.

Resident MAY/MAY NOT participate on off-site activities.
(Circle One)

_____ _____
Resident/Responsible Party (Print Name) Relationship to Resident

_____ _____
Resident/Responsible Party (Signature) Date

Resident Trust Fund Authorization

The facility allows each resident the right to manage his/her own financial affairs. The resident is under no obligation to deposit funds with the facility. The resident designates the following:

☐ Authorizes himself/herself to receive, retain and manage his/her personal funds or to have this done by a legal guardian. (Note-If a Medicaid recipient/resident becomes incapable of managing his/her own funds and does not have a representative payee, responsible party or guardian, the facility will notify the regional office of the Department of Human Services.)

☐ Authorizes application to the Social Security Administration to have representative payee designated for Federal or State benefits entitled to.

☐ Designates _____ to manage the resident's personal funds.
(Name of person)

☐ Designates the facility to hold, safeguard and account for the resident's personal funds.

Any administrative charges for the handling of Medicaid recipient's funds are included in the vendor rate.

I understand the Facility maintains a Resident Trust Fund account for both private and Medicaid residents. The account is subject to audit and inspection by the Texas Department on Aging and Disability Services, the Texas Attorney General's Medicaid Fraud Control Unit, and the U.S. Department of Health and Human Services.

_____ _____
Resident/Responsible Party (Signature) Date

_____ _____
Facility Representative (Signature) Date

Acknowledgment

I/We acknowledge that members of the staff at *The Springs Nursing Center* have provided me/us with the following written information: (1) The facility policy regarding advance directives, and (2) a question and answer summary of Texas state law on advance directives entitled "Your rights to make treatment decisions".

They have made themselves available to answer my/our questions regarding advance directives to the best of their ability. I/we am/are aware that the facility personnel are not attorneys licensed by The State Bar of Texas and that their information is not provided as legal advice, but only as information regarding advance directives. I/we further understand that if I/we have any legal questions concerning advance directives, I/we should consult with my/out attorney.

I also understand it is my responsibility to supply The Springs Nursing Center with any advance directives that are currently in effect. (Check only one)

☐ I **DO** have an advance directive.

☐ I **DO NOT** have an advance directive.

_____	_____
Resident/Responsible Party (Print Name)	Facility Representative (Print Name)
_____	_____
Resident/Responsible Party (Signature)	Facility Representative (Signature)
_____	_____
Date	Date

Consent Form to use Nurse Practitioner and/or Physician's Assistant

I hereby give my consent to receive the services of a nurse practitioner and/or physician's assistant. I realize that I may see my personal physician at my request.

_____ _____
Resident/Responsible Party (Signature) Date

_____ _____
Facility Representative (Signature) Date

Hospital Transfer

In the event that hospitalization be required, it is my request that

_____be transferred to _____.
Name of Resident Hospital

_____ _____
Resident/Responsible Party (Signature) Date

Medical Equipment

The Springs Nursing Center will furnish medical equipment which can be used by more than one person, such as wheelchairs, walkers, and canes. If a resident desires the full time use of equipment for convenience, its purchase is the responsibility of the resident.

_____ _____
Resident/Responsible Party (Signature) Date

Transfer within Facility

I realize that at the discretion of the Facility's Administration and Director of Nursing Services, I the resident, may be transferred in the future no sooner than five (5) days after written notice has been mailed, explaining the reasons for the transfer, the new location within the facility, and the expected date of the transfer.

_____ _____
Resident/Responsible Party (Signature) Date

Influenza Immunization
Proof of Education and Informed Consent

☐ I hereby give the facility permission to administer an **influenza vaccination** annually, in the fall (October 1st through March 15th). To the best of my knowledge, I have not had an anaphylactic reaction to eggs. I have been instructed that as a result of this vaccination, I may experience some side effects, such as:

- Slight Discomfort
- Soreness of the arm
- Redness of the arm
- Slight fever (occasionally) and
- Muscle aches (occasionally)

Flu vaccine is the most effective way to decrease the risk of complications of influenza such as pneumonia leading to hospitalization or death. The vaccine is given under the direction of your physician who has full knowledge of your medical status.

_____ _____

Resident/Responsible Party (Signature) Date

_____ _____

Facility Representative (Signature) Date

Influenza Immunization Refusal

☐ I hereby **do not** give the facility permission to administer an **influenza vaccination.**

Reason _____

_____

_____

_____ _____

Resident/Responsible Party (Signature) Date

_____ _____

Facility Representative (Signature) Date

Pneumococcal Immunization
Proof of Education and Informed Consent

☐ I hereby give the facility permission to administer a **pneumococcal vaccination.** To the best of my knowledge, I have not had a pneumococcal vaccination.

☐ I hereby give the facility permission to administer a **pneumococcal revaccination**.

I have been instructed that as a result of this vaccination, I may experience some side effects, such as:

- Slight Discomfort
- Joint aches (rarely)
- Soreness of the arm
- Rash (rarely)
- Redness of the arm
- Slight fever (occasionally)
- Muscle aches (occasionally)

Pneumococcal vaccination helps decrease risk of hospitalization or death from pneumonia. The risk of complications is 2 or 3 times greater in people over 65 years of age. The vaccine is given under the direction of your physician who has full knowledge of your medical status.

_____ _____

Resident/Responsible Party (Signature) Date

_____ _____

Facility Representative (Signature) Date

Pneumococcal Immunization Refusal

☐ I hereby **do not** give the facility permission to administer a **pneumococcal vaccination.**

Reason _____

_____

_____

_____ _____

Resident/Responsible Party (Signature) Date

_____ _____

Facility Representative (Signature) Date

Release of Responsibility
for Retention of Cash, Jewelry and Valuables

I have been advised by administration not to keep cash, jewelry and other valuables in my possession while a patient in this facility. But, notwithstanding this advice, I wish to **retain the following items** in my possession and I absolve the administration and its personnel of all responsibility against possible loss.

_____

_____

_____

_____

_____

_____

_____ _____

Resident/Responsible Party (Signature) Date

_____ _____

Facility Representative (Signature) Date

Policy on Restraint/Proper Environment

It is the policy of *The Springs Nursing Center* that the resident has the right to be free from restraint, to be defined as a device, chemical, physical, or environmental that is used to inhibit or retrain voluntary or involuntary movement that leads to harm to self or others.

Restraints will not be used for purposes of discipline or staff convenience, and only when required to treat the resident's medical symptoms.

The use of all restraints will be accompanied by an appropriate consent form.

_____ _____

Resident/Responsible Party (Signature) Date

Inspection Reports

Copies of *The Springs Nursing Center* inspection, surveys and visits are available in the administrator's office during normal facility office hours. Reports are also posted in one of the facility halls.

_____ _____

Resident/Responsible Party (Signature) Date

Complaints about Services

Complaints made to the charge nurse, a department head, or the administrator will be investigated by administrative staff and appropriate corrective action will be taken. All complaints are taken seriously, as we continually strive to provide the best services possible to our residents. I further understand that I may file complaints with the Texas Department of Health in Austin, the staff of the facility have notified me that the 1-800 number for the Texas Department of Health is clearly posted in one of the halls of the facility, and that reports may be made twenty-four (24) hours a day.

_____ _____

Resident/Responsible Party (Signature) Date

Consent for Display of Care Plan

The Springs Nursing Center requests your permission to display the Care Plan of

_____ in their room.
Resident

_____ _____
Resident/Responsible Party (Signature) Date

Assignment of Benefits

_____
Name of Resident

In consideration of services rendered, or to be rendered, to the above named patient, I hereby authorize payment directly to *The Springs Nursing Facility* of any and all medical insurance benefits, as well extend benefits to such medical coverage to which I, or the above named patient, may otherwise be entitled for services rendered by *The Springs Nursing Facility*, but not to exceed *The Springs Nursing Facility's* regular charges for such services.

I hereby authorized *The Springs Nursing Facility* to file such claims in my behalf so that *The Springs Nursing Facility* may realize payment of its charges. I understand that if *The Springs Nursing Facility* does not receive payment from the insurer, I am personally responsible for the timely payment of *The Springs Nursing Facility's* charges unless application is filed promptly and eligibility is established for Medicaid in the state in which the patient resides and *The Springs Nursing Facility* has an agreement with.

I authorize *The Springs Nursing Facility* to request from my, or the above named patient's medical insurance payer, either in writing or orally, the remaining benefits that patient is entitled to:

_____ _____
Resident/Responsible Party (Print Name) Relationship to Resident

_____ _____
Resident/Responsible Party (Signature) Date

_____ _____
Facility Representative (Signature) Date

The Springs
Nursing Center
704 N. Taylor | Hughes Springs, TX 75656
903-639-2531 | Fax: 903-639-1763

Statement of Permit Payment of Medicare Benefits to Provider

Beneficiary _____ HIC Number _____

I request that payment of authorized Medicare benefits be paid to *The Springs Nursing Center* on my behalf for any services furnished me by *The Springs Nursing Center*.

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

Resident/Responsible Party (Print Name) _____

Resident/Responsible Party (Signature) _____ Date _____

Medicare Secondary Payor (MSP) Screening

Patient Name: _____ Medicare #: _____

Service Dates: _____

It is important to ask all questions and document all answers regarding MSP. A provider may be held liable if an overpayment occurs and Medicare finds that the provider furnished erroneous information relevant to payment.

Illness/Injury Caused by Accident

1. Is the illness or injury due to any kind of accident?
   - ☐ No – Proceed to question #2.
   - ☐ Yes – Medicare may be secondary. Check the appropriate box (A-E), and answer the questions.

     ☐ A. Motor vehicle: name of patient's automobile insurer _____
     - ☐ No fault insurance (auto insurance primary)
     - ☐ Liability insurance (bill Medicare primary for conditional payment with insurance information)

     ☐ B. Motor Vehicle: name of third party's liability insurer_____
     (Bill Medicare primary for conditional payment. Send name, address and numbers of insurance, attorney name, etc.)

     ☐ C. Work Related: name of Workman's Comp insurer_____
     (Workman's Compensation is primary)

     ☐ D. Slip and Fall: explain where fall occurred _____
     If fall occurred at place other than patient's home, determine if liability claim or suit will be filed or if any kind of compensation can be made.
     ☐ No ☐ Yes – give information on third party/insurer/attorney

     _____
     (Bill Medicare primary with liability information)

     ☐ E. Other accident, no third party can pay. Give description of accident/location.

     _____
     (Bill Medicare primary with pertinent documentation)

Medicare Secondary Payor (MSP) Screening

Coverage through other Governmental Entity

2. A. Does the patient have coverage through the Department of Labor's Black Lung Program or some other federal or state agency? (Does not include state welfare)
   - ☐ No – Proceed to question #3 below.
   - ☐ Yes, the entity has coverage which must be billed primary to Medicare. Medicare may reject the claim unless the entity pays as primary or submits a denial of the services.

   B. Does the patient have VA coverage because of a service related condition?
   - ☐ No – Proceed with question #4 below.
   - ☐ Yes – VA must be billed primary.

3. Is the patient 65 or above?
   - ☐ No – Answer questions #6 and #7 only.
   - ☐ Yes – Answer questions #4 and #5 only.

Employer Group Health Coverage

4. Is the patient employed at the time of this service?

   ☐ No – What is patient retirement date?_____ Proceed to question #5.

   ☐ Yes – Give the patient's date of birth _____ Give the name of

   patient's company/employer: _____

   A. Does the employer employ 20 or more employees?
   - ☐ No
   - ☐ Yes

   B. Does the patient have Employer Group Health Plan (EGHP) coverage by reason of his/her current employment?
   - ☐ No
   - ☐ Yes, give the name of the EGHP _____

   (If the patient answered yes to A and B, the EGHP shown is primary to Medicare. Bill them first.)

Medicare Secondary Payor (MSP) Screening

5. A. Does the patient have a spouse who is employed at the time of this service?

☐ No – What is the spouse's retirement date? _____ Proceed to question #6.

☐ Yes – Give the patient's date of birth _____

Give the name of the spouse's company/employer _____

B. Does the spouse have Employer Group Health Plan (EGHP) coverage by reason of his/her current employment which covers the patient?
☐ No
☐ Yes, give the name of the EGHP _____

(If the patient answered yes to A and B, the EGHP shown is to be billed before Medicare. If the patient also has an EGHP [see #4 above] Medicare will be billed third.)

Employer Group Coverage for those entitled to Medicare solely due to End Stage Renal Disease. (ESRD)

6. Is the patient under the age of 65, entitled to Medicare solely because of ESRD, and in the first 12 months of Medicare entitlement?
☐ No – Proceed to question #7.
☐ Yes – Patient's date of entitlement shown on Medicare card_____
Does the patient have coverage through his/her or his/her spouse's, parent's, or guardian's EGHP?
☐ No
☐ Yes – Give the name of the employer _____

Give the name of the EGHP _____

(If the patient answered "yes" to both questions, the EGHP is primary to Medicare.)

Medicare Secondary Payor (MSP) Screening

Employer Group Coverage for those entitled to Medicare solely because of Disability

7. Is the patient under the age of 65, entitled to Medicare solely (does not have/has not had ESRD) because of disability?
   - ☐ No
   - ☐ Yes – Give the patient's date of birth _____

     Does the patient have coverage through his/her or his/her spouse's, parent's, or a guardian's EGHP?
     - ☐ No
     - ☐ Yes – Give the name of each insured whose policy covers the patient:

_____	_____
Name of insured	Name of corresponding employer
_____	_____
Name of insured	Name of corresponding employer
_____	_____
Name of insured	Name of corresponding employer

(If patient answered "yes" to both questions, the EGHP(s) is/are primary to Medicare.)

_____ _____

Resident/Responsible Party (Signature) Date

Notice of Information Practices (as of 02/19/2004)

Uses and disclosers of health information

This notice describes how medical information about you may be sued and disclosed and how you can get access to this information. Please review it carefully.

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice on our bulletin board. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you a reasonable fee for each page. We will accommodate reasonable requests you may have for health information to be communicated by alternate means or at alternate locations. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. We will notify you if we are unable to agree to a requested restriction.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. A complaint will not result in retaliation. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon your request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

Tim Thornton
The Springs Nursing Center
903-639-2531

Rights of Nursing Facility Residents

The elderly (sixty (60) years of age and older) have all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States. They have the right to be free of interference, coercion, discrimination, reprisal in exercising these civil rights.

By law, every Texas nursing facility resident has the right…

To be treated with dignity, respect, courtesy and consideration without regard to race, religion, national origin, sex, age, disability, marital status or source of payment.

- To make their own choices regarding personal affairs, care, benefits and services;
- To be free from abuse, neglect and exploitation;
- To designate a guardian or representative to ensure the right to quality stewardship of their affairs, if protective measures are required; and
- To live in safe, descent and clean conditions.

To receive all care necessary to have the highest possible level of health.

To be free from physical or chemical restraints used for discipline or convenience and not required for medical symptoms.

To communicate in their native language with other individuals or employees for the purpose of acquiring or receiving any type of treatment, care of services.

To complain about care or treatment and receive prompt response to resolve the complaint without fear of reprisal or discrimination by the person providing services; to organize or participate in any program that presents resident's concerns to the facility administrator.

To receive visitors

To privacy during visits and telephone calls and while attending to personal needs, unless providing privacy would infringe on the rights of others.

To participate in activities of social, religious or community groups, inside or outside of a care setting, unless the participation interferes with the rights of others.

To send and receive unopened mail and to receive assistance in reading or writing correspondence.

To manage their own personal financial affairs in the least restrictive method by;

- Written authorization for another person to manage or provide accounting money and property;
- Choosing another manner, including a representative payee program, a money management program, a financial power of attorney, a trust, or a similar method.

To access and to have an accounting of their money and property deposited with the facility and of all financial transactions made with or on behalf of them.

To access personal and clinical records which will be maintained as confidential and may not be released without their consent, except to a person providing services at the time they are transferred or as required by another law.

To be fully informed about their total medical condition, in a language that they can understand, and to be notified whenever there is a significant change in their medical condition, by the person providing services.

To retain the services of a physician of their choice, at their own expense or through and insurance plan, and to be fully informed in advance about treatment or care that may affect their well-being.

To participate in developing a plan of care that describes their medical, psychological and nursing needs and how the needs will be met, including reasonably expected effects, side effects and risks associated with psychoactive medications.

To refuse medical treatment and to refuse to participate in experimental research after being advised by the person providing services of possible consequences; and acknowledging that they clearly understand the consequences.

To receive information about prescribed psychoactive medication from the person who describes the medication or that person's designee, **to have** any psychoactive medications prescribed and administered in a responsible way, as mandated by the HSC 242.505, and **to refuse** to consent to the prescription of psychoactive medications;

To place in their room an electronic monitoring device that is owned and operated by the resident or provided by the guardian or legal representative.

To receive a written statement or admission agreement describing the services provided by the facility and the related charges.

To be informed, not later than the 30th day after the admission, by a person providing services, of entitlement to benefits under Medicare or Medicaid and items and services covered by these benefits, including those for which they may not be charged.

To discharge themselves from the facility unless they have been adjudicated mentally incompetent.

To not be transferred or discharged by a person providing services unless:

- Transfer is for their welfare and their needs cannot be met by the person providing services;
- Their health has improved sufficiently so that services are no longer needed;
- Their health and safety or the health and safety of another individual would be endangered if the transfer or discharge was not made;
- The service provider ceases to operate or to participate in the program which pays for their treatment or care; or
- They fail, after reasonable and appropriate notices, to pay for services.

To not be transferred or discharged, except in an emergency, until the 30th day after the date of written notice to the individual, legal representative or a family member stating:

- Intent to transfer or discharge;
- Reason for the transfer or discharge;
- Effective date of transfer or discharge;
- If transferred, the location to which they will be transferred; and
- The right to appeal the action to the Texas Department of Human Services if it is a Medicaid-certified facility and the person to whom the appeal should be directed.

To not be relocated within the facility except in accordance with nursing facility regulations.

To keep and use personal possessions, including clothing and furnishings, as space permits, secure from theft or loss. The number of personal possessions may be limited for the health and safety of other individuals.

To wear their own clothes.

To refuse to perform services for the person or facility providing services.

To use advance directives to:

- Make a living will by executing a directive under the Texas Advance Directive Act;
- Execute a medical power of attorney; or
- Designate a guardian in advance of need to make decisions regarding their health care should incapacity occur.

To receive a copy of the Statement of Resident Rights and responsibilities before receiving services or as soon as possible after receiving services and to be informed of changes or revisions by the person providing services. The provider must post the Statement in a conspicuous location.

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

These described rights are cumulative of other rights or remedies which an elderly individual may be entitled under law.

Chapter 102, Human Resource Code and Nursing Facility Requirements for Licensure and Medicaid Certification.

The Texas Department of Human Services has determined that the rights listed on this poster apply to all residents of licensed Texas nursing facilities, regardless of age or disability.

_____ _____

Resident/Responsible Party (Signature) Date

YOUR RIGHTS TO MAKE TREATMENT DECISIONS

You have rights regarding your own medical treatment decisions. This includes the right to accept or refuse medical or surgical treatment. You also have the right to plan and direct the types of health care you may receive in the future. If you become unable to express your wishes you can name a person to make decisions for you in a Durable Power of Attorney for Health Care and also say what treatment you want and when you want it. If you don't have someone to make decisions for you, you may write your wishes about treatment in a Directive to Physicians. These documents are known as Advanced Directives.

WHAT IS AN ADVANCE DIRECTIVE?
An Advance Directive tells, in writing, your choices regarding the treatments you want, or do not want, or about health care decisions that are to be made for you. If you become incapacitated and cannot express your wishes, an Advance Directive will consider issues like dying, living as long as possible, being kept on machines, being independent, and quality of life.

WHO CAN MAKE AN ADVANCE DIRECTIVE?
If you are 18 years of age or older and of "sound mind" you can make an advance directive.

WHY MIGHT I WANT TO MAKE AN ADVANCE DIRECTIVE?
If you are too sick to make treatment decisions, family members or close friends usually will decide with the doctor and nurses what is best for you. And most of the time, that works, but sometimes everyone doesn't agree about what to do. That is why it is helpful to let everyone know what you want, and it truly helps your family and your doctor if they know what you want and expect. In some situations, your family may need to go to court in order to make decisions for you, so leaving a written form stating what you want them to do is much simpler. An Advance Directive speaks for you when you are unable to do so.

HOW DO I MAKE AN ADVANCE DIRECTIVE?
There are two ways to make an Advance Directive. You can either complete a Durable Power of Attorney for Health Care or a Directive to Physicians/Living Will.

WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTHCARE?
A Durable Power of Attorney for Health Care allows you to say what treatments you want, and to name a person to make medical decisions for when you can't yourself. These can include the decision or refuse or withdraw consent to medical treatment. The person you name is called the agent. Your agent can make medical decisions for you when you lack the capacity to make them yourself regardless of whether or not you are in a terminal condition. With some exceptions, you can choose an adult relative or friend you trust to speak for you when you are too sick to make your own decisions. Your agent may not be one of the following:

- Your Healthcare provider
- An employee of your healthcare provider, unless the person is your relative
- Your residential care provider; or
- An employee of your residential care provider

Both parts of the Durable Power of Attorney for Healthcare, the disclosure statement and Power of Attorney portions, must be properly executed and witnessed. Witnesses may not be:

- Your agent
- Your health or residential care provider, or an employee of your health or residential care provider;
- Your spouse or heir
- A person entitled to any part of your estate on your death under a will or deemed in existence or by operation of law; or
- Any other person who has any claim against your estate. (Staff members not providing any direct care, housekeepers, dietary personnel, etc. are not included in this list if they do not have nay claim to your estate and can be a witness.)

WHAT IS A DIRECTIVE TO PHYSICIANS (LIVING WILL)?
A Directive to Physicians can let your doctor know of your wishes even if you don't name an "Agent". You can write down the treatments you would or wouldn't want and when you would or wouldn't want them. If you are in a terminally ill condition, or dying, and you sign this form, it tells the doctor that you don't want any treatment that would prolong your dying and the doctor and facility staff must go along with your wishes. You may add specific instructions of your own to the form. You might want to list particular treatments to be withheld if you are in a terminal condition, for example, "I don't want antibiotic, surgery, cardiac resuscitation, a respirator, etc." You might even want, to emphasize your desire to be kept comfortable and pain free, even though medication may shorten your life.

_____ _____

Resident/Responsible Party (Signature) Date

Office of the Ombudsman

Protecting Resident Rights

To serve consumers through prompt, professional and courteous services as a neutral resource for resolution of health and human services-related inquiries and complaints.

What we do

The Health and Human Services Commission's Office of the Ombudsman helps people when the agency's normal complaint process cannot or does not satisfactorily resolve the issue.

The Office of the Ombudsman's services include:

- Conducts independent reviews of complaints concerning agency policies or practices
- Ensures policies and practices are consistent with the goals of the Texas Health and Human Services Commission
- Ensures individuals are treated fairly, respectfully and with dignity
- Makes referrals to other agencies as appropriate

Who we are

The Office of the Ombudsman is comprised of a team of professionals committed to a high level of customer service. We take in, refer and respond to calls and correspondence from the public, working closely with health and human services agencies' leadership, management and program staff.

For help contact Texas Long Term Care Ombudsman at **1-800-252-2412**

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