Libby Bortz
Assisted Living

Dear Applicant,

Thank you for expressing an interest in The Libby Bortz Assisted Living Center.

To continue the process for admittance, please complete, sign and return the following enclosed documents as soon as possible:

1) Application for Residency
2) CHFA Questionnaire
3) Income and Asset Verification Forms
4) Physician Evaluation completed by your primary care physician.
5) Activity Interest Survey

If you have questions, please contact our Marketing Director, Patrice, at 720-551-7619. We all look forward to your moving into our beautiful community to begin a mutual relationship centered around a warm and caring environment.

Sincerely,

Sarah Leon
Executive Director

Encl.

5844 South Curtice Street • Littleton, Colorado 80120 • 303.347.9755 • Fax 303.347.3064
www.LibbyBortzAssistedLiving.org

Libby Bortz
Assisted Living

Admission Procedure

To better understand the procedures for admission into our Center please take the time to review the following:
All residents must meet age and income requirements. A resident must be at least 62 years of age with an income for a single person not exceeding $54,780 annually and for a married couple $62,640 annually.

1. Complete the Application for Residency.
   _____ (initial)

2. Complete the Consent to Release Medical Information and return to us. This form allows us to contact your primary care physician regarding the general status of your health and the medications you are taking. This information is required by Colorado state regulations.
   _____ (initial)

3. A criminal background check will be performed by RentGrow. Results of the criminal background check will be used as a tool, along with the physician and facilities pre-admission assessment as to whether a resident will be approved for admission into our Center. This information is required by federal law for low-income housing assistance.
   _____ (initial)

4. Verification of Income. To verify that income guidelines are met we must have a separate asset verification form for EACH AND EVERY SOURCE OF INCOME, (social security, pension, annuity, etc.) AND EACH AND EVERY LOCATION OF ASSETS (bank, investment company, etc.) We will be responsible for faxing the completed asset verifications out to the appropriate agency. This information is required by federal law for low-income housing assistance.
   _____ (initial)

5. When we receive the Physician Evaluation and all asset verification forms back, we will reschedule a time to meet with the resident and/or their legal representative to complete our in-house pre-admission assessment. During the resident assessment the Resident, Care Coordinator, and Resident Services Director will develop a resident care plan which when completed and signed becomes a legal document and an addendum to the residency agreement. The resident care plan outlines the residents' ability to perform basic daily living skills, and outlines what services the facility, family, or outside contractors will provide. The pre-admission assessment also provides an opportunity for the resident and/or their legal representative to make requests for reasonable accommodation of a disability.
   _____ (initial)

6. If a resident is planning to self-administer their own medication, residents must bring all current medications they are taking to the pre-admission assessment. THIS INCLUDES OVER THE COUNTER MEDICATION; residents who are taking scheduled II narcotics must bring the prescription for the narcotic from the primary care physician to the pre-admission assessment.
_____ (initial)

7. During the pre-admission assessment the Care Coordinator will review and compare the signed physician's orders with the medications the resident has brought with them to the pre-admission assessment. If there are any discrepancies with the medications or physicians orders – the admission process cannot continue until the physician's orders and medications match. Residents who are planning to self-medicate must be able to do so without the assistance or oversight of another person.
_____ (initial)

8. Residents who are going to be on the Center's Medication Administration Program will have all of their medication ordered from the pharmacy by the Care Coordinator/designee after the pre-admission assessment. This includes all over-the-counter medication. If a medication or over the counter medication is not available with the Center's contract pharmacy, the Care Coordinator will be responsible to call the residents primary care physician to obtain an alternative medication to take the place of the medication not on the Center's contract pharmacy formulary. If an over-the-counter medication is not available through the Center's contract pharmacy and the resident wants to continue taking the over-the-counter medication; the resident, families, or friend must see the Care Coordinator to review our policy for the resident/families/friends being responsible to obtain and deliver the over-the-counter medication to the staff at Libby Bortz Assisted Living Center in a timely manner. (Resident care plan being updated to reflect who the responsible person/s are to obtain and deliver the over-the-counter medication to Libby Bortz Assisted Living Center.)
_____ (initial)

9. LIBBY BORTZ WILL NOT ACCEPT/USE ANY MEDICATIONS THAT THE RESIDENT BRINGS IN FROM HOME AFTER THE INITIAL PRE-ADMISSION ASSESSMENT
_____ (initial)

10. Residents who will be on the Medication Administration Program will need to have an account set up with the Center's contract pharmacy. The Care Coordinator will be responsible to fax the resident face sheet and signed physician's orders to the pharmacy.
_____ (initial)

11. The Residency Agreement is a legal document and will outline the financial terms, services provided by the facility, additional charges, and how to terminate the agreement. In addition, you will receive and review the Resident Handbook which outlines the House Rules, Admission & Discharge Policy, Grievance Procedure, Residents Rights, among others. The Residency Agreement will state the start date of the lease. We will require a personal check for the first month's rent & services. If you are moving in after the first of the month the amount will be pro-rated.
_____ (initial)

12. Libby Bortz Assisted Living Center requires a security deposit which equals one month of rent and service charges. The deposit is due at the time of the lease signing.
_____ (initial)

13. If you should have any questions regarding the admission procedure please feel free to contact our Admission/Marketing Director or Executive Director directly.
_____ (initial)

_____ _____
Resident Signature Date

_____ _____
Resident Legal Representative Date

Libby Bortz
Assisted Living

Application for Residency

Date: _____

I. General Information

Name: _____ Phone: (_____) _____

Current Address: _____

City/State/Zip: _____

Gender: M ☐ F ☐ Date of Birth: _____/_____/_____ Age: _____

Social Security #: _____-_____-_____

Marital Status (please click): ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Present Living Arrangements (ie: Alone, Another Facility, With Relatives):

_____

Primary Contact for Application Process

Name: _____ Relationship:_____

Address: _____

City/State/Zip: _____

Phone: (_____) _____ Work Phone: (_____)_____

E-Mail Address: _____

Advanced Directive Information

Power of Attorney: ☐ Yes ☐ No Name: _____

Guardianship: ☐ Yes ☐ No Address: _____

Conservator: ☐ Yes ☐ No City/State/Zip: _____

Phone: (_____)_____

Please attach copies of documentation showing POA for both medical & financial, as well as guardianship, and/or conservatorship (if applicable). This information is required pursuant to moving into Libby Bortz Assisted Living Center.

II. Medical Information Resident Name: _____

This information is required pursuant to Colorado state regulations

Physician Information

Name: _____

Clinic: _____

Address: _____

City/State/Zip: _____

Phone: (_____)_____ Fax: (_____)_____

Other Medical Provider: _____ Phone: (_____)_____

Health Insurance: _____ Policy #:_____ Group#: _____

Secondary Info: _____

Please provide copy of health insurance cards and ID

Diagnosis:

_____

_____

_____

Allergies: _____

Medications (Prescribed): _____

_____ _____

_____ _____

_____ _____

Non-Prescription Medications (such as pain relievers, antacids, vitamins):

_____ _____

_____ _____

_____ _____

_____ _____

III. Physical Status Resident Name: _____

1. Are you able to ambulate without assistance? ☐ Yes ☐ No

   Do you utilize a cane? ☐ walker? ☐ wheelchair? ☐

   Explain any mobility difficulties:

   _____

2. Are you able to bathe without assistance? ☐ Yes ☐ No

   Explain any bathing difficulties:

   _____

3. Are you able to dress without assistance? ☐ Yes ☐ No

   Explain any dressing difficulties:

   _____

4. Are you able to eat without assistance? ☐ Yes ☐ No

   Explain any eating difficulties:

   _____

5. Are you able to handle all of your toileting needs without assistance? ☐ Yes ☐ No

Explain any toileting difficulties:

_____

6. Other information regarding physical status:

_____

_____

Emergency Information Contact Sheet

Resident Name: _____ Apt. #: _____

Date of Birth: _____ Soc. Sec. #: _____

Physician Name: _____ Phone: (_____)_____

Address: _____ City/State/Zip: _____

Hospital Preference: _____

Burial Arrangements: _____ Phone #: _____

Special Information or Instructions:

_____

_____

Emergency Contact

1. Name: _____ Relationship: _____
   Address: _____ City/State/Zip: _____
   Phone: (_____)_____ Work Phone: (_____)_____
   Pager: (_____)_____ Cellular: (_____)_____
2. Name: _____ Relationship: _____
   Address: _____ City/State/Zip: _____
   Phone: (_____)_____ Work Phone: (_____)_____
   Pager: (_____)_____ Cellular: (_____)_____

3. Name: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Phone: (_____)_____ Work Phone: (_____)_____

Pager: (_____)_____ Cellular: (_____)_____

Insurance Information

Health Insurance Provider: _____ Policy #: _____

Supplemental Ins. Carrier: _____ Policy#: _____

Please provide copy of health insurance cards and ID

Miscellaneous Information:

Religion Preference: _____ Church: _____

Clergy's Name: _____ Phone#:_____

Address: _____

****

I hereby certify that all information contained on this application is correct and complete to the best of my knowledge and that any misrepresentation of material will result in my being ineligible for admission.

I agree to give The Libby Bortz Assisted Living Center the authority to investigate any income and/or asset sources necessary to determine eligibility and to verify the above stated information.

_____ _____

Applicant's Signature Date

_____ _____

Responsible Party Signature Date

****

It is illegal to discriminate against any person based on race, religion, sex, national origin, familial status or handicap.

EQUAL HOUSING OPPORTUNITY

assisted living certification questionnaire

Property Name	Unit Number

The information on this form is needed to certify/recertify your household. **Please complete this entire form and leave no blanks.** If there are any questions that you do not understand, please ask the Administrator. Thank you for your cooperation.

part 1 household composition

full name	date of birth

part 2 resident income

income source (pension, social security, ssi, etc.)	gross monthly income
1.	$
2.	$
3.	$
4.	$

part 3 asset information

asset source (including bank accts, trusts, iras, real estate, stocks, bonds, whole life insurance policies)	cash value of asset*	annual income from asset
1.	$	$
2.	$	$
3.	$	$
4.	$	$

* Cash value is defined as market value less the cost of converting the asset to cash. Costs may include broker's fees, settlement costs, outstanding loans, early withdrawal penalties, etc. Personal property held for investment purposes may include, but is not limited to, gem or coin collections, art, or antique cars. Do not include items such as household furniture, daily-use autos, clothing, active business assets, or special equipment for use by the disabled.

part 3 asset information (continued)

☐ Yes ☐ No	I/we have disposed of assets (i.e., gave away money/assets) for less than the fair market value in the past two years. If yes, list items and date disposed.

part 4 student status certification

Students include individuals attending public or private elementary schools, middle or junior high schools, senior high schools, colleges, universities, technical, trade, or mechanical schools. Students do not include individuals participating in on-the-job training or correspondence courses.

please mark the box below **if** it correctly describes your status

☐ I am not currently a **full time** student, **and** I have not been, and will not be a **full time** student for five months or more out of the current calendar year (months need not be consecutive).

If forms are completed electronically, one of the following boxes must be checked:

☐ **This form was completed electronically by the resident.**

☐ **Management or someone outside of the household assisted with completing the form electronically. (Authorization to Assist is attached).**

signatures

Under penalties of perjury, I certify that the information presented on this form is true and accurate to the best of my/our knowledge. The undersigned further understands that providing false representations herein constitutes an act of fraud. False, misleading, or incomplete information will result in the denial of application or termination of the lease agreement.

Print Name of Resident | Signature | Date

Reviewed by (Signature of Owner/Representative) | Date

supplementary demographic information

Colorado Housing and Finance Authority (CHFA) requests the following information in order to comply with the Housing and Economic Recovery Act (HERA) of 2008, which requires all Low Income Housing Tax Credit (LIHTC) properties to collect and submit to the U.S. Department of Housing and Urban Development (HUD), certain demographic and economic information on tenants residing in LIHTC-financed properties.

Although CHFA would appreciate receiving this information, you may choose not to furnish it. You will not be discriminated against on the basis of this information, or on whether or not you choose to furnish it. If you do not wish to furnish this information, please check the box below.

☐ Resident/Applicant: I do not wish to furnish information regarding ethnicity, race, and other household composition.

Please initial:							
HH #:	#1	#2	#3	#4	#5	#6	#7

enter both ethnicity and race codes for each household member (see below for codes)

hh mbr #	last name	first name	mi	race code	ethnicity code	disability code
1						
2						
3						
4						
5						
6						
7						

race code	
1	African American/Black
2	American Indian/Alaskan Native
3	Asian
4	Asian Indian
5	Asian Other
6	Chinese
7	Filipino
8	Guamanian/Chamarro
9	Japanese
10	Korean
11	Native Hawaiian
12	Native Hawaiian/Pacific Islander
13	Pacific Islander Other
14	Samoan
15	Vietnamese
16	White
17	Other
18	Refused
19	Missing
20	Tenant declined to respond

ethnicity codes	
1	N/A
2	Hispanic
3	Non-Hispanic
4	Hispanic or Latino
5	Not Hispanic or Latino
6	Tenant declined to respond
7	Missing

disability codes	
1	Yes
2	No
3	Tenant declined to respond
4	Missing

authorization to assist

Head of Household Name	Unit Number

I,_____,

authorize _____

to assist in completing my certification forms.

The person assisting is:

☐ Property staff

☐ My caseworker

☐ A family member

☐ Other: _____

I require assistance due to:

☐ Difficulty writing

☐ Difficulty understanding the forms

☐ Limited English proficiency

☐ Other: _____

If forms are completed electronically, one of the following boxes must be checked:

☐ **This form was completed electronically by the resident.**

☐ **Management or someone outside of the household assisted with completing the form electronically.**

signatures

Resident Name (Print)	Signature	Date

Name of Person Assisting (Print)	Signature	Date

Libby Bortz
Assisted Living

5844 S. Curtice Street
Littleton, CO 80120
Phone #: (303) 347-9755 Fax #: (303) 347-3064

Please Read through these instructions thoroughly

Enclosed with your application are several Verification Forms for various sources of income and various assets. These forms must be completed by a third party. Libby Bortz Center will send these to the third party institutions.

Third Party Verification Forms:

1. At the top of the verification form, fill in the name of the recipient and include the social security number.

2. Complete the name and address for the institution on the applicable verification forms.

3. Sign the authorization release at the top of each asset verification form. Please have the applicant sign rather than a POA or other responsible party.

4. **DO NOT** include financial amounts or interest rates at the bottom of the page.

5. Please note, Wells Fargo Bank has a unique verification form called the Verification of Deposit which is also included in the application. Only use this verification form if the applicant banks at Wells Fargo. Use this form instead of the Asset Verification Form.

These forms must be completed by a third party which Libby Bortz will coordinate. Please **DO NOT FILL IN THE AMOUNTS** of income or assets at the bottom of on any of these forms.

After filling out the Verification Forms, return them directly to the Libby Bortz Center. When returning the application and verification forms, please include copies of the following items:

1. Bank Statements, showing deposits, withdrawals and final balance. **FOR CHECKING ACCOUNTS-PROVIDE THE MOST RECENT 6 MONTHS OF STATEMENTS, FOR SAVINGS ACCOUNTS AND CERTIFICATES OF DEPOSIT-PROVIDE THE MOST RECENT STATEMENT.**

2. Social Security Benefit letter (most recent).

3. Broker statements for stocks, bonds, mutual funds, IRAs, Annuities, etc. showing the address of the institution-**PROVIDE THE MOST RECENT STATEMENT**.

4. Property tax statements for any property owned by the applicant

5. Any document proving asset value for any other asset.

6. For income sources such as rent, loan payments or alimony, a copy of the lease or promissory note.

If you should have any questions, please feel free to contact Patrice, Marketing Director, at admissions@lbalc.org.

Sincerely,

Sarah Leon
Executive Director

EQUAL HOUSING OPPORTUNITY

Libby Bortz
Assisted Living

5844 S. Curtice St.
Littleton, CO 80120
Phone 303-347-9755
Fax 303-347-3064

Asset Verification Form

I hereby grant you permission to disclose information regarding my assets to the Libby Bortz Assisted Living Center in order to determine income eligibility for rental of an apartment in the development which has received a "low income housing tax credit" allocation from the Colorado Housing and Finance Authority.

_____ _____
Name of Resident Social Security Number

_____ _____
Signature of Resident Date

Please send to Institution of Declared Asset:

_____
_____
_____
_____

Resident DO NOT FILL out anything below this line - For 3rd Party Verification ONLY

Type of Asset	Value of Asset	Annual Income or interest rate
Checking 6 mo average	_____	_____
Savings current balance	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Name (Please Print) Title (Please Print)

_____ _____
Signature Date

EQUAL HOUSING OPPORTUNITY

Libby Bortz
Assisted Living

5844 S. Curtice St.
Littleton, CO 80120
Phone 303-347-9755
Fax 303-347-3064

Pension Verification Form

I hereby grant you permission to disclose information regarding my pension benefits to the Libby Bortz Assisted Living Center in order to determine income eligibility for rental of an apartment in the development which has received a "low income housing tax credit" allocation from the Colorado Housing and Finance Authority.

_____ _____
Name of Resident Social Security Number

_____ _____
Signature of Resident Date

Please send to Institution of Declared Pension:

_____
_____
_____
_____

Resident DO NOT FILL out anything below this line - For 3rd Party Verification ONLY

Name of Pension Monthly Gross Benefit Annual Benefit

_____ _____ _____

_____
Name (Please Print) Title (Please Print)

_____ _____
Signature Date

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Libby Bortz
Assisted Living

5844 S. Curtice St.
Littleton, CO 80120
Phone 303-347-9755
Fax 303-347-3064

IRA Verification Form

I hereby grant you permission to disclose information regarding my assets to the Libby Bortz Assisted Living Center in order to determine income eligibility for rental of an apartment in the development which has received a "low income housing tax credit" allocation from the Colorado Housing and Finance Authority.

_____ _____
Name of Resident Social Security Number

_____ _____
Signature of Resident Date

Please send to Institution of Declared Asset: _____
_____
_____
_____

Resident do not fill out anything below this line - For 3rd Party Verification ONLY

Type of Asset	Value of Asset	Annual Income or interest rate
Required minimum	_____	_____
Distribution amount:	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Name (Please Print) Title (Please Print)

_____ _____
Signature Date

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Libby Bortz
Assisted Living

5844 S. Curtice St.
Littleton, CO 80120
Phone 303-347-9755
Fax 303-347-3064

Annuity Verification Form

I hereby grant you permission to disclose information regarding my annuity benefits to the Libby Bortz Assisted Living Center in order to determine income eligibility for rental of an apartment in the development which has received a "low income housing tax credit" allocation from the Colorado Housing and Finance Authority.

_____ _____
Name of Resident Social Security Number

_____ _____
Signature of Resident Date

Please send to Institution of Declared Annuity:

_____
_____
_____
_____

Resident do not fill out anything below this line - For 3rd Party Verification ONLY

Name of Annuity _____
Cash Value if accessible to owner_____
Interest rate_____Interest Paid Last Year_____YTD Interest_____
Are there regular and systematic payments to owner? ☐ Yes ☐ No
If yes, how often?_____Amount?_____

_____
Name *(Please Print)* Title *(Please Print)*

_____ _____
Signature Date

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Verification of Deposit

Medical or Public Assistance Agencies

For faster processing, please complete the form on your computer before printing.

This form is for medical or public assistance agencies requesting consumer deposit information. Please complete the form including the customer authorization signature and fax to the number below. Your completed request will be faxed to the return fax number provided on this form.

TYPE or complete in BLACK INK. Use only CAPITAL LETTERS

Fax Requests To.....1-844-879-0412
Online Instructions.....www.wellsfargo.com/biz/vod
Balance Confirmation Services.....1-540-563-7323

SECTION 1: REQUESTER INFORMATION

Libby Bortz Assisted Living
Company Name

COLLEEN DENNIS
Attention

5844 South Curtice Street
Street Address

Littleton | | 80120
City | State | Zip

Requester Email (optional)

303 - 347 - 9755
Requester Phone Number

303 - 347 - 3064
Return Fax Number

SECTION 2: CUSTOMER INFORMATION

Customer One Full Name (First Middle Last)

Customer Two Full Name (First Middle Last)

Account Number(s) (Required)

- -
Customer One Social Security Number

/ / 20
Month Day Year

CUSTOMER AUTHORIZATION

I/We authorize and direct Wells Fargo Bank to release the following information to the above mentioned requestor on my deposit accounts listed above or if only a Social Security Number is provided, all open depository accounts: Account Number, Account Type, Open or Closed, Account Holder(s), Current/Closing Balance, Open/Close Date, Current Interest Rate, Previous Six Average Statement Balances and Previous Six Months Interest Paid. In addition, CDs and IRAs will include: Term, Maturity Date, Interest Payment, Interest Method and Penalty.

Signature of Account Holder **Date** **Signature of Account Holder** **Date**

Libby Bortz
Assisted Living

Agreement, Authorization and Consent for
Release of Criminal Background Information

I,_____ understand that in conjunction with my application for residency, Libby Bortz Assisted Living Center will use the services of an outside agency, RentGrow, to perform a criminal background check. This is required as part of the Resident's pre-admission assessment pursuant to federal regulations. Results of the criminal background check will be used as a tool, along with the physician and a facilities pre-admission assessment, as to whether a Resident will be approved for admission into Libby Bortz Assisted Living Center.

I agree, authorize and consent to the procurement of a criminal background check.

_____ _____
Signature Today's Date

_____ _____
Print Full Name Social Security Number

_____ _____
Street Applicant's Date of Birth

_____
City, State & Zip Code
Applicant's Current Address

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Libby Bortz
Assisted Living

5844 S. Curtice Street
Littleton, CO 80120
(303) 347-9755

Applicant's Consent to Release Medical Information

I hereby authorize:

Any physician, clinic, hospital, nursing home, rehab center, or assisted living community to answer fully any request from The Libby Bortz Assisted Living Center for medical, psycho-social or mental health information concerning me as an applicant or while I am a Resident.
LBALC requests this information pursuant to Colorado state regulations.

_____
Printed Name

_____ _____
Signature Date

EQUAL HOUSING OPPORTUNITY

Libby Bortz Assisted Living

Activity History

Apt #: _____

Name: _____ Date: _____

Birthdate: _____ Birthplace: _____

Religion: _____ Church: _____ Regular Attendance: ☐ Yes ☐ No

Marital Status: ☐ Widowed ☐ Divorced ☐ Married ☐ Never Married

Primary Occupation: _____ How Long: _____

Military Services ☐ Yes ☐ No Branch: _____

It is helpful for the Activity Director to understand the lifestyle you enjoy. Most people have a customary routine they follow each day which consists of activities they must do (bathing, dressing, cleaning) and activities they do for pleasure (reading, socializing, TV watching). The following is a general itinerary. Please complete it by filling in the blanks with the usual activities you do for pleasure at the appropriate time during a routine day.

Wake-up/Breakfast
6:00 – 7:00 am: _____

7:00 - 8:00 am: _____

9:00 - 11:00 am: _____

Lunch Time
11:00 – 1:00 pm: _____

2:00 - 4:00 pm: _____

Evening Meal
5:00 - 6:00 pm: _____

7:00 - Bedtime: _____

Please list other regular activities in which you participate:

_____

EQUAL HOUSING OPPORTUNITY

Do you or have you enjoyed group activities? ☐ Yes ☐ No

The following are typical **group activities**. Please check activities listed below that you enjoy.

☐ Church/Bible Study ☐ Music ☐ Parties ☐ Exercise ☐ Story Time

☐ Painting ☐ Bingo ☐ Arts/Crafts ☐ Trivia ☐ Food Committee

☐ Movies ☐ Outings ☐ Writer's Group ☐ Ice Cream/Popcorn Socials

☐ Card Games ☐ Word Games ☐ Cooking/Baking ☐ Intellectual/Discussion groups

☐ Men/Women's Groups Other_____
(please list)

The following are typical **independent activities**. Please check activities you enjoy.

☐ Reading ☐ Correspondence ☐ TV Viewing ☐ Napping

☐ People Watching ☐ Crossword Puzzles ☐ Word Search ☐ Jigsaw Puzzles

☐ Radio Listening ☐ Computer Use ☐ Telephone Visits ☐ Crafts

☐ Volunteering ☐ Card Games ☐ Sewing/Needle Craft ☐ Smoking

☐ Cleaning/Organizing ☐ Family Visits/outings Other _____
(please list)

Do you have a disability that prevents you from engaging in a past leisure interest? (Please Describe):
_____

_____

Do you have any special conditions (decreased vision, hearing loss, etc) which limit leisure pursuits?

_____

Please list any type of volunteer work you may enjoy: _____

Family members are welcome to participate in activity programs. Please be sure to let us know if you plan on having guests so proper accommodations are made.

EQUAL HOUSING OPPORTUNITY

Libby Bortz
Assisted Living

5844 South Curtice Street
Littleton, CO 80120
Phone: (303) 347-9755, fax: (303) 347-3064

Date _____

RE: _____

Dear Dr. _____:

We are pleased to inform you that your patient has applied for residency at our community.

Our community provides the following types of service to the general population.

1) Three meals a day
2) Weekly housekeeping and laundry
3) Medication Administration
4) Minimal assistance with bathing and dressing.

In addition to the above services, staff also are able to provide additional care and services to private pay residents on our extended care unit; some of which include incontinent care management, full bathing and dressing, assistance with personal hygiene and grooming, and escorts to meals and activities.

In order for residents to reside at our community; residents must:

1) Be able to perform activities of daily living with the assistance provided
2) Be willing to accept the necessary assistance from staff

In order for us to schedule a pre-admission assessment of your patient, we are requesting that you complete and return the attached physician evaluation including signed and dated physicians orders. Please fax the completed physician's evaluation to us at (303) 347-3064.

If you should have any questions please feel free to contact me at (303) 347-9755.

Sincerely,

Sarah Leon
Executive Director

EQUAL HOUSING OPPORTUNITY

Libby Bortz Assisted Living
5844 South Curtice Street
Littleton, CO 80120
Phone: (303) 347-9755 Fax: (303) 347-3064

Physician Evaluation

1) Patient Name: _____ DOB: _____

Height: _____ Weight: _____ Blood Pressure: _____

Nutritional Status: _____ Allergies: _____

Is the patient taking any nutritional supplements?

☐ Yes ☐ No If yes, what supplements? _____

_____

2) List Significant Diagnosis/Medical Diagnosis

a. _____ f. _____

b. _____ g. _____

c. _____ h. _____

d. _____ i. _____

e. _____ j. _____

3) Physical and/or Sensory Limitations: _____

_____

4) Cognitive and/or Behavioral Status: _____

_____

5) In your professional opinion, can this individual's needs be met in a residential facility (assisted living facility) that is <u>not</u> a medical, nursing, or psychiatric facility?

_____

6) Is this resident able to safely leave the facility and travel throughout the community alone?

☐ Yes ☐ No

7) Is the resident bedridden? ☐ Yes ☐ No

Patient Name: _____

8) Does this resident have a communicable disease that could be transmitted to other residents or staff? _____

9) Treatments/Therapies

To your knowledge is the patient receiving:

☐ Physical Therapy Name of Agency: _____

☐ Occupational Therapy Name of Agency: _____

☐ Speech Therapy Name of Agency: _____

☐ Other Home Health Services: Type of Services and Name of Agency: _____

_____

Is the patient utilizing oxygen? ☐ Yes ☐ No If yes, how many liters? _____

Name of oxygen company if known: _____

Is the patient on Coumadin? ☐ Yes ☐ No

If yes please complete the applicable statement:

☐ a) Primary Care Provider is responsible for monitoring the patient PT/INR.
PCP Name: _____

☐ b) How often? ☐ weekly ☐ monthly or other –how often _____

☐ c) Is the patient diabetic? ☐ Yes ☐ No

☐ d) Primary Care Provider responsible for monitoring the patient glucose levels.
PCP Name: _____

☐ e) How often are glucose levels checked? ☐ weekly ☐ monthly
☐ other please indicate: _____

Please note that the staff of Libby Bortz Assisted Living Center do not perform services that include PT/INR, checking glucose levels, or administering any type of injection.

10) To your knowledge has the patient had an upper respiratory or gastrointestinal illness?

☐ Yes ☐ No If yes, when: _____

11) To your knowledge has the patient fallen in the past year?

☐ Yes ☐ No If yes, how often? _____

12) Does the patient appear to be oriented to person, place and time? ☐ Yes ☐ No

Patient Name: _____

13) To your knowledge, has this patient showed any signs of confusion? ☐ Yes ☐ No

If yes, please explain? _____

14) To your knowledge, has this patient ever wandered? ☐ Yes ☐ No

If yes, please explain incident: _____

15) Does this resident require 24-hour nursing or psychiatric care? If so, this resident is not appropriate, as this is not a skilled facility. _____

16) To your knowledge, does this patient have any history of mental illness or abnormal behaviors including hospitalization for this issue? ☐ Yes ☐ No If yes, in your opinion is this a current problem? Please explain: _____

_____

17) To your knowledge has this patient ever expressed suicidal ideation?

☐ Yes ☐ No If yes, please explain: _____

_____

18) Does the patient have any history of substance abuse? ☐ Yes ☐ No

If yes, please explain: _____

19) Is the patient continent of bladder? ☐ Yes ☐ No

Is the patient continent of bowel? ☐ Yes ☐ No

20) Does the patient require assistance with bathing? ☐ Yes ☐ No

21) Does the patient require any adaptive device to assist with ambulation, bed mobility, dressing or bathing? ☐ Yes ☐ No

If yes, type of adaptive equipment?

☐ Walker ☐ Bed Cane ☐ Wheelchair

☐ Cane ☐ Shower Chair/Bench ☐ Reacher

☐ Other: _____

Patient Name: _____

22) Does this resident pose a danger to him/herself or others? ☐ Yes ☐ No

23) Does this resident have any stage 2, 3, or 4 pressure sores? _____

24) Can this resident eat a regular diet? (Note: LBALC only offers a REGULAR diet-we cannot accommodate special needs of any kind. Diabetic residents are offered sugar-free desserts as an alternative to regular desserts. ☐ Yes ☐ No

25) What was the date that the patient was last seen by you? _____

26) When was the last history and physical exam? _____

27) Does the patient have a communicable disease? ☐ Yes ☐ No

28) Is the patient/resident safe to live unsupervised in an apartment at Libby Bortz Assisted Living Center? (The apartment consists of a large bedroom and private bathroom)
☐ Yes ☐ No

29) Is the resident capable of operating a motor vehicle? ☐ Yes ☐ No

THE PATIENT MUST BE CAPABLE OF SAFELY SELF ADMINISTERING MEDICATION WITHOUT THE ASSISTANCE OR OVERSIGHT OF ANOTHER PERSON. (MUST BE CAPABLE OF SETTING UP OWN MEDICATION REMINDER BOX, OR ADMINISTERING MEDICATION FROM A BOTTLE, ETC)

PHYSICIAN ORDER SHEET

Patient/Resident Name: (First) (Last) (Middle) Date Form Completed

_____

Generic equivalent is authorized ☐ Yes ☐ No

Routine medications include any over the counter medications, vitamins and supplements

(state diagnosis or rationale)

RX Name	Strength	Dosage	Route	Frequency	Diagnosis/Rationale for drug

PRN Medications	(☐May DC after 60 days for non-use)				

Please note all of the above needs to be complete and have a Physician Signature in order for the resident to move into Libby Bortz Assisted Living Center

☐ **Resident is capable of safely self administering medications.**

☐ **Physician feels and thereby orders that staff should administer and monitor medications.**

Physician Name (print): _____ Physician NPI #: _____

Physician Signature: _____ Date: _____

EQUAL HOUSING OPPORTUNITY

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (MOST)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- **Everyone shall be treated with dignity and respect.**

Legal Last Name		
Legal First Name/Middle Name		
Date of Birth		Sex
Hair Color	Eye Color	Race/Ethnicity

In preparing these orders, please inquire whether patient has executed a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed. *(See additional instructions on page 2.)*

A — Check one box only

CARDIOPULMONARY RESUSCITATION (CPR)

******Person has no pulse and is not breathing.******

☐ **Yes CPR:** Attempt Resuscitation ☐ **No CPR:** Do Not Attempt Resuscitation

NOTE: *Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B.*
When not in cardiopulmonary arrest, follow orders in Section B.

B — Check one box only

MEDICAL INTERVENTIONS

******Person has pulse and/or is breathing.******

☐ **Full Treatment–primary goal to prolong life by all medically effective means:**
In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ **Selective Treatment–goal to treat medical conditions while avoiding burdensome measures:**
In addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. **Do not intubate.** May use noninvasive positive airway pressure. Transfer to hospital if indicated. **Avoid intensive care.**

☐ **Comfort-focused Treatment–primary goal to maximize comfort:**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

Additional Orders: _____

C — Check one box only

ARTIFICIALLY ADMINISTERED NUTRITION

Always offer food & water by mouth if feasible.

Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA], Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section ***does not*** imply any one of the choices—further discussion is required. ***NOTE:*** *Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOST form") for details.*

☐ Artificial nutrition by tube long term/permanent if indicated.
☐ Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders")
☐ No artificial nutrition by tube.

Additional Orders: _____

D

DISCUSSED WITH (check all that apply):

☐ Patient
☐ Agent under Medical Durable Power of Attorney
☐ Proxy-by-Statute (per C.R.S. 15-18.5-103(6))
☐ Legal guardian
☐ Other: _____

SIGNATURES OF PROVIDER AND PATIENT, AGENT, GUARDIAN, OR PROXY-BY-STATUTE AND DATE (*MANDATORY*)

Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Durable Power OA, CPR Directive, living will, or other advance directive (attached if available). To the extent that previously completed advance directives do not conflict with these *Medical Orders for Scope of Treatment*, they shall remain in full force and effect.

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.

Patient/Legal Decision Maker Signature *(Mandatory)*	***Name*** *(Print)*	***Relationship/ Decision maker status*** *(Write "self" if patient)*	***Date Signed*** *(Mandatory; Revokes all previous MOST forms)*

Physician / APN / PA Signature *(Mandatory)*	***Print Physician / APN / PA Name, Address, and Phone Number***	***Date Signed*** *(Mandatory)*
Colorado License #:		

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Authority for this form and process is granted by C.R.S. 15-18.7: Directives Concerning Medical Orders for Scope of Treatment, enacted 2010.

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

ADDITIONAL INFORMATION: *Please provide contact information below, in case follow up or more information needed.*

Patient Legal Last Name	***Patient Legal First Name***	***Patient Middle Name (if any)***	***Patient Date of Birth***

Primary Contact Person for the Patient	*Relationship and/or MDPOA, Proxy, Guardian*	*Phone Number/email/Other contact information*	

Healthcare Professional Preparing Form	*Preparer Title*	*Phone Number/Email*	*Date Prepared*

Patient Primary Diagnosis	*Hospice Program (if applicable) /Address*	*Hospice Phone Number*

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

For more information, please refer to the "Getting the MOST Out of the Medical Orders for Scope of Treatment: Guidelines for Healthcare Professionals," www.ColoradoMOST.com

Completing the MOST form:

- MOST form master may be downloaded from www.ColoradoMOST.com and photocopied onto **Astrobrights® "Vulcan Green"** or **"Terra Green"** 60lb paper. This special paper is strongly encouraged but not required. Visit www.ColoradoMOST.com for a link to paper suppliers.
- The form must be signed by a physician, advanced practice nurse, or physician assistant to be valid as medical orders. Physician assistants must include physician name and contact information. In the absence of a provider signature, however, the patient selections should be considered as valid, documented patient preferences for treatment.
- Verbal orders are acceptable with follow-up signature by physician, advanced practice nurse, or physician assistant in accordance with facility policy, but not to exceed 30 days.
- **Completion of the MOST form is *not* mandatory.** "A healthcare facility shall not require a person to have executed a MOST form as a condition of being admitted to, or receiving medical treatment from, the healthcare facility" per C.R.S. 15-18.7-108.
- Patient preferences and medical indications shall guide the healthcare professional in completing the MOST form.
- Patients with capacity should participate in the discussion and sign these orders; a healthcare agent, Proxy-by-Statute, or guardian may complete these orders on behalf of an incapacitated patient, *making selections according to patient preferences, if known.*
- "Proxy-by-Statute" is a decision maker selected through a proxy process, per C.R.S. 15-18.5-103(6). Such a decision maker may not decline artificial nutrition or hydration (ANH) for an incapacitated patient without an attending physician and a second physician trained in neurology certifying that "the provision of ANH is merely prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning."
- **Photocopy, fax, and electronic images of signed MOST forms are legal and valid.**

Following the Medical Orders:

- Per C.R.S. 15-18.7-104: **Emergency medical personnel, a healthcare provider, or healthcare facility *shall* comply with an adult's properly executed MOST form that has been executed in this state or another state and is apparent and immediately available.** The fact that the signing physician, advanced practice nurse, or physician assistant does not have admitting privileges in the facility where the adult is receiving care does not remove the duty to comply with these orders. Providers who comply with the orders are immune from civil and criminal prosecution in connection with any outcome of complying with the orders.
- If a healthcare provider considers these orders *medically* inappropriate, she or he should discuss concerns with the patient or surrogate legal decision maker and revise orders only after obtaining the patient or surrogate consent.
- If Section A or B is not completed, full treatment is implied for that section.
- **Comfort care is never optional.** Among other comfort measures, oral fluids and nutrition must be offered if tolerated.
- When "Comfort-focused Treatment" is checked in Section B, hospice or palliative care referral is strongly recommended.
- If a healthcare provider or facility cannot comply with these orders due to policy or ethical/religious objections, the provider or facility must arrange to transfer the patient to another provider or facility and provide appropriate care until transfer.

Reviewing the Medical Orders:

- These medical orders should be reviewed
  - regularly by the person's attending physician or facility staff with the patient and/or patient's legal decision maker;
  - on admission to or discharge from any facility or on transfer between care settings or levels;
  - at any substantial change in the person's health status or treatment preferences; and
  - when legal decision maker or contact information changes.
- If substantive changes are made, please complete a new form and void the replaced one.
- **To void the form, draw a line across Sections A through C and write "VOID" in large letters. Sign and date.**

REVIEW OF THIS COLORADO MOST FORM

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Libby Bortz Assisted Living

Medication Administration Program

The medication administration program is offered as an additional service. The cost of the service is $275.00 a month for eight or less routine medications and $300.00 a month for nine or more routine medications. Medication management is included in 'Expanded Care Wing" fee. The charge is added to your monthly statement.

If it has been determined that a resident is not safely able to administer his or her own medication the resident will need to be placed on the Medication Administration Program.

_____(initial) ***Please Note there are 4 places to initial in this document***

IMPORTANT POINTS TO REMEMBER

1. A resident has the right to refuse or question any medication. We can encourage residents to take medication but we CANNOT force them.

2. The management staff will periodically conduct safety checks of the residents' apartments to insure residents have current physician's orders for medication they are administering in their apartment, that medications have not expired, and that the resident is capable to safely self-administer their medication.

3. All residents, whether on the program or not, must supply current signed physician orders, or prescriptions, for all new or discontinued medications.

    - Schedule II Narcotics – Residents being placed on the medication program must provide a copy of the schedule II narcotic prescription to the Care Coordinator /designee prior to the residents lease signing.
      _____(initial)
    - Residents being admitted to Libby Bortz Assisted Living Center must provide current signed physician's orders or prescriptions prior to the resident's admission or re-admission to the Center.
    - Failure to provide current physicians orders or prescriptions prior to the resident's admission/re-admission could result in a delay in:

    a) resident's admission or re-admission to the Center or
    b) Resident being placed on the Medication Administration Program and family will be responsible to safe guard and administer the resident's medication until signed physicians orders are received or medication becomes available.
    c) _____(initial)

4. It is Colorado State regulation that a current and complete list of medications be on file for every resident in the facility. This includes over the counter medications such as vitamins, Tylenol, aspirin, and cold remedies. The care coordinator will send a copy of this list to your physician requesting his signature every six months in order to ensure that the list is current.

5. Residents who are going to be on the Center's Medication Administration Program will have all of their medications ordered from the Center's contracted Pharmacy by the Care Coordinator/designee after the pre-admission assessment. This includes all over the counter medication. If an over the counter medication is not available on the Center's contracted pharmacy, the Care Coordinator/designee will be responsible to call the residents primary care physician to attempt to obtain an alternative over the counter medication to take the place of the over the counter medication not on the Center's contracted pharmacy formulary. If an alternative over the counter medication cannot be ordered, then the Care Coordinator/designee will inform the resident and resident's family of the option for the resident/family to obtain the medication from an independent pharmacy and bring it to the Care Coordinator/designee. The resident and family must agree and have available alternative contacts and telephone numbers; that can pick up and deliver medication in a timely manner as outlined in the residents' service plan.

6. Families/friends are not allowed to routinely provide medication or over the counter medication to residents who are placed on the Medication Administration Program after admission to the facility. Libby Bortz will not accept any medications that the residents or family bring in from home at the time of admission unless prior arrangements were made preadmission to use the current medications. Physician orders must be received for these medications and only up to a Supply for 30 days.

7. If the resident will be out of the facility during one or several medication times, it is the responsibility of the family to pick up the medications from the resident assistant and return them to a resident assistant. **Twenty-four hours' notice is required if the resident will be out of the facility overnight or longer, this is to ensure that the medications are ready for you to pick up when you are ready to leave.** The medications will not be given to the resident. You may be asked to sign for any controlled substances before leaving the building.

8. Every effort will be made to provide medications for our residents in a safe and timely manner. If a resident is out of the center and neglects to pick up medication before they leave the dose cannot be made up upon return to the center if it is more than ½ hour past the dosage time. Some medications may be given at the discretion of the Manager on Duty. (Pain Medications & Antibiotics)

9. All medications must be in a blister pack form. If a doctor would like a medication started immediately, it is suggested that the family pick up the medication from a local pharmacy and give copy of prescription and medication to the resident assistant. In this case a bottle will be accepted.

10. Residents who utilize blood glucose monitoring lancets or who self administer injectables will be required to store and dispose of their lancets and syringes in a Sharps container in accordance with Center for Disease Control recommendations.

11. For the residents' safety, and to comply with State Regulations, Libby Bortz Assisted Living Center requires updated signed physicians orders prior to a residents admission/re-admission to the Center, including the order for resident to self-administer their own medication-if applicable. A resident will not be admitted or readmitted without updated signed physicians orders.

I understand and agree to the above

_____ _____

Resident (Print & Signature) Date

_____ _____

Responsible Party/Family (Print & Signature) Date

Libby Bortz Assisted Living

Medication Administration Program Startup

To start on the medication program you must:

1. Provide a current list of medications, both prescribed and over the counter, dated and signed by your physician to the Care Coordinator at least 48 hours prior to admission.
   - Schedule II Narcotics – Residents that take scheduled II narcotics must provide a copy of the schedule II narcotic prescription to the Care Coordinator/designee prior to the residents lease signing.
     _____(initial)

2. Libby Bortz Assisted Living Center contracted pharmacy is PharMerica (720) 652-4500. All medication must be packaged in bubble packs.

3. Regardless of whether you are on the medication administration program or not an account will need to be set up with the Center's contracted pharmacy. LBALC staff will fax the resident's face sheet and physician's orders to the Center's contracted pharmacy.

4. If your medication is provided by the VA pharmacy, it is still necessary to set up an account with one the Center's contracted pharmacy.

5. Residents and their responsible party must schedule a pre-admission assessment with the Care Coordinator or designee at least 48 hour prior to the residents lease signing and admission into the Center. The Care Coordinator will review the physician orders to insure:

   a) Residents who are self administering their own medication are able to do so safely and that the physician orders match the medication that the resident will be taking. Residents that will self administer their own medication MUST BRING THE MEDICATIONS THEY ARE CURRENTLY TAKING TO THE PRE-ADMISSION ASSESSMENT.

   b) Residents that are to be placed on the Centers Medication Administration Program will have thirty (30) day supply of Medication ordered from the Center's contracted pharmacy. Residents planning on bringing in medication from home to be used up MUST BRING ALL MEDICATION TO THE PRE-ADMISSION ASSESSMENT. The Care Coordinator will check the physician orders on file against the medication being brought in from home. NO MEDICATION CAN BE ADMINISTERED WITHOUT A SIGNED PHYSICIANS ORDER.

If you are a client of Innovage, medications will be ordered through the InnovAge Pharmacy. Medications will not be accepted or administered without a current signed physicians order. The Medication Administration Program is covered under your Innovage provider agreement, your co-pay, and payment from Innovage.

<u>If a move is anticipated over a weekend all of the above must be completed by noon on Thursday. Adjustments to this policy may be required according to the availability of the Medication Coordinator.</u>

Please contact a Care Coordinator with any questions at (303) 347-9755.

I have read, understand and agree to the medication start-up procedure.

Signature: _____ Date: _____

Medication Reminder Box Labeling
Set Up By Resident

This facility does not set up medication reminder boxes for residents. The resident has to have the ability to safely set up their own medication reminder box and be capable of administering their own medication without the assistance or oversight of another person. A current list of medications that the resident self-administers must be with the medication reminder box or prescription bottle at all times. Residents who administer medication from a bottle must do so without the assistance or oversight of another person.

The Medication Reminder Box must be labeled very clearly with:

1. Resident's first and last name.
2. Name of each medication.
3. Dosage of each medication.
4. Number of pills to be given.
5. Time for each medication to be taken.

- **Per the Colorado State Health Department, the medication reminder box can only be filled for two (2) weeks at a time.**

I have read, understand and agree to the above.

_____ _____

Resident Date

_____ _____

Responsible Party Date

Libby Bortz Assisted Living

Advanced Directive Disclosures

Resident Name: _____

_____(initial) I have received a copy of the "Your Right To Make Health Care Decisions" pamphlet.

1. Yes ☐ No ☐ I have an individual or individuals listed as my Medical Durable Power of Attorney.
2. Yes ☐ No ☐ I have a Living Will.
3. Yes ☐ No ☐ I have a legal guardian.
4. Yes ☐ No ☐ I have a Health Care Proxy.

Libby Bortz Assisted Living Center requires a copy of any of the above marked documents.

Cardio Pulmonary Resuscitation (CPR Directive)

_____ I do have a CPR Directive signed by myself, or legal representative and my attending physician.

_____ I do not have a CPR Directive and choose not to initiate a CPR directive at this time.

The Resident Services Director or designee will review the CPR directive with the resident or the resident's legal representative during the pre-admission assessment. The Resident Services Director will document the CPR directive on the initial service plan. Upon the residents admission, the Admission/Marketing Director will be responsible to obtain a copy of the residents advance directives.

The original and copies of the residents advance directives will be kept on file at the receptionist desk, a copy in the resident's medical record and a copy in the Resident Services Directors office. The residents advance directives will be reviewed annually during each resident's service plan meeting, or upon a significant change in the residents' condition by the Resident Services Director.

_____ _____
Signature of Resident Date

_____ _____
Signature of Legal Representative Date

_____ _____
Signature of Facility Representative Date

EQUAL HOUSING OPPORTUNITY

Libby Bortz Assisted Living

Admission or Re-Admission and Medication Administration Program
Policy and Procedure

For the resident's safety, and to comply with State regulations, Libby Bortz Assisted Living Center requires updated and signed physician orders prior to a resident's admission/re-admission to the Center following discharge from the hospital or skilled nursing facility (SNF) stay, including an order for the resident to self-administer his or her own medications, if the resident had been taking medications prior to the hospital/rehab stay.

A resident will not be admitted or re-admitted to the Center following discharge from a hospital or SNF without the Center receiving updated and signed physician's orders prior to admission or re-admission.

Residents who were previously self-administering one or more of their medications prior to hospitalization or SNF stay will be immediately placed on the Center's medication administration program upon return to the Center if Physician orders are not received from the hospital/SNF stating that the resident is able to self-administer their medication, if the resident is taking any medications. Residents who return from the hospital or SNF and are placed on the Medication Administration Program, who wish to self-administer their own medication:

1) Will need to see the Care Coordinator to schedule a time for evaluation to determine that the resident is safe to self-administer their own medication; and
2) Will not be removed from the Medication Administration Program and cannot begin self-administrating their own medication until the Center receives an updated, signed physician's order stating the resident can self-administer their own medication.
3) Residents who were self-administering all or some of their own medication prior to a hospital/rehab stay and return without orders to self administer their own medication will be placed on the community medication administration program, and not be charged for the medication administration program until the staff at Libby Bortz Assisted Living Center completes an evaluation to determine if the resident is safely able to self- administer their own medication, and a physician's order has been received stating the resident is able to self-administer their own medication.
4) The resident and responsible party will be notified by the Care Coordinator/designee if a medication is identified during the SAM evaluation that is not on the signed physician's orders. The resident's responsible party will have 48 hours to obtain a signed physician's order for the medication or over

the counter medication that the resident has in their apartment and provide a signed copy of the order to the Care Coordinator. If the responsible party is not able to obtain a signed order within 48 hours the responsible party agrees to immediately remove the medication from the resident apartment until such order is received.

Treatments:

If the resident (1) has a physician order for the following types of treatment; (2) cannot self-administer the treatment; and (3) is on the Center's Medication Administration Program, the Center will:

(a) apply topical gels, ointments, creams, liniments, and lotions to intact skin
(b) apply skin sprays or aerosols to intact skin
(c) assist with throat gargles
(d) apply transdermal skin patches (medicated adhesive patches) to intact skin
(e) assist with the administration of an inhaler
(f) apply eye ointments or drops
(g) apply ear drops
(h) apply nose drops or nasal sprays

For any physician treatment order outside of the above list and not excluded in the "Services Not Provided" list, the Center will review the physician's order and will need to make a case-by-case determination of whether the Center can provide the treatment based on applicable law and Quality Medication Administration Program training. If the Center determines it cannot perform the treatment order, it will consult with the resident and the family to arrange for a family member or an external service provider to perform the treatment order.

The Center's staff cannot administer insulin injections or any other injections which are considered a treatment. For any residents that have been assessed as unable to administer their own insulin or other injections, the Center will follow up with the resident and resident's family to arrange external service providers to provide the injections according to physician's orders. Residents returning from the hospital/SNF prior to their return to the Center to ensure the resident is capable of self-administering their insulin injections or other injections, or have a documented discharge plan which includes an external service provider who will provide the insulin injections or other injections upon the resident's return to the center.

By signing this form, I consent to being placed on the Center's Medication Administration Program if I return to the Center after a hospital or skilled nursing facility stay without an updated and signed physician's order stating that I can self-administer my own medication(s), if I am taking any medications.

Resident Name:_____

Resident Signature:_____ Date:_____

Legal Representative Name:_____

Legal Representative Signature:_____ Date:_____

Indicate in what status you are signing as Legal Representative.

Omnicare®
a CVSHealth company

Resident Pharmacy Enrollment Form

Community Name* Libby Bortz Assisted Living **Room Number** (IF AVAILABLE) _____

Move-in Date* _____ **Future Admit** ◉ **Yes** ○ **No**

Resident Information

*Required field

Last Name* (PLEASE PRINT) First Name* Middle Initial

Date of Birth* (MM / DD / YYYY) Phone Number* Gender

Street Address (FOR BILLING PURPOSES) City State Zip Code

Social Security Number* Medicare ID Number

Is Omnicare the Resident's primacy pharmacy? ○ Yes ○ No

If no, what is their emergency pharmacy?* (SERVICE CHARGE MAY APPLY) _____

Are the Resident's medications managed by community? ○ Yes ○ No (SELF ADMINISTERED)

Is the Resident responsible for all pharmacy services, including the bill and any other finances?

○ Yes ○ No (IF NO, PLEASE COMPLETE THE NEXT SECTION BELOW)

Financially Responsible Party

Only complete if there is a Responsible Party, other than the Resident, who agrees to be responsible for payment of all amounts owed by the Resident for prescription drug products and services provided to the Resident by Omnicare.

Responsible Party Last Name* Responsible Party First Name*

Email Phone Number*

Billing Address* City State Zip Code

People involved in the Resident's health care

The following people are involved in the Resident's health care and have permission to manage the Resident's prescriptions.

Full Name* _____ Phone Number* _____

Check all that apply:

○ Same as financially responsible party ○ Legal Guardian by power of attorney ○ Legal Guardian by court order

○ Spouse ○ Child ○ Other _____

Payment sources for pharmacy products and services

Does the Resident have prescription insurance coverage?* ○ Yes ☐ No

If yes, please check all pay sources that apply:

○ **Medicare Part B**

Effective Date: _____

Medicare Part B Number: _____

☐ **Medicare Part D or Rx Insurance (Commercial) Plan Name**

Plan Name: _____

ID Number: _____

Group Number: _____

BIN/PCN: _____

Phone Number: _____

○ **Medicaid**

Number: _____

State: _____

Date: _____

○ **Hospice**

Hospice Name: _____

Phone Number: _____

○ **Veteran Drug Benefit**

Name: _____

Signature

By signing below, the Resident or Resident's Representative acknowledges and agrees as set forth below.

_____

Resident Signature / Representative Signature*

_____

Printed Name Date

Omnicare Prescription Medication Service Terms

1. Prescription Containers: Resident understands that the prescription drug products provided by Omnicare will be dispensed in containers that are not child resistant.
2. Legal Representative: Any individual signing on behalf of Resident and representing that they are the Resident's Guardian or Legal Representatives ("Representative") will provide Omnicare with documentation establishing his/her legal authority to enter into this Agreement. If this Agreement is executed by the Representative, the Representative hereby affirms that s/he has the authority to enter into Agreements on the Resident's behalf. References in these Service Terms to "Resident" will include the Representative, as appropriate.
3. Assignment of Benefits: Resident hereby requests and authorizes any third-party payer to make payment directly to Omnicare for products and services provided to the Resident. Resident will immediately notify Omnicare in writing of any change to the Resident's ability to make health care decisions independently or change in Representative.
4. Payment: Payment in full amount owed by Resident is due within 30 days of the invoice date, and a finance charge equal to the lesser of 1.5% per month or the maximum rate permitted by law may accrue on all delinquent accounts beginning on the day after the payment is due.
5. Fees and Expenses: The Resident and/or Financially Responsible Party are responsible for paying all costs and expenses incurred by Omnicare in the collection of amounts owed and the enforcement of its rights under this Agreement, including without limitation, attorneys' fees, court costs and expenses.
6. Delinquent Payment: The Resident and/or Financially Responsible Party acknowledge that if the Resident is delinquent on payment of any amount owed to Omnicare, Omnicare may, in its sole discretion, (a) condition its continued provision of products and services to the Resident upon Omnicare's receipt of assurance of payment acceptable to Omnicare, which may include, without limitation, a requirement that Omnicare receive authorization to charge all amounts owed, past and future, to a valid credit card number; and/or (b) suspend or terminate its provision of products and services to the Resident. Such suspension or termination will in no way affect the obligation to pay all amounts owed under this Agreement, including costs of collection.
7. Successors: This Agreement shall inure to the benefits of, and be binding upon, each party and its respective affiliates, successors and assigns, heirs, executors, and administrators.
8. Disclosure or Use of Resident Information for Treatment, Payment, and Healthcare Operations. The Resident or Legal Representative hereby acknowledges Omnicare has made available a copy of its Notice of Privacy Practices and that Omnicare may use and disclose Resident's personal health information in compliance with Federal and state laws.
9. People listed as being involved in resident's healthcare have permission to perform activities necessary to manage resident's prescriptions, including, but not limited to, submitting prescriptions to be filled, viewing resident's prescription records and medical profile, discussing resident's care with Omnicare pharmacists, accessing financial information related to resident's prescriptions, providing guidance and direction to Omnicare pharmacy in connection with resident's prescriptions, and/or undertaking any activity that resident personally could undertake to manage resident's prescriptions. Resident's Caregiver may manage resident's prescriptions in person at Omnicare pharmacy, telephonically, or through any other channel that Omnicare pharmacy makes available. This consent is valid until revoked on by telephonically calling 866-397-8935.

TO: All Libby Bortz Residents and Applicants
DATE: November 25, 2021
RE: Limiting Resident Spaces Available for InnovAge Assistance

We are providing this notice to let you know that, effective December 25, 2021, Libby Bortz Assisted Living center will cap the number of residents utilizing InnovAge to pay all or a portion of their rent and support services. Beginning December 25, 2021, LBALC will allocate no more than 40 resident spaces for utilization of InnovAge benefits.

Q: Why is LBALC limiting the number of InnovAge resident spaces?
A: The current costs of administering InnovAge benefits combined with the costs of the rent and support services provided to InnovAge participants have increased markedly in the last two years and are not fully-compensated by the payments made to LBALC under the InnovAge program.

Q: What if I am currently an LBALC resident using InnovAge to pay all or a portion of my rent and support services?
A: Current LBALC residents utilizing InnovAge will be allowed to continue to utilize InnovAge without change after December 25, 2021.

Q: What if I am currently and LBALC resident or a new LBALC applicant and want to apply for InnovAge assistance after December 25, 2021?
A: After December 25, 2021, new InnovAge participants will only be allowed if one of the 40 InnovAge resident spaces is available.

Q: What if there are no InnovAge resident spaces available when I apply or when I wish to transfer into the InnovAge program?
A: Residents and applicants may use other resources to pay the costs of rent and support services and continue as tenants at LBALC.

Libby Bortz remains committed to providing the best possible care in the best possible living environment for all of its residents. We believe this change will help LBALC to continue to meet that goal.

We are available to answer any other questions you may have about this transition. Please contact Sarah Jane Leon, Executive Director.

_____ _____
Resident Signature Date

_____ _____
Legal Representative Signature Date

EQUAL HOUSING OPPORTUNITY