

St. Elizabeth Briarbank Admission Contract

St. Elizabeth Briarbank Assisted Living for Women
39315 Woodward Avenue
Bloomfield Hills, MI 48304
248-644-1011
248- 644-1596(fax)

This is a contract between _____ (Resident) and/or
_____ (Authorized Representative) and St. Elizabeth Briarbank Home
for the Aged, a Michigan corporation, whose place of business is located at 39315 Woodward
Avenue, Bloomfield Hills, MI 48304. This contract will begin on the day of admission and end
on the day the Resident leaves of her own accord or on the day she moves to a facility that
offers a greater level of care than that which is provided by St. Elizabeth Briarbank Home for
the Aged.

Type of residency:

____ Permanent

____ Respite

____ Day

Type of Room

____ one room with shared bathroom

____ two rooms with connecting bathroom

I DEFINITIONS

“Resident” means the person named above who receives care or services at the Home for the
Aged. The Resident or her Authorized Representative is personally liable for all payment to St.
Elizabeth Briarbank for care or services under this contract.

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“Authorized Representative” means that person or agency which has either a durable power of attorney or letters of conservatorship for financial matters, and a signed Health Care Declaration, Patient Advocate Form or letters of guardianship for medical decisions.

“Payment” means any monies due for care and services.

“The Home” means St. Elizabeth Briarbank, Home for the Aged.

“Service Plan” means a written statement prepared by the Home in cooperation with the Resident and/or her Authorized Representative or agency responsible for the placement of the Resident, if any. The service plan identifies the specific care and maintenance services and activities appropriate for the Resident’s physical, social and behavioral needs as well as the methods of providing the care and services. The preferences and competency of the Resident will be taken into account in the process of completing the Service Plan.

II SERVICES

The services provided under the Contract are those services which are normally defined as routine services which are listed below. Charges for these services are included in the monthly fee. Please check “yes” or “no” where applicable.

- Furnished private room and shared bathroom.
- All rooms are furnished with a twin bed and box spring and mattress, a chest of drawers, a bed stand, a large chair, and lamp.
- The Resident may use her personal bedding and linens; otherwise, sheets, pillowcases and towels will be provided by the Home.
- A one-room unit is a private bedroom with a connecting bathroom to another private room. The bathroom is shared with the Resident who lives in the adjoining room.
- A two-room suite is two private rooms connected by a bathroom.

Utilities

The cost of gas and electricity and water are included in the monthly fee. Residents choosing to have a refrigerator in their room will have \$10 per month added to their monthly bill. Oxygen concentrator users will have \$10 per month added to their monthly bill.

Twenty-four hour supervision

Residents are supervised during the day as well as during the night hours. For the protection of the Resident, caregivers are with the Residents at all hours. Doors leading outside of the buildings are locked with an alarm system with the exception of the front office door during normal office hours.

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Safety

For the safety and protection of all Residents, the buildings are equipped with a fire alarm system. All exit doors with the exception of the front office door during normal office hours are locked with an alarm system. Emergency drills are scheduled to practice exiting the buildings during an emergency situation. Handrails are in all hallways of Franciska Hall as well as in the breezeway leading to chapel and the main building. Nightlights are placed in each Resident room.

Medical Emergency

For the safety and protection of the Resident, in the event of an emergency, American Ambulance Response (AMR) and the Authorized Representative will be notified. AMR personnel assess the condition of the Resident and advise whether or not to transport to Hospital Emergency. The Authorized Representative is to follow up with the Resident's physician to identify changes in care that may occur and communicate any changes to St. Elizabeth Briarbank staff.

Evidence of Tuberculosis Screening Prior to Admission and Annual TB Screening

The State of Michigan requires that individuals admitted to St. Elizabeth Briarbank Home for the Aged (a state-licensed facility for women) provide evidence of tuberculosis screening within 12 months of admission placed in the Resident record in the home through evidence of:

- intradermal skin test (TST)
- chest x-ray
- Or other method recommended by the Oakland County Health Department

Thereafter, Residents who live in community settings must be screened for tuberculosis annually. For annual screening, if chest x-ray findings are more than 12 months in the past, and the participant is unable to be screened via the TST, the health care professional will screen the Resident for TB by assessing: temperature, weight loss, fatigue, cough, shortness of breath, hemoptysis and chest pain.

Flu vaccination

Although the Home does not provide vaccination against influenza, the Resident and/or her Authorized Representative is advised to obtain the influenza vaccination annually in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the US Department of Health and Human Services Center for Disease Control and Prevention as approved by the Michigan Department of Community Health

Nutrition

Three **nutritious home-made meals** and a snack are served daily in the Resident dining room during scheduled hours. If a Resident is ill and temporarily unable to walk to the dining room, meals will be brought to her room.

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Medication administration

Medications are administered by health professional according to the prescriptions as written by the Resident's physician or PCP. Resident's and/or Authorized Representative's consent to have medications administered by staff member of the Home must be on file in Resident chart.

I wish to have St. Elizabeth Briarbank administer medications

_____ Yes

_____ No Signature and date _____

If Resident is to administer her own medications, a *Release of Liability* statement at the end of this document must be signed indicating that Resident or Authorized Representative assumes full responsibility for her health and safety and relieves the Home and all other persons from any liability for whatever illness or injury that may occur as a consequence of self-administration of medications prescribed by her physician.

Medication management/ordering

Medications are set up individually for each Resident by a local pharmacy and delivered to St. Elizabeth Briarbank for the health care professional to administer unless other arrangements have been requested and agreed upon by the Resident and/or her Authorized Representative and the Home for the procurement of her medications.

*I agree to have medications prepared by the local pharmacy*_____ *(please initial)*

Other (explain) _____

The Resident and/or her Authorized Representative agrees to provide Resident medications and refills on time; otherwise, all medications (Prescribed and Over the Counter) will be ordered and billed to Resident and or Authorized Representative by the local pharmacy.

Resident Service Plan

The nurse completes a Service Plan for each Resident upon admission to the Home and at least annually; the nurse updates the Service Plan whenever there is a change in the Resident health or activity. Any changes needed to safely care for the Resident will be documented on the Service Plan and communicated with the Resident and/or her Authorized Representative.

Housekeeping

Rooms are vacuumed and dusted regularly. Trash is emptied and bathrooms are cleaned daily.

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Personal Care Assistance

Assistance with bathing, dressing and grooming is provided, if needed, by care providers. The Service Plan documents caregivers' assistance to Resident identified needs.

Resident will require assistance with showering at least once per week, or as necessary.

- Yes _____
- No _____

Laundry service

Bedding and linens are laundered by the Home. Clothing and personal items that are laundered in the Home are to be labeled with Resident initials and room number. Resident requests that clothing and personal items be laundered by Home.

- Yes _____
- No _____

III BASIC RATES, FEES AND CHARGES

- Furnished private bedroom and shared bathroom \$2000
- Two bedroom suite with private bath \$2800
- Respite care (short term stay) \$65 per day
- Day Program \$40 per day
- Annual Intradermal Skin Test for Tuberculosis Screening \$5
- Monthly Personal laundry fee - \$5 per month
- Refrigerator in room \$10 per month
- Oxygenator in room \$10 per month
- Copy of Resident record/chart \$50

Other services that are not provided by St. Elizabeth Briarbank can be arranged and paid for by the Resident and/or her Authorized Representative such as:

- Podiatry
- Visiting Physicians
- Hairdresser (Sofia's schedule of rates is included with the admission packet.)
- Phone
- Cable TV
- Newspapers or periodicals

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- Ambulance Service
- 24-hour custodial care if deemed necessary by St. Elizabeth Briarbank staff/administration

Please check if you wish to have the services of the:

	<i>Cable TV</i>
	<i>Hairdresser</i>
	<i>Newspaper</i>
	<i>Phone</i>
	<i>Podiatrist</i>

Changes in Rates, Fees or Charges

St. Elizabeth Briarbank reserves the right to adjust its rates and charges commensurate with any changes in the nature and schedule of services provided to the Resident or with any changes in the cost of providing the appropriate care and services by the Home. The Home will notify the Resident and/or her Authorized Representative at least thirty (30) days before any change takes effect.

Liability for Payment

The Resident and or her Authorized Representative agrees to pay all monies on the first of each month the rate for room and board and services that are to be provide by the Home during that month. Rent payment made after the first of the month will be considered late; a \$25 late fee will be assessed.

A foreseeable nonpayment of rent should be discussed with the administrator in a **BEFORE** it occurs so that the schedule of payment is not interrupted.

If the Resident is in a rehabilitation center and she and/or the Authorized Representative choose(s) to keep her belonging in the room in the Home, she and/or her Authorized Representative agree(s) to pay the monthly rent for the use of the room.

Refund Policy

Payment is due on the first of each month. If the Resident decides to move out of the Home, she and/or her Authorized Representative are to give notice to the Home thirty (30) days in advance of this date. If the Resident must spend a period of time in a rehabilitation center and keeps her belongs in the room with the intention of returning to the Home, there will be no refund of the monthly fee. If however, she is hospitalized, and her physician recommends that she move to a nursing home, the monthly fee will be refunded if this has occurred before the 15th of the month.

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IV ADMISSION POLICY

The conditions for admission are required of all Residents for Permanent Residency, Respite Stay and Day Program.

1. St. Elizabeth accepts for permanent residency, respite care, or daytime care women at least sixty (60) years of age, in good health, who are ambulatory and able to dress themselves. The Home does not have the level of care for the needs of women who are diagnosed with Alzheimer Disease, insulin dependent diabetes, and bladder and/or bowel incontinence. For the safety of our Residents, the Home does not admit for residency women who smoke.
2. The Home shall not deny admission to an individual because of her race, religion, color, or national origin.
 - Prospective Residents must interview with the administrator or acting administrator of the Home. Previous to the time of admission, the Home will document the needs of the individual seeking admission. An applicant, who at the time of admission, is under the care of a licensed health care professional for ongoing treatments, or prescription medications that require the home's intervention or oversight, must provide a written statement from that licensed health care professional completed within the 90-day period **before** the applicant's admission to the Home. The statement shall list those treatments or medications for the purpose of developing and implementing the Resident's Service Plan. Occasionally an applicant or Authorized representative seeks emergency admission to the Home.
 - ***For emergency admissions, the following documentation must be provided at time of admission. NO ADMISSION AFTER NOON ON FRIDAY AND BEFORE 9 AM ON MONDAY***
 - i. Signed Physician Admission Examination (not the hospital or nursing home discharge orders) that include all medication orders
 - ii. Evidence of TB screening
 - iii. Consent for Use of Health Care Information and Treatment
 - iv. Assessment Plan for Resident
 - v. Durable medical power of attorney include advance directive (Do Not resuscitate)

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- vi. A durable power of attorney or letters of conservatorship for financial matters, and a signed Health Care Declaration, Patient Advocate Form or letters of guardianship for medical decisions
3. The applicant, and/or her Authorized Representative state that the information provided in the Assessment Plan for Residents is complete and true. This Assessment Plan is included in the resident's chart.
- Yes _____
 - No _____ signature and date _____
4. A woman who is eligible for admission to the Home will tour the Home, interview with the Administrator or with the acting Administrator, ask any questions she may have, and choose a room (if several are available). An admission date will be agreed upon between the applicant and/or her Authorized Representative and the Administrator of the Home.
5. The Home shall not accept an individual seeking admission unless her needs can be adequately and appropriately met within the scope of the Home's program statement.
6. Required documents for admission include
- A completed application form
 - A report of a complete physical examination by physician including identifying all medications and their purpose
 - Evidence of tuberculosis screening on record which consists of an intradermal skin test, chest x-ray, or other methods recommended by the local health authority performed within 12 months before admission. Screening of Residents for tuberculosis annually consists of an intradermal skin test which will be performed by the staff nurse, with written permission from the Resident's primary care physician
 - Assessment Plan for Residents fully completed by applicant and/or Authorized Representative
 - Completed, signed contract
 - Signed Consent for Use or Disclosure of Health Information
 - Copy of Advanced Directives
 - Copies of all legal documents designating Power of Attorney or Authorized Representatives

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- 7. The Home shall not admit a Resident who requires continuous nursing care services of the kind normally provided in a nursing home. The Home does not have services for women who are extremely confused, combative, non-ambulatory, insulin dependent, bladder and/or bowel incontinent, nor for women who have been diagnosed with Alzheimer Disease. For the safety of all Residents, women who smoke will not be accepted for admission to the Home.***

V DISCHARGE POLICY

1. The Resident may choose to terminate this contract if she elects to move to another facility. She and/or her Authorized Representative are to give the Home notice of thirty (30) days.
2. The Resident will be required to move to a facility which offers a greater level of care than that offered at the Home if her needs change such that she requires more care than the Home is able to provide.
3. A Resident will be required to move to a facility where her needs can be met if she shows emotional incompatibility, serious mental disturbance, or a need for nursing care.
4. A Resident will be required to move from the facility if she becomes a danger to herself or is a danger to the welfare or safety of other Residents or staff.
5. The Home will provide the Resident and/or her Authorized Representative with a thirty (30) day written notice before discharge from the Home. ***The Home may discharge the Resident before the 30-day notice if*** the Home has determined and documented that either, or both, of the following exist:
 - a substantial risk to the Resident due to the inability of the Home to meet her needs or due to the inability of the Home to assure the safety and well-being of the Resident, other Residents, visitors, or staff of the Home;
 - a substantial risk or an occurrence of the destruction of property. The Home will notify the Resident and/or her Authorized Representative and the agency responsible for her placement (if any) not less than 24 hours before discharge. The notice will be verbal and issued in writing according to the regulations of Michigan State Law.

VI NON PAYMENT

Every effort will be made to resolve a situation where there is nonpayment of the monthly fee. Application for Supplemental Security Income should be anticipated and applied for through Social Security in a timely manner so that monthly payments to the Home do not become delinquent. Go to http://www.michigan.gov/dhs/0,1607,7-124-5453_5526-15508--,00.html for more information on this program.

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VII CHANGE OF ADDRESS NOTICE IF DISCHARGE OCCURS

The US Post Office will not forward mail to a former Resident of the Home unless there is application by the Resident or her Authorized Representative. Three methods can be used to forward US mail:

- US government website: USPS.gov for forwarding information
- visit the Bloomfield Hills, MI Post Office;
- obtain a forwarding form from any US Post Office.

VIII RESIDENT RIGHTS AND RESPONSIBILITIES

I have been given a copy of the Resident Bill of Rights and Responsibilities

Yes _____ No _____ Initial and date _____

IX PRIVACY ACT REQUIREMENT

The Home abides by the requirements of Federal law and regulation with respect to Protected Health Information. The Resident and/or her Authorized Representative acknowledge and understand that the Resident has certain rights and responsibilities regarding the disclosure of her health information. These rights and responsibilities are set forth in the following two documents, the receipt of which the Resident and/or her Authorized Representative acknowledge the following:

1. The Consent for the Use or Disclosure of health Information for Treatment, Payment or Health Care Operations; and
2. The Notice of Privacy Practices for Protected Health Information

The two aforementioned documents are included in the Admission Application and are attachments to this contract.

The Home requests that the Resident and/or Authorized Representative sign the consent. ***The Resident and/or her Authorized Representative understand and acknowledge that if she/they refuse(s) or fail(s) to sign the Consent, the Home may refuse to admit or give her services.***

The Home is authorized to release Protected Health Information only as permitted by applicable law and regulation. On request, the Home will provide the Resident with access to the Resident's medical and/or financial records. A fee of \$50.00 is charged for this service

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X USE OF RESIDENT'S NAME AND/OR PHOTOGRAPH

The Home is permitted to publish the Resident's name in the Home publication while the Resident is under the care of the Home or for medical purposes or for the purpose of assisting in the training of personnel to best assist the Residents in the Home. The community may also use the Resident's photograph, with the Resident's authorization for community displays or public affairs.

_____ I agree Initial _____ Date _____

_____ I do not consent to have the Home use my photograph for community displays, public affairs or marketing. I understand that there will be no form of compensation for the use of photographs.

XI PERMISSION FOR OUTINGS

I am interesting in attending the Senior Luncheons at several local churches. I agree to be driving to the church by volunteers from those parishes.

_____ Yes

_____ No Signature and date _____

XII DETERMINATION OF ADVANCE DIRECTIVES

_____ I have _____ I have not provided the Home with Advance Directives. In the event of a life threatening emergency, my Authorized Representative knows my wishes and will make decisions for me if I am unable to do so.

XIII PATIENT FUNDS

The Home does not hold the personal funds of residents. The Home does not assume responsibility for articles of value or money left with the Resident or in the Resident's room.

XIV RECOVERY OF DAMAGES INCURRED BY RESIDENT

CONDITION OF PREMISES. Individual (resident and/or Authorized Representative) agree that they have examined the Premises, and that they are at the time of this contract in good order, repair, and in a safe, clean condition. In the event the Premises are destroyed or rendered wholly uninhabitable by the negligence of applicant, St. Elizabeth Briarbank exercises the right to repair such uninhabitable portion and the resident shall pay the full cost of the repair. Resident room examined on _____ and applicant and/or Authorized representative find the premises without defect.

Signature and date: _____

XV RELEASE AND HOLD HARMLESS

1. By signing this document, this document, the above-named individual (Resident and/or Authorized Representative and the individual's respective heirs, personal or Authorized Representatives, agents, successors, and assigns agree to hold harmless and release St. Elizabeth Briarbank from any and all claims against St. Elizabeth Briarbank that she/they/ has/have or may have, both known or unknown, losses, damages, or expenses (including but not limited to, reasonable attorney fees) incurred by the above name individual resident of St. Elizabeth Briar bank arising from any charges, actions, causes of action, demands, assessments, suits, proceedings, or claims asserted against St. Elizabeth Briarbank, including but not limited to any personal injury or property damage incurred by the individual during the individual's residency at St. Elizabeth Briarbank.
2. Binding Effect. Subject to the provisions of this Agreement, this Agreement will be binding upon and shall inure to the benefits of the parties, and their respective heirs, personal or Authorized Representatives, guardians, agents, successors and assigns.

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IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first above written.

**St. Elizabeth Briarbank
Home for the Aged**

**Resident and/or her
Authorized Representative**

By _____

Its _____

Date _____

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Consent for the Use or Disclosure of Health Information For Treatment, Payment, or Health Care Operations

I understand that as part of my health care, St. Elizabeth Briarbank and the physician(s) and healthcare workers who care for me develop and maintain health records describing my health history, symptoms, examination, test results, diagnoses, and treatment, as well as any plan for future care or treatment. I understand that this information serves the following purposes:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A written health record as required by the State of Michigan for residents of Homes for the Aged

I have been provided with, have read, and understand the Notice of Privacy, Practices for Protected Health Information, which provides a more complete description of information, uses and disclosures of my health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the Home reserves the right to change its notice and practices, and that prior to implementation of those changes, will mail a copy of the revised notice to me and/or my Authorized Representative. I have been informed that if I refuse to sign this consent for the use and disclosure of my health information, the Home may refuse to admit me as a Resident of the Home.

I understand that I have the right to the following:

- Object to the use of health information for directory purposes
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the Home is not required to agree to the restrictions requested. If the Home agrees to any restrictions, then it is bound by those restrictions.
- Revoke this consent at any time, except to the extent that the Home has already taken action in reliance thereon. I understand that if I revoke my consent, then the Home will no longer be able to treat me and that I will need to be discharged from the Home. The revocation must be in writing.

Signature of Resident and/or
Authorized Representative

Date

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Your Health Information Rights

Although your health record is the physical property of the Home, the information in your health record belongs to you. You have the following rights:

- You or your representative may request that we not use or disclose your health information for a particular reason related to treatment, payment, the Home's general health care operations, and/or to a particular family member, other relative, or close personal friend. We ask that such requests be made in writing to the administrator. The request must be signed and dated by you or your representative. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it.
- If you are dissatisfied with the manner in which or the location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such a request must be made in writing and submitted to the administrator of the Home. We will attempt to accommodate all reasonable requests.
- You or your representative may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. If you request copies, we will charge you a reasonable fee for the cost of supplies for and labor of copying and postage if the copies are mailed to your designated representative.
- If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made to the administrator in writing and must provide a reason to support the amendment.
- You or your representative may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed 6 years). We ask that such requests be made in writing to the administrator of the Home. Please note that an accounting will not apply to any of the following types of disclosures: disclosures made for reasons of treatment, payment or health care operations; disclosures made to you or your legal representative, or any other individual involved with your care; disclosures for national security purposes. You will not be charged for your first accounting request in any 12-month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee.

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- You or your representative has the right to obtain a paper copy of our Notice of Information Practices upon request, even if you have previously agree to receive the Notice electronically.
- You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing to the administrator of the Home.

For more information or to report a problem

If you have questions and would like additional information, or if you believe that your privacy rights have been violated, you or your representative may file a complaint with us. These complaints must be filed in writing, either on paper or electronically and sent to the administrator of the Home. You or your representative may also file a complaint with the secretary of the Federal Department of Health and Human Services. There will be no discrimination, intimidation, or retaliation to you or your representative for filing a complaint.

END