Illinois Council on Long Term Care

Standardized Admission Packet

Updated for 2014

Contract, Care Issues, Lifestyle Issues, Financial Notifications and Information, Privacy Act Statement – Health Care Records

A Commitment to Professionalism and Quality Care
A Partnership for Excellence

Illinois Council on Long Term Care

Standardized Admission Packet

Updated for 2014

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A Commitment to Professionalism and Quality Care
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Contract Between Resident and Facility

(A CONTRACT IS REQUIRED BY FEDERAL AND STATE REGULATIONS)

____(“Resident”) and

____(“Facility”) agree as follows:

In this contract: “Facility Standards” means the Rules and Regulations of the Illinois Department of Public Health for Long Term Care Facilities, applicable federal rules and regulations and, if the resident’s care is funded by Medicaid, regulations of the Illinois Department of Human Services and the Illinois Department of Healthcare and Family Services.

A. Facility Agreement

1. The facility shall offer personal care, room, board, dietary services and laundry services. The facility will also offer nursing care, activities, restorative and rehabilitative services and psychosocial care as identified in the resident’s Plan of Care established by the facility (“Plan of Care”) to the extent required by the facility Standards and in accordance with the policies of the facility.
2. Medicines, treatments or special diets will be offered to the resident if ordered by physician, the facility Medical Director, or any other physician approved by either of them or the resident (“Physician” means any of the foregoing).
3. The facility will offer equipment required under Facility Standards. If any Physician orders special equipment not required under Facility Standards it will be offered at the resident’s expense. Residents must have consent of the facility to bring special equipment; use of such equipment is at the resident’s risk.
4. The facility will exercise reasonable care toward the resident. However, the facility is not an insurer of the resident’s welfare or safety and assumes no such liability.
5. The facility may change the resident’s roommate. The facility will notify the resident before such change is made, and will try to accommodate the resident’s preferences.

B. Resident’s Rights and Obligations

1. The resident acknowledges receipt of the written items identified in **Supplement D: Admissions Checklist**, and acknowledges that each item has been explained in language that the resident understands.
2. All items identified and checked in **Supplement D: Admissions Checklist** are incorporated into this contract. The resident will abide by all rules and regulations of the facility and will cooperate in the carrying out of the resident’s Plan of Care.

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B. Resident's Rights and Obligations (Continued)

1. No food, liquids or medicines will be brought into the facility without permission of the Administrator or nurse in charge. Food must be sealed in containers. No medication will be kept in the resident's room or possession unless in accordance with a Plan of Care.
2. The facility may use, at the resident's cost, the pharmacist, laboratory, and other outside service providers recommended by the facility. If the resident prefers to use any other provider, it will be at the resident's cost. To compensate the facility for costs of monitoring such services, the resident will pay to the facility an amount to be set by the facility not to exceed $75.00 per month.
3. The resident will be responsible for damage to any property or injury to any person caused by the resident.
4. The resident will be responsible to comply with the facility's smoking policies.
5. The resident has the right to manage his or her financial affairs and need not deposit personal funds with the facility.
6. The resident will provide his or her own spending money.
7. Upon the resident's written authorization, the facility will hold the resident's personal funds in a Trust Account as further described in the **"Resident Trust Fund Policy Notification and Agreement."**
8. The facility is not responsible for money, valuables, or personal effects of the resident unless delivered to the Administrator for safekeeping.

C. Financial Agreement

1. **Charges for Services:**

   (a) Basic Rate. The Basic Rate includes personal care, laundry, room, board, and nursing care as required by Facility Standards. If a resident is paying privately, the resident will pay monthly in advance as set out in **Supplement A: The Basic Rates**.

   (b) Costs for Specified Supplemental Services and Products. The resident may also be charged for services of the type stated in **Supplement B: Additional Charges**. In addition to the Basic Rate, the resident agrees to pay for the Services and Products set out on the attached Facility Price List.

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(c) Additional Costs. The resident is liable for any special treatment, services or supplies ordered by any Physician or requested by the resident and which is not covered in paragraphs C(1)(a) or C(1)(b). These costs cannot be determined in advance.

(d) Changes in Charges. The above charges may be changed at any time subject to notice under paragraph 4 of Section G.

2. **Residents Paying Privately:**

(a) Definition. A "Resident Paying Privately" is a resident for whom the facility does not receive payment from the Medicaid or from the Veteran's Administration. A Resident Paying Privately may be covered by Medicare.

(b) Agreement and Undertaking. The resident paying privately represents to the facility that charges incurred by or on behalf of the resident will be paid from all available income, assets, benefits, and other resources. Persons with access to resident resources must sign **Supplement C: Income and Personal Resource Statement**.

(c) Pending Public Aid Approval. If the resident applies for Medicaid funding, the resident will be responsible to pay all charges through the date Medicaid authorizes the billing for the resident's care. The parties further agree that the facility may require a deposit or assurance of payment from the resident prior to approval of Medicaid eligibility for nursing home care. To the extent that the deposit covers time after the date Medicaid payments are authorized, the deposit shall be returned to the depositor within 30 days of the date of such authorization except as such deposits may be drawn upon in accordance with Medicaid requirements.

(d) Billing. The resident shall be billed monthly, payable within 7 days of billing. Delivery of a bill shall be deemed demand for payment. If any sum of money due to the facility under this contract is not paid when due, then the resident shall pay to the facility interest on such sum at the rate of nine percent (9%) per year and reasonable costs of collection, including reasonable attorney's fees.

3. **Residents Receiving Public Assistance**:

The facility accepts Medicaid Recipients. Making application for Medicaid or veteran's coverage and appeals of any decision are solely the responsibility of the resident. If the resident is a Medicaid Recipient, payment shall be in accordance with Medicaid regulations. The facility may require a deposit and the resident shall pay charges for services to the extent Medicaid determines that the resident pay from the

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resident's sources. If eligibility for Medicaid payments is terminated, the resident shall pay all charges thereafter as a Resident Paying Privately.

4. If the source of payment for the resident's care changes from private to public or public to private funds, or if the consent for the resident's Veteran's Administration funded care is terminated, the resident shall execute a new written contract with the facility substantially the same as this Contract. If the change is to private funds, the resident will pay all charges as a Resident Paying Privately after the change and all other terms of this Contract shall remain in effect until the new contract is signed.

D. Transfer or Discharge

The facility may transfer or discharge the resident in compliance with Facility Standards:

1. If necessary for the resident's health, safety or welfare or if the safety or health of other individuals in the facility would otherwise be endangered.
2. If the resident's health has improved sufficiently so the resident no longer needs the facility's services.
3. If the resident fails to pay any charges when due.

E. Term and Termination

This Contract shall initiate on the day it is signed by the resident or authorized representative and shall end under the following conditions:

1. If the resident is compelled by a change in physical or mental health to leave the facility, this Contract shall terminate on 7 days' notice or immediately upon the resident's death. The resident may terminate the Contract on 30 days' notice to the facility.
2. The resident's absence from the facility for 30 consecutive days (except for therapeutic home leave, or hospitalization) shall be deemed a voluntary termination of this Contract by the resident and shall be a basis for involuntary discharge proceedings under the Nursing Home Care Act. Notice shall be served on the resident by mailing to the resident's last known address.
3. The resident's refusal upon 7 days' notice to execute a new contract when required shall be deemed voluntary termination of this Contract by the resident and shall be a basis for voluntary discharge proceedings under the Nursing Home Care Act.
4. The facility may change any charge on 30 days' written notice to the resident or to the person executing this Contract for the resident. The resident or the person executing

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this Contract for the resident may elect to terminate this Contract and to transfer from the facility by giving the facility notice within such 30 days. The written notice to the resident shall become an addendum to this Contract and the Contract as so modified shall be in force if the resident does not terminate the Contract.

5. All other terms of this Contract shall remain in effect from termination until the resident is transferred from the facility.

F. General

1. (**Optional: There is no Resident's Representative unless designated in writing.**)

   The Resident's Representative is ________________________________. The resident may cancel or change the "Resident's Representative" in writing at any time.

2. If any part of this Contract is ruled invalid by a court or is in violation of any applicable law, such part shall be deleted and the balance of this Contract shall remain in full force and effect.

3. If any law hereafter requires changes or additions to this Contract, such changes or additions shall be part hereof from the effective date.

4. This Contract may be assigned by the facility to any successor in ownership or operation of the facility.

4. **THE UNDERSIGNED RESIDENT HAS RECEIVED A COPY AND HAS READ AND AGREES TO THE TERMS AND CONDITIONS OF THIS CONTRACT.**

For the Facility:

____

Signature of Licensee, or by Administrator of the Facility as an Agent of the Licensee

____

Date of Signature | Title of Facility Representative

For the Resident:

____

Resident, Resident's Guardian, Resident's agent under a Power of Attorney executed pursuant to the Illinois Power of Attorney Act or a member of Resident's immediate family

____

Date of Signature | Specify Capacity if Signer is not the Resident

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Contract Between Resident and Facility

Supplement A: Basic Rates

Effective _______ / _______ / ____________.
[month] [day] [year]

___________________________________ per day (Private Room)

___________________________________ per day (Two-Bed Room)

___________________________________ per day (Three-Bed Room)

___________________________________ per day (Four Bed Room)

The above charges are subject to change with 30 days written notice

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The following list provides examples of common charges that may be incurred during a stay at the facility, and are not included in the facility's Basic Rate.

Residents of this facility will be charged for the following services/products:

- Clothing
- Shoes
- Cigarettes
- Beautician or barber
- Special outings (field trips)
- Optical care, including glasses
- Podiatric care not covered under Medicare Part B
- Hospice services not covered by Medicare Part A
- Pharmacy for items not covered by Medicaid or Medicare

Residents MAY also be charged for the following, if not covered by resident payor source:

- Pharmacy services and medications
- Laboratory services
- Physician services
- Routine dental care
- Radiological (x-ray) services
- Ambulance services
- Oxygen tank usage
- Medical supplies
- Isolation care
- Tracheostomy care
- Incontinence care
- Therapies
- Other similar items

Actual charges cannot be given because of market fluctuations, and/or until the nature of the service is known.

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Agreement and Undertaking

I hereby agree as follows:

- I hereby represent to the facility that I have access to the resident's income and resources available to pay for care provided by the facility as follows:

- I shall pay such income and resources of the resident or funds I receive from the resident to the facility when and to the extent needed for payment for the resident's care at the facility.

- I shall not use such income and resources for any purposes other than the foregoing or for the resident's benefit.

- I shall assign such income and resources to the facility at the facility's request to the extent necessary to pay for the resident's care at the facility.

This agreement and Undertaking is limited to the resident's income and resources to which I have access and does not bind me to make any payment for the resident from my personal assets.

____

Signature(s) of Person or Persons with Access to the Resident's Funds   Date

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Contract Between Resident and Facility

Supplement D: Admissions Checklist

Care Issues

	Item	Action
☐	**Residents' Rights Handbook**	• Provide One Copy to Resident/Authorized Representative
☐	**Choice of Physician and Physician Policy Notification**	• Complete Form and Obtain Signatures • Provide One Copy to Resident/Authorized Representative • Keep One Copy for Facility Records
☐	**Admission Information on Advance Directives and Potential Health Care Surrogate**	• Complete Form and Obtain Signatures • Provide One Copy to Resident/Authorized Representative • Keep One Copy for Facility Records
☐	**Statement of Facility Policy To Our Residents: Advance Directives and Life Sustaining Treatment and the Statement of Illinois Law on Advance Directives**	• Provide One Copy of each to Resident/Authorized Representative
☐	**State and Federal Notification Requirements**	• Complete Form • Provide One Copy To Resident/Authorized Representative
☐	**Notification of Federal MDS Electronic Data Transfer / Identified Offender Notification Criminal Hx Background Checks**	• Provide One Copy to Resident/Authorized Representative
☐	**Notice of Facility Privacy Practices Privacy Act Statement – Health Care Records Privacy Act Statements**	• Obtain Signatures • Provide One Copy to Resident/Authorized Representative • Keep Original for Facility Records
☐	**Consent for Release of Information (HIPAA)**	• Complete Form • Provide One Copy to Resident/Authorized Representative • Keep Original for Facility Records
☐	**Authorization and Release for Pneumococcal Vaccine / Vaccine Information Sheet**	• Complete Form and Obtain Signatures • Provide One Copy to Resident/Authorized Representative • Keep One Copy for Facility Records
☐	**Authorization and Release for Influenza Vaccine / Vaccine Information Sheet**	• Obtain Signatures • Provide One Copy to Resident/Authorized Representative • Keep Original for Facility Records
☐	**Resident and Visitor Smoking Policy Notification**	• Complete Form • Provide One Copy To Resident/Authorized Representative
☐	**Consideration of a Funeral Home**	• Complete Form • Provide One Copy to Resident/Authorized Representative • Keep Original for Facility Records

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Contract Between the Resident and Facility

Supplement D: Admissions Checklist

Lifestyle Issues

☐ **Bed Reserve Policy Notification**	• Enter Facility Bed Reserve % • Provide One Copy to Resident/Authorized Representative
☐ **Resident Trust Fund Policy Notification and Authorization**	• Complete Form and Obtain Signatures • Provide One Copy to Resident/Authorized Representative • Keep Original for Facility Records
☐ **Laundry Services**	• Complete Form • Provide One Copy to Resident/Authorized Representative • Keep Original for Facility Records
☐ **Notification of Facility Policy Regarding Personal Property**	• Provide One Copy to Resident/Authorized Representative
☐ **Authorization to Inspect and Open Official Correspondence**	• Complete Form and Obtain Signatures • Provide One Copy to Resident/Authorized Representative • Keep Original for Facility Records
☐ **Special Notifications:** • **Resident Council** • **Care Plan Conferences** • **Participation in Resident Field Trips** • **Special Notice to Families and Visitors**	• Provide One Copy to Resident/Authorized Representative
☐ **Audio, Video and Photographic Release Form**	• Complete Form and Obtain Signatures • Provide One Copy to Resident/Authorized Representative • Keep Original for Facility Records

Financial Notifications and Information

☐ **Assignment of Medicare Benefits and Authorization for Release of Information**	• Obtain Information and Signatures
☐ **Your Benefits Under Medicare**	• Provide One Copy to Resident/Authorized Representative
☐ **Your Benefit Rights and Eligibility Information Under Medicaid**	• Choose the Appropriate Form, For Single Individuals or Married Couples With One Person in the Community) • Provide One Copy to Resident/Authorized Representative
☐ **Medicaid Services and Supplies Covered By the Illinois Medical Assistance Program**	• Provide One Copy to Resident/Authorized Representative

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Contract Between the Resident and Facility

Supplement D: Admissions Checklist

Medicare-Specific Issues (If Applicable)

Item	Instructions
☐ **Medicare as Second Payor - Screening Questionnaire**	• Complete Form • Provide One Copy to Resident/Authorized Representative • Keep One Copy for Facility Records
☐ **Waiver of Medicare Benefits (Optional)**	
☐ **Notice of Non-Coverage Under Medicare** • **Determination on Admission** • **Determination on Continued Stay** • **Technical Denial** • **Intermediary Decision** • **Advanced Beneficiary Notice**	

Advance Directives (Optional)

Item	Instructions
☐ **Illinois Statutory Short Form Power of Attorney for Health Care**	• Complete Form and Obtain Signatures • Provide One Copy to Resident/Authorized Representative • Keep Original for Facility Records • Forward One Copy to the Resident's Chart
☐ **Illinois Living Will Declaration**	
☐ **Certification for Surrogate Decision-Making (With Qualifying Conditions)**	
☐ **Certification for Surrogate Decision-Making (Without Qualifying Conditions)**	
☐ **Uniform Do-Not-Resuscitate (DNR) Advance Directive** ☐ **IDPH Advance Directive Guidance for Individuals**	• Complete Form and Obtain Signatures • Provide One Copy of form plus IDPH Guidance to Resident/Authorized Representative • Keep Original for Facility Records • Forward One Copy to the Resident's Chart

I acknowledge that the areas of this checklist that have been marked have been explained to me in terms that I understand. I have been provided with an opportunity to ask questions, and those questions have been answered to the best of the facility's ability. Additionally, I have received copies of all appropriate handouts and supplemental materials.

______________________________________ ________________

Signature of Resident/Authorized Representative   Date

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Choice of Physician and Physician Policy Notification

- This facility wants you to feel comfortable with your medical care. To this end, each resident has the right and obligation under the law to select their own physician for the time he or she is a resident of this facility. All residents of the facility must use this form to select a physician.
- A physician selected to provide services in this facility is expected to comply with applicable laws and regulations, and with the facility's policies and procedural systems. A physician is also expected to maintain in good standing his or her medical license and carry adequate professional liability insurance.
- Under certain circumstances, this facility may select a physician for you. The facility may assign a physician to provide medical care if (1) a physician is not selected upon admission, (2) a physician has been terminated, (3) a physician fails to comply with any legal requirements, or (4) a physician places a resident's health in jeopardy. At any time, the resident has the right to assign or replace a physician.
- Each resident is solely responsible for payment of all fees of his or her physician. Depending upon circumstances and the nature of the services, some or all of these fees may be reimbursed by Medicare, Medicaid or another third-party payor.
- The facility has obtained a medical director to act as liaison with the physicians serving the facility's residents, and to assist the facility in addressing any issue related to medical care. However, the facility does not endorse or recommend any physician, and each resident's attending physician is solely responsible for his or her medical care.
- Since this facility does not employ any physicians to provide medical care, it is important to inform you that all physicians providing service in this facility are independent of the facility's management and not under its direction or control.

____

Name of Physician

____

Phone Number of Physician　　　　　Specialty of Physician

I acknowledge that I have read the information provided above, and have selected the above-named physician to be my attending physician during my stay at the facility subject to the understandings and conditions set forth above.

____

Signature of Resident/Authorized Representative　　　　　Date

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Admission Information on Advance Directives

Federal and State law require the following questions:

Do you have an existing written Advance Directive regarding life-sustaining treatment?

☐ **YES.** I hereby indicate that I have an existing, written, and signed Advance Directive (a Living Will or Health Care Power of Attorney). Within the next five days, I will provide a copy of this written statement to my physician and to the facility. I understand that this facility cannot implement an Advance Directive until it receives a written copy.

☐ **NO.** At this time, I do not have an existing Advance Directive

____
Signature of Resident/Authorized Representative Date

____
Signature of Facility Representative Receiving the Advance Directive Date Received

Potential Health Care Surrogate When No Advance Directive is Present

If you do not have an Advance Directive, you have the right to provide the name of one or more people that you would want the treating physician to consider appointing as your surrogate should you lose the ability to make health care decisions for yourself.

☐ **My preference for a person/s to make decisions for me if I lose decision making capacity is:**

____
Print Name of Person(s)

☐ **I choose not to name a Health Care Surrogate at this time**

____
Signature of Resident/Authorized Representative

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Statement of Facility Policy to Our Residents: Advance Directives and Life-Sustaining Treatment

Under state and federal law, you have the right to make your own decisions regarding healthcare treatment. This includes your right to determine in advance what life-sustaining treatment you should be provided if, in the future, you might be unable to communicate those desires yourself.

Life-sustaining treatments are the measures we take to sustain your life and health. For example, in the event you suffer a heart attack, we will perform cardiopulmonary resuscitation (CPR) in an attempt to get your heart started again. Further, we will take any other measures ordered by your physician, including IV's, tubes, and the administration of medications, antibiotics, and artificial hydration and nutrition in order to maintain your life. In the hospital you could have surgical procedure, a respirator, a ventilator, a dialysis machine, and blood transfusions in order to keep your vital functions working. This is called life-sustaining treatment.

You have a right to provide written instructions to your physician and your family about your desires for treatment in the future, including life-sustaining treatment. Medical science and technology have advanced to the point that with some incurable or irreversible situations where death is expected, these life-sustaining procedures prolong the dying process rather than contribute to recovery. If you desire to limit some or all of these life-sustaining treatment procedures in those situations, you should inform your doctor in writing. These instructions are called "Advance Directives." State law has established standard Advance Directive forms called "Living Wills" or "Healthcare Powers of Attorney" in order to communicate your instructions. These forms are available at this facility, should you desire to obtain one.

It is the policy of this facility to follow your physician's orders made in accordance with state law regarding Advance Directives limiting life-sustaining treatment. If there are any limitations on implementing any Advance Directives at this facility, they will be stated at the end of this informational statement. You are not required by this facility to have an Advance Directive, nor are you discouraged by this facility from having an Advance Directive. Quality healthcare is provided to you here whether or not you have developed a written Advance Directive regarding your treatment.

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Statement of Facility Policy to Our Residents: Advance Directives and Life-Sustaining Treatment

If you have a signed Advance Directive (either a Living Will or Healthcare Power of Attorney), you should provide a copy of this document to your physician and to this facility. We cannot follow an Advance Directive until we have received a copy for your medical record and your physician writes an order implementing your Directive. If, in the future, you wish to change an Advance Directive which you have provided the facility, you should make your wishes known to a facility staff member and your physician.

If you do not have an Advance Directive, treatment consistent with your plan of care will be provided, in accordance with accepted professional practice and with state and federal public health law. If we do not have any advance instructions from you, in the event of a heart attack, we will perform cardiopulmonary resuscitation (CPR) to start your heart again, and follow any other life-sustaining treatment your physician may order. If you have not given us any advance instructions regarding life-sustaining treatment, and have a terminal or incurable condition and cannot make decisions for yourself at that time, under the Illinois Health Care Surrogate Act, it is possible that someone who knows you well will be asked by your physician to make life-sustaining treatment decisions on your behalf. We will ask you upon admission if you have anyone you recommend to your physician to act as your surrogate when you are unable to make health care decisions for yourself. This healthcare facility provides you and all other residents with information regarding Advance Directives, as we are required to do so by federal and state law. After reading the written material, if you have any questions or would desire to discuss the matter further with someone, you may contact our administrator who will be pleased to assist you and your family in obtaining additional information regarding making your own treatment decisions.

This facility honors all Advance Directives limiting life-sustaining treatment, except in the following circumstances:

If this facility is presented with an Advance Directive which, under the Illinois Right of Conscience Act, we cannot implement, our administrator will inform you of this as soon as possible.

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Statement of Illinois Law on Advance Directives

Illinois Department of Public Health

You have the right to make decisions about the health care you get now and in the future. An advance directive is a written statement you prepare about how you want your medical decisions to be made in the future, if you are no longer able to make them for yourself. A do not resuscitate order (DNR order) is a medical treatment order that says cardiopulmonary resuscitation (CPR) will not be used if your heart or breathing stops.

Federal law requires that you be told of your right to make an advance directive when you are admitted to a health care facility. Illinois law allows for the following three types of advance directives: (1) health care power of attorney, (2) living will, and (3) mental health treatment preference declaration. In addition, you can ask your physician to work with you to prepare a DNR order. You may choose to discuss with your doctor different types of advance directives and DNR orders. After reviewing information regarding advance directives and DNR orders, you may decide to make more than one. For example, you could make a health care power of attorney and a living will.

If you make one or more advance directives and/or a DNR order, tell your doctor and other health care providers and provide them with a copy. You may also want to provide a copy to family members, and to those you appoint to make these decisions for you.

State law provides copies of sample advance directives forms and DNR order forms.

Health Care Power of Attorney

The health care power of attorney lets you choose someone to make health care decisions for you in the future, if you are no longer able to make these decisions for yourself. You are called the "principal" in the power of attorney form and the person you choose to make decisions is called your "agent." Your agent would make health care decisions for you if you were no longer able to make these decisions for yourself. So long as you are able to make these decisions, you will have the power to do so. You may use a standard health care power of attorney form or write your own. You may give your agent specific directions about the health care you do or do not want.

The agent you choose cannot be your doctor or other health care provider. You should have someone who is not your agent witness you signing the power of attorney.

The power of your agent to make health care decisions on your behalf is broad. Your agent would be required to follow any specific instructions you give regarding care you want provided or withheld. For example, you can say whether you want all life-sustaining treatments provided in all events; whether and when you want life-sustaining treatment ended; instructions regarding refusal of certain types of treatments on religious or other personal grounds; and instructions regarding anatomical gifts and disposal of remains. Unless you include time limits, the health care power of attorney will continue in effect from the time it is signed until your death. You can cancel your power of attorney at any time, either by telling someone or by canceling it in writing. You can name a backup agent to

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continue in effect from the time it is signed until your death. You can cancel your power of attorney at any time, either by telling someone or by canceling it in writing. You can name a backup agent to act if the first one cannot or will not take action. If you want to change your power of attorney, you must do so in writing.

Living Will

A living will tells your doctor whether you want death-delaying procedures used if you have a terminal condition and are unable to state your wishes. A living will, unlike a health care power of attorney, only applies if you have a terminal condition. A terminal condition means an incurable and irreversible condition such that death is imminent and application of any death delaying procedures serves only to prolong the dying process.

Even if you sign a living will, food and water cannot be withdrawn if it would be the only cause of death. Also, if you are pregnant and doctors think you could have a live birth, your living will cannot go into effect.

You can use a standard living will form or write your own. You may write specific directions about the death-delaying procedures you do or do not want.

Two people must witness your signing of the living will. Your doctor cannot be a witness. It is your responsibility to tell your doctor if you have a living will if you are able to do so. You can cancel your living will at any time, either by telling someone or by canceling it in writing.

If you have both a health care power of attorney and a living will, the agent you name in your power of attorney will make your health care decisions unless he or she is unavailable.

Mental Health Treatment Preference Declaration

A mental health treatment preference declaration lets you say if you want to receive electroconvulsive treatment (ECT) or psychotropic medicine when you have a mental illness and are unable to make these decisions for yourself. It also allows you to say whether you wish to be admitted to a mental health facility for up to 17 days of treatment.

You can write your wishes and/or choose someone to make your mental health decisions for you. In the declaration, you are called the "principal" and the person you choose is called an "attorney-in-fact." Neither your doctor nor any employee of a health care facility in which you reside may be your attorney-in-fact. Your attorney-in-fact must accept the appointment in writing before he or she can start making decisions regarding your mental health treatment. The attorney-in-fact must make decisions consistent with any desires you express in your declaration unless a court orders differently or an emergency threatens your life or health.

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Your mental health treatment preference declaration expires three years from the date you sign it. Two people must witness your signing the declaration. The following people may not witness your signing of the declaration: your doctor; an employee of a health care facility in which you reside; or a family member related by blood, marriage or adoption. You may cancel your declaration in writing prior to its expiration as long as you are not receiving mental health treatment at the time of cancellation. If you are receiving mental health treatment, your declaration will not expire and you may not cancel it until the treatment is successfully completed.

Do-Not-Resuscitate Order

You may ask your doctor about a do-not-resuscitate order (DNR order). A DNR order is a medical order stating that cardiopulmonary resuscitation (CPR) will not be started if your heart or breathing stops. You may sign a document directing that should your heart or breathing stop, efforts to resuscitate you will not be started. Your attending physician may also sign a DNR order.

Before a DNR order may be entered into your medical record, either you or another person (your legal guardian, health care power of attorney or surrogate decision maker) must consent to the DNR order. This consent must be witnessed by two people who are 18 years or older. If a DNR order is entered into your medical record, appropriate medical treatment other than CPR will be given to you.

What happens if you don't have an advance directive?

Under Illinois law, a health care "surrogate" may be chosen for you if you cannot make health care decisions for yourself and do not have an advance directive. This health care surrogate will be one of the following persons (in order of priority): guardian of the person, spouse, any adult child(ren), either parent, any adult brother or sister, any adult grandchild(ren), a close friend, or guardian of the estate.

The surrogate can make all health care decisions for you, with certain exceptions. First, a health care surrogate cannot tell your doctor to withdraw or withhold life-sustaining treatment unless you have a "qualifying condition," which is a terminal condition, permanent unconsciousness, or an incurable or irreversible condition. A "terminal condition" is an incurable or irreversible injury for which there is no reasonable prospect of cure or recovery, death is imminent and life-sustaining treatment will only prolong the dying process. "Permanent unconsciousness" means a condition that, to a high degree of medical certainty, will last permanently, without improvement; there is no thought, purposeful social interaction or sensory awareness present; and providing life-sustaining treatment will only have minimal medical benefit. An "incurable or irreversible condition" means an illness or injury for which there is no reasonable prospect for cure or recovery, that ultimately will cause the patient's death that imposes severe pain or an inhumane burden on the patient, and for which life-sustaining treatment will have minimal medical benefit.

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Statement of Illinois Law on Advance Directives

Illinois Department of Public Health

Two doctors must certify that you cannot make decisions and have a qualifying condition in order to withdraw or withhold life-sustaining treatment. If your health care surrogate decision maker decides to withdraw or withhold life-sustaining treatment, this decision must be witnessed by a person who is 18 years or older. A health care surrogate may consent to a DNR order; however, this consent must be witnessed by two individuals 18 years or older.

A health care surrogate, other than a court-appointed guardian, cannot consent to certain mental health treatments, including treatment by electroconvulsive therapy (ECT), psychotropic medication or admission to a mental health facility. A health care surrogate can petition a court to allow these mental health services.

Final Notes

You should talk to your family, your doctor, or any agent or attorney-in-fact that you appoint about your decision to make one or more advance directives or a DNR order. If they know what health care you want, they will find it easier to follow your wishes. If you cancel or change an advance directive or a DNR order in the future, remember to tell the same people about the change or cancellation.

No facility, doctor or insurer can make you execute an advance directive or DNR order as a condition of providing treatment or insurance. It is entirely your decision. If a facility, doctor or insurer objects to following your advance directive or DNR order then they must tell you or the individual responsible for making your health care decisions. They must continue to provide care until you or your decision maker can transfer you to another health care provider who will follow your advance directive or DNR order.

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State and Federal Notification Requirements

In compliance with Federal and State regulations, these addresses and phone numbers are provided for the protection of our residents.

The Illinois Department of Public Health
525 West Jefferson Street
Springfield, Illinois 62761
Illinois Department of Public Health
Complaint Hotline:
(800) 252-4343

Ombudsman of the State of Illinois
421 East Capitol Drive
Suite 100
Springfield, Illinois 62706
Illinois Department on Aging Senor Helpline:
(800) 252-8966

Equip for Equality
(Formerly Protection and Advocacy, Inc.)
20 North Michigan Avenue
Suite 300
Chicago, Illinois 60602
(312) 341-0022
(800) 537-2632
(800) 610-2779 (TTY)

Illinois State Police
Medicaid Fraud Control Unit
801 South Seventeenth Street
Suite 500 - A
Springfield, Illinois 62703
(217) 785-3322
(888) 557-9503

If you have questions about eligibility requirements or application information under Medicare or Medicaid or need information about how to receive funds for previous payments covered by such benefits, please call the following offices:

____
Local Social Security Office Phone Number

____
Illinois Department of Human Services Regional Office

The results of the most recent long term care inspection survey(s) conducted by Federal and State surveyors and any approved plan(s) of correction in effect with respect to this facility are accessible 24 hours a day to residents. This facility makes the results available for examination at the following location(s):______________________________

____

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Resident Criminal History Background Checks
Identified Offender Notification Procedures

It is the policy of this facility to establish a resident sensitive and resident secure environment. In accordance with provisions of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility, in order to identify previous criminal convictions.

It is the right of all residents, visitors and staff, pursuant to Public Act 094-0752 Section 2-216, to ask this facility's administrator whether any residents are identified offenders, as defined in the Nursing Home Care Act 210 ILCS, 45/1-114.01.

Information regarding registered sex offenders may be accessed through the Illinois State Police website at www.isp.state.il.us.

Information regarding persons serving terms of parole, or mandatory supervised release, may be accessed through the Illinois Department of Corrections website at www.idoc.ste.il.us.

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Notice of Facility Privacy Practices

This notice is required by federal law and describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

One of our highest priorities is protecting the privacy and confidentiality of your personal health information, as required by law. As a normal part of your care and treatment, your personal health information is used and shared on a need to know basis for the following reasons:

- The coordination and planning of your health care with the many professionals involved in your care
- Referrals to another provider, such as a specialist, therapist, or hospital
- Determining coverage and obtaining payment from health plans, such as private insurance or Medicare or Medicaid
- Assessing our practices, improving our care and conducting training programs for the staff involved in your care
- Operational activities designed to maintain the required accreditation, certification, licensing and credentialing
- To help our accountants, auditors, lawyers and other consultants maintain and improve our overall operations and delivery of care
- Requests from or referrals to public health authorities, government oversight agencies, law enforcement agencies, the courts, coroners, or a funeral home, to the extent required by law.
- Notification and communication with your family members or your personal representative, unless you object

By signing this notice at the end, you are acknowledging that you understand and consent to the above uses of your personal information as a normal part of your care and treatment. If there is a specific area you object to, there is a space to record those objections and we will make reasonable attempts to accommodate, to the extent the law allows us.

We will NOT release or disclose your personal health information for any other uses without your specific written authorization, which you may revoke at any time. Among the circumstances where your information will NOT be released without your knowledge and specific written authorization are:

- Research information unrelated to treatment
- Psychotherapy notes containing private conversations
- Disclosure of your information to other companies for the purpose of marketing products or services to you
- Fundraising purposes

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Notice of Facility Privacy Practices

Your Health Information Rights

- Although your health record is the physical property of the nursing facility, the information in your health record belongs to you.
- You may request restrictions on certain uses and disclosures of your health information. We will attempt to accommodate if we can; however, when it relates to your treatment or billing for care provided, we are not required to agree to the restriction.
- You may request to inspect your health records and obtain copies for a reasonable copying fee. If you request your records be sent somewhere else, we cannot ensure their privacy if we do not have a privacy agreement with that agency. You may also request written copies of electronic transmissions.
- You may request in writing that we correct a medical record if you feel the record is incorrect or information is missing.
- You may request a listing of the times we disclosed your health information to outside parties with your authorization.
- You may revoke in writing any prior written authorizations you made to disclose health information.

If you have any questions or concerns about your privacy rights or feel your privacy rights have been violated, ask to speak with the facility's privacy officer. Contacting the privacy officer will in no way diminish the quality of care or services you receive at our facility. You may also file a complaint with the Secretary of the federal Department of Health and Human Services.

Name of Privacy Officer: ___________________________________ Phone:_________________

If any terms of this notice change, we will provide a revised notice to all residents. In compliance will federal law, this notice is in effect as of January 1, 2003.

I have received a copy of this Notice of Facility Privacy Practices, and I consent to the normal uses of my personal health information for treatment, billing and operational purposes.

____________________________________ ______________________________

Resident/Responsible party Date

Restrictions: I request that my personal health information not be shared in the following circumstances:____

____

____

Facility response:____

____

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Privacy Act Statement – Health Care Records

Long Term Care-Minimum Data Set (MDS) System of Records revised 04/28/2007

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974 (5 U.S.C.A. 552a). THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. **AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.** *Authority for maintenance of the system is given under* Sections *1102(a),* 1819*(b)(3)(A),* 1819(f), 1919(b)(3)(A), *1919(f)* and 1864 of the Social Security Act.

   The system contains information on all residents of long-term care (LTC) facilities that are Medicare and/or Medicaid certified, including private pay individuals and not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer data containing other party liability insurance information necessary for appropriate Medicare claim payment.

   Medicare and Medicaid participating *LTC* facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information *is also* used by the Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. *42 CFR §483.20, requires LTC facilities* to establish a database, *the Minimum Data Set (MDS),* of resident assessment information. *The MDS data are required to be* electronically transmit*ted* to the CMS *National Repository*.

   Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures. These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS LTC System of Records.

2. **PRINCIPAL PURPOSES *OF THE SYSTEM* FOR WHICH INFORMATION IS INTENDED TO BE USED.** *The primary purpose of the system is to aid in the administration of the survey and certification, and payment of Medicare/Medicaid LTC services which include skilled nursing facilities (SNFs), nursing facilities (NFs) and non-critical access hospitals with a swing bed agreement.*

   Information in this system is also used to study and improve the effectiveness and quality of care given in these facilities. This system will only collect the minimum amount of personal data necessary to achieve the purposes of the MDS, reimbursement, policy and research functions.

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3. **ROUTINE USES** ***OF RECORDS MAINTAINED IN THE SYSTEM.*** The information collected will be entered into the LTC MDS *S*ystem of *R*ecords, System No. 09-70-0528. *This system will only disclose the minimum amount of personal data necessary to accomplish the purposes of the disclosure.* Information from this system may be disclosed *to the following entities* under specific circumstances (routine uses), which include:

   (1) To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS;

   (2) To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent for purposes of contributing to the accuracy of CMS' proper payment of Medicare benefits and to enable such agencies to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds and for the purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State, and determine Medicare and/or Medicaid eligibility;

   (3) To assist Quality Improvement Organizations (QIOs) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Title XI or Title XVIII of the Social Security Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans;

   (4) To assist insurers and other entities or organizations that process individual insurance claims or oversees administration of health care services for coordination of benefits with the Medicare program and for evaluating and monitoring Medicare claims information of beneficiaries including proper reimbursement for services provided;

   (5) To support an individual or organization to facilitate research, evaluation, or epidemiological projects related to effectiveness, quality of care, prevention of disease or disability, the restoration or maintenance of health, or payment related projects;

   (6) To support litigation involving the agency, this information may be disclosed to The Department of Justice, courts or adjudicatory bodies;

   (7) To support a national accrediting organization whose accredited facilities meet certain Medicare requirements for inpatient hospital (including swing beds) services;

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Privacy Act Statement – Health Care Records

(8) To assist a CMS contractor (including but not limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program to combat fraud, waste and abuse in certain health benefit programs; and

(9) To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste and abuse in a health benefits program funded in whole or in part by Federal funds.

4. **EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION.** The information contained in the *LTC MDS System of Records* is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, *e.g. thorough* medical history, inappropriate and potentially harmful care may result. Moreover, payment for services *by Medicare, Medicaid and* third parties, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

NOTE: Residents or their representative must be supplied with a copy of this notice. This notice may be included in the admission packet for all new nursing home admissions, or distributed in other ways to residents or their representative(s). Although signature of receipt is NOT required, providers may request to have the resident or his or her representative sign a copy of notice as a means to document that notice was provided and merely acknowledges that they have been provided with this information.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

____________________________________ ________________
(Signature) (Date)

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Consent for Release of Medical Information

Resident Name:____

I hereby authorize the use or disclosure of my individually identifiable health information as specifically described below. I understand that this authorization is voluntary. The information may contain records and other information about my medical condition and mental status and any drug and/or alcohol usage.

Facility authorized to provide information: ____
____
____

Persons/organizations receiving the information: ____
____
____

Information to be disclosed (including dates) and the purpose for which each disclosure is being released. If initiated by the individual for their own purpose, it is not necessary to state "purpose."

____
____
____
____

If initiated by the individual for their own purpose, check here: ☐

I agree to waive all claims against the facility for the release of the requested information. I understand that once the information described is disclosed, the facility can no longer ensure its privacy if we do not have a privacy agreement with that agency.

I understand that a reasonable fee may be assessed for copying the records.

I understand that I may revoke this authorization at any time by notifying the facility in writing; however, it will not affect any actions taken before they received the revocation.

I understand that this authorization will expire on _ _/_ _/_ _ _ _ (DD/MM/YYYY)
(Not to exceed 2 years from date signed)

____ ______________________
Signature of resident or resident's representative Date

Printed name of resident's representative: ____

Relationship/authority to act on part of individual:____
Power of Attorney, Guardian, Executor, Court Order
or Legally Binding Request for Information

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Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests

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- Respond to lawsuits and legal actions

Your Rights:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide access to your medical records within 24 hours (excluding weekends and holidays), and a copy or a summary of your health information within two (2) working days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures:

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

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Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

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Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information visit:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

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Authorization and Release for Pneumococcal Vaccine

The Centers for Disease Control (CDC) has identified residents in long term care facilities as persons at risk for contracting Pneumonia (Pneumococcal disease). **Medical studies have shown that the Pneumococcal bacteria can cause serious infections of the lungs, bloodstream, or the covering surrounding the brain. Any person can get Pneumococcal disease, however, persons over the age of 65, the very young, and persons of any age who have special types of health problems are at the greatest risk of infection.**

The CDC recommends that all residents in long term care facilities receive the Pneumococcal vaccine unless medically contraindicated, refused, or already immunized. A one-time vaccination provides long-term protection for most people. In certain cases, some individuals may need a revaccination in six years.

The possible side effects associated with the Pneumococcal vaccine are redness and pain at the site of injection, fever, muscle aches, and local reactions. In rare circumstances, an allergic reaction, Guillan-Barre' and Guillan-Barre-like illnesses are a possible risk of vaccination.

I understand that I am in a group at high risk of illness or death from Pneumococcal disease and the most effective means to prevent this disease is the Pneumococcal vaccine. Unless my physician feels that it is medically unadvisable, I give my consent to receive the Pneumococcal vaccine. I understand that the vaccine is administered only one time, but that there is a possibility that a booster vaccination may be required in about six years.

I additionally understand the risks associated with this vaccine and will not hold the attending physician, this facility, or its agents responsible for any reactions as a result of the Pneumovax vaccine injection.

____

Print Name of Resident

____

Signature of Resident/Authorized Representative Date

☐ Refused to sign

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PNEUMOCOCCAL POLYSACCHARIDE VACCINE

WHAT YOU NEED TO KNOW

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis.

1 Pneumococcal disease

Pneumococcal disease is caused by *Streptococcus pneumoniae* bacteria. It is a leading cause of vaccine-preventable illness and death in the United States. Anyone can get pneumococcal disease, but some people are at greater risk than others:

- People 65 years and older
- The very young
- People with certain health problems
- People with a weakened immune system
- Smokers

Pneumococcal disease can lead to serious infections of the:

- Lungs (pneumonia),
- Blood (bacteremia), and
- Covering of the brain (meningitis).

Pneumococcal pneumonia kills about 1 out of 20 people who get it. Bacteremia kills about 1 person in 5, and meningitis about 3 people in 10.

People with the health problems described in Section 3 of this statement may be more likely to die from the disease.

2 Pneumococcal polysaccharide vaccine (PPSV)

Treatment of pneumococcal infections with penicillin and other drugs used to be more effective. But some strains of the disease have become resistant to these drugs. This makes prevention of the disease, through vaccination, even more important.

Pneumococcal polysaccharide vaccine (PPSV) protects against 23 types of pneumococcal bacteria, including those most likely to cause serious disease.

Most healthy adults who get the vaccine develop protection to most or all of these types within 2 to 3 weeks of getting the shot. Very old people, children under 2 years of age, and people with some long-term illnesses might not respond as well, or at all.

Another type of pneumococcal vaccine (pneumococcal conjugate vaccine, or PCV) is routinely recommended for children younger than 5 years of age. PCV is described in a separate Vaccine Information Statement.

3 Who should get PPSV?

- All adults 65 years of age and older.
- Anyone 2 through 64 years of age who has a long-term health problem such as:
  - heart disease
  - lung disease
  - sickle cell disease
  - diabetes
  - alcoholism
  - cirrhosis
  - leaks of cerebrospinal fluid or cochlear implant
- Anyone 2 through 64 years of age who has a disease or condition that lowers the body's resistance to infection, such as:
  - Hodgkin's disease
  - lymphoma or leukemia
  - kidney failure
  - multiple myeloma
  - nephrotic syndrome
  - HIV infection or AIDS
  - damaged spleen, or no spleen
  - organ transplant
- Anyone 2 through 64 years of age who is taking a drug or treatment that lowers the body's resistance to infection, such as:
  - long-term steroids
  - certain cancer drugs
  - radiation therapy
- Any adult 19 through 64 years of age who:
  - is a smoker
  - has asthma

PPSV may be less effective for some people, especially those with lower resistance to infection.

But these people should still be vaccinated, because they are more likely to have serious complications if they get pneumococcal disease.

Children who often get ear infections, sinus infections, or other upper respiratory diseases, but who are otherwise healthy, do not need to get PPSV because it is not effective against those conditions.

4 How many doses of PPSV are needed, and when?

Usually only one dose of PPSV is needed, but under some circumstances a second dose may be given.

- A second dose is recommended for people 65 years and older who got their first dose when they were younger than 65 and it has been 5 or more years since the first dose.
- A second dose is recommended for people 2 through 64 years of age who:
  - have a damaged spleen or no spleen
  - have sickle-cell disease
  - have HIV infection or AIDS
  - have cancer, leukemia, lymphoma, multiple myeloma
  - have nephrotic syndrome
  - have had an organ or bone marrow transplant
  - are taking medication that lowers immunity (such as chemotherapy or long-term steroids)

When a second dose is given, it should be given 5 years after the first dose.

5 Some people should not get PPSV or should wait

- Anyone who has had a life-threatening allergic reaction to PPSV should not get another dose.
- Anyone who has a severe allergy to any component of a vaccine should not get that vaccine. Tell your provider if you have any severe allergies.
- Anyone who is moderately or severely ill when the shot is scheduled may be asked to wait until they recover before getting the vaccine. Someone with a mild illness can usually be vaccinated.
- While there is no evidence that PPSV is harmful to either a pregnant woman or to her fetus, as a precaution, women with conditions that put them at risk for pneumococcal disease should be vaccinated before becoming pregnant, if possible.

6 What are the risks from PPSV?

About half of people who get PPSV have mild side effects, such as redness or pain where the shot is given.

Less than 1% develop a fever, muscle aches, or more severe local reactions.

A vaccine, like any medicine, could cause a serious reaction. But the risk of a vaccine causing serious harm, or death, is extremely small.

7 What if there is a severe reaction?

What should I look for?

Any unusual condition, such as a high fever or behavior changes. Signs of a severe allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- Call a doctor, or get the person to a doctor right away.
- Tell the doctor what happened, the date and time it happened, and when the vaccination was given.
- Ask your provider to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form. Or you can file this report through the VAERS website at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS does not provide medical advice.

8 How can I learn more?

- Ask your provider. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC's website at www.cdc.gov/vaccines.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Authorization and Release for Influenza Vaccine

Influenza viruses have demonstrated an ability to cause respiratory disease in individuals who, because of their age or underlying health problems, are unable to cope with the disease and as a result may require medical attention or hospitalization.

An annual vaccination with an inactivated influenza vaccine is considered by the Centers for Disease Control (CDC) to be the single most effective measure in preventing or lessening influenza infection.

Because the CDC has identified residents in long term care facilities as persons at high risk for contracting the influenza virus, this vaccine is provided to all residents, unless refused or medically contraindicated.

The possible side effects associated with the influenza vaccine include: soreness at the injection site; flu-like symptoms; fever; muscle weakness; and allergic reactions such as hives, rashes and allergic asthma. Guillan-Barre' is an infrequent, but possible risk of this vaccine. Additionally, the influenza vaccine may cause an adverse reaction of you are allergic to eggs, egg products, merthiolate (thimersal) or substances containing mercury.

I understand that I am in a group at high risk of illness or death from influenza and that the most effective means to prevent this disease is the influenza vaccine. Unless my physician feels that it is medically contraindicated, I give my consent to receive the influenza vaccine. I understand that the vaccine is administered annually prior to the influenza season and that I will receive yearly vaccinations unless I withdraw my consent in writing. Further, I understand the risks associated with this vaccine, and I will not hold the attending physician, this facility, or its agents responsible for any reactions as a result of the influenza vaccine injection.

____

Print Name of Resident

____

Signature of Resident/Authorized Representative Date

☐ Refused to sign

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VACCINE INFORMATION STATEMENT

Influenza Vaccine

What You Need to Know

(Flu Vaccine, Inactivated)

2013-2014

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de Información Sobre Vacunas están disponibles en Español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every winter, usually between October and May.

Flu is caused by the influenza virus, and can be spread by coughing, sneezing, and close contact.

Anyone can get flu, but the risk of getting flu is highest among children. Symptoms come on suddenly and may last several days. They can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can make some people much sicker than others. These people include young children, people 65 and older, pregnant women, and people with certain health conditions—such as heart, lung or kidney disease, or a weakened immune system. Flu vaccine is especially important for these people and anyone in close contact with them.

Flu can also lead to pneumonia, and make existing medical conditions worse. It can cause diarrhea and seizures in children.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine is the best protection we have from flu and its complications. Flu vaccine also helps prevent spreading flu from person to person.

2 Inactivated flu vaccine

There are two types of influenza vaccine:

You are getting an **inactivated** flu vaccine, which does not contain any live influenza virus. It is given by injection with a needle, and often called the "flu shot."

A different, **live, attenuated** (weakened) influenza vaccine is sprayed into the nostrils. *This vaccine is described in a separate Vaccine Information Statement.*

Flu vaccine is recommended every year. Children 6 months through 8 years of age should get two doses the first year they get vaccinated.

Flu viruses are always changing. Each year's flu vaccine is made to protect from viruses that are most likely to cause disease that year. While flu vaccine cannot prevent all cases of flu, it is our best defense against the disease. Inactivated flu vaccine protects against 3 or 4 different influenza viruses.

It takes about 2 weeks for protection to develop after the vaccination, and protection lasts several months to a year.

Some illnesses that are not caused by influenza virus are often mistaken for flu. Flu vaccine will not prevent these illnesses. It can only prevent influenza.

A "high-dose" flu vaccine is available for people 65 years of age and older. The person giving you the vaccine can tell you more about it.

Some inactivated flu vaccine contains a very small amount of a mercury-based preservative called thimerosal. Studies have shown that thimerosal in vaccines is not harmful, but flu vaccines that do not contain a preservative are available

3 Some people should not get this vaccine

Tell the person who gives you the vaccine:

- **If you have any severe (life-threatening) allergies**. If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get a dose. Most, but not all, types of flu vaccine contain a small amount of egg.
- **If you ever had Guillain-Barré Syndrome** (a severe paralyzing illness, also called GBS). Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well.** They might suggest waiting until you feel better. But you should come back

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U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With a vaccine, like any medicine, there is a chance of side effects. These are usually mild and go away on their own.

Serious side effects are also possible, but are very rare. Inactivated flu vaccine does not contain live flu virus, so **getting flu from this vaccine is not possible**.

Brief fainting spells and related symptoms (such as jerking movements) can happen after any medical procedure, including vaccination. **Sitting or lying down for about 15 minutes after a vaccination can help prevent fainting and injuries caused by falls.** Tell your doctor if you feel dizzy or light-headed, or have vision changes or ringing in the ears.

Mild problems following inactivated flu vaccine:
- soreness, redness, or swelling where the shot was given
- hoarseness; sore, red or itchy eyes; cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

Moderate problems following inactivated flu vaccine:
- Young children who get inactivated flu vaccine and pneumococcal vaccine (PCV13) at the same time may be at increased risk for seizures caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Severe problems following inactivated flu vaccine:
- A **severe allergic reaction** could occur after any
- vaccine (estimated less than 1 in a million doses).
- There is a small possibility that inactivated flu vaccine could be associated with Guillain-Barré Syndrome (GBS), no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.

The safety of vaccines is always being monitored. For more information, visit:
www.cdc.gov/vaccinesafety/

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5 What if there is a serious reaction?

What should I look for?
- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.
- Look Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?
- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS is only for reporting reactions. They do not give medical advice.

6 The National Vaccination Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**.

7 How can I learn more?

- Ask your doctor.
- Call your local or state health department.
- the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/flu**

Vaccine Information Statement (Interim)
Inactivated Influenza Vaccine

7/26/2013

42 U.S.C. § 300aa-26

Office Use Only

Resident and Visitor Smoking Policy Notification

General Policy

There will be no smoking in any patient rooms.

Residents

All residents shall smoke only in designated areas. Resident who pose a hazard with smoking materials will have supervised smoking times provided for and may be placed in a supervised program for safe smoking. Residents who may pose a hazard to themselves and others with smoking materials may have their cigarettes, lighters and matches removed from them and kept in a designated location for safety, until such time as responsible smoking habits in compliance with facility safety rules are demonstrated by the resident. **Residents who fail to comply with this facility's smoking policies may be recommended for an involuntary discharge.**

Visitors

Visitors may smoke only in designated smoking areas. It is suggested that if cigarettes are brought into the facility for a resident, that prior arrangements be made with the Administrator or designee.

This facility requests your cooperation in observing the above policies. The State Fire Marshall and the local Fire Department require rules in the interest of fire prevention and resident safety.

☐ The authorized area(s) in this facility for permitted smoking is/are:

____

____

____

☐ This is a NO SMOKING facility.

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Consideration of Funeral Home

(THIS FORM IS REQUIRED BY STATE OF ILLINOIS LAW)

Considering a funeral home for a loved one is a sensitive issue. This facility understands the difficulties associated with this decision. Nevertheless, due to the nature of the care and services provided in long term care facilities we encourage you and your family to review your choice for a funeral home in the event that the services of a mortician are necessary. Furthermore, state and federal laws also require this facility to ask the families of all residents upon admission to make their choice of a funeral home. Thank you for your consideration in this sensitive matter.

____

(Name of Resident)

____

(Name of Funeral Home)

____

(Address of Funeral Home [if known])

____

(Phone Number of Funeral Home [if known])

☐ I do not wish to designate a funeral home at this time.

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Bed Reserve Policy Notification

This Bed Reserve Policy will be given to you at the time of admission and a copy will be given to you each time you are transferred from the facility.

Under normal circumstances, if you leave the facility for a hospitalization, you will be readmitted to the first available bed in a semi-private room.

Under certain conditions, we can reserve your existing bed for you at your request, so when you return to the facility, you will have the same bed and room as before.

Neither Medicare nor Medicaid will pay to hold your same bed if you are hospitalized. If you are a private pay, Medicare or Medicaid resident, we will hold your same bed and room for you as long as you wish, at a charge to you of _____% of the normal daily rate.

If your care is being paid for by the Veteran's Administration, we will hold your bed for 48 hours unless prior approval for a longer period has been received from the VA that initiated your contract.

The Nursing Home Care Act requires a nursing facility to hold a bed for a maximum of ten days when you are hospitalized. The facility must hold a bed (not necessarily your specific bed) for up to 10 days during a hospitalization. On the 11th day there is no requirement to hold a bed, but you are still a resident and will receive the next available bed when you are ready to return, even if there is a waiting list.

There is no requirement under the Nursing Home Care Act to hold a bed for ten days during a therapeutic home visit. However you are still considered a resident and will be given the next available bed when you are ready to return, even if there is a waiting list.

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Resident Trust Fund Policy Notificationn and Authorization

Residents of this facility have the right to manage their own financial affairs and handle their own spending money. Residents also have the right to have the facility keep their money in a trust account to safeguard and manage personal spending money. This facility has a resident trust fund available, upon the written authorization of the resident or authorized representative, to any resident that wishes to deposit funds for safekeeping. The facility will maintain a separate accounting of funds available to the resident or authorized representative. Upon discharge, all funds and a final accounting will be provided to the resident, the administrator of the resident's estate, or agent legally entitled to such funds.

Accessible Cash and Savings Accounts: Resident funds under $50 are kept in a non-interest bearing accessible cash account for use by residents. Any funds in excess of $50 are deposited in an interest bearing savings account. Residents may have an individual savings account in his or her name. Any interest on the account is accrued to the resident. According to Medicaid regulations, residents receiving Medicaid may not have more than $2,000 in this account. Any resident funds in excess of $2,000 will be taken by Medicaid and used toward the cost of care. The facility will inform the resident or authorized representative whenever the trust fund balance approaches $2,000.

Purchases and Withdrawals: Purchases and withdrawals may be paid out of either the accessible cash account or the savings account, as long as funds are available. No funds will be distributed or purchases made without appropriate written authorization of the resident or authorized representative.

In accordance with state and federal laws, individuals making purchases and withdrawals on behalf of a resident out of the resident's trust fund must sign an affidavit assuring that funds will be used for the resident's benefit. The facility will pay any charges presented to it by contract services such as the barber and beauty shop pr clothing suppliers. Statements from trust fund accounts will only be made if the resident has appropriately authorized the purchase. Quarterly statements are issued to all residents detailing account activity.

Residents and/or their authorized representatives are asked to observe the trust fund banking hours that are posted in the facility. Those residents wishing to withdraw or deposit money may do so at these times. Residents will be asked to sign their name or make their mark acknowledging receipt of money.

I have received a copy of the facility's Trust Fund Policy and wish to have my personal funds handled as follows:

☐ **I DO** authorize this facility to hold my personal funds for safekeeping in accordance with their written policy and to disburse them as authorized below.

☐ **I DO NOT** wish to participate in the Resident Trust Fund.

Print Name of Resident Signature of Resident/Guardian

Signature of Witness who has no financial or employment relationship with the facility

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Laundry Services

Residents have a choice to have their personal laundry done by their families or through the commercial laundry services of the facility. If you choose to have this facility do your laundry, there will be no extra charge. However, you should be aware of special circumstances. Our machines are of commercial strength; we cannot guarantee the handling of delicate fabrics. We cannot be responsible for damage to or loss of personal clothing in our laundry. **Whether or not you make use of this facility's laundry service, please be sure all personal clothing is properly labeled.** Please notify the facility in the event that you wish to start or stop laundry service.

Please check one of the following:

☐ I will require laundry services

☐ I will not require laundry services

For Office Use Only

Resident's Name:____

Room Number:____

☐ Facility to do laundry

☐ Facility not to do laundry

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Notification of Policy Regarding Personal Property

Basic Clothing Requirements:

The purchase of your personal clothing is your responsibility. Each resident of this facility should have **at least** six (6) changes of clothing, including underwear, socks, and outer garments. In addition, residents need at least two pairs of washable shoes, preferably walking shoes or sneakers. Slippers and pajamas are optional, but suggested. All clothing and shoes must be in good condition.

Replacement of Clothing:

Periodically, this facility will check each resident's clothing and shoes. Families will be notified as to what each resident needs, if anything. Replacement clothing, **properly labeled**, is to be brought in by the family within two weeks of notification. Please let an appropriate staff member know that the family is bringing in clothes before they are taken to the resident's room, so that the clothing can be properly inventoried.

If this facility is not able to contact family, or if the requested clothing is not brought in by the requested date, the needed items will be purchased by the facility and billed to the resident/authorized representative or the resident's trust fund account. The resident will be notified of the cost of each item prior to any purchase using trust fund moneys. No purchase will be made at any time without the prior written authorization of the resident or authorized representative.

Proper Labeling of Clothing:

The proper labeling of resident clothing before it is brought into the facility is very important. Labeled clothing is much less likely to be lost or misplaced. In respecting and preserving the resident's dignity and appearance, resident clothing should NOT be labeled on the outside of clothing or footwear. Shirts, blouses, jackets, and coats should be labeled on the inside of the collar. Pants, skirts, and undergarments should be labeled on an easily noticeable hem. Footwear and socks should be marked on the inside as well. Other items such as hats, ties, scarves, and other personal items should also be marked. It is preferable to use labeling or laundry markers that will not fade in the laundry process. We strongly suggest the use of laundry tape, which does not easily come off in our laundry machines.

Valuables:

Any time you receive new clothing or other items such as jewelry, perfume, knickknacks, radios, televisions, etc., ask the nurse in charge to please record these items on an inventory sheet that can be stored in your records. The facility cannot update an inventory of your personal items unless you and your family provide this information.

If you receive a large sum of money, please take it to the administrative offices and deposit the money into a bank account. Do not keep money on you and do not leave it lying around your room. If you have something that is of value to you, such as a wedding ring or other jewelry, and would like to safeguard it during your stay, you can store these items in the facility's secured area. If you wish to take advantage of this safeguarded area for your valuable personal items, please contact the Administrator of designee.

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Notification of Policy Regarding Personal Property

Lost or Misplaced Personal Items:

This facility understands the value and importance of everyone's personal property. Because we care, we make every effort to assure that your possessions are not lost, misplaced, or stolen. However, the ownership, administration, staff, and residents of this facility also recognize the need to address the problem of missing personal items, whenever that situation might occur. The loss of valuable personal property is an unfortunate event and a very difficult task to manage in a long term care facility where many diverse residents reside and employees work. There are many valuables to control, including the presence of confused and/or ambulatory residents, multiple occupancy rooms, visitation by friends and relatives, residents frequently leaving the facility, etc.

Investigating Lost Personal Items:

By defining an approach to investigate complaints of theft or misplaced personal property, the administration wishes not only to discover lost items, but also to gather information and determine potential patterns that may lead to the reduction and eventual prevention of lost items or theft.

If you are missing an item, or an apparent theft has taken place, please take the following steps:

1. Note the time, date, and last know place of the missing items.
2. Report the incident to the nurse in charge with the exact description of the missing item, including the color, size, and the last time and place you saw it.
3. Follow-up on the reported loss by also contacting either the Administrator or designee with the description of the item, time of loss, date, and color as stated.
4. If you see someone go into a room where they do not belong, report this to the nurse in charge, or any of the people listed above. Please give a description of the person if you do not know their name, along with what you saw them doing. This will be kept confidential.

Discharge of Personal Property:

The resident and/or the resident's family/authorized representative is required to remove all clothing and other personal property from the facility within 14 days after transfer or discharge. All clothing remaining in the facility after the 14 days will be considered abandon by the resident, and the facility will take possession of the property and dispose of it without an accounting to the resident and/or authorized representative.

This facility shall not be liable for the loss of or damage to personal property, unless it has been placed in this facility's aforementioned secure area for the safekeeping of money and valuables. Please be aware of this policy and take the precautions necessary to protect your valuables.

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Authorization to Inspect and Open Official Correspondence

I understand that I have the right to receive personal mail delivered to me unopened. However, I also do not want important mail affecting my financial or legal affairs to get lost or misplaced. Consequently, I hereby agree to and authorize representatives of this facility to inspect, open, and remove the contents of the following mail, realizing that I will be informed of issues deemed necessary:

- Social Security Checks
- Pension Checks
- Veteran's Administration Checks
- Correspondence from Illinois Department of Human Services and Illinois Department of Healthcare and Family Services
- Social Security
- Medicare Insurance
- Doctor and Hospital Bills

Print Name of Resident:____

Signature of resident/Authorized Representative:____

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Special Notifications

Resident Council:

At least once a month, the residents of this facility participate in Resident Council meetings to discuss the diverse matters of nursing home life. The Officers of the Resident Council communicate any matters of concern to the facility's management. The staff at our facility and the Resident Council will work cooperatively to effectively address resident concerns and advice. Each resident is encouraged to attend Resident Council meetings. To encourage participation, the facility will post the time and place of the meeting in prominent locations within the facility. Additionally, Resident Council meetings will be announced over the public address system prior to the meetings. Participation in the Resident Council is not mandatory, and any issues raised by the residents, whether at the Resident Council meeting or otherwise will be addressed.

Family and Resident Participation in Care Plan Conferences:

This facility conducts care planning conferences at regular intervals in order to develop the interdisciplinary approach to the care that is delivered. Members of each professional discipline attend care planning meetings and every aspect of care is addressed at these meetings. Care plan meetings are utilized to discuss any changes in condition or developments related to the resident's well-being.

This facility encourages the participation of both residents and families in the care planning process. In fact, participation by the resident and family is considered to be vital to the staff understanding the needs of the resident and family. At a designated time prior to the care planning conference, both the resident and family/authorized representative will be informed of the time and place of this scheduled meeting.

Participation in Resident Field Trips:

As part of our attempt to create fun and exciting activities for our residents, our Activity Department often plans trips outside the facility. Before we can permit a resident to participate in any of these activities, we are required to receive authorization from the resident's physician. If requested, before any field trips are taken, we will notify the resident's family or representative of the activity, so that any appropriate scheduling can be arranged. Any expenses related to the field trips will be the responsibility of the resident or authorized representative.

Special Notice to Families and Visitors:

Please sign in and out when visiting the facility. Children of all ages are encouraged to visit the facility, provided they are under close supervision of an adult who will ensure their proper behavior. Let the nurse in charge know when you are taking the resident off the unit. Never leave a resident alone when outside of the facility. When you are leaving the facility, please return the resident to their room/floor and let the nurse in charge know that the resident has returned.

When bringing treats for a resident, please check with the nurse in charge as to whether the resident is on a special diet. DO NOT leave any food in the bedside cabinet, dressers, etc. DO NOT leave perishable items with residents.

No resident is allowed medications of any kind in their bedside table, dresser, purse, clothing, and/or personal effects, UNLESS ordered by their attending physician. All medications are to be given to residents by licensed nurses only. This includes aspirin, Tylenol, and all other over the counter medications.

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Audio, Video and Photographic Release Form

Intended for Internal Use Only:

Audio recordings, videotapes and photographs are an important medical tool and therapeutic activity at our facility. We use audio, video and photographs to record resident health conditions, milestones, events and other successes. We use names and pictures of the residents in arts and crafts projects, scrapbooks, bulletins, room nameplates, visitor books, newsletters, displays and activity boards, as well as in medical records. We will share your name with clergy and other volunteer groups visiting our residents under facility supervision.

☐ I understand that my name and picture may be used for the internal uses of this facility. This includes, but is not limited to medical records, scrapbooks, bulletin boards, and displays.

☐ Please do not use my name or photograph within the facility in the following circumstances:

____

____

____

Intended for External Use:

Audio recordings, videotapes and photographs offer a positive image of this facility and our residents to the community as a whole. On occasion, audio recordings, videotape and/or photographs are published in brochures, magazines, newspapers, or via other media outlets in order to present our resident's milestones, events and other successes in a positive light.

☐ I understand that my picture may be used by this facility for external purposes. This includes, but is not limited to: brochures, magazines, newspapers, and/or other media outlets.

☐ Please do not release my name or photograph outside the facility without my specific written authorization.

Print Name of Resident____

Signature of resident /Authorized Representative:_______________________________

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Standardized Admission Packet

Updated for 2014

Medicare Specific Issues (If Applicable)
Additional Advance Directive Information (Optional)

A Commitment to Professionalism and Quality Care
A Partnership for Excellence

Illinois Council on Long Term Care

Standardized Admission Packet

Updated for 2014

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A Commitment to Professionalism and Quality Care
A Partnership for Excellence

Assignment of Medicare Benefits
Authorization to Release Information

Name of Beneficiary ___________________________ HIC # ________________

I request payment of authorized Medicare benefits to me on my behalf for any services furnished me by or in ____________________, including physician services. I authorize any holder of medical or other information to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signature _______________________________ Date: ___________________
Signature of resident or resident's representative

Relationship/authority to act on part of individual: _______________________
POA, Guardian, Executor

Authorization for Release of Information
Third Party Payor Needing Medicare Claims Information

I authorize ________________________ (provider name) to disclose the following information to ______________________________ (name of insurance company):

____ Beneficiary health insurance claim number (Medicare Number)
____ Coinsurance and deductible amounts
____ Dates of Medicare entitlement
____ Copies of Medicare claims forms
____ Medicare report of eligibility
____ Explanation of Medicare benefits (EOMB)

I understand this information is required to verify appropriateness of payment for services rendered. This authorization may be revoked at any time. I authorize payment of medical benefits directly to the provider shown.

Signature _______________________________ Date: ___________________
Signature of resident or resident's representative

Relationship/authority to act on part of individual: _______________________
POA, Guardian, Executor

Authorization Expiration: _____________ (not longer than 2 years)

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Your Benefit Rights under Medicare

(2014)

Medicare is a health insurance program funded by the federal government. With certain exceptions, an individual must be 65 years of age or older to be eligible for Medicare. The program is administered by the federal Centers for Medicare and Medicaid Services through private intermediaries.

Part A of the Medicare program helps pay for certain services provided by a hospital, skilled nursing facility, hospice or home health agency. **Part B** of the Medicare program helps pay for physicians, therapists and other services not covered by Part A. **Part D** helps pay for some of your medications.

Unless you have been automatically enrolled in Medicare, you may be required to file an application at your local Social Security office. Once enrolled in Medicare, you should receive a Medicare card that will state your recipient claim number, and whether you are enrolled in Part A, Part B, or both. Health care providers may require you to produce this card in order for you to use your Medicare benefits to help pay for services or products. You must enroll for the Part D medications benefits separately.

Medicare Part A presently will pay, under certain conditions a portion of inpatient skilled nursing or rehabilitation services provided in a participating nursing facility for **up to** one hundred days after at least a three-day qualifying hospital stay. Medicare will pay all of the covered services for the first twenty days. During the last eighty days, the recipient is required to pay a daily co-insurance charge, and Medicare will pay the balance over and above the co-insurance amount. While the **maximum** Medicare Part A benefit for a nursing home stay is one hundred days, each resident's coverage will vary based on individual medical conditions.

As of January 1, 2014, the daily Medicare co-insurance amount for the 21st to 100th day of skilled nursing home care is $152.00 per day. This amount is annually adjusted for inflation. Medicare Part B services are billed by the provider of the service. The Part B service provider is additionally responsible for providing you with the appropriate co-insurance amount to pay. Medicare Part B insurance requires a 20 percent co-payment after a $147 annual deductible.

When you enroll in the Part D medication assistance program, you will be asked to choose a Prescription Drug Plan (PDP). You should ensure that the PDP you choose covers the medications you need. Based on the PDP you choose, you may have different monthly premiums, deductibles and co-insurance. Your income level may also influence the amount of your premiums, deductibles and co-insurance. You may apply for Low Income Subsidy Assistance for your Part D expenses by calling your local Social Security Office.

If you have any questions about your Medicare benefits, call your local Social Security office or 800-MEDICARE or visit the web site www.medicare.gov.

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Your Benefit Rights and Eligibility Information under Medicaid

Single Individuals (2014)

Depending on your assets and level of income each month, you may be eligible to receive assistance for your medical bills, including your care in the nursing home. This assistance program is call Medicaid, and is administered through the Illinois Department of Healthcare and Family Services. The eligibility requirements for a nursing home resident are different, depending on whether you are an individual, or whether you are married with a spouse living in the community. **This notice explains the eligibility requirements for a single individual**.

If you are an individual, you may be eligible to receive assistance for your medical bills and nursing home care if your total assets do not exceed any of the following limits:

- No more than **$2,000** in cash, bank assets, stocks, bonds or securities
- No more than **$1,500** either for a revocable pre-paid burial plan or the cash value of your life insurance policy
- No more than **$6,153** specifically and irrevocably set aside for funeral expenses (burial space, mausoleums, urns, caskets, grave-markers, and opening and closing of the gravesite are also exempt from consideration as assets, either under the **$1,500** revocable or the **$6,153** irrevocable burial plans).

Trusts set up after August 11, 1993 are considered to be assets. Assets distributed over the last 60 months for less than fair-market value are considered countable assets.

To apply for medical financial assistance under Medicaid:

You should contact your local Illinois Department of Healthcare and Family Services office. If you do not know where your local Human Services office is, or if you have further questions, you may call the Illinois Department of Healthcare and Family Services toll-free at 800-843-6154 or visit the website www.dhs.state.il.us. At the point that you request financial assistance from the local Healthcare and Family Services office, you will be required to fill out a financial statement listing your assets and income. The agency will also be asking you, or a person helping you, to provide verification of your financial statement and supporting documentation.

The Illinois Department of Healthcare and Family Services will require the Applicant and/or Authorized Representative to provide copies of the following:

- Last **five years** of SAVINGS ACCOUNT statements
- Last **five years** of CHECKING ACCOUNT statements
- An explanation of deposits and withdrawals from either of the above if over $500, excluding Social Security income
- Social Security card
- Medicare card
- Blue Cross/Blue Shield, AARP or other Health Insurance cards
- Proof (check, Benefit Letter, etc.) of Social Security income
- Proof of Pension income
- Proof of other income
- Health and life insurance policies with a statement of cash value of life insurance and cost of health insurance
- Any pre-paid burial plans, funeral arrangements or cemetery lots with an itemized statement of date of purchase and cash value
- Stocks, bonds, other securities and safe deposit box receipts
- Deeds and tax statements for property owned currently or sold in the last **three years**
- Verification of any accounts closed in the last **five years**
- Trusts and annuities

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Your Benefit Rights and Eligibility Information under Medicaid

Married Couples With One Person in the Community (as of January 2014)

Depending on your assets and level of income each month, you may be eligible to receive assistance for your medical bills, including your care in the nursing home. This assistance program is call Medicaid, and is administered through the Illinois Department of Healthcare and Family Services. The eligibility requirements for a nursing home resident are different, depending on whether you are an individual, or whether you are married with a spouse living in the community. **This notice explains the eligibility requirements if you are married with a spouse living in the community.**

You may be eligible to receive assistance for your medical bills and nursing home care if your total assets do not exceed **$109,560** and the combined monthly income for both the husband and the wife do not exceed **$2,739** a month. In addition, when you go into a nursing home, your spouse may keep your home, your car and your household furnishings, and they are not counted toward the assets. Trusts set up after August 11, 1993 are considered to be assets. Assets distributed over the last 60 months for less than fair-market value are considered countable assets.

To apply for medical financial assistance under Medicaid:

Contact your local Illinois Department of Healthcare and Family Services office. If you do not know where your local Healthcare and Family Services office is, or if you have further questions, you may call the Illinois Department of Healthcare and Family Services toll-free at 800-843-6154 or visit the website www.dhs.state.il.us. At the point that you request financial assistance from the local Healthcare and Family Services office, you will be required to fill out a financial statement listing your assets and income. The agency will also be asking you or a person helping you, to provide verification of your financial statement and supporting documentation.

The Illinois Department of Healthcare and Family Services will require the Applicant and/or family to provide copies of the following for BOTH spouses, indicating ownership:

- Last **five years** of SAVINGS ACCOUNT statements
- Last **five years** of CHECKING ACCOUNT statements
- An explanation of deposits and withdrawals from either of the above if over $500, excluding Social Security income
- Social Security card
- Medicare card
- Blue Cross/Blue Shield, AARP or other Health Insurance cards
- Proof (check, Benefit Letter, etc.) of Social Security income
- Proof of Pension income
- Proof of other income (e.g., spouse's income)
- Health and life insurance policies with a statement of cash value of life insurance and cost of health insurance
- Any pre-paid burial plans, funeral arrangements or cemetery lots with an itemized statement of date of purchase and cash value
- Stocks, bonds, other securities and safe deposit box receipts
- Deeds and tax statements for property owned currently or sold in the last **three years**
- Verification of any accounts closed in the last **five years**
- Marriage certificate
- Trusts and annuities

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Notice to Medicaid Residents

Medicaid Services and Supplies Covered By The Illinois Medical Assistance Program

COVERED SERVICES as promulgated by the Illinois Department of HealthCare and Family Services, effective 11-17-05.

The Medical Assistance Program provides payment for receipt of documented long term care facility services that are determined essential, based on the attending physician's orders and the medical and/or social needs of the resident. All participating long term care facilities are to provide the following services at no additional charge, as they are recognized costs under the Department's cost-related reimbursement system:

1. All staff, routine equipment and supplies (including oxygen, if less than one tank has been furnished per resident during each service month) required to provide the services needed by residents accepted for care by a facility. (Examples of equipment and supplies to be provided include, but are not limited to: standard wheelchair, walker, floatation pad and mattress, intermittent positive pressure machine, and those included in the program as "Personal Care Items," listed below in Appendix C-26);
2. Room and board, supervision and oversight, and all laundry services;
3. Food substitutes and nutritional supplements;
4. Medications which are regularly available without prescription at a commercial pharmacy and which may be stocked by the facility under Department of Public Health regulations, including, but not limited to, those listed in Appendix C-26;
5. Over the counter drugs or items ordered by a physician (including, but not limited to, drugs and items listed in the Department's Long Term Care Provider Handbook, Appendix C-26 and excluding drugs and items reimbursed under the Department's Drug Program); and
6. All other services necessary for compliance with the requirements of the Department of Public Health as set forth in Skilled Nursing and Intermediate Care Facilities Code, Rules and Regulations (77 Ill. Adm. Code, Section 300).

APPENDIX C-26: PERSONAL CARE AND GENERAL HEALTHCARE EQUIPMENT AND SUPPLIES

Adhesive Tape
Administration equipment & Supplies for Parenteral Fluids-Intravenous or Subcutaneous (excluding TPN solution and administration equipment)
Alcohol, Alcohol Swabs, Wipes, Sticks
Antiseptics
Aspirator Bulbs
Atomizers
Band-Aids and Bandages
Bedpans and Urinals
Bilevel Positive Airway Pressure (BiPAP)
Blood Pressure Kits
Body Lotion
Brushes
Underpads
Catheters
Combs
Comfort Lotions and Creams
Corn Starch
Cotton, Cotton Balls, Cotton Swabs
Continuous Positive Airway Pressure (CPAP)
Cushions, Non-Custom
Dental Floss and Denture Supplies
Deodorant, Antiperspirant
Diabetic Testing Supplies
Diapers, Disposable and/or Non-disposable
Disinfectants
Disposable Enemas
Drainage Tubing and Receptacles
Dressings
Durable Equipment Non-Custom (i.e., walkers, wheelchairs, beds, etc.)
Dusting Powder
Elbow and Heel Protectors
Emesis Basins
Emollients
Enteral Therapy Equipment & Supplies
Eye Patches
Gauzes
Germicides
Hair Conditioner
Hearing Aid Batteries
Heat Lamps
Hot Water Bottles
Hydrogen Peroxide
Ice Bags
Irrigation Solutions
IV Poles and Supplies
Jay Cushions
Lubricating Jelly
Mattress Covers
Mouthwash
Nail Care Supplies
Nebulizers
Orthotics, Non-custom (i.e., helmets, elastic braces)
Oximeters and Oxygen Analyzers
Oxygen and Equipment and supplies necessary for its administration
Pads (i.e., sheepskin, moleskin)
Petroleum (i.e., Vaseline)
Razors
Rectal Tubes
Restraints
Roho Cushions
Rubber Gloves and Finger Cots
Sanitary Napkins and Related Items
Scissors
Shampoo, Non-prescription
Sharps Collectors
Shaving Cream
Soaps and Soap Substitutes
Suppositories
Syringes and Needles
Suction Catheters and Suction Machine
Talcum Powder
TENS Unit and Supplies
Thermometers
Tissues, Towels, and Washcloths
Tongue Depressors
Toothbrush and Toothpaste
Trach Supplies and Trach Care Kits
Urological Supplies
Ventilators
Vinegar Douche

Drugs and Medications:

Acetaminophen and Pain Relief/Analgesics
Antacids/Acid Reducer
Aspirin (buffered, enteric coated)
Bicarbonate of Soda Powder
General Multivitamins
Iron Replacements
Laxatives and Lozenges
Lice Treatment
Milk of Magnesia
Non-Sedating Antihistamines
Saline Nasal Spray

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Medicare As Second Payer – Screening Questionnaire

(May be used as a guide to help identify payers that may be primary to Medicare)

Resident Name:________________________________ Medicare Number:________________

Service Dates:________________________________

Note: It is important to ask all questions and document all answers regarding Medicare as Second Payor (MSP). A provider may be held liable if an overpayment occurs and Medicare finds that the provider furnished erroneous information or failed to disclose facts it know relevant to payment.

1. Is the resident covered by Black Lung (BL) Benefits? **(BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL).**

   ☐ Yes: Date benefits began: _____/ _____/ ________ (MM/DD/YYYY)

   ☐ No.

2. .Are services to be paid by a government program such as a research grant?

   ☐ Yes: **(THAT GOVERNMENT PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES, NOT MEDICARE).**

   ☐ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this Facility?

   ☐ Yes: **(DVA IS PRIMARY FOR THESE SERVICES, NOT MEDICARE).**

   ☐ No.

4. Was the illness/injury due to work related accidents/condition? ***Also complete Part A on page 2.***

   ☐ Yes: Date of injury/illness: _____/ _____/ ________ (MM/DD/YYYY)
   (WORKER'S COMPENSATION IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS.)

   ☐ No.

5. Is the illness or injury due to non-work related accident? ***(Also complete Part B on page 2).***

   ☐ Yes: Date of accident: _____/ _____/ ________ (MM/DD/YYYY)

   ☐ No.

6. Entitled to Medicare based on (check all that apply). Cannot select "Age" and "Disability" together.

   ☐ Age ***(Also complete Part C on page 2).***

   ☐ Disability ***(Also complete Part D on page 3).***

   ☐ End Stage Renal Failure (ESRD) ***(Also complete Part E on page 3 and 4).***

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Medicare As Second Payer – Screening Questionnaire

(May be used as a guide to help identify payers that may be primary to Medicare)

PART A. WORK RELATED ACCIDENT/ CONDITION

1. Name and address of Worker's Comp plan:

   ____

   ____

2. Policy or identification number:______________________
3. Name and address of your employer:

   ____

   ____

   ____

WC IS PRIMARY ONLY FOR CLAIMS RELATER TO WORK RELATED INJURIES OR ILLNESS

PART B. NON-WORK RELATED ACCIDENT

1. What type of accident caused illness/injury?

   ☐ Automobile ☐ Non-Automobile ☐ Other

2. Name and address of no-fault or liability insurer:

   ____

   ____

   ____

3. Insurance claim number:__________________________

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT

4. Was another party responsible for this accident?

   ☐ No

   ☐ Yes. If yes, complete the following questions

   Name and address of any liability insurer:

   ____

   ____

   Insurance claim number: ___________________________

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT**PART C. MEDICARE ENTITLED DUE TO AGE**

PART C. MEDICARE ENTITLED DUE TO AGE

1. Resident employed at time of this service:

   ☐ Yes. Name and address of resident's employer:

   ____

   ____

   ☐ No. Date of retirement: ____/ ____/ ______

   ☐ No. Never employed

2. Resident's spouse employed at time of service?

   ☐ Yes. Name and address of spouse's employer:

   ____

   ____

   ☐ No. Date of retirement: ____/ ____/ ______

   ☐ No. Never employed

IF THE RESIDENT ANSWERED "NO" TO QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE RESIDENT ANSWERED "YES" TO QUESTIONS 1-5 ON PAGE 1

1. Do you have a Group Health Plan (GHP) coverage based on your own, or a spouse's current employment?

   ☐ No

IF NO, MEDICARE IS PRIMARY PAYOR UNLESS ANSWERED "YES" TO QUESTIONS 1-5 ON PAGE 1

   ☐ Yes.

2. Does the employer that sponsors your GHP employ 20 or more employees?

   ☐ No.

IF NO, MEDICARE IS PRIMARY PAYER UNLESS ANSWERED "YES" TO QUESTIONS 1-5 ON PAGE 1

   ☐ Yes.

GHP IS PRIMARY, OBTAIN THE FOLLOWING INFORMATION:

Name and address of GHP:

____

____

Policy identification number (this number is sometimes referred to as the health insurance benefits package number):

____

Group identification number:_____________________

Name of policy holder:__________________________

Relationship to resident:________________________

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Medicare As Second Payer – Screening Questionnaire

(May be used as a guide to help identify payers that may be primary to Medicare)

PART D. MEDICARE ENTITLED, DUE TO DISABILITY

1. Resident employed at time of this service.

   ☐ Yes: Name and address of resident's employer:

   ____

   ____

   ☐ No. Date of retirement: ____/ ____/ ______

   ☐ No. Never employed

2. If married, spouse employed at time of service?

   ☐ Yes: Name and address of spouse's employer:

   ____

   ____

   ☐ No. Date of retirement: ____/ ____/ ______

   ☐ No. Never employed

IF THE RESIDENT ANSWERED "YES" TO QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS RESIDENT ANSWERED "YES" TO QUESTIONS 1-5 ON PAGE 1

3. Do you have a Group Health Plan (GHP) coverage based on your own, or a family member's current employment?

   ☐ No.

IF NO, MEDICARE IS PRIMARY PAYER UNLESS ANSWERED "YES" TO QUESTIONS 1-5 ON PAGE 1

   ☐ Yes.

4. Are you covered under the Group Health Plan of a family member other than your spouse?

   ☐ Yes.

   Name and address of your family member's employer:

   ____

   ____

   ☐ No.

5. Does the employer that sponsors the GHP employ more than 100 or more employees?

   ☐ No.

IF NO, MEDICARE IS PRIMARY PAYER UNLESS ANSWERED "YES" TO QUESTIONS 1-5 ON PAGE 1

   ☐ Yes

GHP IS PRIMARY, OBTAIN THE FOLLOWING INFORMATION:

Name and address of GHP:

____

____

Policy identification number (this number is sometimes referred to as the health insurance benefits package number):

____

Group identification number:____________________

Name of policy holder:________________________

Relationship to resident:________________________

PART E. END STAGE RENAL DISEASE

1. Do you have Group Health Plan (GHP) coverage?

   ☐ No

IF NO, MEDICARE IS PRIMARY PAYER UNLESS ANSWERED "YES" TO QUESTIONS 1-5 ON PAGE 1

   ☐ Yes

   Name and address of GHP:_________________

   ____

   ____

   Policy identification number (this number is sometimes referred to as the health insurance benefits package number):

   ____

   Group identification number:_________________

   Name of policy holder:_____________________

   Relationship to resident:_____________________

   Name and address of employer, if any, from which you receive GHP coverage:

   ____

   ____

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Medicare As Second Payer – Screening Questionnaire

(May be used as a guide to help identify payers that may be primary to Medicare)

2. Have you received a kidney transplant?

   ☐ Yes: Date of transplant: ___/___/_______

   ☐ No

3. Have you received maintenance dialysis treatments?

   ☐ Yes: Date dialysis began: ___/___/______

   If you participated in a self-dialysis training program, provide date training started:_________

   ☐ No

4. Are you within the 30-month coordination (*) period?

   ☐ No

   IF NO, MEDICARE IS PRIMARY PAYOR UNLESS ANSWERED "YES" TO QUESTIONS 1-5 ON PAGE 1

   ☐ Yes

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

   ☐ Yes

   ☐ No

6. Was your initial entitlement to Medicare (including simultaneous or duel entitlement) based on ESRD?

   ☐ Yes

GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.

   ☐ No

INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement)?

   ☐ Yes

GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD

   ☐ No

MEDICARE CONTINUES TO PAY PRIMARY

*The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis). If the individual is participating in a self-dialysis training program or has a transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.

If no MSP data is found in the *Common Working File (CWF)* for the beneficiary, the provider still asks the types of questions above and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update the CWF through the billing process.

_______________________________________ _______________________________________

Signature of Resident/Authorized Representative Print Name/Date

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Waiver of Medicare Benefits
(If Applicable)

Patient's Name____ Date:__________________

Medicare #:________________________ Name of Beneficiary:_____________________________

Address:____

City, State, Zip: ____

The above named person is being placed in a non-Medicare-certified bed for the following reason:

☐ A Medicare bed is not available.

☐ It has been determined by _________________________ (the facility) that specific services to be furnished to _________________________________ (resident) meets the requirements for coverage under Medicare. However, it is the decision of the beneficiary to be placed in a portion of this facility that is not eligible for Medicare benefits. **(MD Certification must be completed if this box is indicated and signed by the beneficiary.)**

Beneficiary Authorization:

I, ______________________________________ (Name of Beneficiary), understand that voluntary placement in a non-certified portion of this facility will disqualify me from payment of any Medicare benefits and freely consent to such placement.

____

Signature of Resident/Authorized Representative Date

Physician Certification:

☐ It is my opinion that ______________________________________ (Name of Beneficiary) **is competent** to make this decision regarding Medicare coverage/payment.

☐ It is my opinion that ______________________________________ (Name of Beneficiary) **is not competent** to make this decision due to:____________________________________

____

Signature of Physician Date

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Notice of Medicare Provider Non-Coverage

Patient name: ________________________________ Patient number: ____________________

The Effective Date Coverage of Your Current _______________________________ *Services Will End:* ___________________

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: Telligen, 630-928-5800, http://www.telligenqio.org/, to appeal, or if you have questions.

See page 2 of this notice for more information.

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Notice of Medicare Provider Non-Coverage

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information ____

____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

____ ______________

Signature of Patient or Representative Date

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Notice of Non-Coverage under Medicare
Determination of Admission
(Page 1 of 3)
(We are required to present this letter to you by Federal law.)

Patient's Name:____ Date:____________________

Name of Beneficiary:____________________________________ Medicare Number:___________________

Address:_______________________________________ City, State, Zip:_______________________________

On____/____/________, this facility reviewed your medical information available at the time of, or prior to, your admission, and we believe that the services __________________________ needed did not meet the requirements for coverage under Medicare. The above named person is being placed in a non-Medicare-certified bed for the following reason:

☐ **Non-Skilled Care-Full Denial:** Medicare covers medically necessary skilled nursing care needed on a daily basis. You only needed oral medications, assistance with your daily activities and general supportive services. There is no evidence of medical complications or other medical reasons that required the skills of a professional nurse or therapist to safely and effectively carry out your plan of care. Therefore, we believe that your care cannot be covered under Medicare.

☐ **Nursing Not Needed for Foley Care:** Medicare covers daily nursing care related to the insertion, sterile irrigation, and replacement of urethral catheters if the use of the catheter is reasonable and necessary for the active treatment of a disease of the urinary tract or for patients with special needs. Skilled nursing is not considered medically necessary when urethral catheters are used only for mere incontinence or the control of incontinence. Since your catheter was inserted for convenience or to control your incontinence, we believe that your care is not covered by Medicare.

☐ **No Material Improvement in Relation to Therapy Services Required-Full Denial:** Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. The _________________ therapy service(s) provided was not/were not reasonable in relation to the expected improvement in your condition. In this case, since you do not need skilled nursing on a daily basis and the therapy services are not considered reasonable and necessary, we believe, your stay is not covered under Medicare.

☐ **Frequency Not Reasonable and Necessary:** Medicare covers medically necessary skilled care when needed on a daily basis. Although __________________________________ (specify service) generally requires the skills of a (nurse, physical therapist, speech-language pathologist, occupational therapist), the frequency with which the service is given must be in accordance with accepted standards of medical practice. The service(s) you received is not/are not normally needed on a daily basis. The medical information does not show medical complications that require the services to be performed on a daily basis. In this case, the services are not considered reasonable and necessary. Since you did not need skilled nursing or skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

☐ **Skilled Rehabilitation Services Not Received Daily-No Skilled Nursing:** Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. Although you required skilled _________________________ therapy, you did not receive therapy each day that it was available in the facility. Therefore, you do not meet the requirement for daily skilled rehabilitation services. Since you also did not need daily skilled nursing, we believe that your stay is not covered under Medicare.

☐ **Skilled Nursing Services Not Daily:** Medicare covers medical necessary skilled care when needed on a daily basis. Although you required skilled nursing services, you do not/did not need them on a daily basis. Because you do not/did not need daily skilled nursing or skilled rehabilitation, we believe Medicare will not cover your stay.

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Notice of Non-Coverage under Medicare

Determination of Admission

(We are required to present this letter to you by Federal law.)

☐ **<u>Specific Non-Skilled Service Provided – No Skilled Care (Full Denial):</u>** Medicare covers medically necessary skilled care needed on a daily basis. You only needed ________________________________. This does not require the skills of a licensed nurse to perform the service or to manage your care. Since you needed neither skilled nursing or skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

☐ **<u>Specific Skilled Service is Not Reasonable and Necessary (Service not Specific or Effective:</u>** Medicare covers medically and necessary skilled care when needed on a daily basis. The ______________________ (specify services) you received is/are considered a skilled service by Medicare. However, based on the medical information provided, this/these service(s) is/are not considered a specific and/or effective treatment for your condition. Since the service(s) you received was not/were not reasonable or necessary for the treatment of your condition, we believe your stay is not covered under Medicare.

☐ **<u>Teaching and Training Activities – No Skilled Service:</u>** Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time when progressive learning is demonstrated. You needed only to be reminded to follow the physician's instructions. This does not require the skills of a professional nurse or therapist. Therefore, we believe that this service is not covered under Medicare.

☐ **<u>Therapy Services for Overall Fitness and Well-Being (Skilled Therapy is Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology:</u>** Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. The therapy services you received were for your overall fitness and general well-being. They did not require the skills of a qualified ______________ therapist to perform and/or supervise the services. Since you did not need skilled nursing or skilled rehabilitation services, we believe your stay is not covered by Medicare.

This decision has not been made by Medicare. It represents our judgment that the services you need did not meet Medicare payment requirements. Normally, under these circumstances, a bill is not submitted to Medicare. **A bill will only be submitted if you request a bill be submitted. If you request that a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with the determination, you may file an appeal.**

Under a provision of the Medicare law, you do not have to pay for uncovered services determined to be custodial care and not reasonable or necessary unless you have had reason to know the services were non-covered. You are considered to know that these services were non-covered effective with the date of this notice.

If you have any questions concerning your liability for payment for services you received prior to the date of this notice, you must request that a bill be submitted to Medicare.

We regret that this notice may be your first notice of non-coverage of services under Medicare. Please check one of the boxes on the accompanying form to indicate whether or not you want a bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

____

Signature of Administrative Officer

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Notice of Non-Coverage under Medicare

Determination of Admission

(We are required to present this letter to you by Federal law.)

Request for Medicare Intermediary Review

☐ I do want my bill submitted to the intermediary for a Medicare decision.

You will be informed when the bill is submitted.

You are not required to pay for services that could be covered by Medicare until a Medicare decision has been made.

If you do not receive a formal "Notice of Medicare Determination" within 90 days of this request, you should contact:____.
(Name and Address of Medicare Fiscal Intermediary)

OR

☐ I do not want my bill submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if no bill is submitted.

Verification of Receipt of Notice

☐ This acknowledges that I have received this notice of non-coverage of services under Medicare on ____/____/________.

____
(Signature of Beneficiary or person acting on Beneficiary's behalf)

OR

☐ This is to confirm that you were advised of the non-coverage of services under Medicare by telephone on ____/____/________.

____
(Name of Beneficiary or Representative contacted)

____
(Signature of Administrative Officer)

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Notice of Non-Coverage under Medicare

Determination on Continued Stay

(Page 1 of 3)

(We are required to present this letter to you by Federal law.)

Patient's Name:____ Date:__________________

Name of Beneficiary:___________________________________ Medicare Number:_________________

Address:____________________________________ City, State, Zip:____________________________

On____/____/________, we reviewed your medical information and found that the services furnished __________________________ no longer qualified for payment by Medicare beginning ____/____/________.

The reason is:

☐ **No Material Improvement in Relation to Therapy Services Required-Partial Denial:** Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. While you required skilled ____________________ therapy from ____/____/________ to ____/____/________, the medical information shows that ____________________ therapy services after that time are not reasonable in relation to the expected improvement in your condition. In this case, since you do not need skilled nursing on a daily basis and the therapy services are not considered reasonable and necessary, we believe your stay after ____/____/________ is not covered under Medicare.

☐ **Observation and Management of Care Plan-Condition Improved:** Medicare covers medically necessary skilled care needed on a daily basis. Because of your condition you needed a skilled nurse from ____/____/________ through ____/____/________ to evaluate and manage your care plan. Your condition has improved, so the services you need can safely and effectively be given by non-skilled persons. Since you no longer require skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your care is not covered under Medicare after ____/____/________.

☐ **Observation and Management of Care Plan-No Significant Change:** Medicare covers medically necessary skilled care on a daily basis. You needed skilled nursing care beginning ____/____/________ to observe and evaluate your condition. There is no indication of further likelihood of significant changes in your care plan or acute changes or complications in your condition. Since you no longer need skilled nursing or skilled rehabilitation services on a daily basis, we believe, your stay after ____/____/________ is not covered under Medicare.

☐ **Repetitive Exercise-Partial Denial:** Medicare covers medically necessary skilled rehabilitation services. The medical information shows that the only therapy services you needed beginning ____/____/________ were repetitive exercises and help with walking. These do not generally require the skills or the supervision of a qualified therapist. There was no evidence of medical complications in your condition. We believe therapy services are not covered under Medicare after ____/____/________.

☐ **Specific Non-Skilled Service Provided-Partial Denial:** Medicare covers medically necessary skilled care needed on a daily basis. You only needed __________________________ after ____/____/________. Since you no longer require skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay beginning ____/____/________ is not covered under Medicare.

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Notice of Non-Coverage under Medicare

Determination on Continued Stay

(We are required to present this letter to you by Federal law.)

☐ **Teaching and Training Activities-Little or No Progress:** Medicare covers medically necessary skilled nursing and rehabilitation services you need, including teaching and training activities for a reasonable time where progressive learning is demonstrated. You received teaching and training for a reasonable time, but demonstrated you were not able, at this time, to learn or make progress to perform the activities ordered by your physician. Therefore, we believe that skilled services are not covered under Medicare after ____/____/________.

☐ **Teaching and Training Activities-Partial Denial:** Medicare covers medically necessary skilled nursing and rehabilitation services you need, including teaching and training activities for a reasonable time where progressive learning is demonstrated. You had learned to perform tasks ordered by your physician by ____/____/________, but the therapist continued services. Since you did not need skilled services after that date, we believe your stay is not covered under Medicare beginning ____/____/________.

☐ **Therapy to Maintain Function After a Maintenance Program has Been Established:** Medicare covers medically necessary skilled rehabilitation services to establish a safe and effective program to maintain your functional abilities. This program was established and beginning ____/____/________, the ______________________ (specify) therapy services you received were to carry out this program. These services do not require the supervision or skills of a ___________________ (specify) therapist and, therefore, we believe that the services are not/would not be covered under Medicare.

This decision has not been made by Medicare. It represents our judgment that the services you need no longer meet Medicare payment requirements. A bill will be sent to Medicare for the services you received before ____/____/________. Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision you must request that the bill submitted to Medicare include the services we determined to be non-covered. Medicare will notify you of its determination. If you disagree with that determination you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for non-covered services determined to be custodial care and not reasonable or necessary unless you have had reason to know the services were non-covered. You are considered to know that these services were non-covered effective with the date of this notice.

We regret that this may be your first notice of non-coverage of services under Medicare. Please check one of the boxes on the accompanying form to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

____

Signature of Administrative Officer

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Notice of Non-Coverage under Medicare
Determination on Continued Stay

(We are required to present this letter to you by Federal law.)

Request for Medicare Intermediary Review

☐ I do want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision.

You will be informed when the bill is submitted.

You are not required to pay for services that could be covered by Medicare until a Medicare decision has been made.

If you do not receive a formal "Notice of Medicare Determination" within 90 days of this request, you should contact:____.
(Name and Address of Medicare Fiscal Intermediary)

OR

☐ I do not want my bill for services I continue to receive submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if no bill is submitted.

Verification of Receipt of Notice

☐ This acknowledges that I have received this notice of non-coverage of services under Medicare on ____/____/________.

____
(Signature of Beneficiary or person acting on Beneficiary's behalf)

OR

☐ This is to confirm that you were advised of the non-coverage of services under Medicare by telephone on ____/____/________.

____
(Name of Beneficiary or Representative contacted)

____
(Signature of Administrative Officer)

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Notice of Non-Coverage under Medicare

Technical Denial

(We are required to present this letter to you by Federal law.)

Patient's Name:____ Date:____________________

Name of Beneficiary:____ Medicare Number:___________________

Address:____ City, State, Zip:_______________________________

On____/____/________, this facility reviewed your medical information available at the time of, or prior to, your admission, and we believe that your stay here will not be covered by Medicare Part A due to the following reasons:

☐ No Medicare Number or Lack of Part A benefits.

☐ No three-day qualifying hospital stay.

☐ Exhausted Medicare benefits – no new benefit period available.

☐ Another payer is primary over Medicare. That payer is:_______________________________________.

We regret that this may be your first notice of the non-coverage of services under Medicare.

Sincerely yours,

____
Signature of Administrative Officer

Verification of Receipt of Notice

☐ This acknowledges that I have received this notice of non-coverage of services under Medicare on ____/____/________.

____
(Signature of Beneficiary or person acting on Beneficiary's behalf)

OR

☐ This is to confirm that you were advised of the non-coverage of services under Medicare by telephone on ____/____/________.

____
(Name of Beneficiary or Representative contacted)

____
(Signature of Administrative Officer)

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Notice of Non-Coverage under Medicare
Intermediary Determination

To: Name:____ Date: ____/____/________

Address: ____

City/State/Zip:____

On ____/____/________, your Medicare Intermediary ____
advised us that the services you receive will no longer qualify as covered, beginning ___/___/_______.

The Medicare Intermediary will send you a formal determination as to the non-coverage of your stay after ____/____/________. If you wish to appeal, the formal notice will contain information about how this can be done. The Intermediary will inform you of the reason for denial and your appeal rights.

We regret that this may be your first notice of non-coverage of services under Medicare. Please verify receipt of this notice by signing below.

Verification of Receipt of Notice

This acknowledges that I have received this notice of non-coverage of services under Medicare on ____/____/________.

____

(Signature of Beneficiary or Person Acting on Beneficiary's Behalf)

This is to conform that you were advised of the non-coverage of services under Medicare by telephone on ____/____/________.

____

(Name of Beneficiary or Representative Contacted)

____

(Facility Representative)

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A. **Notifier:**____

B. **Patient Name:**____

C. **Identification Number:**______________________________

Advanced Beneficiary Notice of Non-Coverage (ABN)

Note: If Medicare doesn't pay for **D.**_____________________________ below, you may have to pay. Medicare does not pay for everything, even in some cases that you or your health care provider have good reason to think you need. We expect Medicare may not pay for **D.**__________________________ below.

D.	**E. Reason Medicare May Not Pay**	**F. Estimated Cost**

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_______________________ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you may have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.
☐ **Option 1.** I want the **D.**________________________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **Option 2.** I want the **D.**________________________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
☐ **Option 3.** I don't want the **D.**________________________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have any questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature	**J. Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form Instructions
Advanced Beneficiary Notice of Non-Coverage (ABN)
OMB Approval Number: 0938-0566

Overview

The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case. “Notifiers” include physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories), as well as hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A. They must complete the ABN as described below, and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice. (Note that although Medicare inpatient hospitals and home health agencies (HHAs) use other approved notices for this purpose, skilled nursing facilities (SNFs) must use the revised ABN for Part B items and services.) Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid; and notifiers must begin using the revised Advance Beneficiary Notice of Non-Coverage (CMS-R-131).

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain the original notice on file.

ABN Changes

The ABN is a formal information collection subject to approval by the Executive Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA). As part of this process, the notice is subject to public comment and re-approval every 3 years. The revised ABN included in this package incorporates: suggestions for changes made by notifiers over the past 3 years of use, refinements made to similar liability notices in the same period based on consumer testing and other means, as well as related Medicare policy changes and clarifications occurring in the same interval. We have made additional changes based on suggestions received during the recent public comment period.

This version of the ABN continues to combine the general ABN (ABN-G) and the laboratory ABN (ABN-L) into a single notice, with an identical OMB form number. As combined, however, the new notice will capture the overall improvements incorporated into the revised ABN while still permitting pre-printing of the lab-specific key information and denial reasons used in the current ABN-L.

Also, note that while previously the ABN was only required for denial reasons recognized under section 1879 of the Act, the revised version of the ABN may also be used to provide voluntary notification of financial liability. Thus, this version of the ABN should eliminate any widespread need for the Notice of Exclusion from Medicare Benefits (NEMB) in voluntary notification situations voluntary notification of financial liability. Thus, this version of the ABN should eliminate any widespread need for the Notice of Exclusion from Medicare Benefits (NEMB) in voluntary notification situations.

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Instructions for completion of the form are set forth below. Once the new ABN approval process is completed, CMS will issue detailed instructions on the use of the ABN in its on-line Medicare Claims Processing Manual, Publication 100-04, Chapter 30, §50. Related policy on billing and coding of claims, as well as coverage determinations, is found elsewhere in the CMS manual system or website (www.cms.hhs.gov).

Completing the Notice

OMB-approved ABNs are placed on the CMS website at: http://www.cms.gov/BNI . Notices placed on this site can be downloaded and should be used as is, as the ABN is a standardized OMB-approved notice. However, some allowance for customization of format is allowed as mentioned for those choosing to integrate the ABN into other automated business processes. In addition to the generic ABN, CMS will also provide alternate versions, including a version illustrating laboratory-specific use of the notice.

ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used.

Sections and Blanks:

There are 10 blanks for completion in this notice, labeled from (A) through (J), with accompanying instructions for each blank below. We recommend that the labels for the blanks be removed before use. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or hand-written, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The notifier must also insert the blank (D) header information into the blanks labeled (D) within the Option Box, Blank (G). The check boxes in the Option Box, Blank (G), must be completed by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

A. Header

Blanks A-C, the header of the notice, must be completed by the notifier prior to delivering the ABN.

Blank (A) Notifier(s): Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier's logo at the top of the notice by typing, hand-writing, pre-printing, using a label or other means.

If the billing and notifying entities are not the same, the name of more than one entity may be given in the Header as long as it is specified in the Additional Information (H) section who should be contacted for questions.

Blank (B) Patient Name: Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary's Medicare (HICN) card. The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.

Blank (C) Identification Number: Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may be used. Medicare numbers (HICNs) or Social Security numbers **must not** appear on the notice.

B. Body

Blank (D): The following descriptors may be used in the header of Blank (D):

- Item
- Service
- Laboratory Test
- Test
- Procedure
- Care
- Equipment

Blank (E) Reason Medicare May Not Pay: In this blank, notifiers must explain, in beneficiary friendly language, why they believe the items or services described in Blank (D) may not be covered by Medicare. Three commonly used reasons for non-coverage are:

- "Medicare does not pay for this test for your condition."
- "Medicare does not pay for this test as often as this (denied as too frequent)."
- "Medicare does not pay for experimental or research use tests."

To be a valid ABN, there must be at least one reason applicable to each item or service listed in Blank (D). The same reason for non-coverage may be applied to multiple items in Blank (D).

Blank (F) Estimated Cost: Notifiers must complete Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially non-covered services.

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed in Blank (D). In general, we would expect that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Thus, examples of acceptable estimates would include, but not be limited to, the following:

For a service that costs $250:

Any dollar estimate equal to or greater than $150

"Between $150-300"

"No more than $500"

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For a service that costs $500:

Any dollar estimate equal to or greater than $375

"Between $400-600"

"No more than $700"

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). Average daily cost estimates are also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

CMS will work with its contractors to ensure consistency when evaluating cost estimates and determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

C. Options

Blank (G) Options: Blank (G) contains the following three options:

☐ **OPTION 1.** I want the (D) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed. *See Ch. 30, §50.14.1 of the online Medicare Claims Processing Manual for instructions on the notifier's obligation to bill Medicare.*

Note: Beneficiaries who need to obtain an official Medicare decision in order to file a claim with a secondary insurance should choose Option 1.

☐ **OPTION 2.** I want the (D) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

This option allows the beneficiary to receive the non-covered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

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☐ **OPTION 3.** I don't want the (D) listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided and thus, there are no appeal rights associated with this option.

The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Under no circumstances can the notifier decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice. However, at the beneficiary's request, notifiers may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.

If there are multiple items or services listed in Blank (D) and the beneficiary wants to receive some, but not all of the items or services, the notifier can accommodate this request by using more than one ABN. The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: "beneficiary refused to choose an option."

D. Additional Information

Blank (H) Additional Information: Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. For example, notifiers may use this space to include:

- A statement advising the beneficiary to notify his or her provider about certain tests that were ordered, but not received;
- Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable ;
- An additional dated witness signature; or
- Other necessary annotations.

Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations.

E. Signature Box

Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice.

Blank (I) Signature: The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out "representative" in parentheses after his or her signature. The representative's name should be clearly legible or noted in print.

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Blank (J) Date: The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.

Disclosure Statement: The disclosure statement in the footer of the notice is required to be included on the document.

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Illinois Statutory Short Form
Power of Attorney for Health Care

(Notice: the purpose of this power of attorney is to give the person you designate (your "agent") broad powers to make health care decisions for you, including your power to require, consent to or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit you to or discharge you from any hospital, home, or other institution. This form does not impose a duty on your agent to exercise granted powers; but when powers are exercised, your agent will have to use due care to act for your benefit and in accordance with this form and keep a record of receipts, disbursements, and significant actions taken as agent. A court can take away the powers of your agent if it finds the agent is not acting properly. You may name successor agents under this form but not co-agents, and no health care provider can be named. Unless you expressly limit the duration of this power in the manner provided below, until you receive this power or a court acting on your behalf terminates it, your agent may exercise the powers given here throughout your lifetime, even after you become disabled. The powers you give your agent, your right to revoke those powers, and the penalties for violating the law are explained more fully in sections 4-5, 4-6, 4-9, and 1-10(b) of the Illinois "Powers of Attorney for Health Care Law" of which this form is a part. That law expressly permits the use of any different form of power of attorney you may desire. If there is anything about this form that you do not understand, you should as a lawyer to explain it to you.)

Power of Attorney made this ________ day of ______________________, 20_________
(month) (year)

1. I, ____
(Insert name and address of principal)

hereby appoint____
(Insert name and address of agent)

As my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning any personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains.

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Illinois Statutory Short Form
Power of Attorney for Health Care

(The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make or obtain or terminate any type f health care, including withdrawal of food and water and other life-sustaining measures, if your agent believe such action would be consistent with your intent and desires. If you wish to limit the scope of your agent's powers or proscribe special rules or limit the power to make an anatomical gift, authorize autopsy or dispose of remains, you may do so in the following paragraphs.)

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as: your own definition of when life-sustaining measures should be withdrawn; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any reason, such as blood transfusion, electro-convulsive therapy; amputation, psychosurgery, voluntary admission to a mental institution, etc.):

____

____

____

____

(The subject of life-sustaining treatments is of particular importance. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below: If you agree with one of these statements, you may initial that statement; but do not initial more than one):

_________ Initialed	I do not want my life prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.
_________ Initialed	I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a coma which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered irreversible coma, I want life-sustaining treatment to be withheld or discontinued.
_________ Initialed	I want my life to be prolonged to the greatest extent possible without regard to my condition, the changes I have for recovery or the cost of the procedures.

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Illinois Statutory Short Form
Power of Attorney for Health Care

(This power of attorney may be amended or revoked by you in the matter provided in section 4-6 of the Illinois "Powers of Attorney for Health Care Law." Absent amendment or revocation, the authority granted in this power of attorney will become effective at the time this power is signed and will continue until your death, and beyond if anatomical gift, autopsy, or disposition of remains is authorized, unless limitation on the beginning date or duration is made by initialing and completing rather or both of the following:)

3. ( ) This power of attorney shall become effective on:______________________

____

(Insert a future date or event during your lifetime, such as a court determination of your disability, when you want this power to first take effect)

4. ( ) This power of attorney shall terminate on ______________________________

____

(Insert a future date or event, such as a court determination of your disability, when you want to terminate prior to your death)

(If you wish to name successor agents, insert the names and addresses of such successors in the following paragraph.)

5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successor to such agent:

____

____

____

____

For purposes of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to health care as certified by a licensed physician.

(If you wish to name your agent as guardian of your person, in the event a court decides that one should be appointed, you may, but are not required to, do so by retaining the following paragraph. The court will appoint your agent if the court finds that such appointment will serve your best interests and welfare. Strike out paragraph 6 if you do not want your agent to act as your guardian.)

6. If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

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Illinois Statutory Short Form
Power of Attorney for Health Care

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed____
(Principal)

The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence.

____________________ Residing at:____
(Witness)

(You may, but are not required to, request your agent and successor agents to provide specimen signatures below. If you include specimen signatures in this power of attorney, you must complete the certification opposite the signatures of your agents.)

Specimen signatures of agent (and successors)	I certify that the signatures of my agent (and successors) are correct.
________________________ (Agent)	________________________ (Principal)
________________________ (Successor Agent)	________________________ (Principal)
________________________ (Successor Agent)	________________________ (Principal)

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Excerpts required by Section 4-10(a) of the Illinois Power of Attorney Act (Ill Rev., Ch.110, Par. 801-1 et. Seq.

Illinois Statutory Short Form Power of Attorney for Health Care

Definitions and Explanations

Section 4-5. **Limitations on health care agencies.** Neither the attending physician nor any health care provider may act as agent under a health care agency; however, a person who is not administering health care to the patient may act as health care agent for the patient even though the person is a physician or otherwise licensed, certified, authorized, or permitted by law to administer health care in the ordinary course of business or the practice of a profession.

Section 4-6. **Revocation and amendment of health care agencies.**

(a) Every health care agency may be revoked by the principal at any time, without regard to the principal's mental or physical condition, by any of the following:
   1. By being obliterated, burnt, torn, or otherwise destroyed or defaced in a manner indicating intention to revoke;
   2. By a written revocation of the agency signed and dated by the principal or person acting at the direction of the principal; or
   3. By an oral or any other expression of the intent to revoke the agency in the presence of a witness 18 years of age or older who signs and dates a written confirmation that such expression of intent was made.

(b) Every health care agency may be amended at any time by a written amendment signed and dated by the principal or person acting at the direction of the principal.

(c) Any person, other than the agent, to whom a revocation or amendment is communicated or delivered shall make all reasonable efforts to inform the agent of the fact as prominently as possible.

Section 4-7 deals with **"Duties of health care providers and others in relation to health care agencies."**

Section 4-8 deals with **"Immunities of health care providers, agents, and others in relation to health care agencies."**

Section 4-9 **Penalties.** All persons shall be subject to the following transactions in relation to health care agencies, in addition to all other sanctions applicable under any other law or rule of professional conduct/

(a) Any person shall be civilly liable who without the principal's consent, willfully conceals, cancels, or alters a health care agency or any amendment or revocation of the agency or who falsifies or forges a health care agency, amendment, or revocation.

(b) A person who falsifies or forges a health care agency or willfully conceals or withholds personal knowledge of an amendment or revocation of a health care agency with the intent to cause a withholding or withdrawal of life-sustaining or death-delaying procedures contrary to the intent of the principal and thereby, because of such act, directly causes life-sustaining or death-delaying procedures to be withheld or withdrawn and death to the patient to he hastened shall be subject to prosecution for involuntary manslaughter.

(c) Any person who requires or prevents execution of a health care agency as a condition of insuring or providing any type of health care services to the patient shall be civilly liable and guilty of a Class A misdemeanor.

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Excerpts required by Section 4-10(a) of the Illinois Power of Attorney Act (Ill Rev., Ch.110, Par. 801-1 et. Seq.

Illinois Statutory Short Form Power of Attorney for Health Care

Definitions and Explanations

Section 4-10. **Statutory Short Form Power of Attorney for Health Care.**

{(a) Paragraph (a) sets out the form of the statutory health care power that is reproduced on the face of this form.}

(b) The statutory short form power of attorney for health care (the "statutory health care Power") authorizes the agent to make any and all health care decisions on behalf of the principal which the principal could make if present and under no disability, subject to any limitations on the granted powers that appear on the face of the form, to be exercised in such manner as the agent deems consistent with the intent and desires of the principal. The agent will be under no duty to exercise granted powers or to assume control of or responsibility for the principal's health care; but when granted powers are exercised, the agent will be required to use due care and act for the benefit of the principal in accordance with the terms of the statutory health care power and will be liable for negligent exercise. The agent may act in person or through others reasonably employed by the agent for that purpose, but may not delegate authority to make health care decisions. The agent may sign and deliver all instruments, negotiate or enter into all agreements and do all other acts reasonably necessary to implement the exercise of the powers granted the agent. Without limiting the generality of the foregoing, the statutory health care power shall include the following papers, subject to limitations appearing on the face of the form.

(1) The agent is authorized to give consent to and authorize or refuse, or withhold or withdraw consent to, any and all types of medical care, treatment, or procedures relating to the physical health of the principal, including any medication program, surgical procedures, life-sustaining treatment, or provision of food and fluids for the principal.

(2) The agent is authorized to admit the principal or discharge the principal from any and all types of hospitals, institutions, homes, residential or nursing facilities, treatment centers, and any other health care institutions providing personal care or treatment for any type of physical or mental condition. The agent shall have the same right to visit the principal in the hospital or other institution as is granted to a spouse or adult child of the principal, any rule of the institution to the contrary notwithstanding.

(3) The agent is authorized to contract for any and all types of health care services and facilities in the name of and on behalf of the principal and to bind the principal to pay for all such services and facilities. And to have and exercise those powers over the principal's property power, to the extent the agent deems necessary to pay health care costs; and the agent shall not be personally liable for any services or care contracted for on behalf of the principal.

(4) At the principal's expense and subject to reasonable rules of the health care provider to prevent disruption of the principal's health care, the agent shall have the same right the principal has to examine and copy and consent to disclosure of all the principal's medical records that the agent deems relevant to the exercise of the agent's powers, whether the records relate to mental health or another medical condition and whether they are in the possession of or maintained by any physician, psychiatrist, psychologist, therapist, hospital, nursing home, or other health care provider.

(5) The agent is authorized: to direct that an autopsy be made pursuant to Section 2 of "An Act in relation to autopsy of dead bodies," approved August 13, 1965, including all amendments; to make disposition of any part or all of the principal's body pursuant to the Uniform Anatomical Gift Act, as now or hereafter amended; and to direct the disposition of the principal's remains.

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Illinois Living Will Declaration

This declaration is made this ___________ day of ______________________________ (month and year)

I, ___________________________________ being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artificially postponed.

If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death-delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only administration of medications, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

Special instructions: ____

____

____

____

In the absence of my ability to give directions regarding the use of such death-delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Signed: ____

City, County, and State of Residence: ____

____

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence, or the declarant acknowledged in my presence or he or she had signed the declaration, and I signed the declaration as a witness in the presence of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death directly financially responsible for declarant's medical care.

Witness:____

(Name and Address)

Witness:____

(Name and Address)

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Certification for Surrogate Decision-Making For Residents with Qualifying Conditions

Resident Name:____

PART I. PHYSICIAN CERTIFICATION OF QUALIFYING CONDITIONS

It has been determined that the resident has one or more of the following Qualifying Conditions:

- ☐ **Terminal Condition:** The resident has an illness or injury for which, according to accepted medical standards, (i) there is no reasonable prospect of cure or recovery; (ii) death will occur in a relatively short period even if CPR is applied; (iii) applying CPR will only prolong the dying process.
- ☐ **Permanent Unconsciousness:** The resident has a condition that, to a high degree of medical certainty, (i) will last permanently without improvement; (ii) in which thought, sensation, purposeful action, social interaction, and awareness of self and environment are absent; and (iii) for which initiating or continuing CPR will provide only minimal benefit in light of the resident's medical condition.
- ☐ **Incurable or Irreversible Condition:** The resident has an illness or injury (i) for which there is no reasonable prospect of cure or recovery; (ii) the ultimately will cause the resident's death even if CPR is initiated or continued; (iii) that imposes severe pain or otherwise imposes an inhumane burden on the resident; and (iv) for which initiating or continuing CPR, in light of the resident's condition will provide only minimal medical benefit.

The cause and nature of the qualifying condition(s) is summarized as follows:

Cause (if known): ____

Nature (if known):____

PART II. PHYSICIAN DETERMINATION OF DECISION CAPACITIES

After personally examining the above-noted resident, it has also been determined to a reasonable degree of medical certainty that the resident lacks decisional capacity to decide whether to forego life-sustaining treatment. The cause, nature, and duration of the lack of decisional capacity are summarized as follows:

Cause:____

Nature:________________________________ Duration:______________________

PART III. DETERMINATION OF SURROGATE

After reasonable inquiry, I have determined that the resident has no health care agent under the Powers of Attorney for Health Care Law and no effective Living Will. I have further determined that the following individual meets the qualifications contained in PART VI: SURROGATE QUALIFICATIONS AND AGREEMENT to act as a surrogate decision-maker under Illinois Health Care Surrogate Act.

____

Print Surrogate Decision-Maker's Name Relationship to Resident

____

Address and Phone Number(s)

PART IV. PHYSICIANS' CERTIFICATION OF QUALIFYING CONDITION, DECISIONAL CAPACITY, SURROGATE DETERMINATION, AND SURROGATE DECISION-MAKING

In conformance with the Illinois Health Care Surrogate Act, the resident has been informed and has not objected to the above determinations, the identity of the surrogate decision-maker, and the decision made by the surrogate whether to forego life-sustaining treatment.

____

Print Name of Attending Physician Signature of Attending Physician Date

After personal examination of the above-named resident, I concur in the determination that this resident has a qualifying condition and lacks decisional capacity.

____

Print Name of Concurring Physician Signature of Concurring Physician Date

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Certification for Surrogate Decision-Making
For Residents with Qualifying Conditions

PART V: DECISION OF SURROGATE ABOUT LIFE-SUSTAINING TREATMENT (To be Completed by Physician)

☐ Withhold CPR (Surrogate and Physician must sign "Request for DNR" form).

☐ Other Life-Sustaining Treatment Instructions:____

____

The decision and substance of the discussion between surrogate and the physician before making the decision is summarized as follows (include information as to date, time, location, and whether the decision by the surrogate was received in person, by telephone, or in writing): ____

____

____

I have witnessed the discussion between the attending physician and the surrogate decision-maker and the decision expressed by the surrogate as a forgoing life-sustaining treatment on behalf of the above-noted resident.

____

Print Name of Witness Signature of Witness Date

____

Witness's Complete Address

PART VI. SURROGATE QUALIFICATIONMS AND AGREEMENT

- I am 18 years of age or older.
- I accept the office of surrogate, and am willing to choose whether or not to withhold CPR or other life-sustaining treatment for a resident.
- I am unaware of any other individual with a higher priority as a surrogate decision-maker under Sections 10 and 25 of the Act (surrogate priority: legal guardian, spouse, adult son or daughter, parent, adult brother or sister, adult grandchild, close friend, guardian of the estate) I am willing to assume responsibility as a surrogate decision-maker.
- All other surrogate decision-makers of the same level of priority agree with my decisions regarding the resident.
- The resident has been informed of my appointment as surrogate and of my decisions regarding life-sustaining treatment, and the resident has not objected to my decision.
- I agree to notify the Administrator of the facility immediately and in writing
  (i) if I become unavailable or unwilling to continue as surrogate decision-maker for the resident, or
  (ii) if any other individual of a higher priority under Section 25 of the Act becomes available as a surrogate decision-maker for the resident, or
  (iii) if anyone initiates guardianship proceedings pertaining to the resident, or
  (iv) if the resident expresses an objection to my decision and direction.
- I have been fully advised by the attending physician of the resident's medical condition, including the resident's lack of decisional capacity, qualifying conditions un the Act, and other matters prescribed in the Certification for Surrogate Decision-Making. I have had an opportunity to ask questions regarding such matters, and all questions have been answered to my satisfaction. I have received and reviewed all medical information and medical records pertaining to the resident that I requested. A description of my relevant substantive discussions with the attending physician is set forth in this Certificate for Surrogate Decision-Making. I understand and appreciate the nature and consequences of the decision and directions affecting life-sustaining treatment, and have communicated my decision and direction as surrogate to the attending physician.
- I understand that the resident's condition may change from time0to-time, but that my direction as surrogate to the attending physician and the facility will remain in effect until they have been revoked by me. I understand I may revoke this direction only by notifying the attending physician orally or in writing. This facility and the attending physician may rely upon my direction regarding life-sustaining treatment until I have taken action to revoke them.
- I agree to release and indemnify the facility, the attending physician, and concurring physician from and for any claim or loss incurred by any one of them resulting from any action taken or not taken in reliance on my surrogate decision and direction.
- I understand that this direction is valid only during the time the resident resides in this facility, and only during the time the resident is under the care of the attending physician, and that this decision will not necessarily be honored by any other health facility or by any other physician.

____

Signature of Surrogate Date

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Certification for Surrogate Decision-Making For Residents without Qualifying Conditions

Resident Name:____

PART I.

☐ **It has been determined that this resident does NOT have a Qualifying Condition for a surrogate to make decisions to forego life-sustaining treatment.**

A Qualifying Condition under the Surrogate Act is a terminal condition, permanent unconsciousness, or an incurable or irreversible condition. Consequently, unless the resident has a Qualifying Condition, the appointed surrogate can only make decisions affecting the ongoing treatment of the resident. A surrogate cannot make decisions to forego life-sustaining treatment, until two (2) physicians determine that the resident has a Qualifying Condition. If it is determined that the resident does have a Qualifying Condition, please use the form "Certification for Surrogate Decision-Making for Resident with Qualifying Conditions."

PART II. PHYSICIAN DETERMINATION OF DECISIONAL CAPACITIES

After personally examining the above-noted resident, it has also been determined to a reasonable degree of medical certainty that the resident lacks the capacity to make decisions regarding his or her treatment. The cause, nature, and duration of the lack of decisional capacity are summarized as follows:

Cause:____

Nature:_______________________________ Duration:_______________________

PART III. DETERMINATION OF SURROGATE

After reasonable inquiry, I have determined that the resident has no health care agent under the Powers of Attorney for Health Care Law. I have further determined that the following individual meets the qualifications contained in PART VI: SURROGATE QUALIFICATIONS AND AGREEMENT to act as a surrogate decision-maker under Illinois Health Care Surrogate Act.

____

Print Surrogate Decision-Maker's Name | Relationship to Resident

____

Address and Phone Number(s)

PART IV. PHYSICIANS' CERTIFICATION OF DECISIONAL CAPACITY, SURROGATE DETERMINATION, AND SURROGATE DECISION-MAKING

In conformance with the Illinois Health Care Surrogate Act, the resident has been informed and has no objection to the above determination, the identity of the surrogate decision-maker, and the decisions made by the surrogate.

____

Print Name of Attending Physician | Signature of Attending Physician | Date

After personal examination of the above-named resident, I concur in the determination that this resident lacks decisional capacity.

____

Print Name of Concurring Physician | Signature of Concurring Physician | Date

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Certification for Surrogate Decision-Making
For Residents without Qualifying Conditions

PART V: DECISION OF SURROGATE ABOUT LIFE-SUSTAINING TREATMENT (To be Completed by Physician)

____

____

____

The decision and substance of the discussion between surrogate and the physician before making the decision is summarized as follows (include information as to date, time, location, and whether the decision by the surrogate was received in person, by telephone, or in writing): ____

____

____

I have witnessed the discussion between the attending physician and the surrogate decision-maker and the decision expressed by the surrogate as to treatment on behalf of the above-noted resident.

____

Print Name of Witness | Signature of Witness | Date

____

Witness's Complete Address

PART VI. SURROGATE QUALIFICATIONMS AND AGREEMENT

- I am 18 years of age or older.
- I accept the office of surrogate, and am willing to make decisions for the resident.
- I am unaware of any other individual with a higher priority as a surrogate decision-maker under Sections 10 and 25 of the Act (surrogate priority: legal guardian, spouse, adult son or daughter, parent, adult brother or sister, adult grandchild, close friend, guardian of the estate) I am willing to assume responsibility as a surrogate decision-maker.
- All other surrogate decision-makers of the same level of priority agree with my decisions regarding the resident.
- The resident has been informed of my appointment as surrogate and of my decisions regarding treatment, and the resident has not objected to my decision.
- I agree to notify the Administrator of the facility immediately and in writing
  (v) if I become unavailable or unwilling to continue as surrogate decision-maker for the resident, or
  (vi) if any other individual of a higher priority under Section 25 of the Act becomes available as a surrogate decision-maker for the resident, or
  (vii) if anyone initiates guardianship proceedings pertaining to the resident, or
  (viii)if the resident expresses an objection to my decision and direction.
- I have been fully advised by the attending physician of the resident's medical condition, including the resident's lack of decisional capacity, and other matters prescribed in the Certification for Surrogate Decision-Making. I have had an opportunity to ask questions regarding such matters, and all questions have been answered to my satisfaction. I have received and reviewed all medical information and medical records pertaining to the resident that I requested. A description of my relevant substantive discussions with the attending physician is set forth in this Certificate for Surrogate Decision-Making. I understand and appreciate the nature and consequences of the decision and directions affecting treatment, and have communicated my decision and direction to the attending physician.
- I understand that the resident's condition may change from time-to-time, but that my direction as surrogate to the attending physician and the facility will remain in effect until they have been revoked by me. I understand I may revoke this direction only by notifying the attending physician orally or in writing. This facility and the attending physician may rely upon my direction regarding life-sustaining treatment until I have taken action to revoke them.
- I agree to release and indemnify the facility, the attending physician, and concurring physician from and for any claim or loss incurred by any one of them resulting from any action taken or not taken in reliance on my surrogate decision and direction.
- I understand that this direction is valid only during the time the resident resides in this facility, and only during the time the resident is under the care of the attending physician, and that this decision will not necessarily be honored by any other health facility or by any other physician.

____

Signature of Surrogate | Date

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Illinois Department of Public Health

UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition, new orders may need to be written. See also Guidance for Health Care Professionals at http://www.idph.state.il.us/public/books/advin.htm.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ❑ M ❑ F	
Address (street/city/state/ZIPcode)		

A Check One

CARDIOPULMONARY RESUSCITATION (CPR) Patient has no pulse *and* is not breathing.

❑ **Attempt Resuscitation/CPR** (*Selecting CPR means* **Intubation and Mechanical Ventilation** *in Section* **B** *is selected*)

❑ **Do Not Attempt Resuscitation/DNR**

When not in cardiopulmonary arrest, follow orders B and C.

B Check One

MEDICAL INTERVENTIONS Patient has pulse and/or is breathing.

❑ **Comfort Measures Only** (Allow Natural Death). Relieve pain and suffering through the use of medication by appropriate route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments.* ***Transfer*** *if comfort needs cannot be met in current location.* **Treatment Plan: Maximize comfort through symptom management.**

❑ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Generally avoid the intensive care unit.* **Treatment Plan: Provide basic medical treatments.**

❑ **Intubation and Mechanical Ventilation** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.* **Treatment Plan: Life support measures, including intubation, in the intensive care unit.**

❑ **Additional Orders** ____________________

C Check One *(optional)*

ARTIFICIALLY ADMINISTERED NUTRITION Offer food by mouth, if feasible and as desired.

❑ No artificial nutrition by tube.

❑ Defined trial period of artificial nutrition by tube.

❑ Long-term artificial nutrition by tube.

Additional Instructions (e.g., length of trial period) ____________________

D

DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

❑ Patient ❑ Agent under health care power of attorney

❑ Parent of minor ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature *(required)*	Name (print)	Date

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature *(required)*	Name (print)	Date

E

SIGNATURE OF ATTENDING PHYSICIAN

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Attending Physician Name *(required)*	Phone ( ) ____ - ____
Attending Physician Signature *(required)*	Date *(required)*

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

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THIS SIDE FOR INFORMATIONAL PURPOSES ONLY

Patient Last Name	Patient First Name	MI

The Illinois Department of Public Health (IDPH) Uniform Do Not Resuscitate (DNR) Advance Directive is **always voluntary** and is for persons with advanced or serious illness or frailty. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive form (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

☐ Health Care Power of Attorney ☐ Living Will Declaration ☐ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH Uniform Do Not Resuscitate (DNR) Advance Directive Form

- **The completion of a DNR form is always voluntary, cannot be mandated and may be changed at any time.**
- A DNR form should reflect current preferences of persons with advanced or serious illness or frailty. Also, encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by attending physician in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a Do Not Resuscitate (DNR) Advance Directive Form

This DNR form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another,
- or there is a substantial change in the patient's health status,
- or the patient's treatment preferences change,
- or the patient's primary care professional changes.

Voiding or revoking a Do Not Resuscitate (DNR) Advance Directive Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a DNR form requires completion of a new DNR form.
- Draw line through sections A through E and write "VOID" in large letters if any DNR form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at http://www.idph.state.il.us/public/books/advin.htm

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

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Illinois Department of Public Health (IDPH)
Do-Not Resuscitate (DNR) Advance Directive
Guidance to Individuals

The Illinois Department of Public Health (IDPH) Uniform Do-Not-Resuscitate (DNR) Advance Directive can be used to create a physician's order that reflects an individual's wishes about receiving cardiopulmonary resuscitation (CPR). The form allows you, in consultation with your health care professional, to make advance decisions about whether CPR should be administered if your breathing and/or heartbeat stops. CPR, when successful, restores heartbeat and breathing. The completed form is intended to be honored across various settings, including hospitals, nursing homes, and by emergency medical services personnel in your residence or en route to a health care facility. You should use the IDPH Uniform DNR Advance Directive to replace the previous orange-colored Emergency Medical Services DNR form.

You should complete the IDPH Uniform DNR Advance Directive only after extensive discussion about treatment preferences with your immediate family members and your health care professional. Items for discussion with your health care professional should include your preferences regarding administration of CPR if your heartbeat and/or breathing stops, in view of the following:

- **Your personal views;**
- **Your medical condition and related medical considerations;**
- **Your views regarding the use of CPR in the event of an unforeseen accident (such as a car crash or choking on food);**
- **Quality of life issues before and after CPR;**
- **Your views regarding use of CPR during surgery or other medical procedure;**
- **Your wishes regarding organ donation; and**
- **Your views regarding use of a mechanical ventilator.**

You are not required to consent to a DNR order as a condition of treatment or care. If you become unable to make decisions for yourself, a decision regarding whether you should have a DNR order can be made by your legal representative and your physician.

I. General Considerations

What is a Do-Not-Resuscitate (DNR) order?

A Do-Not-Resuscitate (DNR) order is a medical treatment order that says cardiopulmonary resuscitation (CPR) will not be attempted if your heart and/or breathing stops.

What is cardiopulmonary resuscitation (CPR)?

CPR refers to various medical procedures, such as chest compressions, electrical shocks and insertion of a breathing tube, used in an attempt to restart your heart and/or breathing.

Why are DNR orders issued?

Health care professionals ordinarily will begin CPR when your heart and/or breathing stops. You may make a choice; however, not to receive CPR under these circumstances. A DNR order states you prefer to be cared for without CPR in the event your heart and/or breathing stops.

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Who may have a DNR order?

An adult, or an emancipated minor, who does not wish to have CPR attempted when his or her heart and/or breathing stops, may have a DNR order. The parent or legal guardian of a minor may also request a DNR order for the minor.

Is there a form my physician can use to enter a DNR order?

The Illinois Department of Public Health (IDPH) has developed the "IDPH Uniform Do-Not-Resuscitate (DNR) Advance Directive" that your physician can use. A DNR order completed on this form should be honored by health care professionals and providers in health care facilities, as well as by EMTs and paramedics in your home or en route to a health care facility. To obtain a copy of the IDPH Uniform DNR Advance Directive, you may request one from your health care professional or facility. Copies are also available on the Illinois Department of Public Health's website, located at www.idph.state.il.us/public/books/advin.htm. Health care facilities may also have its own form, but this guidance addresses only the IDPH Uniform DNR Advance Directive.

Where may a DNR order be used?

A DNR order may be used by all health care professionals and providers. If you choose to use the IDPH Uniform DNR Advance Directive, it is required by law to be honored in licensed hospitals, in certain licensed long term care facilities such as nursing homes, and by licensed emergency medical services personnel.

II. Completing and Reviewing the IDPH Uniform DNR Advance Directive

On the IDPH Uniform DNR Advance Directive, what is meant by "full cardiopulmonary arrest?"

Full cardiopulmonary arrest means both your heart and breathing have stopped.

On the IDPH Uniform DNR Advance Directive, what is meant by "pre-arrest emergency?"

Pre-arrest emergency means your breathing is labored or stopped, but your heart is still beating. If CPR is not initiated, full cardiopulmonary arrest may follow a pre-arrest emergency.

The IDPH Uniform DNR Advance Directive identifies two options you may select in the event of a "pre-arrest emergency." What is the difference between the two options?

The first option is "Do Attempt Resuscitation," which means CPR will be attempted if your breathing is labored or stopped.

The second option is "Do Not Attempt Resuscitation." This option says you do not want CPR attempted if your breathing has become labored or stopped, but your heart is still beating. The care provided in this category is intended to keep you comfortable and promote your dignity during the emergency, rather than to prolong your life.

If I want all resuscitation efforts under all circumstances, do I still have to complete the IDPH Uniform DNR Advance Directive?

No. If you do not have a completed DNR order, CPR should be attempted if your heartbeat and/or breathing stop.

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Illinois Department of Public Health (IDPH)
Do-Not Resuscitate (DNR) Advance Directive
Guidance to Individuals

If I do not have a completed DNR order, what will happen if I suffer some type of cardiopulmonary arrest?
Again, CPR should be attempted in the event your heart and/or breathing stop.

Who may provide the consent required on the IDPH Uniform DNR Advance Directive?
Generally, consent may be obtained from you or another person legally authorized to act on your behalf. If you are unable to make your own health care decisions, a legal guardian, a health care agent under a health care power of attorney or a health care surrogate may consent on your behalf to the DNR order. A parent or legal guardian typically may grant the required consent for a minor, and emancipated minors may also consent to a DNR order.

Does the IDPH Uniform DNR Advance Directive require the signature of the person who is consenting to the DNR order?
Yes. You or your legal representative, health care agent or health care surrogate must sign the section of the form concerning consent.

Is a witness required for the IDPH Uniform DNR Advance Directive?
Yes. After 1/1/2010 at least one individual, 18 years of age or older, must witness your signature or your legal representative's signature granting consent on the IDPH Uniform DNR Advance Directive. A witness may include family members, friends, and health care workers.

III. Implementing a Completed IDPH Uniform DNR Advance Directive

Once I have a completed a DNR order on an IDPH Uniform DNR Advance Directive, what medical care will be given to me?
When the DNR order is entered into your medical record, you will continue to receive appropriate medical care. However, if your heartbeat and/or breathing stops, appropriate medical treatment will only be given to you according to your wishes as expressed in the IDPH Uniform DNR Advance Directive.

Does the cause of the cardiopulmonary arrest matter when invoking my DNR order?
Generally, no. The order generally applies when your heartbeat and/or breathing stop, regardless of what caused the cardiopulmonary arrest. For example, if you go into cardiopulmonary arrest from an accident, and you have a DNR order, your wishes as stated in the order will likely be followed to the extent the order is readily available to the health care provider.

A DNR order may not be appropriate for you, should you want CPR administered if your heartbeat and/or breathing stop as a result of an accident or during a medical procedure such as surgery. Therefore, it is very important to discuss your wishes with your health care professional prior to consenting to a DNR order. You and your health care professional might want to consider placing your wishes regarding application of the order in the event of an accident or medical procedure in the portion of the form designated for other instructions.

What if I change my mind about having a DNR order?
You (or your legal representative on your behalf) can change your mind at any time about having a DNR order. The DNR order can be revoked in a variety of ways, such as by writing "VOID" in large letters across the front of the form. If you revoke a DNR order, you also should tell your family members, as well as each health care

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professional and provider that has received a copy of the order. You may then choose not to have a DNR order, or you may choose to complete a new DNR order reflecting any changes you wish.

Does my completed DNR order have an expiration date?

No. The order is valid until you revoke it. If you are unable to revoke it, your legal representative may do so.

Must all health care providers honor my DNR order?

Licensed hospitals, certain licensed long term care facilities such as nursing homes, and licensed emergency medical services personnel are required by law to honor a DNR order completed on the IDPH Uniform DNR Advance Directive.

If an ambulance is called to take me to the hospital, should my DNR order be honored by licensed emergency medical services personnel?

Yes, as long as someone provides the emergency medical services personnel with a copy of your DNR order, and the order appears to be complete and valid. If a form other than the IDPH Uniform DNR Advance Directive is used, however, there may be barriers to honoring your DNR order.

If I am transferred from one facility to another, should my DNR order be sent with me?

Your DNR order, or a copy of it, should accompany you to the next setting, whether it is a hospital, rehabilitation facility, nursing home, or your own home.

Are photocopies of the IDPH Uniform DNR Advance Directive valid?

Generally, yes. Photocopies of a completed IDPH Uniform DNR Advance Directive are valid. Each health care facility, however, may have different policies on whether copies of DNR orders completed on a form other than an IDPH Uniform DNR Advance Directive are accepted as valid. It is advisable to check with a health care facility regarding its DNR policy.

Who keeps the completed DNR order?

You should keep the original DNR order with you where you reside, whether at home or on file in your medical record at a long term care facility and your physician should keep a copy in your medical record. A copy also should be with you if you are transported to a hospital or other health care facility. If you have a legal guardian, have named an agent under a power of attorney for health care, or have a surrogate (substitute) decision maker, he or she should also have a copy of the order readily accessible.

Are DNR orders ever suspended during surgery or other medical procedures?

Certain health care providers in Illinois have written policies indicating that a DNR order may be suspended during a surgical procedure after discussion with you or your legal representative.

Further, your wishes regarding applicability of a DNR order during surgery, or in the event of an unforeseen accident (e.g., a car crash or choking on food), may be placed on the form in the space designated for “other instructions.”

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Illinois Department of Public Health (IDPH)
Do-Not Resuscitate (DNR) Advance Directive
Guidance to Individuals

What other documents might I consider signing to direct my care when I am no longer able to make health care decisions for myself?

You may choose to make your wishes known by appointing an agent through a Power of Attorney for Health Care or by executing a living will. Read the "Statement of Illinois Law on Advance Directives" for further information regarding the various advance directives available in Illinois.

The statement is located on the Illinois Department of Public Health's website at www.idph.state.il.us/public/books/advin.htm. You can also obtain the following forms at this website: IDPH Uniform DNR Advance Directive, Health Care Power of Attorney, Living Will, and Mental Health Treatment Preference Declaration.

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