Prescribed by State Board of Accounts

County Form 77-A (2000)

ADMISSION RECORD/CONTRACT

RESIDENT # _____
ADM. DATE _____
ADM. FROM _____
ADM. TO _____
ADM. TIME _____
ADM. VIA _____

LEVEL OF CARE: ___ RESIDENTIAL R.B.A.

RESIDENT NAME Last First Middle

SOCIAL SECURITY #

LEGAL ADDRESS: Street, City, County, State, Zip

MEDICARE #
Part A? Part B?

MARITAL STATUS | BIRTHDATE | ALIEN REGISTRATION #, If Applicable | MEDICAID #, If Applicable

CHURCH AFFILIATION: Name of Church and Address

VETERANS ADMINISTRATION CLAIM # If Applicable

PREFERRED MORTUARY: Name and Address

Have Arrangements Been Made? ___ Yes ___ No
Paid for: ___ Yes ___ No

BLUE CROSS/BLUE SHIELD IDENTIFICATION # ACCOUNT #

PAYMENT SOURCE: ___ Private Pay ___ Veterans Administration Contract
_____ Room Board Assistance (Residential Financial Assist Only)

Have you applied? ___ Yes ___ No

BENEFIT CODE:

WHO WILL BE RESPONSIBLE FOR RESIDENT'S FINANCES? (Guarantor)

Name: _____ Telephone # _____

Address: _____

Relationship: _____

OTHER INSURANCE, SPECIFY:

IS THERE A:

_____ Court Appointed Guardian _____ Power of Attorney

_____ Responsible Person. If any of the Above, Please Specify:

Name: _____ Telephone # _____

Address: _____

Relationship: _____

INCOME (MONTHLY) AMOUNT:

1. Social Security: _____
2. Supplemental Sec. _____
3. Veterans Pen. _____
4. Other, Specify _____

_____ _____
_____ _____
_____ _____
_____ _____

Total _____

BANKING:

Name of Bank: _____

Checking: ___ Yes ___ No

Savings: ___ Yes ___ No

Approximate Assets: _____

Do You Own Real Estate? ___ Yes ___ No

Type: _____ Value: _____

Location: _____

MILITARY SERVICE, Date of War:

EX-MILITARY SERVICE #

FATHER'S NAME

FATHER'S BIRTHDATE

MOTHER'S NAME

MOTHER'S BIRTHDATE:

IN CASE OF EMERGENCY, NOTIFY: (IN ORDER OF PRIORITY, PLEASE.)

#	Name:	Address:	Home Tel. #	Work Tel. #	Relationship
1.					
2.					
3.					
4.					

TERMS:

1. Resident: Person listed on page one, line one of the admission record/contract will be referred to in the admission record/contract as "resident."
2. Responsible Person: Individual(s) listed on page one of the admission record/contract as designated as "responsible persons," "power of attorney," "guarantor," and/or "guardian," will be referred to in the admission record/contract as "responsible person."
3. Health Care Rate: The per day rate established by the Board of Directors that reflects the per day cost of caring for a resident. This rate changes periodically and notice is given to the responsible person(s) and/or resident. The rate and goods and services covered by the rate are published at regular intervals and are included in all admission packets.

I. STATEMENT OF RESIDENT COMPETENCY
(Check one of the statements below)

_____ The resident is legally competent to complete an admission record/contract. (Does not have a court appointed guardian and MUST sign the admission record/contract.)

_____ The resident is not legally competent and is not able to complete an admission record/contract. The responsible person is legal guardian (court appointed) and will submit to the facility a court original of the guardianship on or prior to admission.

If the resident is legally competent and has a responsible person who is power of attorney, an original of the power of attorney must be submitted to the facility on or prior to admission.

II. CONSENT FOR ADMISSION

1. The resident and/or responsible person understands that the admission record/contract is for the admission of the resident to the health care facility.

III. CONSENT AND AUTHORIZATION FOR THE ADMISSION AND APPLICATION OF MEDICAL AND MINOR AND SURGICAL SERVICES

1. The resident and/or responsible person authorizes the facility to provide health services for the resident. This is to include basic nursing care and supervision, medical and minor surgical services and routine and special diagnostic tests as needed by the resident. These services will be administered by nursing service and by the attending house physician(s) and designees, including, but not restricted to (a) dentistry, (b) podiatry, (c) ophthalmology, (e) x-ray, and (f) laboratory.

2. Consent is granted for referrals to specialists and/or the temporary transfer of the resident to a Hospital, when in the opinion of the attending physician(s) it is in the best interest of the resident.

   (A) If the resident and/or responsible person prefers a particular hospital, they may arrange with their outside physician and/or specialist for the transfer of the resident to the hospital of their choice, at their own expense. It is also the responsibility of the resident and/or responsible person to inform the facility of the preferred hospital in the space here provided. The resident and/or responsible person prefers that said resident be transferred when in need of hospitalization to:

   _____

   (B) If the resident and/or responsible person refuses hospitalization they MUST sign a statement to that effect which becomes part of the resident's permanent clinical record.

   (C) If is fully understood that the facility is not responsible for any expenses incurred by the resident during hospitalization or outside of said facility.

3. The resident/responsible person fully understands that they have the right to the choice of their own "physician" and/or own "pharmacist" and are not required to utilize the facility's attending physician and/or pharmacy which is included in the all-inclusive rate. However, if the physician and/or pharmacist of the resident's and/or responsible person's choice is utilized, it is at the expense of the resident and/or responsible person, not the facility. It is also the resident's and/or responsible person's responsibility to see that the physician of choice visits and reviews medications on a regular basis and as established by the state and federal regulations, and that medication from the pharmacy of choice is always available. Please check the appropriate boxes:

_____ The facility's attending physician(s) will be utilized.

_____ An outside physician of choice will be utilized.

_____ The facility pharmacy will be utilized.*

_____ An outside pharmacy of choice will be utilized.

*The resident and/or responsible person hereby gives permission to the facility pharmacists to substitute a generically equivalent drug product for the brand name drug prescribed by the physician according to the Indiana law.

4. The resident and/or responsible person authorizes the facility to dispense all medications as ordered by either the attending physician(s) and/or outside physician of choice. If an outside medication is brought into the facility, it must be identified and relabeled by the facility pharmacy.

5. It is understood that before seeking medical services outside those supplied by the facility, the facility's physician/medical department will be informed by the resident and/or responsible person.

IV. CONSENT TO HOLD HEALTH FACILITY/RESIDENT BED

The policy of the facility is to hold a bed available for a resident who is hospitalized (for up to fifteen days) at full rate unless the business office is otherwise informed not to do so by the resident and/or responsible person. The resident and/or responsible person understands and agrees to this stated policy.

V. CONSENT TO FACILITY ROOM TRANSFER

The resident and/or responsible person consents to in-facility room transfer for medical reasons (including level of care changes), psycho-social reasons, and/or reasons necessitated for changing admission patterns.

VI. DISPOSAL AUTHORIZATION

1. The resident and/or responsible person authorizes the facility to dispose of any and/or all of the resident's personal items seven days after discharge or discontinuance of resident status, if the items are not removed within this time.

VII. RELEASE OF RESPONSIBILITY FOR LEAVE OF ABSENCE

1. The resident and/or responsible person accepts complete responsibility for the resident while away from the facility and absolves the management of the facility, its personnel and the attending physician of responsibility for any deterioration in condition, or accident that may happen while the resident is away.

2. It is understood that a pass for all out-of-facility functions (not escorted by staff) must be issued by nursing service. If the resident leaves without a pass, the said resident's bed will be held for seventy-two hours, after which an automatic discharge is issued.

VIII. FACILITY AGREEMENT/CONTRACT

The resident and/or responsible person hereby agrees to the following terms and arrangements for the facility to provide in-facility medical, nursing, and personal care for the resident.

A. Facility Agreement

1. The facility agrees to provide the services, supplies, and equipment as may be required for the health, safety, good grooming, and well being of the resident as stated in the Health Care Rates Publication.

2. It is understood that the Health Care Rates Publication, its contents, considerations, goods and services provided are established by the Board of Directors of the facility to reflect changes in level of care and cost in providing goods and services. The rates are subject to change, given thirty days written notice to the resident and/or responsible person.

3. The facility agrees to exercise such reasonable care toward the resident as known condition may require; however, the facility is in no sense an insurer of the resident's safety or welfare, and assumes no liability as such.

4. The facility will not be responsible for any valuables or money left in the possession of the resident while residing in the facility.

5. The facility will refund any unused fees according to the established policy of the facility.

B. Resident/Responsible Person Agreement

1. To provide the resident clothing and other personal items as needed or desired by the resident.

2. To deposit enough funds in Resident Trust Fund to cover expected expenditures for personal items.

3. To be responsible for hospital charges and transportation charges if hospitalization becomes necessary.

4. To pay the per day rate agreed upon and stated in the Facility Health Care Rate Publication. This rate changes periodically and notice is given to the resident and/or responsible person.

5. To assist the facility in the application for RBA assistance when such assistance becomes necessary to cover the health care rate.

C. Duration of Agreement

1. Either party may terminate this agreement on written notice. Otherwise it will remain in force until a different agreement is executed. This does not mean that the resident will be forced to remain in the facility against his or her will for any length of time.

2. No resident will be forced to reside in the facility.

IX. AUTHORIZATION FOR RELEASE OF MEDICAL AND SOCIAL DATA

The resident and/or responsible person hereby authorizes the release to the facility by any party and/or parties any and all medical, psychological, and/or social information, reports, tests, summaries, and other data the facility requests on the attached request form. This release covers any and all requests for information that the facility may make prior to, during, or after admission and while the resident is in the facility's care.

The resident and/or responsible person further authorizes the facility to release and/or utilize any and all data collected by the facility from any source at the facility's discretion.

X. AUTHORIZATION FOR ACTIVITY INVOLVEMENT

Permission is given for the resident to participate in in-facility and out-of-facility recreational and creative activities. This permission will include transportation to and from the activities in the facility, volunteer, and/or hired vehicles.

XI. GUARANTEE OF PAYMENT

Payments due by 10th of each month. Balances over 30 days past due will be charged at 12% per year. Contracting parties are responsible for all collection costs, including attorney fees, court costs, etc.

In consideration of the facility providing residential care and services to the resident pursuant to the resident's agreement, I/we guarantee payment of all charges and expenses of the resident per the resident's agreement with the facility. This guarantee of payment shall remain in full force and effect during the entire term of the resident's agreement unless modified in writing by the guarantors and the facility. I/we hereby waive all right to notice of default and demand for payment.

XII. AFFIDAVIT OF RESIDENT AND RESPONSIBLE PERSON

THE RESIDENT AND/OR RESPONSIBLE PERSON CERTIFIES THAT ALL INFORMATION CONTAINED IN THE FOREGOING ADMISSION RECORD/CONTRACT IS TRUE AND CORRECT. FURTHERMORE, THE ADMISSION RECORD/CONTRACT HAD BEEN READ AND IS CLEARLY UNDERSTOOD.

_____ _____

SIGNATURE OF RESIDENT

SIGNATURE OF RESPONSIBLE PERSON
TITLE: RESPONSIBLE PERSON, POWER OF ATTORNEY, GUARANTOR, AND/OR GUARDIAN

STATE OF INDIANA)
) SS
COUNTY OF _____)

SUBSCRIBED AND SWORN OR AFFIRMED TO BEFORE ME, THIS _____ DAY OF _____ A.D. 20__. IN TESTIMONY WHEREOF I _____ HAVE HEREUNDER SET MY HAND AND OFFICIAL SEAL.

_____, A NOTARY PUBLIC

FOR THE COUNTY OF _____, STATE OF INDIANA,

MY COMMISSION EXPIRES: _____