ADMISSION PACKET

Ollie Steele Burden Manor
St. Clare Manor

Franciscan Missionaries of Our Lady Health System

Ollie Steele Burden Manor and St. Clare Manor

Nursing Homes abide by

- *The Ethical and Religious Directives for Catholic Health Care Services*, as promulgated by the United States Conference of Catholic Bishops;
- Catholic Social Teachings, and
- The Mission and Values of the Franciscan Missionaries of Our Lady Health System
### Resident’s Information

**Resident’s Name:**

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<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Maiden</th>
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**Previous Address:**

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**Previous Phone:** (______)_____________

SSN: _________________________________

Marital Status  □ M  □ S  □ W  □ D  □ S

**Date of birth:** __________ **Age:** __

**Education Level:** ________________

**Primary Language:** __________________

**National origin:**  □ Caucasian  □ Hispanic  □ African-American  □ Asian  □ Other

**Medicare #:** ______________________

**Medicare Part A** □ Yes  □ No  **Effective Date:** __________

**Medicare Part B** □ Yes  □ No  **Effective Date:** __________

**Medicare Part D** □ Yes  □ No  **Effective Date:** __________

**Veterans #:** ______________________

**VA income?** □ Yes  □ No  **TRICARE:** □ Yes  □ No

**Medicaid** □ Yes  □ No  

**Medicaid #:** ______________________

**Insurance Name:** ____________________

**Policy #:** ____________________  **Group #:** __________

**Other insurance:** ____________________

**Policy #:** ____________________  **Group #:** __________

**Primary Physician:** ____________________

**Phone #:** ____________________

**NH Physician:** ____________________

**Phone #:** ____________________

**Dentist:** ____________________

**Phone #:** ____________________

**Optometrist:** ____________________

**Phone #:** ____________________

**Hospital:** ____________________

**Pharmacy:** ____________________

**Church Affiliation:** ____________________

**Religion:** ____________________

**Funeral Home:** ____________________

**Phone #:** ____________________

**Responsible Party:** ____________________

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<tr>
<th>Last</th>
<th>First</th>
<th>Relationship</th>
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**Address:** __________________________________________________________

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**Work # (______)_____________ **Cell #: (____)_____________ **E-mail:** ____________________

**Next of Kin Name:** ____________________

**Relationship:** ____________________

**Address:** __________________________________________________________

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**Work # (______)_____________ **Cell #: (____)_____________ **E-mail:** ____________________

**Revised 4/7/2014**
ADMISSION AGREEMENT

___________________________, ________________________
Nursing Home                                                      Resident                                                      Responsible Party

hereby enter into the following financial terms and arrangements, providing for the medical, nursing and personal care of the previously-named resident.

I. Agreement of Nursing Home
1. To furnish room, board, linens and bedding, nursing care, and such personal services as may be reasonably required for the health, safety, good grooming and well-being of the resident.
2. To arrange for transfer of the resident to the hospital of the resident’s choice when ordered by the attending physician and to immediately notify the Responsible Party of such transfer.
3. To make refunds after all entities are paid in full.

II. Agreement of Resident and Responsible Party
1. To provide such personal clothing and effects as needed or desired by resident.
2. To provide such spending money as needed by the resident.
3. To be responsible for hospital charges.
4. To be responsible for physicians’ fees, medications, and other treatments or aids ordered by the physician.
5. To pay in advance the amount agreed upon with Ollie Steele/St. Clare Manor by the _____ th day of current month.
6. Facility is not responsible for any expenses not provided by the nursing home.
7. To be responsible for any damage caused by the resident to personal property or facility property.

Standard Admission Waiver
1. The management of this home has agreed to exercise such reasonable care toward this person as his or her known condition may require; however, this home is in no sense an insurer of his/her safety or welfare and assumes no liability as such.
2. The management of this home will not be responsible for any valuables or money left in possession of the resident while he/she is a resident of this home.

II. Agreement for payment of Resident’s Financial Obligations
1. The resident and/or responsible party agrees to pay, by the _____ th day of each month, all charges for services, which will be provided by the facility (except those covered by Medicare or Medicaid), from resident’s income and/or resources available for such payments.

   Semi-Private Room Rate: $________________________ per month
   Private Room Rate:              $________________________ per month
2. **Respite Care Only:** The resident or responsible party agrees to pay, by the ____th day of each month, all charges for services that will be provided by the facility, except those covered by Medicare, from resident’s income and/or resources available for such payments.

The rate of $______________ per month, plus $______________ daily Provider Fee.

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<tr>
<th>Nursing Home Representative</th>
<th>Title</th>
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**St. Clare Manor Only:**

III. It is the responsibility of the LA Department of Health and Hospitals (DHH) to determine eligibility for long-term care benefits. If certified it is DHH’s responsibility to determine the resident’s private liability amount. Also, if certified, any increase or decrease in income and/or allowable deductibles will result in changes to the resident’s private liability amount per DHH. Also, the resident agrees to supplement all amounts up to and equal to the rate per month not covered by Title XIX.

IV. If not certified by DHH within 45 days of admission, the Nursing Facility reserves the right to convert the resident to private-pay status and demand payment in full.

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BUSINESS AND FINANCIAL ARRANGEMENTS

Room and Board charges include room, meals, laundry service, nursing care, and personal care. Ancillary charges are in addition to room and board charges and include medications and some supplies, such as incontinence supplies. Other charges not included in the room and board fee include telephone, cable, beauty shop, and transportation costs.

Should certain supplies or services billable under Medicare Part B be necessary, the resident/responsible party must choose a provider of those services. Ollie Steele/St. Clare Manor can provide these supplies and services; however, an independent third-party provider may be selected.

Fees for all resident’s charges are billed in advance of each month and are payable by the tenth day of each month for Ollie Steele Burden Manor and the fifth day of each month for St. Clare Manor. A late payment charge of 1% per month (annual percentage rate of 12%) will be assessed after 21 days of delinquency.

It may become necessary, because of inflation or other factors, to increase room and board charges. The resident/responsible party will receive thirty (30) days of written, advance notice of any adjustments to monthly room and board charges. However, due to frequent fluctuation in supply costs, there will be no advance notification for adjustments to supply charges.
COMPREHENSIVE AUTHORIZATION AND ACKNOWLEDGEMENT

1. Authorization for Medical Treatment
Authorization is hereby granted to __________________________
Physician __________________________
Phone #
(and/or whomever he/she may designate as his/her assistant) to administer such treatment as necessary. I hereby certify that I have read and fully understand the above authorization for Medical Treatment. I also certify that no guarantee or assurance has been made regarding any result that may be obtained.

☐ Yes  ☐ No

2. Authorization for Drug Purchase
Authorization is hereby granted to the facility to order drugs from __________________________
Pharmacy. I understand that I shall be responsible for all charges not reimbursed by a third-party payer.

☐ Yes  ☐ No

3. Release of Responsibility for the Retention of Cash, Jewelry, Valuables, and Resident’s Other Personal Property
I have been advised by this facility not to keep cash, jewelry, or other valuables in my possession while a resident of this facility. I also understand that, notwithstanding this advice, wishing to retain certain items in my possession, I absolve the facility and its personnel of all responsibility against possible loss including dentures, hearing aids, glasses, television, remote control, clothing, etc.

________________________________________________________  ____________________
Resident or Responsible Party  Date

4. Rate and Reimbursement Information
Upon admission, a monthly rate will be determined as the financial liability for the resident. A daily rate will be calculated and charged for any portion of a month used. Refunds will be made for any unused portion of a month due to discharge or death after the account balance has been determined and after any outstanding charges have been deducted. MEDICAID RESIDENTS ONLY: I have been advised that I can apply to receive Medicaid benefits at any time. Medicaid may assist me provided my financial status meets the requirements of the Medicaid program. If I have a financial change in status, it is my responsibility to notify nursing home administration prior to depletion of resources.

5. Bed Hold and Room Change Policy and Procedure
- All residents who vacate their beds to be hospitalized are required to pay for a bed hold in order to guarantee placement back in the facility.
- Private pay residents will be billed daily from the day of hospitalization.
- Medicaid residents will be billed daily from the eighth day of hospitalization, at the amount the state pays the facility each month. The office will prorate the amount for the family.
- Responsible parties are required to contact the business office when the resident leaves the facility to make necessary financial arrangements for holding a bed. If this does not occur, and this agreement has not been signed, then the facility cannot guarantee that a bed will be available when the resident is discharged from the hospital.

Revised 4/7/2014
COMPREHENSIVE AUTHORIZATION AND ACKNOWLEDGEMENT, CONTINUED

➢ If you are reserving a bed during hospitalization and are concerned about the resident’s personal belongings, please secure them or make arrangements with the Administration to lock them up during the resident’s absence. At the time of death or discharge, the facility will gather up personal belongings and put them in a secure area until the family is able to come and get them.

➢ Residents may be asked to relocate during their stay. This occurs to facilitate the best roommate combination, to accommodate physical and mental changes and to accommodate new residents. You will be notified should this become necessary. The needs and desires of all residents are always considered in this event.

➢ In situations where residents are experiencing discord with another resident, it is the facility’s policy to reasonably attempt to relocate the resident depending on room available to be responsive to his/her concerns.

6. Physical, Speech, Occupational and Respiratory Therapy Screening Consent

If therapy is indicated, appropriate consultation and order(s) will be obtained. The proposed therapy will be discussed with the responsible party in order to obtain consent for the therapy.

When physical, speech, occupational, or respiratory therapy is provided, there is a charge, generally covered by insurance. Details of financial coverage will be discussed and prior approval will be obtained before therapy is provided.

___________________________________________________________  __________________________
Resident                                                                                      Date

___________________________________________________________  __________________________
Facility Representative                                                                 Date
PHARMACY PURCHASE AUTHORIZATION

I acknowledge that I am aware of my opportunity to choose a provider of pharmacy services that will comply with nursing home packaging, emergency services and resident record-keeping requirements.

Resident’s name: ________________________________________________  Resident’s #: __________________

Facility: _________________________________________________________  Doctor: _________________________

Private Pay?  □ Yes   □ No  Medicaid?  □ Yes   □ No  Medicaid #________________

Insurance?  □ Yes   □ No  Insurance Company Name: ____________________________

Policy # __________________________ Group #___________________________

Insurance Company Address: _________________________________________

Insurance Company Phone: ___________________________________________

Personal Charges to be Billed to:

Full Name: ________________________________________________________

Home Address: ______________________________________________________

Phone 1: ____________________________  Phone 2: ________________________

Alternate Family Member Name: _______________________________________

Home Address: ______________________________________________________

Phone 1: ____________________________  Phone 2: ________________________

I authorize the facility to order medication from __________________________ Pharmacy for the above-named resident. I promise to pay monthly charges upon receipt of statement. I understand this includes all charges that Medicare, Medicaid or private insurance does not pay. I understand that if a claim is denied, such charges will be billed to me.

___________ Please notify family before ordering any medication not covered by Medicaid.

I agree with and consent to the information above.

_________________________________________________________    ______________________
Signature of Responsible Party                                        Date

Revised 4/7/2014
ADVANCE DIRECTIVES INFORMATION

Advance Directives center on the principle of your right to die with dignity. With an advance directive, you can express how much or how little you want done for you when you are no longer able to make these decisions.

- Advance directives are a way of making your voice heard when you can no longer speak. They allow you to appoint someone to make your healthcare decisions for you when you no longer can and to administer or withhold treatment and procedures in accordance with your expressed wishes. Advance directives are not just for the elderly. All people who desire to direct their medical care in the future should complete advanced directives.

- An advance directive does not mean “do not treat.” This is a common mistake and is not correct. Of course, if you want to mean, “do not treat,” then that is something your surrogate needs to know.

Definitions
Advance directives: An advance directive is a written document or series of forms. You sign it to make it binding. The document indicates your choices about medical treatment if you are unable to make these decisions or choices by yourself. By completing the appropriate advance directives, you can predetermine end-of-life decisions about your future medical care in a legally-sound way.

Two types of advance directives are generally completed: a living will and a medical power of attorney (also referred to as designation of a healthcare surrogate or healthcare proxy).

Living Will
A Living Will is a written statement that tells healthcare providers what time of life-prolonging treatments or procedures to perform if you have a terminal condition or are in a persistent vegetative state. Living Wills should not be confused with a regular will. A Living Will only deals with issues related to your medical care, while you are still living.

Medical Power of Attorney (or designation of a healthcare surrogate)
This legal document allows you to select any person to make medical decisions for you if you should become temporarily or even permanently unable to make those decisions for yourself. This person is also referred to as your attorney-in-fact, but it is not necessary for him or her to be a lawyer.

Life-Prolonging Treatment
Life-prolonging treatments are procedures that are not expected to cure your terminal condition or make you better. They only prolong the dying process. Examples include a ventilator (breathing machine), kidney dialysis, and cardiopulmonary resuscitation (CPR).

Terminal Condition
If you have certain incurable conditions, medical treatment will only prolong the dying process; cure is not possible. Without such treatment, death will occur in a short time.

Persistent Vegetative State
This permanent coma or state of being unconscious is caused by injury, disease, or illness. You are not aware of your surroundings and there is no reasonable expectation of recovery.

Revised 4/7/2014
ADVANCE DIRECTIVES INFORMATION, CONTINUED

Do Not Resuscitate (DNR)
Your doctor discusses this form with you and it tells healthcare providers and emergency personnel that if your heart stops beating (cardiac arrest), or if you stop breathing (respiratory arrest), then they are not to attempt to revive you by any means. A DNR is not the same as a Living Will.

Artificial Nutrition and Hydration
Artificial nutrition and hydration are the invasive administration of nutrition and fluids through IV lines and feeding tubes. It is not the natural process of eating food or drinking liquid.

Facts About Advance Directives
- You can designate information regarding organ donation in most Advance Directives.
- You can withdraw or revoke your Advance Directives at any time you choose.
- The laws regarding Advance Directives vary from state to state. If you plan to spend an extended period of time in another state, complete the necessary papers in that state regarding your wishes concerning medical treatment. Legal experts agree, however, that most states will honor out-of-state Advance Directives if they meet the legal requirements in the state in which they were executed.
- Give copies of your Advance Directives to as many people as you can. In the untimely event of a medical emergency, those closest to you will need to know where the papers are in order to provide them to medical personnel. Give copies to your family, neighbors, clergy, doctor, lawyer, and the staff of the facility where you live. Too often, a person with a terminal condition goes into cardiac arrest at home and the family cannot find the paperwork that relates to the person’s wishes for emergency personnel. This situation often results in excessive resuscitation efforts, despite your wishes and desires. Unfortunately, without the legal paperwork, without the Advance Directive, emergency personnel must do everything possible to revive someone.
- A Living Will does not mean withholding pain medication. The whole purpose of completing a Living Will is to express your wishes for medical treatment and, if the situation warrants, die with dignity. For this reason, pain medication would be provided whenever appropriate to minimize suffering and make you feel as comfortable as possible.
ADVANCE DIRECTIVES ACKNOWLEDGEMENT

Resident’s Name: ___________________________________________ SSN: ______________________

Date of birth: _________________________________________________________

Please read the following 5 statements. Please initial each statement if you agree.

1) _______ I have been given written material about my right to accept or refuse medical treatment.

2) _______ I have been informed of my rights to write Advance Directives.

3) _______ I understand that I am not required to have Advance Directives in order to get care in this facility.

4) _______ I understand that the terms of any Advance Directive that I may have executed will be followed by the healthcare facility and my caregivers to the extent permitted by law.

5) _______ I have been given “Do Not Resuscitate” (DNR, No Code) information.

Please check ONE of the following statements.

☐ I have signed Advance Directives.

☐ I have not signed Advance Directives.

___________________________________________________     ______________________
Resident or responsible party Date

___________________________________________________     ______________________
Witness Date

Revised 4/7/2014
CODE STATUS

Name: ___________________________  DOB: ___________________ □ Male  □ Female

1. □ DO NOT attempt Cardiopulmonary Resuscitation (CPR) (DNR)

**Patient Statement:** I, the undersigned, am an adult capable of making an informed decision regarding withholding or withdrawing CPR, including treatments listed below and I direct that none of the following resuscitation measures be initiated or continued in the event that I should stop breathing and/or my heart should stop beating: **Cardiopulmonary Resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation.**

- □ I understand that this decision will not prevent me from receiving other healthcare, such as the Heimlich maneuver or oxygen and other comfort care measures.
- □ I understand that I may revoke this consent at any time by making an oral, written or other act of communication to a physician or other healthcare provider of the healthcare agency. If I am incapacitated, my representative may revoke the do-not-resuscitate consent by written or oral notification to physician or healthcare provider of the agency.

I consent to a physician implementing a DNR Order.

______________________________   ________________________________  _______________
Signature                                     Printed Name                          Date

**Responsible Party:**

I am the resident’s (check one)

- □ Court-appointed curator
- □ Agent under healthcare Power of Attorney
- □ Spouse, not judicially separated
- □ Adult offspring of patient (son or daughter)
- □ Sibling

I direct that none of the following resuscitation measures be initiated or continued on behalf of the Resident in every event that the resident should stop breathing and his or her heart should stop beating: **Cardiopulmonary Resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation.**

______________________________   ________________________________  _______________
Signature                                     Printed Name                          Date

Revised 4/7/2014
CODE STATUS, CONTINUED

Name: _________________________________________  DOB: _______________________ □ Male    □ Female

2. DO attempt Cardiopulmonary Resuscitation (CPR) (FULL CODE)

Resident’s Statement:
I direct that CPR is to be used in the event that I should stop breathing or my heart should stop beating

________________________________________   ________________________________  _______________
Signature                                             Printed Name                                             Date

Responsible Party:
On behalf of the resident, I direct that CPR be given in the event that the resident stops breathing or heart stops beating.

I am the resident’s (check one)
   □ Court-appointed curator
   □ Agent under healthcare Power of Attorney
   □ Spouse, not judicially separated
   □ Adult offspring of patient (son or daughter)
   □ Sibling

________________________________________   ________________________________  _______________
Signature                                             Printed Name                                             Date
**RESIDENT AUTHORIZATION OF BENEFITS AND RELEASE OF INFORMATION**

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<tr>
<th>Resident’s Name ____________________________</th>
<th>Supplier ____________________________</th>
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<tr>
<td>Facility: □ OSBM □ St. Clare Manor</td>
<td>SSN ____________________________________</td>
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<tr>
<td>□ Medicare Part B □ DMEPOS Operations</td>
<td>DOB: _________________________________</td>
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<td>□ Male □ Female</td>
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<td>Medicare# _________________________________</td>
<td>Phone # ______________________________</td>
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<td>Medicaid/State # __________________________</td>
<td>Policy # ____________________________</td>
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<tr>
<td>SUPPLEMENTAL INSURANCE</td>
<td>Group # ______________________________</td>
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<td>Insurance: ________________________________</td>
<td>Phone # ______________________________</td>
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<td>Address: __________________________________</td>
<td>Relationship to resident: ______________</td>
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<td>RESPONSIBLE PARTY</td>
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<td>Name ____________________________________</td>
<td>Phone # ______________________________</td>
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I request that payment of insurance benefits be made to the above-mentioned supplier for any enteral, wound care, urological, orthotic, ostomy or tracheotomy products that are ordered by my physician and that may be furnished to me by that supplier in accordance with such physician orders. Enteral pumps will be provided as a rental item unless I choose to purchase the pump. The supplier is responsible for keeping the pump operational during the rental period. I acknowledge that my choice of the above supplier as the provider of such services is made freely, recognizing that there are other companies that provide similar services and that financial benefit may accrue to the supplier. If no secondary or supplemental insurance exists, I understand that I, the beneficiary or the financially-responsible party indicated in my facility records, will be obligated to pay for any coinsurance or deductible amounts not covered by my primary insurance carrier. I understand that authorization will remain in effect during any period in which I receive products from the supplier and that this authorization may be revoked at any time. I should address any complaints to facility representatives who will then contact the supplier for restitution.

I authorize any holder of medical information about me to release such information to the above supplier or its billing service or to the appropriate insurance carrier as necessary to determine benefit eligibility. I permit a copy of this authorization to be used in place of the original.

Resident Signature: __________________________  Date: __________________
Printed Name: __________________________________________
Witness Signature: __________________________  Date: __________________
Printed Name: __________________________________________

**Complete of signed by other than resident:**

Signature: __________________________  Date: __________________
Printed Name: __________________________________________  Relationship: ____________________
ASSIGNMENT OF BENEFITS

Resident’s Name: ________________________________________________________________

Facility: □ Ollie Steele Burden Manor □ St. Clare Manor

Medicare Provider #: □ 195566 □ 195590

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of the services received or to be received, I assign to Ollie Steele Burden Manor or S. Clare Manor any third-party payment due to me or that may become due to me under all insurance policies held by me or for my benefit for services rendered on this admission or a related admission. I do hereby authorize and direct all insurance benefit payments to be made directly to Ollie Steele Burden Manor or St. Clare Manor. I recognize that if payment is made directly to me by said insurance company, the amount received up to the amount billed charges for services rendered, is the property of Ollie Steele Burden Manor or St. Clare Manor and should be paid to Ollie Steele Burden Manor or St. Clare Manor. A copy of this assignment shall be valid as the original.

____________________________________________________________

Resident/Responsible Party ________________________________ Date

ASSIGNMENT OF INSURANCE BENEFITS

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

Executed this ___________________________ day of ________________________________, 20________.

____________________________________________________________

Resident/Responsible Party ________________________________ Date

____________________________________________________________

Nursing Home Representative ________________________________ Date

Revised 4/7/2014
EMERGENCY PLAN / EVACUATION

Date: _______________   Resident’s Name __________________________________________________________

Please indicate your response below:

If an emergency requires Ollie Steele Burden Manor or St. Clare Manor to be evacuated:

□ I DO want my family member to be evacuated with the facility.

□ I DO NOT want my family member to be evacuated with the facility and I agree to pick up my family member as soon as possible when notified by the facility. I understand that if my family member is not picked up timely, he or she will be evacuated with the facility.

____________________________________________________________

Signature of responsible party

Date

Please complete the following contact information. Please be sure to include cell phone numbers and E-mail addresses:

Responsible Party: ____________________________________________________________________________

Last name                                                                 First name                                   MI

Address ______________________________________________________________________________________

City                                                                                               State       Zip

Relationship: ____________________________________ Home phone: __________________________

Work phone: __________________________ Cell phone: __________________________

E-mail address: _____________________________________________________________________________

Please complete the following if you know where you will be evacuating to:

Responsible Party Name: _________________________________________________________________

Evacuating Destination: _________________________________________________________________

Evacuation Address (if known): _____________________________________________________________

Phone # to evacuation site: ________________________________________________________________

Revised 4/7/2014
AUTHORIZATION FOR ADDITIONAL CHARGES

Resident’s Name: ___________________________________________ SSN ____________________________

Responsible Party: ___________________________________________ Phone ____________________________

For Ollie Steele Burden Manor Residents Only:
**Cable service and phone service:** Resident or Responsible Party is responsible for setting up cable and phone services with the appropriate companies.

For St. Clare Manor Residents Only:
**Cable Service:** At an additional charge of $_________ per month. Which is applied to the monthly billing statement, the resident is provided with basic cable service for his or her television. Basic cable service consists of Baton Rouge TCI Cable channels with no premium-pay channels. If the resident wishes to receive premium-pay channels in addition to the basic cable services provided by the facility for the above cost, then the resident and/or responsible party should contact TCI Cable for installation.

- □ Yes, I would like basic cable at the additional charge per month.
- □ No, I would not like basic cable service.

For St. Clare Manor and Ollie Steele Burden Manor Residents:
**Beauty/Barber Shop:** Ancillary services will be billed to the responsible party or resident. Please choose services and indicate how often:

________________________________________________________________________________________
________________________________________________________________________________________

For responsible party: Would you like to be notified if the stylist/resident feels that a chemical service is necessary? □ Yes □ No

**Incontinent Fees:**
- □ No. The responsible party will provide the resident with disposable undergarments.
- □ Yes. I authorize the facility to provide the disposable undergarments and bill me monthly.

**Size:** ________________ □ Pull-ups □ Diapers

_____________________________________________________________  __________________________
Resident/Responsible Party Date
NURSING HOME RESIDENT’S RIGHTS

As a resident of Ollie Steele Burden Manor or St. Clare Manor, you have the following rights. If you are unable to exercise these rights on your own, your legal representative (either the person possessing your Medical Power of Attorney or your family members) may exercise these rights for you.

1) To exercise your civil and religious liberties without interference, coercion, discrimination or reprisal in exercising your rights.

2) To be informed of your rights, the rules, and the regulations of the nursing home.

3) To be informed of the bed reservation policy for a hospitalization.

4) To be told of all services available, including those charges covered or not covered under Medicare, Medicaid, and the basic per-diem rate.

5) To be informed of your condition and planned treatment and participate in or refuse treatment.

6) To have access to all records pertaining to you, including current clinical records and to purchase copies of such records.

7) To receive a prompt response to all reasonable requests and inquiries.

8) To be transferred or discharged only after reasonable notice is given and only for medical reasons, the welfare of other residents, or for non-payment. **(Medicaid only: This right includes the right to appeal any transfer or discharge to the Department of Health and Hospitals, which shall provide a fair hearing for such appeals.)**

9) To receive adequate and appropriate healthcare and protective and support services.

10) To be treated courteously, fairly, and with the fullest measure of dignity.

11) To manage your personal financial affairs or, if this is delegated, to receive an accounting every three months upon request.

12) To be free of mental and physical abuse and of restraints not documented as medically necessary.

13) To refuse treatment and/or refuse to participate in any medical research projects.

14) To have your personal and medical records treated as confidential.

15) To be treated with consideration and respect for your personal privacy.
NURSING HOME RESIDENT’S RIGHTS, CONTINUED

16) To refuse to perform work for the facility.
17) To have private and uncensored communications, including but not limited to receiving and sending unopened correspondence, access to a telephone, visitation with family and friends, and overnight visitation outside the facility with family and friends in accordance with nursing-home policies, physicians’ orders, and federal and state regulations.
18) To take part in various activities of the nursing home.
19) To have your own clothing and possessions.
20) To use tobacco in accordance with applicable policies, rules, and laws.
21) To consume a reasonable amount of alcoholic beverages.
22) To have privacy for visits with your spouse.
23) To have your choice of pharmacy and physician.
24) To withhold payment of physician visitation if the physician did not examine you.
25) To retire and rise in accordance with reasonable requests.
26) To share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.
27) To have any significant changes in your health status reported to you.
28) To present grievances and recommend changes in policies and services to nursing home staff and administration or appropriate governmental officials, including, but not limited to, access to the resident’s sponsor and the Department of Health and Hospitals.
29) To be a member of or active in, and to associate with advocacy or special-interest groups.
30) To view the most recent Department of Health and Hospitals annual licensing survey results provided by the nursing units.
NURSING HOME RESIDENT’S RIGHTS

St. Clare Manor/Ollie Steele Burden Manor respects the rights of residents to make choices about aspects of their life in the facility that are significant to the residents, within the bounds of the rules, regulations, policies, and procedures of St. Clare Manor/Ollie Steele Burden Manor. St. Clare Manor/Ollie Steele Burden Manor is not responsible for the actions or inactions of other persons or entities not employed or selected by the resident or the resident's responsible party.

By signing below, I acknowledge that I have been informed of my Resident Rights as stated in Part 483, Requirements for Long Term Care Facilities in the Code of Federal Regulations.

________________________________________________________________  ________________________
Resident or Responsible Party  Date

If Responsible Party signed, please complete the following:

________________________________________________________________  ________________________
Print Name  Date

________________________________________________________________  ________________________
Nursing Home Representative  Date

Revised 4/7/2014
ST CLARE MANOR/OLLIE STEELE BURDEN MANOR RESIDENT RESPONSIBILITIES AND CODE OF CONDUCT

St. Clare Manor/Ollie Steele Burden Manor is part of a nonprofit corporation operated under the sponsorship and traditions of the Roman Catholic Church. The business of St. Clare Manor/Ollie Steele Burden Manor shall be conducted in accordance with and in furtherance of the guiding principles of the Ethical and Religious Directives for Catholic Healthcare Services and Catholic Social Teachings.

It is the intent of St. Clare Manor/Ollie Steele Burden Manor to promote a positive and healthy environment that enhances community living among the residents in its facilities. Residents of St. Clare Manor/Ollie Steele Burden Manor are expected to abide by the following rules of conduct:

1. Resident and resident’s family members and visitors shall abide by the rules, regulations, policies and procedures of St. Clare Manor/Ollie Steele Burden Manor, including the guidelines set forth in the Admission Packet.
2. Resident acknowledges and understands his/her rights and responsibilities and privileges as well as the rights, responsibilities and privileges of other residents.
3. Resident and resident’s family members and visitors are requested to participate in a positive way by respecting people, privacy, and property.
4. Resident and resident’s family members and visitors at all times are expected to treat the other residents of St. Clare Manor/Ollie Steele Burden Manor, as well as staff members, volunteers and facilitators of St. Clare Manor/Ollie Steele Burden Manor, with respect, civility, courtesy and consideration.
5. Resident and resident’s family members and visitors shall respect the rights, privileges and property of all other residents and their guests.
6. Resident and resident’s family members and visitors shall conduct themselves in a way that ensures the good condition of St. Clare Manor/Ollie Steele Burden Manor’s buildings and grounds.
7. Resident and resident’s family members and visitors are requested to report any known damage or vandalism to the property of St. Clare Manor/Ollie Steele Burden Manor or to the property of its residents, or report persons known to be responsible for such damage or vandalism.
8. Resident is allowed to have a personal pet during visitation hours, but the pet is not allowed to resident with the resident or on the premises. Resident shall review and abide by the St. Clare Manor/Ollie Steele Burden Manor policy pertaining to pet visitation.
9. Resident shall not smoke outside of the designated smoking areas on the premises of St. Clare Manor/Ollie Steele Burden Manor. Resident will be assessed for safe handling of tobacco products and will be assisted by family members or staff members to appropriately-designated smoking areas.
10. Resident is required to notify the responsible staff member prior to leaving the premises of St. Clare Manor/Ollie Steele Burden Manor.
11. Residents are prohibited from cohabiting with residents of the opposite sex other than a spouse.
RESIDENT TRUST FUND AUTHORIZATION

I, ________________________________ hereby authorize the Administrator/Director of Accounting of St. Clare Manor/Ollie Steele Burden Manor Nursing Facility to handle my personal funds in accordance with the Resident Trust Fund Policies and Procedures established by the nursing facility. I understand that I have the right to manage my own financial affairs and am making this decision voluntarily and of my own free will. The nursing facility is authorized to hold and dispense my personal funds as my needs require to pay for personal and medical expenses and monthly resident liability due to the nursing facility. Furthermore, I understand that the nursing facility will keep complete records of all deposits and disbursements to these funds and will make these records available to me or my representative upon request.

______________________________
Resident

______________________________
Legal Representative or Responsible Party

I, ________________________________ will handle my personal funds and do not desire my funds to be handled by the St. Clare Manor/Ollie Steele Burden Manor Resident Trust Fund account.

______________________________
Resident

______________________________
Legal Representative or Responsible Party

For St. Clare Manor residents only:
I understand that the facility co-mingles private pay and Medicaid recipients’ funds in the same resident fund account. It is Federal and State law that these funds be placed in an interest-bearing account. Permission is hereby granted for inspection of Resident Trust Fund records by the appropriate State and Federal agencies.

I authorize the above nursing facility to pay for medication that is not covered by Medicaid from my resident fund account.

______________________________
Resident

______________________________
Legal Representative or Responsible Party

______________________________
Date

______________________________
Authorized Representative of Nursing Facility

Revised 4/7/2014
REQUEST FOR EXCLUSION IN FACILITY DIRECTORY

☐ I hereby request that my name, general condition, religious affiliation, and location not be included in the Facility Directory. By invoking this right, I understand that people inquiring by phone and visitors will be told, “I have no information about this patient.” No deliveries, including cards or flowers, will be forwarded to me.

Print name: ____________________________________________________________ Date: ______________
Signature: ____________________________________________________________ Time: ______________
Witness Printed Name/Title: __________________________________________________
Witness Signature: __________________________________________________________________________"

☐ I hereby request that my name, general condition, religious affiliation, and location be included in the Facility Directory. I no longer wish to “opt out” as previously indicated.

Print name: ____________________________________________________________ Date: ______________
Signature: ____________________________________________________________ Time: ______________
Witness Printed Name/Title: ______________________________________________
Witness Signature: __________________________________________________________________________

AUTORIZATION TO TAKE PHOTOGRAPHS

☐ Yes ☐ No

I do hereby authorize the facility to take such photographs of me as may be necessary for identification, publicity, and/or medical purposes at any time during my residence at the facility. This authorization is based on a full understanding of my rights to privacy and my right not to consent to such photography and, accordingly, is knowingly and voluntarily given. I understand that two photographs will be taken of me, regardless, for purposes of identification on the Medication Administration Record and my medical chart.
PRIVATE PAY RESIDENTS

I, __________________________________________________________, understand that in the event that I may need to apply for Medicaid certification during my stay in the nursing facility, if I am placed in a private-pay bed that is not Medicaid Certified, I, or my Responsible Party, should contact a member of the administration team no less than three months prior to my becoming eligible and applying for Medicaid. The amount of countable resources for a resident applying for Medicaid is $2,000 for an individual and $4,000 for a couple.

If an appropriate Medicaid bed is not available at the time that one is needed for me or my loved one, I, or my Responsible Party, will continue to pay privately until a Medicaid bed is available (resource list provided by Social Worker) or find alternative placement until a Medicaid bed becomes available.

_________________________________________  __________________________________________________
Resident's Name          Room Number

_________________________________________  ________________________________
Responsible Party        Date

_________________________________________  ________________________________
Nursing Home             Date

Revised 4/7/2014
OLLIE STEELE BURDEN MANOR
Franciscan Missionaries of our Lady
Health System

ST. CLARE MANOR
Franciscan Missionaries of our Lady
Health System

ST. VINCENT DE PAUL PHARMACY CONSENT

Resident’s Name: ________________________________________________________________

Ollie Steele Burden Manor and St. Clare Manor Nursing Homes are participating in the St.
Vincent de Paul Community Pharmacy Program. Many residents have medications that are
discontinued by their physicians and are destroyed. This program recycles medications
(except controlled substances) and dispenses them to the indigent, free of charge. If you
would like to participate in this program, please sign below.

St. Vincent de Paul thanks you for your help.

______________________________________________________________________________

__________________________  ______________________
Signature of Responsible Party  Date
CONSENT FOR INFLUENZA AND PNEUMOCOCCAL VACCINES

Resident: __________________________ Location: __________________________ Date:________

INFLUENZA VACCINE: The influenza vaccine has been shown to protect adults from hospitalization and deaths resulting from influenza infection. Centers for Medicare and Medicaid Services require that influenza vaccine be provided to all residents of nursing facilities annually, prior to the influenza season. Reactions at the site of injection may occur. Mild fever or aches may also occur. This facility conducts an organized vaccine campaign between October 1 and March 31 of the subsequent year.

I, the resident or resident’s representative, was provided with a copy of the Vaccine information Statement for Influenza. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and the risks involved in refusing the influenza vaccine. I also understand that I may not be a candidate for the influenza vaccine because the vaccine is medically contraindicated for me.

INFLUENZA VACCINE:

__________  YES, I wish to receive the influenza vaccine annually.

__________  NO, I do not wish to receive the influenza vaccine this year.

__________  NO, I cannot receive the influenza vaccine because it is medically contraindicated.

__________  NO, I have already received the influenza vaccine this year:

________________________

Date and location of vaccine

PNEUMOCOCCAL VACCINE: The Pneumococcal Polysaccharide vaccine is effective against 23 pneumococcal types that cause 90 percent of all pneumococcal pneumonia and is effective for approximately five (5) years. Anyone 65 years of age or older or having chronic health problems is considered high risk for exposure to and complications from pneumococcal infections such as pneumonia, septicemia, and meningitis. Centers for Medicare and Medicaid Services require that pneumococcal vaccine be provided to all residents of nursing facilities.

I, the resident or resident’s representative, was provided with a copy of the Vaccine information Statement for Pneumococcal Polysaccharide vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of pneumococcal polysaccharide vaccine. I also understand that I may not be a candidate for the pneumococcal polysaccharide vaccine because the vaccine is medically contraindicated for me or I have received the vaccine in the past five years.

PNEUMOCOCCAL VACCINE:

__________  YES, I wish to receive the pneumococcal vaccine as recommended.

__________  NO, I do not wish to receive the pneumococcal vaccine this year.

__________  NO, I cannot receive the pneumococcal vaccine because it is medically contraindicated.

__________  NO, I have already received one dose of pneumococcal vaccine.

________________________

Resident or responsible party printed name

________________________

Resident or responsible party Signature

________________________

Date

________________________

Witness

Revised 4/7/2014
NUTRITION SCREENING

Name ____________________________________________ Date ________________________________

DOB: ________________________________ Height: _______________________ Weight: __________________

Please answer the following questions. Check the appropriate response.

Do you have allergies or intolerances? □ Yes □ No
If yes, specify what: __________________________________________________________________________

Do you have any other dietary restrictions: ______________________________________________________

Has an illness or condition caused you to change the kind or amount of food he/she eats?
 □ Yes □ No

Are you on a feeding tube? □ Yes □ No
If yes, specify nutrition: _________________________________________________________________

Is pump required? □ Yes □ No

Have you ever been told to cut back on any foods? □ Sugar □ Salt □ Fat □ Protein
If any identified above, please specify:

Check if YES. Do you eat □ Fruit □ Vegetables □ Milk products

Do you need assistance while eating? □ Yes □ No

Please specify your usual meal pattern:

Do you eat breakfast? □ Yes □ No Do you eat mid-morning snack? □ Yes □ No
Do you eat lunch? □ Yes □ No Do you eat mid-afternoon snack? □ Yes □ No
Do you eat supper? □ Yes □ No Do you eat an evening snack? □ Yes □ No

Do you eat alone most of the time? □ Yes □ No

Have you gained or lost 10 pounds in the past six months? □ Yes □ No
If yes, gained or lost? □ Gained □ Lost

Do you have natural teeth? □ Yes □ No

Do you have dentures? □ Yes □ No □ Uppers □ Lowers □ Partials

Do you frequently experience
Nausea? □ Yes □ No
Constipation? □ Yes □ No
Problems chewing? □ Yes □ No

Problems swallowing? □ Yes □ No

This information was obtained from: _____________________________________________________________

Revised 4/7/2014
SPECIAL UNIT ADMISSION CONSENT

I give my consent for ____________________________________________
Resident’s name
to be placed in a Special Care Unit for his/her safety and security due to his/her present
status with dementia. I understand that he/she will be evaluated ____________________________________________
Frequency
according to facility policy for continued stay. If the evaluation team finds that continued
stay on the unit is no longer appropriate, the resident and/or resident’s representative will
be informed and the facility will make arrangements for the transfer of the resident to the
appropriate bed when available.

COMMENTS
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

SIGNATURES

_________________________________________  ______________________  _____________
Responsible party/legal representative:    Date

_________________________________________  ______________________
Nursing facility representative:          Date

Last    First    MI    Attending Physician    Chart #
PHYSICAL RESTRAINT CONSENT  
(Form to be utilized by the nursing department)

In order to protect our residents from harm or to promote them to a higher level of independence, it is sometimes necessary for us to use a physical restraining device. Please indicate your consent or refusal below by checking the appropriate box.

<table>
<thead>
<tr>
<th>STATEMENT OF CONSENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ I DO □ I DO NOT consent to the use of restraints if the appropriate healthcare professionals have assessed the need for such a restraining device is indicated a part of my recommended plan of care.</td>
</tr>
<tr>
<td>□ I DO □ I DO NOT consent to the use of restraints on a temporary basis for treatment of life-threatening medical symptoms</td>
</tr>
</tbody>
</table>

Restraint to be used: ____________________________________________

Specific type of restraint to be used

Medical reason for use: ____________________________________________

________________________________________________________________________________________________

<table>
<thead>
<tr>
<th>ACKNOWLEDGEMENT SIGNATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have been informed of the potential benefits and risks of restraint use and hereby assume full liability for any adverse outcomes to my decision.</td>
</tr>
</tbody>
</table>

I understand that I have the right to alter my decision concerning restraints at any time. I also understand that the nursing home reserves the right to discharge or transfer the resident if the resident/responsible party is not compliant with physician’s recommendation of appropriate and necessary use of restraints.

Resident/Resident representative: __________________________ Date: ______________

If signed by representative: __________________________ Relationship: ______

Staff representative: __________________________ Date: __________

Print Name

Signature/Title
UNDERSTANDING RESTRAINT USE

At times, it becomes necessary to protect residents from injury or to assist them in promoting a higher level of independence by using physical restraints.

Physical restraints include but are not limited to the following: leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions, lap trays, bed/side rails, safety bars, geri-chairs, wrist and waist restraints. Using devices in conjunction with a chair, such as trays, tables, bars, or belts, that the resident cannot easily remove or that prevent rising, are also classified as restraints.

Restraints are only used if other interventions have failed and the use of restraints has been fully assessed by the interdisciplinary team and ordered by a physician.

This facility does not and will not use restraints for the purpose of discipline or convenience. Restraints are used only for safety and medical reasons. The need for continued use of restraints is assessed on an ongoing basis.

The following outlines the potential risks and benefits of using restraint devices:

**RISKS**

1. Bowel/bladder accidents, or possible total incontinence
2. Decreased physical functioning, possible development of contractures or possible development of pressure sores.
3. Reduced social interaction, possible withdrawal or possible development of depression.
4. Possible sense of loss of autonomy, dignity or self-respect.
5. Possible increased symptoms of agitation or onset of delirium.
6. Possible accident hazards such as falls, Head trauma, strangulation or entrapment.
7. Possible increased incidence of infection.

**BENEFITS**

A. Injury prevention.
B. Protection from re-injury.
C. Promotion of the healing process.
D. Prevention of complications.
E. Enhancement of mobility and Independence.
F. Therapeutic intervention enhancement

**ALTERNATIVES**

A. ____________________________________________
B. ____________________________________________
C. ____________________________________________
D. ____________________________________________
E. ____________________________________________
F. ____________________________________________
NOTIFICATION PRIOR TO DISCHARGE

Please note that the facility MUST have 48 hours notification prior to discharging residents from a skilled unit. This is to ensure that the facility can appropriately set up services to home or another facility. Otherwise, the facility is NOT liable for any services not provided upon discharge.

Please sign below to acknowledge that you understand the above text. Thank you.

________________________________________  _________________________
Signature of resident or responsible party Date
PASTORAL CARE SPIRITUAL ASSESSMENT

Name: ___________________________________________ Admission Date:_______________ Room:_______

Address: _________________________________________________________________________________________

Phone(s): ________________________________________    ______________________________________________

Individual is:    _______ Alert and oriented
                 _______ Alert and disoriented
                 _______ Unable to communicate

Religious affiliation: _____________________________________________________________________________

Church: __________________________________________________________________________________________

Level of congregation activity prior to admission:   _______ Active    _______ Inactive

Name of pastoral contact: _____________________________ Phone: ____________________

Desires visits from parish pastor and/or laypersons?    _______ YES    _______ NO

Desires to receive Communion     _____ daily     _____ 3 x per week     _____ only Sunday

Choose to attend Mass     _____ daily     _____ 3 x per week     _____ only Sunday

Comments: ______________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Revised 4/7/2014
OLLIE STEELE BURDEN MANOR  
Franciscan Missionaries of our Lady Health System

ST. CLARE MANOR  
Franciscan Missionaries of our Lady Health System

LAUNDRY SERVICE

Resident’s Name: ___________________________________________ Room #:_________________

☐ YES, I want St. Clare Manor/Ollie Steele Burden Manor to handle my personal laundry.

☐ NO, I do not want St. Clare Manor/Ollie Steele Burden Manor to handle my personal laundry. I have designated this responsibility to my family or responsible party.

_________________________________________________________ __________________________
Resident Date

_________________________________________________________ __________________________
Responsible Party Date

_________________________________________________________ __________________________
Nursing Facility Representative Date

Revised 4/7/2014
HMO FOR SKILLED RESIDENT

Resident, ________________________________, has an HMO policy with ______________________ for medical coverage. Due to coverage with an HMO, Medicare is not currently enforced. This plan has a deductible of $________________________ and co-pay of $________________________ per day, which is applicable from day ______________ to day ______________ of skilled care.

Resident, ________________________________, agrees to terms and conditions of the HMO policy when he or she obtained it and, as such, agrees to pay the applicable deductible and co-pay to St. Clare Manor/Ollie Steele Burden Manor Nursing Home.

I, ________________________________, as resident/responsible party, understand the above and agree to pay such deductible and co-pay amounts as required by the HMO policy.

_________________________ ________________________
Resident or representative Date

If signed by representative: ___________________________ Relationship: ______
Print Name

_________________________ ________________________
Responsible Party Date
Medicare Part A Certified Section

Room and Board  Routine nursing care, routine supplies and equipment  $152/day

Note: This is the coinsurance rate starting day 21 of Part A care.

Medicare Part A covers charges for the following ancillary services when approved:

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Physical Therapy</th>
<th>Radiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech/Language Pathology</td>
<td>Laboratory</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Medical Supplies, Chargeable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Personal Laundry</th>
<th>Transportation</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment Rental</td>
<td>Private Room</td>
<td>Television/Cable Hook-up</td>
</tr>
<tr>
<td>Private Duty Nurse</td>
<td>Beauty/Barber Shop</td>
<td></td>
</tr>
<tr>
<td>Briefs</td>
<td>Massage Therapy</td>
<td></td>
</tr>
</tbody>
</table>

If the beneficiary meets the qualifying conditions, Medicare will pay 100% of the daily room rate plus all covered ancillary charges for the first twenty (20) days. You (the beneficiary) are required to pay a portion of the charges for the 21st through 100th day of coverage for each benefit period. That portion is called “co-insurance.” The co-insurance amount is established by the federal government and presently is $152 per day. Medicare pays the remaining portion. Some supplemental insurance may cover the coinsurance amount.

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

When a beneficiary meeting qualifying conditions is no longer covered for Medicare Part A inpatient services, Medicare Part B may pay 80% of the following ancillary services and you, the beneficiary, or a third-party payer service such as Medicaid or insurance company, will be billed 20% coinsurance:

<table>
<thead>
<tr>
<th>Occupational Therapy</th>
<th>Speech/Language Pathology</th>
<th>Physical Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Dressings</td>
<td>Tube Feedings</td>
<td>Radiology</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>Laboratory</td>
<td></td>
</tr>
</tbody>
</table>

____________________________________________________    ___________________________________________
Facility representative                      Beneficiary/Responsible Party

___________________________________________
Date

Revised 4/7/2014
MEDICARE SECONDARY PAYER

This form should be completed for every resident receiving services and supplies under Medicare Part A and B.

Date: __________________________

Facility Name: Ollie Steele Burden Manor

Provider Medicare # 195566

Resident’s Name: ___________________________________________________ HIC #____________________

Resident’s DOB: ____________________________ Age: __________ Acct. #____________________

I. WORK-RELATED ACCIDENT. Is this injury/illness due to a work-related accident?

_________ NO→ Go to PART II.

_________ YES→ COMPLETE THE FOLLOWING: State date, time & place of accident:
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Covered by Workers’ Compensation? _____ YES _____ NO

Covered by Federal Black Lung Program? _____ YES _____ NO

Give the name and address of Workers’ Compensation or Federal Black Lung Program:
_____________________________________________________________________________________________

Patient policy or ID#: ________________________________________________________________

II. NON-WORK-RELATED ACCIDENT. Is this injury/illness due to a non-work-related accident?

_________ NO→ Go to PART III.

_________ YES→ What type of a accident caused the accident? ________________

For accident caused by vehicle, give the name and address of vehicle insurer:____________________
__________________________________________________________________________________________________

Is there litigation? _______ YES _______ NO

Name and address of attorney: ____________________________________________________________
__________________________________________________________________________________________________

III. GROUP HEALTH INSURANCE. Is the resident age 65 or older?

_________ NO→ Go to PART IV.

_________ YES→ Is patient employed and covered by employer’s group health plan?

_________ NO

_________ YES Policy # __________________________

Give name/address of that insurer: _________________________________________________________
__________________________________________________________________________________________________

Is spouse currently employed?

_________ NO→ Go to PART IV.

_________ YES→ Is patient covered by employer health plan of spouse?

_________ NO

_________ YES Policy # __________________________

Give name/address of that insurer: _________________________________________________________
__________________________________________________________________________________________________

Resident ID #:______________________________
MEDICARE SECONDARY PAYER, CONTINUED

This form should be completed for every resident receiving services and supplies under Medicare Part A and B.

IV. END STAGE RENAL DISEASE. Is the resident undergoing kidney dialysis for ESRD?
   _______ YES→ MEDICARE IS PRIMARY PAYER.
   _______ NO→ Is patient covered by Employer Group Health Plan?
                  _______ YES→ Give name & Address of Employer Group Health Plan:

   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

   Has the patient been undergoing kidney dialysis for more than 18 months or been entitled to Medicare for more than 12 months?
   _______ YES→ MEDICARE IS PRIMARY PAYER.
   _______ NO→ Is patient within an 18-month time period as defined by Section 264.4 (par. 4143.85)?
                  _______ YES* Employer Group Health Plan is primary payer.
                  _______ NO MEDICARE is primary payer.

   _______ NO→ MEDICARE IS PRIMARY PAYER.
   _______ YES*→ Is resident covered by a group health insurance plan based on own employment or the employment of a spouse or parent?
                  NO _______ YES*→ ___ Own/___Spouse

   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

   _______ NO→ MEDICARE IS PRIMARY PAYER.
   _______ YES*→ Policy #: ____________________________

   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

   V. DISABLED BENEFICIARY UNDER AGE 65. Is the resident a disabled Medicare beneficiary under age 65?
   _______ NO→ MEDICARE IS PRIMARY PAYER.
   _______ YES*→ Is resident covered by a group health insurance plan based on own employment or the employment of a spouse or parent?
                  NO _______ YES*→ ___ Own/___Spouse

   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

   VI. OTHER HEALTH INSURANCE. Does the resident have other health insurance that will pay for nursing home benefits (not supplementary insurance) before Medicare?
   _______ NO→ MEDICARE IS PRIMARY PAYER.
   _______ YES*→ Policy #: ____________________________

   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

   VII. GOVERNMENT PROGRAM. Are services to be paid by a government program such as a research grant?
   _______ NO→ Go to Part VIII.
   _______ YES→ Government Program will pay primary benefits for services.

   VIII. DEPARTMENT OF VETERANS AFFAIRS. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   _______ NO.
   _______ YES→ DVA is primary payer for these services.*

   * NOTE: When one of these cases exists, MEDICARE is the secondary payer and the facility MUST bill the other payment source before MEDICARE.
MEDICARE SECONDARY PAYER, CONTINUED

By signing below, I attest that information provided above related to benefit coverage is true and complete to the best of my knowledge.

__________________________________________________________________________________________
Resident or Resident’s Representative                      Date

__________________________________________________________________________________________
If Signed by Representative, Printed Name & Relationship

__________________________________________________________________________________________
Facility Representative                      Date
PRIVATE PAY AND SKILLED RESIDENT

I, ________________________________, understand that if I am placed in a private-pay bed that is not Medicaid Certified, I must contact a member of the administration team when the resident has three-months of funds left prior to applying for Medicaid. If an appropriate Medicaid bed is not available at the time one is needed for resident, I will continue to pay privately until a Medicaid bed becomes available.

Resident’s Name ________________________________ Room # ________________________________

Responsible Party ________________________________ Date ________________________________

Nursing Home Staff Member ________________________________ Date ________________________________
NOTICE OF PRIVACY PRACTICES
Ollie Steele Burden Manor, Inc.

This Notice of Privacy Practices (the “Notice”) describes the legal obligations of Ollie Steele Burden Manor, Inc., on behalf of Ollie Steele Burden Manor Nursing Home and St. Clare Manor Nursing Home (hereinafter collectively referred to as the “Organization”) and your legal rights regarding protected health information held by the Organization under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). HIPAA protects only certain health information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to:

(1) Your past, present or future physical or mental health or condition;
(2) The provision of health care to you; or
(3) The past, present or future payment for the provision of health care to you.

WHO WILL FOLLOW THIS NOTICE
This Notice describes the Organization’s practices and that of:

- All employees, staff, volunteers, contractors and other personnel.
- All departments and units of the Organization.
- Any member of a volunteer group we allow to help you while you are in our care.
- Any physician or allied health professional who is a member of the Medical Staff and involved in your care.
- All entities, sites and locations will follow the terms of this Notice. When this Notice refers to “we” or “us”, it is referring to the following entities, sites and locations. In addition, these entities may share medical information with each other for treatment, payment or health care operations purposes described in this Notice.

The Organization, the members of its Medical Staff, and other health care providers affiliated with the Organization typically work together in a clinically integrated setting to provide you with health care. In such settings, HIPAA permits the use of a single Notice to describe how the Organization, Medical Staff members, and other health care providers who participate in our health care arrangements will use or disclose your health information.
NOTICE OF PRIVACY PRACTICES, CONTINUED

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive at our Organization. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by our Organization, whether recorded in your medical record, invoices, payment forms, videotapes or other ways, that include protected health information. Physicians and other care providers who are not employed by the Organization may have different policies or notices regarding the use and disclosure of your protected health information created in the physician’s office or clinic.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgement of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

In some circumstances we are permitted or required to use or disclose your protected health information without obtaining your prior authorization and without offering you the opportunity to object. The following categories describe these different circumstances. For each category of uses or disclosures we will explain what we mean and list an example. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use and disclose your protected health information to provide you with medical treatment or services. We may disclose your protected health information to doctors, nurses, technicians, medical students, or other health care providers who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the hospital also may share medical information about you in order to coordinate the different things you need, such as medications, lab work and x-rays and we may disclose your protected health information to third parties with whom we coordinate and manage your care.

- **For Payment.** We may use and disclose your protected health information so that the treatment and services you receive at the hospital may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may inform your health insurance company of your diagnosis and treatment in order to assist the insurer in processing our claim for the health care services provided to you or share information with a person who helps pay for your care.
NOTICE OF PRIVACY PRACTICES, CONTINUED

- **For Health Care Operations.** We may use and disclose your protected health information for our day-to-day operations and functions. For example, we may we may compile your protected health information, along with that of other patients, in order to allow a team of our health care professionals to review that information and make suggestions concerning how to improve the quality of care provided at our Organization. We may also disclose information to doctors, nurses, technicians, medical students, members of our quality improvement team, and other participants in our organized health care arrangements for review and learning purposes and to improve the quality and effectiveness of the services you receive.

- **To Business Associates.** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain and/or transmit protected health information about you, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information.

- **Appointment Reminders.** We may contact you as a reminder that you have an appointment for treatment or medical care at our Organization.

- **Treatment Alternatives.** We may contact you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services.** We may contact you about health-related benefits or services such as disease management programs and community-based activities in which we participate that may be of interest to you.

- **Fundraising Activities.** We may contact you as part of our effort to raise funds for our Organization. You have a right to opt out of receiving fundraising communications and all fundraising communications will include information about how you may opt out of future communications.

- **Research.** Under certain circumstances, we may use and disclose your protected health information for research purposes through a special approval process designed to protect patient safety, welfare, and confidentiality. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. We may also disclose your protected health information to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the information they review does not leave the hospital.

- **As Required By Law.** We will disclose your protected health information when required to do so by federal, state or local law.
NOTICE OF PRIVACY PRACTICES, CONTINUED

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**SPECIAL SITUATIONS**

- **Organ and Tissue Donation.** If you are an organ donor, we may disclose your protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose your protected health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may disclose your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose your protected health information for public health activities. These activities generally include the following:
  
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report to state and federal tumor registries;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to provide proof of immunization to a school that is required by state or other law to have such proof with agreement to the disclosure by a parent or guardian of, or other person acting in loco parentis for an un-emancipated minor;

- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
NOTICE OF PRIVACY PRACTICES, CONTINUED

- **Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Judicial and Administrative Proceedings.** We may disclose your protected health information in response to and in accordance with a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute after we have received assurances that efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement.** We may disclose your protected health information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim’s agreement;
  - About a death we suspect may be the result of criminal conduct;
  - About criminal conduct at the Organization; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may disclose your protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine cause of death. We may also release health information about patients of the Organization to funeral directors as necessary to carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official. This release would be permitted (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- **National Security and Intelligence Activities.** We may release your protected health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

- We may also use or disclose your protected health information in the following circumstances. However, except in emergency situations, we will inform you of our intended action prior to making any such uses and disclosures and will, at that time, offer you the opportunity to object.

Revised 4/7/2014
NOTICE OF PRIVACY PRACTICES, CONTINUED

- **Hospital Directory.** We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

- **Individuals Involved in Your Care or Payment for Your Care.** We may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the hospital. In addition, we may disclose your protected health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

With few exceptions, we must obtain your written authorization for uses and disclosures of your protected health information involving (1) certain marketing communications about a product or service and whether financial remuneration is involved, (2) a sale of protected health information resulting in remuneration not permitted under HIPAA; and (3) psychotherapy notes, except for certain treatment, payment and health care operations purposes, if the disclosure is required by law or for health oversight activities, or to avert a serious threat.

Except as permitted under HIPAA or as described above, disclosures of your protected health information will be made only with your written authorization. You may revoke your authorization at any time, in writing, unless we have taken action in reliance upon your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.
NOTICE OF PRIVACY PRACTICES, CONTINUED

YOUR RIGHTS:

You have the following rights regarding health information we maintain about you:

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  Except as provided below, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. Effective September 23, 2013, we will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the Organization has been paid out-of-pocket in full. The Organization is not responsible for notifying subsequent healthcare providers of your request for restrictions on disclosures to health plans for those items and services, so you will need to notify other providers if you want them to abide by the same restriction.

  To request restrictions, you must make your request in writing to the Ollie Steele Burden Manor, Inc., Compliance Officer, 1125 West Hwy 30, Gonzales, LA 70737. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request communications, you must make your request in writing to the Ollie Steele Burden, Inc., Compliance Officer, 1125 West Hwy 30, Gonzales, LA 70737. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

- **Right to Inspect and Copy Health Information.** You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, information compiled in anticipation of or for use in civil, criminal or administrative proceedings, or certain information that is governed by the Clinical Laboratory Improvement Act. If the requested protected health information is maintained electronically and you request an electronic copy, we will provide access in an electronic format you request, if readily producible, or if not, in a readable electronic form and format we mutually agree upon. We may charge a reasonable cost-based fee consistent with HIPAA and Louisiana law.
Despite your general right to access your protected health information, access may be denied in limited circumstances. For example, access may be denied if you are an inmate at a correctional institution or if you are a participant in a research program that is still in progress. Access may be denied if the federal Privacy Act applies. Access to information that was obtained from someone other than a health care provider under a promise of confidentiality can be denied if allowing you access would reasonable be likely to reveal the source of the information. The decision to deny access under these circumstances is final and not subject to review. Otherwise, we will provide a written explanation on the basis for the denial and your review rights.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Administrator, 4250 Essen Lane, Baton Rouge, LA 70809. If you request a copy of the information, in accordance with Louisiana state law, you will be charged a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Request Amendment. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Organization.

- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for the hospital;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

To request an amendment, your request must be made in writing and submitted to the Compliance Officer, 1125 West Hwy 30, Gonzales, LA 70737. In addition, you must provide a reason that supports your request. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.
NOTICE OF PRIVACY PRACTICES, CONTINUED

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information made during the six-year period preceding the date of your request. However, the following disclosures will not be accounted for: (i) disclosures made for the purpose of carrying out treatment, payment or health care operations unless HIPAA provides otherwise, (ii) disclosures made to you, (iii) disclosures of information maintained in our patient directory, or disclosures made to persons involved in your care, or for the purpose of notifying your family or friends about your whereabouts, (iv) disclosures for national security or intelligence purposes, (v) disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure, (vi) disclosures that occurred prior to April 14, 2003, (vii) disclosures made pursuant to an authorization signed by you, (viii) disclosures that are part of a limited data set, (ix) disclosures that are incidental to another permissible use or disclosure, or (x) disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks us not to account to you for such disclosures and only for the limited period of time covered by that request. The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person’s address (if known), and a brief description of the information disclosed and the purpose of the disclosure for the period requested unless the period or right to receive the accounting is limited under HIPAA.

To request this list or accounting of disclosures, you must submit your request in writing to the Compliance Officer, 1125 West Hwy 30, Gonzales, LA 70737. Your request must state a time period. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we will charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may obtain a copy of this Notice at our website, www.ololrmc.com/elderly. To obtain a paper copy of this Notice, contact the Compliance Officer, 225-743-2463.
NOTICE OF PRIVACY PRACTICES, CONTINUED

OUR DUTIES

- We are required by law to make sure that health information that identifies you is kept private;
- We are required to provide you this Notice of our legal duties and privacy practices;
- We are required to notify you in the event that we discover a breach of unsecured protected health information, as that term is defined under federal law; and
- We are required to follow the terms of this Notice. We reserve the right to change the terms of this Notice and to make those changes applicable to all protected health information that we maintain. Any changes to this Notice will be posted on our website and at our facility, and will be available from us upon request.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact the Administrator, 4250 Essen Lane, Baton Rouge, LA 70809, 225-926-0091. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint.

CONTACT INFORMATION

You may contact the Compliance Officer at 225-743-2463 for further information about the complaint process or for further information about this document.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read the Notice of Privacy Practices and have had the chance to ask any questions.
Printed name of resident:

________________________________________

Signature of resident or resident’s representative:

________________________________________

If representative, printed name and relationship:

________________________________________

Date: _________________________________

FOR OFFICE USE ONLY
I attempted to obtain the resident’s signature to acknowledge receipt of Notice of Privacy Practices, but was unable to do so for the reasons documented below:

________________________________________

________________________________________

________________________________________

Employee Printed Name:

________________________________________

Employee signature: ______________________________ Date: ______________

PATIENT LABEL

Revised 4/7/2014
SURVEY RESULT NOTIFICATION

By signing below, you acknowledge that you have received notification that recent survey results are posted in the following areas:

**Ollie Steele Burden Manor:**

a) Lobby  
b) Unit Two Nursing Station

**St. Clare Manor:**

a) Blue binder located in a clear mailbox just outside the Administrator’s Office.

___________________________________________________________  _____________________________  
Resident or responsible party                                                Date
Resident Beauty and Barber Shop

Resident: ___________________________ Date of Admission: ____________________

Account # __________________________ Room # ___________________________

What hair and/or manicure services would you like for the resident?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How frequently? ___________________________________________________________
________________________________________________________________________

Would you like us to contact you before performing any chemical service (such as permanent or hair color)? □ YES □ NO

Comments: ___________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

_________________________________________ ________________________________
Printed name of Responsible Party Signature of Responsible Party

Contact Phone #, Responsible party: _______________________________ ______________________________
OLLIE STEELE BURDEN MANOR
Franciscan Missionaries of our Lady Health System

OLLIE STEELE BURDEN MANOR
BEAUTY SALON/BARBER SHOP PRICE LIST

<table>
<thead>
<tr>
<th>Service</th>
<th>Price</th>
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</thead>
<tbody>
<tr>
<td>Haircut and style</td>
<td>$22.00</td>
</tr>
<tr>
<td>Men’s hair cut</td>
<td>$10.00</td>
</tr>
<tr>
<td>Shampoo and set</td>
<td>$14.00</td>
</tr>
<tr>
<td>Shampoo</td>
<td>$4.00</td>
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<tr>
<td>Perm, cut and style</td>
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<td>Scalp treatment</td>
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<td>Hair color</td>
<td>$25.00 and up</td>
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