Windy Hill VILLAGE

*A Tradition of Care. A Heritage of Trust.*

17024 Veterans Memorial Hwy, Kingwood, WV 26537
Phone: 304-329-2741 Fax: 304-329-2744

# RESIDENCY AGREEMENT

Resident's Name: _____

Admission Date: _____ Admitting Room #: _____

## DUTIES OF THE FACILITY

The Facility shall provide:

1. Personal assistance on a nondiscriminatory basis so that all residents are admitted and receive benefits and services without regard to race, religion, color, national origin, age, handicap, or source of payment.

2. Disclosure of a written list of services to be offered and their costs, including the Facility's policy regarding refunds.

3. Written list of information and referral services to be provided by the Facility with respect to assisting in the resident's utilization of social, recreational, and vocational activity within the community.

4. Protection of the resident's personal property from loss and theft; however, the Facility is not responsible for any personal belongings, money or jewelry kept at the Facility by the Resident.

5. Assurances that the resident or his/her legal representative will be allowed to exercise his/her rights as a citizen.

6. Thirty (30) days written notice to the resident of possible discharge in the event of one of the following circumstances occurring:

    a) The resident's care needs change, thus rendering him/her ineligible to remain in the Facility because he/she requires extensive and on-going nursing care based upon the policies of this facility. The determination of whether the facility can meet the resident's needs shall be made at the discretion of the facility and any new or existing polices. A thirty (30) day written notice is not required when a medical problem or behavior problem cannot be resolved. See Bed Hold Policy,

    b) Failure to meet the financial terms of this contract.

7. Assistance, if needed, to the resident in making appointments for appropriate medical, dental, nursing or mental health services, assistance with arrangements for transportation to and from these services, and for relocation in the event of resident's change in level of care needed. The Facility is not solely responsible for such arrangements nor shall the Facility provide transportation or be responsible for payment of services so arranged.

8. Maintenance of resident care records and retention of such for at least five (5) years past the death or discharge of a resident, or closure of the Facility.

9. The following services are provided during the term of this Agreement as part of the Monthly Fee:

    a) Utilities. The Facility will furnish water, electricity, heat and telephone service for local calls. Residents may elect at their own expense to have televisions and telephones in their rooms.

    b) Housekeeping. The Facility will perform daily housekeeping tasks.

    c) Meals. On a daily basis, the Facility will provide three (3) meals available and served in the dining room. Snacks are also provided. Diets may be provided under order of your physician as outlined in the doctor's medical statement, but there may be limitations which will be discussed with the MD to provide appropriate dietary nutrition in accordance with their medical condition.

    d) Laundry. A change of bed linen (bed sheets and pillowcase) will be provided weekly. The Facility will be responsible for the laundering of your personal things.

    e) Other Services. The Facility will also provide various planned activities.

10. The Facility will provide CPR and basic first aide to a resident, should the same be required. The Facility does further provide limited and ongoing care at the discretion of the RN-on-Call and the Administrator and with approval via waiver from OHFLAC to the residents. The Facility does provide health care through licensed nurses and/or AMAP (Approved Medication Assistive Personnel) being present in the facility at various times throughout the day; first aide and CPR certified aides twenty-four (24) hours a day, seven (7) days a week; a registered nurse is on call during all hours, as well as having a designated physician for each resident. The RN-on-Call shall assess injuries or changes in condition of Resident and determine if further hospital evaluation is necessary.

11. The Facility shall attempt to maintain the resident in his/her original unit as assigned at time of admission, unless the resident or responsible party requests a move to a different unit or it is necessary for the Facility to move the resident to another unit, which said move shall be within the discretion of the Facility. Should the resident be moved, the Facility will make reasonable efforts to notify the resident and/or the responsible party of such move. The facility is required to give a 72 hour notice of room change unless an emergency situation such as unsafe to a resident or isolation need is required.

## DUTIES OF RESIDENT AND/OR RESPONSIBLE PARTY

The resident and/or responsible party shall:

1. Understand and agree that in order to live at this Facility, resident must be in reasonably good health, capable of assisted living with services provided by Facility and free of communicable diseases.

2. Arrange for the services of attending physician of choice, who will be responsible for annual history and physical, medication and treatment orders, availability for consultation and emergency situations. Attending physicians must sign all verbal orders within thirty (30) days of order date.

3. Provide verification of a physical examination, prior to admission, which states the resident is appropriate for assisted living environment.

4. Provide such personal clothing and effects as needed or desired by the resident and accept full responsibility for all items, including but not limited to, money, personal possessions, and/or valuables kept in the Resident's room, and to mark all clothing with resident's initials before they are brought into the Facility. Provide a written inventory of personal belongings and/or things at the time of admission and as items are added or removed. Please limit wardrobe to seven (7) outfits per resident.

5. Be financially responsible for hospital charges and transportation to hospital, if hospitalization of the resident becomes necessary.

6. Be financially responsible for payment of fees for all care provided in accordance with provisions of this agreement. Payment is due prior to the beginning of each month for the month being billed.

7. Be financially responsible for any and all physician's fees, medications, special equipment,, private sitters, private nurses, and other services or aids ordered by the attending physician engaged for resident.

8. Participate to the fullest extent possible in the overall plan of care.

9. Accept full responsibility for the consequences, should the resident leave the Facility against the advice of the attending physician.

10. Participate in making arrangements for placement in an alternate care setting should the resident's care needs change requiring extensive and on-going nursing care without waiver approval from OHFLAC to remain in facility.

11. Shall, prior to , or at the time of admission, execute documents for a medical power of attorney and a durable power of attorney, unless a guardian/conservator has previously been appointed by the Court of appropriate jurisdiction.

12. A Responsible Person is the individual who has individually and personally assumed the financial and physical responsibility for the resident, even if this Agreement is executed as the appointed Guardian, Power of Attorney or as a relative. The Responsible Person becomes so named when he/she accepts the personal responsibility to comply with all regulations and requirements, including payments due, as set forth in this Agreement.

13. When the responsible party supplies medication for the resident, the Facility shall give a forty-eight (48) hour notice of the need for medication prior to depletion. Should the responsible party fail to supply the medication within forty-eight (48) hour notice, the Facility will supply the same through Facility contracted Precision Care Pharmacy and the responsible party shall be liable for payment.

14. Shall be responsible for all personal belongings, money and jewelry kept at the Facility.

## LODGING OF COMPLAINTS

All verbal and written complaints shall be directed to the Administrator of the Facility. Should this staff person not be available on the premises of the Facility, the complaint shall be addressed to the Supervisor in charge, who shall then direct the complaint to the administration upon their return to the premises. The administration and the Supervisor in charge who may receive the complaint are advised by the Facility that any filed complaint is to be confidential and shall not be discussed, except by Administration and not with anyone else, unless necessary due to the cause of the complaint and then no resident name shall be used unless completely unavoidable. The written complaint forms are available in the main hallway in a wall folder and may be obtained by the person wanting to file the complaint at their discretion. Residents/and responsible party shall be shown the location of complaint forms on admission. Once complaints are lodged, the complaints are accessible only to the Administrator and shall be kept in a secure location. The Administrator shall be responsible for investigating the complaint and notifying the resident of the results of the investigation. Complaints will be answered within 4 days. If the persons wanting to file complaint do not wish to be known they may call Adult Protective Services (APS) Hotline 1-800-352-6513 or Office of Health Facility Licensure and Certification (OHFLAC) 1-304-558-0050. Your Ombudsmen are:

Ed Hopple, Regional Ombudsman
165 Scott Ave. Suite 209
Morgantown, WV 26508
(800) 834-0598 ext. 3912

Suzanne Messenger, State Ombudsman
1900 Kanawha Blvd East
Charleston, WV 25305
304-558-3317

## MEDICATIONS/PHARMACY RULES OF FACILITY

The Facility shall maintain a secure area in which all medications are kept for the Residents. The Facility shall be responsible for the storage, disposition and administration of all medications. The Facility will provide licensed/trained personnel to administer the medications to the residents. The resident and/or responsible party has the right to provide his/her own medications, subject to action required to obtain medication upon notice of near depletion by the Facility as hereinbefore addressed. The Facility also provides pharmacy services through a contractual agreement with another agency and the Facility, upon request and execution of agreement for said services, will provide medication for the resident upon receiving appropriate prescriptions for the same. Should the resident demise, be discharged from the facility, or a change in physician's orders occur the medications will be destroyed according to the Facility procedure. Should the resident have entered into an agreement to obtain medications through the contractual arrangements for medications provided by the Facility, medications will be returned to the contracted agency.

## HOUSE RULES

1. Smoking is not permitted inside the Facility. Residents will smoke in designated areas outside the building. Use of metal ashtray is mandatory. Smoking is not permitted in resident's room.
2. Alcoholic beverages are not permitted, except as prescribed by a physician.
3. Visiting hours are from 8:00 a.m. until 8:00 p.m.
4. A large television is provided in our Day Room. Residents may bring their own televisions with them, with basic cable being provided with no extra charge to residents. The volume of the television must be lowered if it disturbs other residents. We have a variety of games for your use. Field trips are scheduled periodically for events which will interest residents.
5. Laundry is included in the basic rate.
6. Forms and pens are provided for anyone who may wish to make a complaint. Tell the administrative staff, if you have a complaint. All complaints are treated with respect and resolved promptly. See rules for Lodging of Complaints set forth hereinbefore.
7. Each resident is provided a bedside stand and chest with drawers to store personal belongings. We have limited storage space for large items, but we will consider these things, if they are important to you. Please limit wardrobe selections to seven (7) outfits.
8. Visitors displaying disruptive behavior will be asked to quiet down or leave, especially if it affects the residents. Residents displaying disruptive behavior will be monitored and their physician notified. See Unmanageable Resident rules hereinafter set forth.
9. Copies of House Rules will be posted for reference within the Facility. Should changes be made in the House Rules by the Facility, the Resident and/or Responsible Party accept notice of same by the posting of notice of change of rules within the Facility ten (10) days prior to enforcement thereof and, by such posting, this Agreement shall be amended as such by the attachment of such notice to this Agreement.

## RESIDENT FUNDS

A resident has the right to manage his/her own financial affairs. **The Facility will not accept any personal funds of the Resident**. The only funds deposited with the Facility will be funds for payment of services hereinafter set forth. Should the resident desire to maintain personal funds at the Facility, it shall be the responsibility of the resident to manage the same and to protect the same.

## LEAVING OF PREMISES AND EMERGENCY MEDICAL SERVICES

By entering into this Agreement, the Resident and/or Responsible Party is being admitted by his/her own volition or upon the direction of the Responsible Party and, by such action, the Resident and/or Responsible Party does absolve the management, its personnel, and the attending physician of any responsibility, if the resident should leave the Facility premises excepting in cases of elopement. Resident and/or Responsible Party agrees to give notice to the administration of the Facility or the Shift Supervisor on duty, at any time Resident leaves facility and will sign in and out upon each time leaving and returning to facility. This includes, but is not limited to, appointments, visits, etc.

Further, by entering into this Agreement, the Resident and/or Responsible Party does give permission to the Facility to secure emergency medical services when deemed necessary. This includes the services of physician and/or transportation to a local hospital, if needed. The Resident and/or Responsible Party shall be financially responsible for said services secured.

Further the Resident and/or Responsible Party does permit the physician designated as the medical consultant by the Facility to review the medical record of the Resident. The Resident and/or Responsible Party further agrees to execute documents as necessary to permit the Facility to obtain medical records of the Resident to assist in providing necessary care to the Resident.

## MISCELLANEOUS

1. Furnishing and decorating: We will furnish the resident room with bed, bedside stand, lamp, dresser, guest chair, and window blind. You are encouraged to bring some personal items and/or a television. Any repairs, maintenance, and replacement of items you bring will be your responsibility. All redecoration must be approved by the facility.
2. Automobiles: You may keep an automobile at your own risk.
3. Personal Effects: This facility cannot be responsible for your personal effects, however we will take the necessary precautions to safeguard your possessions.
4. Entry: We will try to provide laundry and cleaning services without undue interference to you. We have the right to enter the suite at reasonable times to inspect, make repairs, decorate, provide medical services, for any other reason and, in the interest of your safety, in time of emergency.
5. The suite may only be used as your personal residence.
6. Your application for admission, medical statement, and all supporting documents are incorporated herein and made a part of this agreement.
7. This facility does have liability insurance.
8. This facility will accept and serve the following types of residents: Independent residents, non-ambulatory residents, residents with limited and with on-going nursing care needs with the approval via a waiver from OHFLAC and at the discretion of the RN-on-Call and the Administrator.
9. This facility will not accept residents that have feeding tubes, intravenous access devices, trachs, or residents receiving kidney dialysis.
10. Outside services are also available in Facility such as hospice, home health, and therapy provided by outside agencies. Resident and/or responsible party will be financially responsible for these or any other outside services rendered.

## TERMS

This Agreement shall continue in effect until terminated by either party according to the provisions hereunder.

## BED HOLD POLICY

In the event the resident is transferred out of the Facility to the hospital or for other reasons, the resident's bed will be reserved unless the resident and/or responsible party notify the Facility otherwise in writing. The monthly fee will continue to accrue, for which payment shall be made by resident and/or responsible party to the Facility in accordance with the terms of this Agreement. No bed shall be held for a Resident, whether hospitalized or transferred out of the Facility for other reasons, unless the monthly fees have been timely paid. Should a prospective resident desire to hold a bed pending transfer to the Facility, the full month's fee must be paid in advance or the bed will not be held. In such a case when a bed is held pending transfer to the Facility, the funds paid shall first be applied to the days for which the bed is held and any remaining fees paid in advance will apply to the days after the resident is transferred to the Facility, subject to the continuing requirement of payment as hereinafter set forth.

1. You or any other person providing the funds for your care upon thirty (30) day written notice may cancel this Agreement. All money paid in excess of the thirty (30) days shall be refunded. If a thirty (30) day written notice is not given NO MONEY WILL BE REFUNDED. The resident or legal guardian shall, upon termination hereof, be responsible for custody of the resident.

2. This Agreement may also be cancelled by this Facility upon a thirty (30) day written notice, if you do not pay your monthly fees in accordance with the terms of this Agreement or as outlined hereinbefore. If you have a medical condition, or engage in behavior which is a threat to property, your own safety or the safety of other residents or staff, and the problem cannot be immediately resolved and your removal from the Facility is necessary, the thirty (30) day notice shall not be required. Notice may be effective immediately or we shall only be required to give reasonable notice, depending upon the Resident's behavior or condition.

## UNMANAGEABLE RESIDENT

If a resident has a medical condition which cannot be met by staff, or is engaged in behavior which is a threat to property, to his/her own safety or to the safety of other residents or staff, and the problem cannot be immediately resolved, the facility policy is as follows:

1. Contact the family immediately to notify of transfer of resident to custody of the family or another medical facility, if needed.
2. Contact the resident's physician to see if, in his/her opinion, the problem is medically or drug related and obtain the physician's opinion of action to take.
3. Administration, facility nurse, and physician confer to ascertain proper solution.
4. Take appropriate transfer action, which may involve calling emergency services.

Should immediate discharge be the final answer to the unmanageable resident, the thirty (30) day removal notice from the Facility is NOT required.

## FINANCIAL AGREEMENT

Upon admission, the resident must be financially capable of paying for the monthly charges set forth for the unit and services provided by the Facility. Long term care residents will be responsible for the payment of a minimum of 30 days. The monthly fee is due on the first day of the month for the following month. The monthly fee is required to be paid in advance (example: the month of November must be paid on the 1st day of November). **THERE IS PER DAY LATE PAYMENT CHARGE OF FIVE PERCENT (5%) OF THE AMOUNT OF THE PAYMENT STARTING ON THE TENTH (10TH) DAY OF EACH MONTH.** Should the Resident move to another Facility or death occurs during the term of the prepaid fees, **NO REFUND WILL BE MADE.** The prepayment of fees secures the use of the room for the period of one month, unless situations occur necessitating removal of the Resident as previously set forth. The Facility's charges may change during the term of this Agreement. Any change in fees shall only be made following a sixty (60) day notice to the Resident and/or responsible party. The Resident and/or the responsible party accept and agree that the attachment to this Agreement of the sixty (60) days' notice letter of any increase in fees shall serve the same as an amendment thereto without additional acknowledgment of this Agreement. The Facility's current charges, based on type of unit and services provided, are listed below. Resident and/or responsible party agree to pay the Facility the amounts noted below, or as amended during the term of this Agreement following appropriate notice.

The resident and/or responsible party will not be held liable for any cost that was not disclosed in this Agreement.

**SERVICES PROVIDED** **CHARGE**

**A.** Monthly room and board (includes items listed in general services and 2 ADLs) _____

a. Section 1, Semi-Private $3258/mo.
b. Section 1, Private $3,800/mo.
c. Section 2, Semi-Private $3658/mo.
d. Section 2, Private $4600/mo.

**B.** **Respite Rate**: $110/day_____ **Adult Day Care** $90/day_____

**C**. The following charges are applied based on level of need.

**Level 1** – Basic care - independent, ambulatory, occasional ADL assist, meds admin
Cost – no extra cost - goes with the room

**Level 2** – Assist of One - need regular help from one staff with one or more ADL's, meds admin
Cost - $150 extra per month

**Level 3** – Assist of Two - need regular help from two staff with one or more ADL's, Confusion related behavior issues, meds admin
Cost - $250 extra per month

**Level 4** – Bedfast /Assist of Nurse - this is a total care resident, non-ambulatory, nurse care for limited or intermittent periods, Foley catheter, Colostomy care, Continuous O2, wound care, insulin, other injections, meds admin, Fall risk, or inappropriate behavior issues. Cost - $350 extra per month

**Level 5**- Wandering- This resident needs to be regularly redirected within the facility or regularly attempts to leave the facility without the ability to return on own Cost-$500 extra per month

**Care Level Charge**

_____

**D.** Salon Services (as charged by beautician) Charges posted in beauty shop

**E**. Incontinent Supplies @ $138/mo. _____

**F**. Health Shakes @ $77/mo. _____

In lieu of a security deposit, the resident and/or responsible party agrees to pay for any damage to Facility property, equipment or furnishings directly resulting from the resident's stay at the Facility.

If you do not pay the monthly fee on or before the 10th day of each month for the current month of care, this Facility has the right to terminate this Agreement immediately and give you thirty (30) days to vacate the suite. You or the Responsible Party must pay monthly fees, late fees, and interest due up to the date that you vacate the suite.

Total Monthly Charges $_____

_____ _____
Resident/Responsible Party Signature Date

_____ _____
Witness Signature Date

_____ _____
Administration Signature Date

# RESIDENT RIGHTS - ASSISTED LIVING RESIDENCES

Every resident of an Assisted Living Resident licensed by the State of West Virginia has the following Rights:

## INFORMATION

- The right to be informed of all services available and all application charges.
- The right to know that choices are available.
- The right to a copy of the residence rules and regulations.
- The right to as many copies as needed of the residents rights.
- The right to be notified whenever there is a change in residents rights.
- The right to be notified at least seventy–two (72) hours before a change in room or roommate assignment, except for an emergency situation.
- The right to be notified in writing at least thirty (30) days before being discharged, except in an emergency situation.
- The right to be kept informed of the address and telephone number of the state long- term care ombudsman, the state licensure office, and other advocacy groups, including adult protective services.
- The right to see the state survey reports for the residence.

## PRIVACY AND CONFIDENTIALITY

- The right to private, unrestricted, communication with the person of their choice, including privacy for phone calls and meeting with family, friends and other residents.
- The right to receive information from, and to contact agencies acting as client advocate, such as states long term care ombudsman program.
- The right to receive unopened mail.
- The right to privacy in treatment and care.
- The right to confidentiality regarding their medical, personal or financial affairs.

## CARE

- The right to receive adequate and appropriate health care.
- The right to be informed of their own medical care and treatment.
- The right to participate in treatment planning, including the development of their service plan.
- The right to make advance directives about their medical care.
- The right to refuse treatment and medication.
- The right to review their own records and to obtain one (1) copy free of charge.
- The right to refuse to refuse to participate in experimental research.

## INDEPENDENT CHOICES

- The right to exercise all of their rights as a citizen of the United States and West Virginia, including the right to vote.
- The right to make choices regarding the activities of their daily lives.
- The right to make independent personal decisions.
- The right to have a legal representative exercise their rights in a manner consistent with federal and state law.
- The right to choose their own physician and pharmacy.
- The right to be free to come and go from the residence and grounds consistent with their needs and capabilities as documented in their service plan.
- The right to participate in community activities, inside and outside the residence.
- The right to be employed outside or inside the residence, provided that employment is not required as a condition of admission or continued stay in the residence.
- The right to refuse to perform services for the facility.

## DIGNITY, RESPECT AND FREEDOM

- The right to be treated with consideration, respect, and dignity.
- The right to be free from mental and physical abuse.
- The right to be free from chemical and physical restraints.
- The right to be free from discriminatory practices related to admission or services on the grounds of race, religion, national origin, age, gender, sexual orientation, or disability.
- The right to retain and use personal possessions, including furnishings and clothing, as space permits, unless to do so would infringe on the rights, health, or safety of other residents.

## CONCERNS OR COMPLAINTS

The right to complain, on their own behalf or on behalf of others, to the staff of the residence, the long term care ombudsman, and/or the state licensing agency, without fear of reprisal or retaliation.

The right to prompt efforts by the residence to resolve issues of concerns, including the right to a written response within four (4) days.

## STATE OMBUDSMAN

**State Ombudsman**
**WV Bureau of Senior Services**
**1900 Kanawha Boulevard East**
**Holly Grove – Building 10**
**Charleston, WV**
**304-558-3317**

## REGIONAL OMBUDSMAN

**Regional Ombudsman**
**Ed Hopple**
**165 Scott Avenue, Suite 209**
**Morgantown, WV26508**
**(800)834-0598 ext. 3912**

## ACKNOWLEDGMENT OF RECEIPT OF THIS AGREEMENT AND RESIDENTS RIGHTS INFORMATION

This is to acknowledge that a Facility representative has informed the resident and/or responsible party both orally and in writing of the Resident's rights and all rules and regulations governing the resident's conduct and responsibilities during his/her stay at this Facility.

Resident and the responsible party acknowledge that they understand the Resident's Rights and this Admission Agreement. The undersigned Resident and Responsible Party guarantee the prompt payment to the Facility of all monthly fees and other charges due under this Agreement. Should a Responsible Party execute this Agreement under power of attorney or as Guardian/Conservator, the Responsible Party shall also execute this Agreement individually in his/her own right as being personally responsible for the payments and requirements set forth within this Agreement.

_____ _____

Resident Date

_____ _____

Responsible Party Date

_____ _____

Witness Date

If the Resident is medically unable to sign his/her Admission Agreement, the Responsible Party shall provide a copy of his/her power of attorney or Guardian/Conservator appointment prior to admission. If this Agreement is executed solely under a power of attorney, a physician's letter shall be required verifying the inability of the Resident to act in his/her own interest.

_____ _____

Resident by Attorney-in-fact or Guardian/Conservator Date

**WINDY HILL VILLAGE**

I certify that the above is a correct list of my belongings. I take full responsibility for retaining in my possession the articles listed on the Clothing Inventory List and any others brought to me while a resident in this facility. I also certify that I have marked with permanent marker, or the like, all items brought into facility, with resident's first and last name and agree to mark items brought in the future.

I understand the management will not be responsible for my valuables, money, and clothing left in the possession of the resident.

Upon discharge, all personal items are sent with resident or picked up by responsible party. Upon discharge, all personal items not taken with resident will be boxed and placed in designated storage area for a safe keeping for up to fifteen (15) days. Items not picked up within fifteen (15) days of discharge will be disposed of. Resident and/or Responsible Party take full responsibility for retrieving the articles listed on the Clothing Inventory List and to acknowledge receipt of same by signature before removing items from facility premises.

| | | |
|---|---|---|
| Resident's washable clothing to be: | Taken home for washing | YES / NO |
| | Laundered @ Windy Hill Village | YES / NO |

If laundry will be taken home for laundering and not done by Windy Hill Village staff, resident and/or responsible party agrees to pick up and deliver laundered items at least twice per week.

_____ _____

Signature of Resident / Relative Date

_____ _____

Signature of Witness Date

_____ _____

Signature of Administration Date

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION**

TO: WINDY HILL VILLAGE
ASSISTED LIVING RESIDENCE
17024 VETERANS MEMORIAL HWY
KINGWOOD, WV 26537
PHONE: 304-329-2741
FAX: 304-329-2744

I, _____, give Windy Hill Village

permission to obtain any medical records or information concerning myself.

_____ _____
Resident Signature Date

_____ _____
Responsible Party Date

_____ _____
Windy Hill Village Administration Date

WINDY HILL VILLAGE
ASSISTED LIVING RESIDENCE
17024 VETERANS MEMORIAL HWY
KINGWOOD, WV 26537
PHONE: 304-329-2741
FAX: 304-329-2744

# PAYMENT GUARANTEE WITH PRECISION CARE PHARMACY OF CHOICE

RESIDENT NAME:_____ ROOM #:_____

Payment Type: ( )Private ( )Medicare ( )Medicaid ( )Other _____

Date of Birth_____ Social Security Number_____

In consideration for the agreement of Precision Care Pharmacy to provide medication and supplies to the above named resident on open account; I _____do hereby unconditionally guarantee payment from resident's income or resources to Precision Care Pharmacy for all medications and supplies purchased and supplied to the resident while at Windy Hill Village. I also agree to provide copies of all payment sources (i.e. medicare card, insurance card, etc.).

I agree, upon request of Precision Care Pharmacy to pay directly to Precision Care Pharmacy any past due account balance and that my financial responsibility shall not be affected by any extensions or arrangements for payment with Precision Care Pharmacy may have made with the above named Resident without notice to me or my consent. I also agree to pay any legal fees and court cost incurred in the collection of this account.

I may terminate this guarantee with thirty (30) days prior written notice. I understand the termination will not affect my financial responsibility for purchases charged to the Resident's account prior to the effective date of the termination.

| | |
|---|---|
| _____ | _____ |
| Resident/Responsible Party | Telephone number |
| _____ | _____ |
| _____ | _____ |
| Address | Date |
| _____ | _____ |
| Witness | Date |
| _____ | _____ |
| Facility Administration | Date |

**WINDY HILL VILLAGE**

**AUTHORIZATION FOR BEAUTY SALON SERVICE**

Resident Name: _____

Check Service Desired:
( ) Cut
( ) Set
( ) Perm
( ) Color
( ) Other

Check Frequency Desired:
( ) Weekly
( ) Monthly
( ) As needed

I agree to pay promptly for any service provided by beautician as listed above.

_____ _____
Resident/Responsible Party Date

_____ _____
Witness Date

_____ _____
Facility Representative Date

**WINDY HILL VILLAGE**
**ADMISSION CHECK LIST**

Resident/Responsible Party to initial each as reviewed and/or completed

_____EXPLANATION OF HOW TO ACCESS ALL POLICIES OF THE FACILITY

_____REVIEW OF THE HOUSE RULES & LOCATION OF THE SAME

_____COPY OF THE RESIDENTS BILL OF RIGHTS

_____HOW TO LODGE A COMPLAINT

_____ADULT PROTECTIVE SERVICES (APS) FORMS-LOCATION & EXPLANATION

_____WHO AND WHERE TO FIND THE NAMES OF THE OMBUDSMANS AND ADDRESSES AND PHONE #

_____REVIEW THE FACLILTY DISASTER PLAN

_____HOW TO ACCESS RULES AND REGULATIONS AND INSPECTION AND SURVEY REPORTS

_____COPY OF RESIDENTS INSURANCE CARDS, SS CARD, AND ID

_____ADMISSION PACKET COMPLETED

_____EXECUTOR OF ESTATE DOCUMENTS

_____DURABLE POWER OF ATTORNEY

_____MEDICAL POWER OF ATTORNEY AND/OR SURROGATE

_____TAKE A PICTURE OF RESIDENT FOR MAR/TAR/CHART/DISASTER/ADMIN

_____PODIATRIST VISIT Q 3 MONTHS YES NO

_____VETERAN PROGRAM ELIGIBILITY

_____HISTORY OF TB, INFLUENZA, AND PNEUMONIA VACCINES

_____COMPLEATED SERVICE PLAN

_____SKIN AND PHYSICAL ASSESMENT (COMPLETED MY NURSE)

_____ COMPLETE FALL ASSESSMENT CHECK LIST

_____ _____
RESIDENT/RESPONSIBLE PARTY DATE

_____ _____
WITNESS DATE

_____
_____
ADMINISTRATION DATE

**WINDY HILL VILLAGE**
**RESIDENT ADMISSION INFORMATION**

Resident Name:_____ Admit Date:

Maiden Name:_____ Admitting Room Number: _____

DOB:_____Social Security Number: _____

Age:_____ Race: _____ Marital Status:_____ Spouse Name (L or D): _____ Sex: _____

Birthplace: _____ Past Occupation: _____

Next of kin address: _____

Father's Name (L/D): _____ Mother's Name (L/D): _____

Religion:_____ Clergy: _____ Phone: _____

Church: _____ Phone: _____

Funeral Home: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy of Choice: _____ Phone: _____

Medicare Number: _____ (Copy of Card Required)

Insurance: _____ (Copy of Card Required)

Additional Payor Source: _____ (Copy of Card Required)

Attending Physician:_____ Phone: _____

Physician Address: _____

City, State, Zip:_____ Pager: _____

Phone: _____ Fax: _____

Dentist: _____ Phone: _____

Podiatrist: _____ Phone: _____

MPOA/HCS (copy required):_____ Phone: _____

DPOA (copy required): _____ Phone: _____

Responsible Party if no POAs: _____ Phone: _____

Does Resident have a living will (copy required): _____ _____ _____

Billing Address: _____

_____

In Emergency, notify: _____ Phone: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Additional Diagnosis: _____

Allergies: _____

**s**_____ _____

**WINDY HILL VILLAGE**

**RESIDENT'S POSSESSIONS LIST**

Resident Name:_____ M/F:_____

**CLOTHING**:

Slacks/Pants/Jeans_____'

_____

Shirts/Blouses/Sweaters _____

_____

Dresses/suits _____

_____

Jackets/Coats_____

_____

Shoes/Slippers_____

_____

Socks/Undergarments _____

_____

**PERSONAL ITEMS**: (Pictures/Bed Linens/etc.)_____

_____

_____

_____

_____

**HEARING AID(S)**: L_____ R_____ **DENTURES**: _____

**FURNITURE/FIXTURES** (include S/N): _____

_____

**MISCELLANEOUS**: _____

_____

_____

_____

Resident/Representative Date

_____

Facility Representative/Witness Date