DELTA
Rehabilitation
& Care Center

1334 S. Ham Lane Lodi, CA 95242
Ph. (209) 334-3825 Fax (209) 224-5262

# Fax

FAXED
6.7.12
aw

**To:** SSI **From:** Angie Walker

**Fax:** 369-1781 **Pages:** 2 (Including Cover)

**Phone:** **Date:**

**Re:** MC171 **cc:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

- **Comments:**

| Section: Clinical | General Policy Guidelines | | |
|---|---|---|---|
| Title: Pyschotherapeutic Medication Use | | Effective Date: | 04/01/11 |
| | | Revision: | |
| | | Reviewed/No Changes | |

**PURPOSE**
To provide procedures to be used when addressing the use of psychotherapeutic medications for a resident

**POLICY**
Psychotherapeutic medications are only considered for use after alternative methods have been tried unsuccessfully and will not be used to limit or control resident behavior for the convenience of the staff.

**REFERENCE**
Title 22, 72527,72528, 483.13 (a) F222, F329

## PROCEDURE

1. A psychotherapeutic medication is defined as medication that manages or treats psychiatric disorders, psychological needs or disordered thought processes. Medications having an impact on the mental status of the resident include antipsychotic, antianxiety, antidepressant, and sedative-hypnotic medication.
2. Residents on psychotherapeutic medications will be monitored for appropriate use, effectiveness, side effects, and possible dose reduction.
3. The nurse shall verify that the resident's health record contains documentation that the resident/responsible party has given informed consent to the physician, including those residents admitted with pre-existing orders for psychotherapeutic medications.
4. The physician order for psychotherapeutic medications will include the name of the medication, dose, route, frequency, diagnosis, and the specific behavior manifestations to be treated.
5. The care plan for each resident will specify the behavior and side effects to be monitored, non-drug interventions, and a method of evaluating the effectiveness of the medication.
6. Routinely, the licensed nurse will evaluate the resident for overall effectiveness of the psychotherapeutic medication and record side effects noted. The Interdisciplinary Team will review the report and recommendations will be documented in the resident's health record.
7. Dose Reduction/Dose Increases will be addressed according to regulatory guidelines and individual resident needs.

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Patient Name: PARVIN,MARY JEAN
Unit No: M053082

| EXAM# | TYPE/EXAM | RESULT |
|---|---|---|
| 001117060 | CT/HEAD W/O CONTRAST | |

History: Delirium.

Findings: Noncontrast axial images obtained from the skull base to the vertex demonstrate moderate generalized ventricular and sulcal prominence without focal mass effect, hemorrhage or specific evidence of acute ischemia. Ill-defined low density changes are seen to the supratentorial white matter, consistent with chronic microvascular ischemic change. A poorly defined lesion in the left parieto-occipital lobe is diminished in density suggestive of a subacute to chronic infarct.

Impression: No evidence of acute intracranial abnormality. Chronic changes as per above with possible subacute to chronic left parieto-occipital infarct.

D/T: /
Date Dictated: 05/13/2012 08:25:19
Date Transcribed: 05/13/2012 08:24:08
Doc ID: 248216
Job ID: 342275

This document was electronically signed by Majid Majidian, M.D. on 05/13/2012 08:25:20.

** REPORT SIGNED IN OTHER VENDOR SYSTEM 05/13/2012 **
Reported By: MAJIDIAN, MAJID MD

CC: Freund,Edmund MD-Mills; Hendrickson,Timothy DO

Technologist: REYES LASHUNDA
Transcribed Date/Time: 05/13/2012 (0826)
Transcriptionist: EWS
Printed Date/Time: 06/26/2012 (0002)



Signed Report

Name: PARVIN,MARY JEAN
Phys: Hendrickson,Timothy DO
DOB: 03/16/1943 Age: 69 Sex: F
Acct No: V023586118 Loc: 377 A
Exam Date: 05/13/2012 Status: DIS IN
Radiology No: 00003311

Lodi
Memorial
Hospital

975 S. Fairmont Avenue • P.O. Box 3004 • Lodi, California 95241 • 209/334/3411 • www.lodihealth.org

May 15, 2012

To Whom It May Concern:

Mary Jean Parvin was admitted to Lodi Memorial Hospital on May 11, 2012 and remains hospitalized as of this date, May 15, 2012. Her release date has not been determined at the time of the writing of this letter. Currently, this patient lacks decision making capacity for finances and health care. At this point, I expect her condition to improve and suggest this patient be re-evaluated in 2 weeks.

Sincerely,

Dr. Kuljeet Multani, M.D.
Lodi Memorial Hospital
(209) 334-3411
License A96874.

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- **Comments:**

Delta MRSA 6-27-12 Released AMA

# NOTIFICATION OF TRANSFER/RELEASE – BED HOLD

**To Be Completed Upon Transfer or Discharge**
**(Place in Patient Chart)**

Date: _____

To: PARVIN, MARY (Resident Name) PARVIN, MARY (Representative)

Pay Status: ( ) Medi-Cal ( ) Private ( ) Other _____

Regulations require each skilled nursing facility:

- Provide a bed hold of up to seven (7) days when a resident is transferred to a hospital or therapeutic leave.
- Inform the resident upon admission and transfer
- The resident or the resident's representative must inform the facility within twenty-four (24) hours after notification if the resident desires to have the bed held.
- Non-Medi-Cal eligible residents are liable for the cost of the bed hold days, insurance may not cover cost

( ) Telephone notification ( ) In person notification

Notification was made on _____ regarding the transfer of the resident named above to

_____ on _____
(Name of Facility/Hospital) (Date)

Response of resident/representative (Please initial)

_____ Yes, I desire the bed to be held for up to 7 days, I understand if the leave exceeds the bed hold period the resident will be admitted immediately upon the first availability of a bed.

_____ No, I do not wish the bed to be held up to 7 days.

24 hour response due by _____, Date & time received _____

_____ _____
Resident/representative Date

_____ _____
Facility representative Date

Distribution: Original Business Office, Copy for Resident, Copy for Medical Records

# PERMISSION TO INFORM SELECTED PERSONS

I, PARVIN, MARY, am a resident of Delta Rehab and Care Center and I
(Print Resident Name)
am responsible for making my own medical decisions.

I, _____, _____, as responsible party
(Responsible Party) (Relationship)
for _____, am responsible for medical decisions.
(Print Resident Name)

I understand that information which concerns medical conditions cannot be shared with any other persons without my permission.

I wish to give consent to release requested medical information to:

_____ (relationship) _____

_____ (relationship) _____

_____ (relationship) _____

_____ (relationship) _____

_____ (relationship) _____

I understand that the persons I name will be informed of any changes in my care and medical condition.

_____ _____
(RESIDENT SIGNATURE) (DATE)

_____ _____
(RESPONSIBLE PARTY SIGNATURE) (DATE)

**By signing below, the Resident and the Facility agree to the terms of this Admission Agreement:**

Representative of the Facility — Date: 6.7.12

Resident — Date: 6.7.12

Resident's Representative – if applicable — Date

# Delta Rehab and Care Center
## Welcome Packet Checklist

**Patient Name:** PARVIN, MARY **Admit Date:** 5/22/12

**A. COMPLETE FOR ALL NEW ADMISSIONS:**

- ✓ 1. Resident Manual
  - ___ a. List of Department Heads…define their roles/responsibilities
  - ___ b. Advocacy Services
  - ___ c. Banking
  - ___ d. Clothing/Laundry
  - ___ e. Appliance Policy – to include cable/telephone/TV etc.
  - ___ f. Ancillary Services (Beauty salon, therapies, labs, etc)
  - ___ g. Food and Dietary
  - ___ h. Mail
  - ___ i. Nursing Services/Medications
  - ___ j. Personal Belongings
  - ___ k. Physician Services
  - ___ l. Activities/Religious Services
  - ___ m. Rehabilitation Services
  - ___ n. Smoking Policy
  - ___ o. Social Services
  - ___ p. Telephones/Televisions
  - ___ q. Transportation Services
  - ___ r. Visiting Hours
  - ___ s. Volunteers
  - ___ t. Personal Inventory Checklist
- ___ 2. Signature Authorization
- ___ 3. Notice Regarding Standards for Medi-Cal Eligibility (DHS 7077)
- ___ 4. Sample Bills – with explanation
- ___ 5. State Agencies Listing
- ___ 6. Service & Supply Rates
- ___ 7. "Your Right to Make Decisions About Medical Treatment" brochure
- ___ 8. Restraint Policy
- ___ 9. Elder Abuse Policy
- ___ 10. Privacy Act Statement

I acknowledge the receipt of the above information and have had the opportunity to ask questions to my satisfaction.

6.7.12 — Facility Representative — Date

Mary Jean Parvin 6.7.12 — Resident/Representative — Date

# CONFIDENTIAL APPLICATION - FINANCIAL PLANNING

Resident's Name PARVIN, MARY Facility: Delta Rehab and Care Center

1. Does the resident have a living spouse? X No _____ Yes Name: _____

2. Does the resident own a home and/or property? _____ No X Yes Identify address and equity:
_____
_____

3. Does the resident have a checking or savings account, CD's annuities, stocks, bonds or Life Insurance Policy with a cash value? Identify the Financial Institution and amount:

Name of financial institution BANK OF STKN
Type of Account _____
Account Number _____
Value of Account _____
Name(s) on Account PARVIN, MARY

Name of financial institution _____
Type of Account _____
Account Number _____
Value of Account _____
Name(s) on Account _____

4. Does the resident receive any monthly income? _____ No _____ Yes Total: $_____
Identify source and amount:
_____ $_____ _____ $_____
_____ $_____ _____ $_____

5. Does resident have skilled nursing insurance coverage? X No _____ Yes Policy #_____
Company name and address: _____
Phone: _____ Type of coverage: _____
The patient remains responsible for payment if the insurance does not pay within 45 days or denies the claim.

6. Does resident have Medicaid/Medi-Cal or SSI financial assistance? X No ___Yes $_____ Share of Cost
Medicaid/MediCal # _____ Certification date: _____ County: _____
Caseworker: _____ Phone # _____

7. Identify to whom private charges should be sent: PARVIN MARY
Address for monthly statement: 2 N. AVENUE AVE LODI CA 95240

8. Do you wish the facility to become Representative Payee for Social Security Funds? X No _____ Yes
(If yes, complete form SSA-11-BK, Request to be Selected as Payee – www.ssa.gov/online/ssa-1696.pdf)

I hereby state that to the best of my knowledge, the information on this form is true, accurate & complete. I understand that if any information has been falsely represented, it may be sufficient cause for denying admission or discharging the resident from the facility. I authorize the facility to verify the information on this form.

Mary Jean Parvin
Resident/Representative Signature

10.7.12
Date

PARVIN, MARY - SELF
Print Name and Identify Relationship to Resident

# Advocacy Groups

| | |
|---|---|
| Department of Public Health<br>District Office | 916-263-5800 |
| Ombudsman Local Offices | |
| Stanislaus County | 209 529-3784 |
| Butte County | 530 898-5923 |
| Sacramento County | 916 376-8910 |
| **San Joaquin County** | **209 468-3785** |
| Ombudsman State Crisis Line | 800 213-4024 |
| California Department of Insurance<br>Consumer Hot Line | 800 927-4357 |
| Medi-Cal Fraud Hot Line | 800 822-6222 |

# Supplies and Services Included in the Private Pay Daily Rate Charge

**Room Fees:**

| | |
|---|---|
| Private | $ N/A /day |
| Semi Private | $ 185.00 /day |
| 3 – Bedroom | $ 180.00 /day |
| 4 – Bedroom | $ 180.00 /day |

**SERVICES INCLUDED IN PRIVATE PAY RATE**

Daily room and board
Therapeutic Diets
Routine Nursing Care
Restorative Nursing Care
Daily Activities
Housekeeping Services
Bed Linens

**SERVICES NOT INCLUDED IN THE PRIVATE PAY RATE**

Pharmaceuticals
Nutritional Supplements
Equipment Rentals
Television Rentals
Disposable Diapers
Telephone
Co-payments not covered by third party insurance
Additional supplies and services listed below that are not covered by third party insurance.

**THERAPY SERVICES**
See Business Office Manger and/or therapist for specific treatment plan and corresponding charges

**RENTAL EQUIPMENT**

| | |
|---|---|
| _____ | $ _____ |
| _____ | $ _____ |
| _____ | $ _____ |

**MONTH RENTAL**

OXYGEN TANKS:

| | |
|---|---|
| E-TANKS | $ _____/tank |
| H-TANKS | $ _____/tank |
| CONCENTRATOR | $ _____/cents per hour |

**BEAUTICIAN SERVICES**

| | |
|---|---|
| HAIR CUT/SHAMPOO SET | $ 14.00/14.00 |
| PERMANENT | $ 45.00 |
| HAIR TINTING | $ 32.00 |
| MUSTACHE WAX | $ N/A |
| MANICURE | $ N/A |

# MEDICAL RECORD RELEASE

## INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION AND RELEASE OF MEDICAL RECORDS

PARVIN, MARY
NAME OF PATIENT

3/16/1943
DATE OF BIRTH

Permission is hereby given to _____ to disclose information for professional use only; including psychiatric, psychological, drug and alcohol disorders and treatment of, contained in the medical record to:

Delta Rehab and Care Center (Facility Name)
Attention: Medical Records Department
1334 S. Ham Lane (Facility Address)
Lodi, CA 95242

Information released may not be re-disclosed without further authorization by the patient representative.

This authorization shall be terminated sixty (60) days from the date of signature or upon completion of treatment, whichever is later, and may be revoked by the patient/representative at any time. Revocation has no effect on action previously taken.

Specific dates of treatment for which information is requested:

Date of Admission: 5/22/12 Date of Discharge: _____

Specific types of information requested:

| | | | |
|---|---|---|---|
| (X) | History & Physical | (X) | Laboratory Results |
| (X) | Transfer Form | (X) | X-Ray Reports |
| (X) | Physician Progress Notes | (X) | MRI Films, CT Scans |
| (X) | Discharge Summary | (X) | Medication Administration Reports |
| (X) | Other: _____ | | |

Form in which information is to be released:

(X) Written (X) Audio

MaryJean Parvin
SIGNATURE OF RESIDENT/REPRESENTATIVE

6.7.12
DATE

SIGNATURE OF FACILITY REPRESENTATIVE

6.7.12
DATE

# LONG TERM CARE FACILITY INFORMATION SHEET FOR PUBLIC ASSISTANCE OR MEDI-CAL RECIPIENTS

The long term care (LTC) facility to which you are being admitted must comply with various federal and state regulations in order for its services to be paid for by the Medi-Cal program. Please cooperate with the LTC facility in completing any federal and state forms that must be prepared. The information you provide on these forms will assist in ensuring that you receive all of the benefits to which you are entitled without any undue delays. The Medi-Cal Long Term Care Facility Admission and Discharge Notification Form (MC 171) which you have just been asked to complete is such a form.

California Administrative Code, Title 22, Section 50185, says that as a Medi-Cal recipient you must report any changes in circumstances that might affect your eligibility for Medi-Cal no later than 10 calendar days following the date of the change. To assist you in reporting this type of change in your circumstances, the LTC facility will send the MC 171 to the appropriate Social Security Office and the county welfare department on your behalf. You are still responsible for ensuring that the proper action is taken in regard to your eligibility for Medi-Cal benefits, and therefore, if you do not hear from either SSA or the county within 45 days, please contact them immediately.

Depending on your individual situation, you may have to pay or obligate to pay a portion of your medical costs before Medi-Cal can pay for the rest of your care. This obligation is referred to as the recipient's share of cost. A worker form the county welfare department will determine whether you have a share of cost and the amount of any obligation now that you have entered an LTC facility. Persons in LTC facilities who have a share of cost pay or obligate the share of cost directly to the facility.

You have the right to a fair hearing if you are dissatisfied with any action taken by the county welfare department or the State Department of Health Services. If you wish to ask for a fair hearing, you must do so within 90 days after the date the notice of action was sent by the county or the date of the action with which you are dissatisfied.

To request a fair hearing, write to the Office of Chief Referee, Department of Social Services, 744 P Street, Sacramento, CA 95814. You may also request a fair hearing by calling Toll Free 1-800-952-5253.

# ASSIGNMENT OF BENEFITS

Resident Name: PARVIN, MARY  Date of Birth 3/16/1943
Facility Name: Delta Rehab and Care Center  Facility ID #
Address: 1334 S. Ham Lane, Lodi, CA 95242
Phone: 209-334-3825  Fax: 209-368-7714

**MEDICARE, MEDICAID and/or INSURANCE DATA**

Medicare #: 5666627161A  Date of Birth: 3/16/1943
MediCal #: N/A  Expiration Date:
Insurance Company: MUTUAL OF OMAHA
Policy ID/Group #: 351655 99  Expiration Date:
Insurance Address:
City:  State:  Zip Code:
Phone #:  Fax #:
(Make sure copies of all insurance cards are forwarded to the pharmacy and medical supplier)

**ASSIGNMENT(S)**

✓ **FACILITY**: **The facility** (identified above) **may bill** Medicare Part A or B and/or the Insurance company (identified above), as appropriate for services provided.

✓ **PHARMACY**: I choose to use CONSONUS for all pharmaceuticals, medications, back up medical supplies and/or equipment and **authorize billing** to the agent(s) (identified above), as appropriate for services provided. I understand that I will be billed by Facility and expected to pay for any expenses that are not covered by my insurance.

____ **SUPPLY**: I choose to use _____, located at _____ as the supplier for my Part B medical supplies, that may include wound care, urological, ostomy, tracheostomy, or enteral supplies and **authorize billing** to Medicare Part B and/or the Insurance company (identified above), as appropriate for services provided.

**I certify** that the information provided in applying for benefits under Title XVIII of the Social Security Act is correct and hereby **request** that payment of authorized Medicare and/or other Insurance benefits be made on my behalf to the Facility named above as appropriate, for authorized services furnished to me. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Finance Administration) and its agents any data needed to determine these benefits or the benefits payable for the related services.

Mary Jean Parvin  6-7-12
Resident Signature (or authorized Representative)  Date

SELF  —
Relationship to Resident  Reason Resident cannot Sign

[signature]  6-7-12
Witness Signature  Date

PARVIN, MARY

State of California—Health and Human Services Agency

Department of Health Care Services

# NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY

If you or your spouse is in or is entering a nursing facility, read this important message!

You or your spouse do not have to use all your resources such as savings, before Medi-Cal might help pay for all or some of the costs of a nursing facility.

You should be aware of the following to take advantage of these provisions of the law:

## Unmarried Resident

An unmarried resident is financially eligible for Medi-Cal benefits if he or she has less than $2,000 in available resources. A home is an exempt resource and is not considered against the resource limit, as long as the resident states on the Medi-Cal application that he or she intends to return home. Clothes, household furnishings, irrevocable burial plans, burial plots, and an automobile are examples of other exempt resources.

If an unmarried resident is financially eligible for Medi-Cal reimbursement, he or she is allowed to keep from his or her monthly income a personal allowance of $35 plus the amount of health insurance premiums paid monthly. The remainder of the monthly income is paid to the nursing facility as a monthly deductible called the "Medi-Cal share-of-cost."

## Married Resident

If one spouse lives in a nursing facility, and the other spouse does not live in a nursing facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $109,560 in available assets. The couple's home will not be counted against this $109,560 as long as one spouse or a dependent relative, or both, lives in the home, or the spouse in the nursing facility states on the Medi-Cal application that he or she intends to return to the couple's home to live.

If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or $2,739, whichever is greater. Of the couple's remaining monthly income, the spouse in the nursing facility is allowed to keep a personal allowance of $35 plus the amount of health insurance premiums paid monthly. The remaining money, if any, generally must be paid to the nursing facility as the Medi-Cal share-of-cost. The Medi-Cal program will pay remaining nursing facility costs.

Under certain circumstances an at-home spouse can obtain an order from an administrative law judge that will allow the at-home spouse to retain additional resources or income. Such an order can allow the couple to retain more than $109,560 in available resources if the income that could be generated by the retained resources would not cause the total monthly income available to the at-home spouse to exceed $2,739. Such an order also can allow the at-home spouse to retain more than $2,739 in monthly income, if the extra income is necessary "due to exceptional circumstances resulting in significant financial duress."

An at-home spouse also may obtain a court order to increase the amount of income and resources that he or she is allowed to retain, or to transfer property from the spouse in the nursing facility to the at-home spouse. You should contact a knowledgeable attorney for further information regarding court orders.

The paragraphs above do not apply if both spouses live in a nursing facility and neither previously has been granted Medi-Cal eligibility. In this situation, the spouses may be able to hasten Medi-Cal eligibility by entering into an agreement that divides their community property. The advice of a knowledgeable attorney should be obtained prior to the signing of this type of agreement.

Note: For married couples, the resource limit ($109,560 in 2010) and income limit ($2,739 in 2010) generally increase a slight amount on January 1 of every year.

## Transfer of Home for Both a Married and an Unmarried Resident

A transfer of a property interest in a resident's home will not cause ineligibility for Medi-Cal reimbursement if either of the following conditions is met:

(a) At the time of transfer, the recipient of the property interest states in writing that the resident would have been allowed to return to the home at the time of the transfer, if the resident's medical condition allowed him or her to leave the nursing facility. This provision shall only apply if the home has been considered an exempt resource because of the resident's intent to return home.

(b) The home is transferred to one of the following individuals:

(1) The resident's spouse.

(2) The resident's minor or disabled child.

(3) A sibling of the resident who has an equity interest in the home, and who resided in the resident's home for at least one year immediately before the resident began living in institutions.

(4) A son or daughter of the resident who resided in the resident's home at least two years before the resident began living in institutions, and who provided care to the resident that permitted the resident to remain at home longer.

This is only a brief description of the Medi-Cal eligibility rules, for more detailed information, you should call your county welfare department. You will probably want to consult with the local branch of the state long-term care ombudsman, an attorney, or a legal services program for seniors in your area.

I have read the above notice and have received a copy.

Mary Jean Parvin 6.7.12

Signature of person being admitted — Date

Signature of spouse — Date

6.7.12

Signature of legal representative — Date

# MEDICARE / MEDI-CAL / SOCIAL SECURITY FORMS and WEBSITES

## WELCOME PACKET

DHCS 7077 (1/10) – Notice Regarding Standards for Medi-Cal Eligibility
www.dhcs.ca.gov/formsandpubs/forms/Forms/dhca7077.pdf

## ADMISSIONS PACKET

SSA-11-K (8/09) – Request to be Selected as Payee
www.ssa.gov/online/ssa-11.pdf

CMS-10055 – Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)
www.cms.gov/BNI/Downloads/cms10055.pdf

SSA-1696-U4 (6/09) – Appointment of Representative
www.ssa.gov/online/ssa1696.pdf

POLST – Physician Orders for Life-Sustaining Treatment
www.finalchoices.org/_pkf/CA-POLST-form-web.pdf

MC 171 (5/07) – Medi-Cal LTC Facility Admission and Discharge Notification
www.dhcs.ca.gov/formsandpubs/forms/Forms/MC%20171.pdf

MC 007 – Medical-Cal General Property Limitations – Information Notice
www.dhcs.ca.gov/formsandpubs/forms/Forms/mc007infonotice.pdf

## FORMS NEEDED TO APPLY FOR MEDI-CAL

DHCS 7077 (1/10) Notice Regarding Standards for Medi-Cal Eligibility
MC 210 (02/10) Medi-Cal Mail-In Application
MC 210 PA (5/07) Property Assessment Statement of Facts
MC 210 PS (5/07) Property Supplement
MC 262 (6/07) Redetermination for Medi-Cal Beneficiaries (Long Term Care in Own MFBU)
MC 306 (6/07) Appointment of Representative

http://www.dhcs.ca.gov/formsandpubs/forms/Pages/MCEBbyNumber.aspx

## SOCIAL SECURITY / MEDICARE WEBSITES FOR FORMS

www.ssa.gov or http://www.socialsecurity.gov/pubs/index.html

# DELTA REHAB AND CARE CENTER
## Admission Packet Checklist

**Patient Name:** PARVIN, MARY **Admit Date:** 5/22/12

**IDENTIFY FINANCE CLASS:**

**PRIMARY:** X Medicare A ____ Private ____ Medi-Cal ____ Other ____

**SECONDARY:** ____ Private ____ Medi-Cal X Other MUTUAL OF OMAHA

Identify if patient has a private insurance which will cover all or part of charges, including coinsurance, and identify if facility will bill the insurance for the patient.

**Other third party:** ____

| Business Office Audit | Admission Audit | |
|---|---|---|
| | | **A. COMPLETE FOR ALL ADMISSIONS:** |
| __ 1. | __1. | Admission Agreement (58 pages) (See Page 58 for Checklist) |
| __ 2. | __2. | Face Sheet (Point Click Care) |
| __ 3. | __3. | Medicare Secondary Payor Questionnaire |
| __ 4. | __4. | Financial Planning |
| __ 5. | __5. | Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) (CMS-10055) |
| __ 6. | __6. | Appointment of Representative (SSA-1696-U4) |
| __ 7. | __7. | Assignment of Benefits |
| __ 8. | __8. | Medical Records Release (fax to hospital) - *Route to Medical Records Dept.* |
| __ 9. | __9. | Advance Directives – POLST (*Place in Patient Chart)* |
| __ 10. | __10. | Ancillary Agreements |
| | | ____a. Pharmacy ____c. Podiatry |
| | | ____b. Optometry ____c. Dental |
| __ 11. | __11. | Prior Stay Worksheet – *Route to DNS and Medical Records* |
| __ 12. | __12. | Insurance Verification/Authorization Form |
| __ 13. | __13. | Medi-Cal Pending Eligibility Log – *Business Office route to Social Service* |
| __ 14. | __14. | LTC Facility Information Sheet for Public Assistance (MC 171) |
| __ 15. | __15. | Bed Hold Acknowledgment |
| __ 16. | __16. | Notification of Transfer/Release – Bed Hold (Complete upon Transfer/Discharge) |
| __ 17. | __17. | Informed Consent Policy (Psychotherapeutic Meds) |
| __ 18. | __18. | Permission to Inform Select Persons |
| __ 19. | __19. | Medi-Cal General Property Limitations (MC 007) |

Photocopy the following items:

| | | |
|---|---|---|
| __ 1. | __1. | Medicare Card – specify coverage available: ___Part A ___Part B<br>If card is not available, document verification of coverage with Social Security; copy of Common Working File |
| __ 2. | __2. | Medi-Cal Card |
| __ 3. | __3. | Proof of legal representation (___conservator, ___legal guardian, ___Power of Attorney (POA), ___ Durable Power of Attorney (DPOA) |
| __ 4. | __4. | Private Insurance Cards (document what coverage is available) |
| __ 5. | __5. | Transfer Sheet (from hospital and/or prior facility) |

**B. ADDITIONAL NEEDED FOR MEDI-CAL ADMISSIONS**

| | | |
|---|---|---|
| __ | 1. | 1. Passar form completed (State Specific Form - dated & signed by nursing) |
| __ | 2. | 2. Obtain Medi-Cal BIC card |
| __ | 3. | 3. Medi-Cal Treatment Authorization Request |
| __ | 4. | 4. Admit/Discharge Notice – *Copy sent to Social Security Administration* |

**C. ADDITIONAL NEEDED FOR INSURANCE/VA/OTHER ADMISSIONS**

| | | |
|---|---|---|
| __ | 1. | Managed Care Authorization (Form and/or Number) |
| __ | 2. | Subsequent Level of Care Authorization |

6.7.12 — Facility Representative — Date

Mary Jean Parvin — 6.7.12 — Resident/Representative — Date

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

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

___ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

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Has the resident been in a Skilled Nursing Facility within the last 60 days? Has the resident used any Skilled Nursing Medicare Days within the last 60 days? If Yes, please list: Name of Facility, Address and dates of service.

LMH — 5/11/12 TO 5/22/12

Name of Qualifying Acute Hospital — Dates of Stay

Skilled Nursing Facility — Dates of Stay — # Medicare Days Used

Other Hospitalization Stays

Number of Medicare Days Available during this stay: _____ Full _____Co-Insurance

**FAILURE TO OBTAIN THE INFORMATION LISTED IN THESE SECTIONS IS A VIOLATION OF YOUR PROVIDER AGREEMENT WITH MEDICARE. (SEE SECTION 142.3F.) THE INFORMATION YOU MUST OBTAIN IS ESSENTIAL TO FILING A PROPER CLAIM WITH MEDICARE OR A PRIMARY PAYER. FAILURE TO FILE A PROPER CLAIM CAN RESULT IN THE UNNECESSARY DENIAL OR DEVELOPMENT OF CLAIMS.**

Mary Jean Parvin — 6.7.12

Signature of Resident/Representative — Date

HIC# (Medicare #): 516616271 61A

Resident Name: PARVIN, MARY

Facility Representative: A. WALKER

PARVIN, MARY

# Delta Rehabilitation & Care Center

## Summary Signatures

I have been given and understand the following:

1. Welcome Packet, Resident Orientation and Consent for Care.
2. Resident Statutory and Regulatory Bill of Rights.
3. Bed Hold Notification.
4. Involuntary Transfer.
5. Advance Directives and Right to Make Medical Decisions.

Date: 5-23-12

Resident/Legal Representative/Agent: Mary Jean Parvin

Facility Representative:

(See Business Office files for completed Admission Agreement)

# Resident Transportation For Outside Appointments

Upon admission to Delta Rehabilitation And Care Center it is the responsibility of families and responsible parties to ensure that each resident is accompanied to outside appointments. We can make arrangements for the transportation but families must meet patients at the drop off sight of Dial a Ride or ambulance.

Date 6.7.12

Resident Name PARVIN, MARY

Responsible Party Name PARVIN, MARY

Responsible Party Mary Jean Parvin

# CONSENT TO TREATMENT

The Parties to this Agreement are:

Resident: PARVIN, MARY

Resident's Respresentative: PARVIN, MARY

Relationship: SELF

DELTA REHABILITATION & CARE CENTER
1334 South Ham Lane
Lodi, CA 95242

III. **CONSENT TO TREATMENT**

The Resident hereby consents to routine nursing care provided by this Facility, as well as emergency care that may be required.

However, you have the right to the extent permitted by law, to refuse any treatment and the right to be informed of potential medical consequences should you refuse treatment. We will keep you informed about the routine nursing and emergency care we provide to you, and we will answer your questions about the care and services we provide you.

If you are, or become, incapable of making your own medical decisions, we will follow the direction of a person with legal authority to make medical treatment decisions on your behalf, such as a guardian, conservator, next of kin, or a person designated in an Advance Health Care Directive of Power of Attorney for Health Care.

Following admission, we encourage you to provide us with an Advance Health Care Directive specifying your wishes as to the care and services you want to receive in certain circumstances. However, you are not required to prepare one, or to provide us a copy of one, as a condition of admission to our Facility. If you already have an Advance Health Care Directive, it is important that you provide us with a copy so that we may inform our staff.

If you do not know how to prepare an Advance Directive and wish to prepare one, we will help you find someone to assist you in doing so.

X Mary Jean Parvin SELF
Resident/Responsible Party Signature Relationship

6.7.12
Date

X
Admission Coordinator Signature

6.7.12
Date

X
Facility Witness (If applicable) Title

Date

# ADMISSION BEDHOLD ACKNOWLEDGEMENT

DATE: 6.7.12

TO: PARVIN, MARY — PARVIN, MARY
Name of Resident — Resident's Representative

PAY STATUS: MCARE

Current regulations require:

That each long term care facility:

1. Provide a bed-hold of up to seven (7) days when a resident is transferred to an acute hospital
2. Permit a resident to be readmitted if stay exceeds the 7 day bed hold period and needs can be met by facility with first available bed.
3. Inform resident upon admission and upon transfer.
4. The resident or resident's representative must inform the facility within 24 hours after the notification if the resident desires to have the bed held.

On Admission (Please initial)

X I hereby acknowledge that I am aware of the 7 day bed hold provision

____ Please hold bed vacant on any occasion during which the above named resident is transferred to an acute hospital and is expected to return in 7 days.

____ In event I cannot be reached at the time of patient transfer, I want to have the bed held 7 days.

____ Yes
____ No

____ In event bed hold leave exceeds 7 day period, place resident on waiting list for next available bed.

** Non Medi-Cal eligible resident are liable for the cost of the bed-hold days – insurance may not cover bed hold costs.*

MaryJean Parvin — 6.7.12
Resident Representative — Date

[signature] — 6.7.12
Facility Representative — Date

Distribution: Original Business Office, Copy for Resident, Copy for Medical Records

State of California—Health and Human Services Agency

Department of Health Care Services

# MEDI-CAL LONG-TERM CARE FACILITY ADMISSION AND DISCHARGE NOTIFICATION

***(Instructions and distribution on reverse.)***

## I. COMPLETE THIS PORTION FOR ALL ACTIONS

| Patient's name (last) | (first) | (MI) | Name of facility |
|---|---|---|---|
| PARVIN | MARY | J. | DELTA REHAB |
| Social security number | | | Address (number and street) |
| 546 62 7161 | | | 1334 S HAM LN |
| Note: Level of care is SNF/ICF unless checked here as board and care. ☐ | | | City: LODI State: CA ZIP code: 95242 |

## II. COMPLETE THIS PORTION ONLY FOR ADMISSIONS

| Medi-Cal ID number (taken from the Medi-Cal card) | Admission date (month/day/year) |
|---|---|
| N/A | 5/22/12 |

A. Do you have Medicare Part A, Hospital Coverage?

☒ Yes ☐ No

B. Expected length of stay:

☐ At least one full month after the month of admission

☒ Less than one full month after the month of admission

C. Medi-Cal is expected to pay over 50% of facility cost of care.

☐ Yes, beginning with month of _____, 20__

☒ No, other insurance, private pay, etc.

D. Current income (check all applicable boxes):

☐ Supplemental Security Gold Checks

☒ Social Security Green Checks

☐ Other Income (i.e., railroad, military retirement, etc.)

☐ None

E. Admission from:

☐ Home ☐ Board and Care

☐ Household of another

☒ Acute Hospital—Home, B&C, other household immediately prior to acute

☐ Acute Hospital—SNF/ICF immediately prior to acute

☐ Acute Hospital extended stay—over 30 days

☐ Another SNF/ICF

F. If known, enter your address prior to facility admission. If admitted from an acute hospital, enter your address prior to the acute hospital admission. (Do not give the acute hospital's address.)

Address (number and street): 2 N. ALVINA AVE

City: LODI State: CA ZIP code: 95240

G. Signature of recipient or representative payee or family member/other:

| Signature of recipient | Signature of Representative Payee | Phone number |
|---|---|---|
| Mary Jean Parvin | | |

If recipient's signature cannot be obtained, please indicate reason in this space.

| Signature of family member/other (Indicate your relationship to the recipient.) | Phone number |
|---|---|
| | |

## III. COMPLETE THIS PORTION ONLY FOR DISCHARGES

A. Reason for discharge:

☐ Discharged to Acute Hospital

☐ Discharged to another SNF/ICF

☐ Discharged to residence/home of another

☐ Discharged to Board and Care

☐ Discharged to other

☐ Discharge due to death

B. Date of discharge (month/day/year)

C. Medi-Cal ID number (taken from the Medi-Cal card)

D. Complete the forwarding address for discharges other than death:

Name of facility (if not discharged home)

Address (number and street)

City State ZIP code

| Facility representative signature | Date |
|---|---|
| | |

MC 171 (05/07)