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 ($113,640 in 2012) and income limit ($2,841 in 2012) 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.

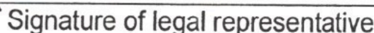
   (4) A son or daughter of the resident who resided in the resident's home at least two years before the resident began living in institutions, and who provided care to the resident that permitted the resident to remain at home longer.

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.

____________________________ Signature of person being admitted   ____________ Date

____________________________ Signature of spouse   ____________ Date



Signature of legal representative   7-13-14 Date

NOTICE REGARDING MEDI-CAL APPLICATION AND SHARE OF COST REQUIREMENTS

For Medi-Cal Beneficiaries and the Individuals Who Handle Their Money.
Regarding the Amount of Income Determined by the California Medi-Cal Program to be the Resident's "Share of Cost" that Must Be Paid to This Facility and the Resident's Right to Appeal Medi-Cal's Share of Cost Determination.

The payment of the Resident's Share of Cost as determined by the California Medi-Cal Program is required by law.

The amount of the Share of Cost that must be paid to this Facility is determined by the California Medi-Cal program through the Department of Social Services. This amount is not something that the Facility decides or controls.

If you believe that the Share of Cost assigned to the Resident by Medi-Cal is not correct, you may apply for a state hearing (through the Medi Cal office that is handling the Resident's case) for a determination as to the accuracy of the amount of the Resident's Share of Cost.

The assigned Share of Cost must be paid to this Facility unless there is a final determination by Medi-Cal following an appeal that the Resident's Share of Cost amount is incorrect.

The telephone number and address of the Medi-Cal field office closest to this Facility is:
Address: 333 E. WASHINGTON STREET, STOCKTON, CA 95202 Phone: (209) 468-1000

If you have any questions regarding this notice or the legal responsibility to pay the Resident's Share of Cost, please contact ARBOR NURSING CENTER BUSINESS OFFICE as soon as possible.

If the Resident has converted from a non Medi-Cal payment category to the Medi-Cal payment category, and you are unsure of the amount of the Resident's Share of Cost that must be paid to the Facility, you may obtain an estimate of the amount by contacting the local Medi-Cal office for this information regarding the amount of the Resident's Share of Cost.

If, for any reason, the Resident becomes ineligible for Medi-Cal benefits, the Resident will be responsible for paying the private rates for care at this Facility unless the Resident qualifies for payment by another third-party payer category.

Resident: PARVIN, MARY Signature: ______ Date: ______

Resident Representative: ANDERSON, TIFFANY Signature: Date: 7-13-14

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)
PARVIN, MARY

Social security number
566-62-7161

Note: Level of care is SNF/ICF unless checked here as board and care. ☐

Name of facility
ARBOR NURSING CENTER

Address (number and street)
900 NORTH CHURCH STREET

City State ZIP code
LODI, CA 95240

II. COMPLETE THIS PORTION ONLY FOR ADMISSIONS

Medi-Cal ID number (taken from the Medi-Cal card)
N

Admission date (month/day/year)
7/10/14

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)
17 LOUIE AVE

City State ZIP code
LODI, CA 95240

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

Signature of recipient	Signature of Representative Payee	Phone number

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
[signature]	

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
☐ Discharged 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 discharge other than death:

Name of facility (if not discharged home)

Address (number and street)

City State ZIP code

Facility representative signature	Date

PHARMACY SERVICES

You have the option to choose your own pharmacy.

☑ I choose to use the pharmacy selected by the Facility

1. **Will pay for all medications and medical supplies**
   Consent is given to the Facility to order from a pharmacy of its choice, all medications and medical supplies, prescribed by the Resident's attending physician, including those not covered by the Medi-Cal program, an HMO and/or other third-party payer. If the Resident is a Medi-Cal beneficiary, this consent includes all medications and medical supplies not covered by Medi-Cal and the Facility is authorized to deduct the cost of eligible medications from the Resident's Share of Cost. The Resident/Representative shall pay the pharmacy directly for all medications and medical supplies furnished to the Resident.

   ☑ **Accepted** ☐ **Denied**

2. **Will pay for no medications or medical supplies**
   The Facility **shall not** order any medications or medical supplies prescribed by the Resident's attending physician that are not covered by the Medi-Cal program, an HMO and/or other third-party payer. The Resident/Representative releases the Facility from any and all liability for outcomes that may result if the Resident is not provided such medications or medical supplies as ordered by the Resident's physician.

   ☐ **Accepted** ☐ **Denied**

3. **Will pay for emergency only medications or medical supplies**
   The Facility shall order from a pharmacy of its choice only those medications and medical supplies that are prescribed by the Resident's attending physician in an emergency, including those not covered by the Medi-Cal program, an HMO and/or other third-party payer. The Resident/Representative shall pay the pharmacy directly for all medications and medical supplies furnished by the Resident. The Resident/Representative releases the Facility from any and all liability for outcomes that may result if the Resident is not provided such medications or medical supplies as ordered by the Resident's physician.

   ☐ **Accepted** ☐ **Denied**

☐ **I do not** choose to use the pharmacy selected by the Facility

I will promptly arrange for delivery of all medications and supplies ordered by the physician providing services to the Resident to the Facility in accordance with the provisions of paragraph VI A.

By signing here, the Resident/Representative acknowledges that medications and medical supplies shall be ordered for the Resident in accordance with the instructions above.

Resident: PARVIN, MARY Signature: ____________ Date: ________

Resident Representative: ANDERSON, TIFFANY Signature: ____________ Date: 7-13-14

Patient Admission Record and Agreement

Facility Name: ARBOR NURSING CENT Admission Date: 7/10/14 Pharmacy Name: OMNI

Room#: SOU

PATIENT INFORMATION

Resident Name: PARVIN, MARY

Medicare (HICN) #: 566627161A Date of Birth: 03/16/1943 Sex: ☐ M ☐ F

Physician's Name: FREUND, EDMUND Phone Number : (209) 334-8540

Patient is solely responsible for the financial and legal authorizations: ☐ **YES** ☑ **NO**
If NO, please list the Legal Representative below:

Address: City: State: Zip:

A Legal Representative is a person who has been granted the authority in writing by either the Patient or a court of law to make medical and/or financial decisions on behalf of the Patient.

PRIMARY CONTACT and FINANCIALLY RESPONSIBLE PARTY INFORMATION

Name: ANDERSON, TIFFANY Relationship to Patient: COUSIN

Address: RP ADDRESS City: State: Zip:

Phone Number : ~~209-747-9005~~ 209-625-8587

Primary Contact is also Financially Responsible Party ☑ **YES** ☐ **NO**
If NO, please list Financially Responsible Party below:

Address: City: State: Zip:

Phone Number :

A Financially Responsible Party is a person, other than the Patient, who agrees to be responsible for payment.

PAYMENT SOURCE FOR PHARMACY PRODUCTS AND SERVICES

To assist in billing for medications and services provided to the patient while at this facility, please check all pay sources that apply:

☑ MEDICARE-A ☐ MEDICARE-B (medications only) ☐ MEDICARE-D ☐ SELF ☐ MEDICAID

☑ INSURANCE ☑ MEDICARE ADVANTAGE ☐ HOSPICE ☐ VETERAN or ☐ OTHER

(Please describe "other" and provide pharmacy with copies (FRONT and BACK) of ALL Drug Coverage cards.)

Authorization for Invoice Payments by the following methods:

☐ Credit Card: Visa/MC/Discover/Amex# ____________________

Exp. Date (mm/yyyy) ____________ Security Code ________

☐ Bank Account Transfer: Name of Bank ____________________ Acct# ____________

Routing Number ____________________ City ____________ State _____ Zip ________

By signing below, the Patient or their Legal Representative and the Financially Responsible Party acknowledge and agree to each of the terms described on the next page.

Patient/Legal Representative Name (Please Print)	ANDERSON, TIFFANY	Signature	[signature]	Date	7-13-14
Financially Responsible Party Name (Please Print)	ANDERSON, TIFFANY	Signature	[signature]	Date	7-13-14

NOTE: If patient **has personally signed,** it is not necessary to complete the information below. If the patient is **unable to sign,** an authorized Representative may sign on his/her behalf, but must complete all information, including the patient's medical reason for an inability to sign. Medical Reason for Patient's Inability to Sign ____________________

____________________ ____________________ ____________________

Authorized Representative's Relationship to Patient Street Address City, State and Zip Code

Patient Name: PARVIN, MARY **Facility Name:** ARBOR NURSING CENTER

Terms of Patient Admission Record and Agreement

1. **Authorizations:** Omnicare, Inc. and its subsidiaries ("Omnicare") are authorized to provide the Patient all products and services prescribed or ordered by the Patient's Physician or by the facility. The Patient requests the products provided by Omnicare be dispensed in containers that are not child resistant. The Patient requests that the facility and/or Omnicare dispose of or otherwise process, all unused and/or discontinued medications dispensed to the patient, according to facility and pharmacy policy as allowed by professional standards and regulations.
2. **Legal Representative:** Legal Representatives will provide Omnicare with documentation establishing their legal authority.
3. **Assignment of Benefits:** The Patient or Legal Representative hereby requests and authorizes any third-party payer to make payment directly to Omnicare for products and services provided to the Patient.
4. **Payment:** The Patient and Financially Responsible Party are responsible for paying all charges for products and services provided to the Patient by Omnicare. As a courtesy, Omnicare will submit claims to any insurance companies or other third-party payers listed above or of which Omnicare is subsequently notified in writing; however, the Patient and Financially Responsible Party are ultimately responsible for paying any charges not covered by insurance or another third party payer. Payment in full is due within 30 days of the invoice date, and a finance charge equal to the lesser of 1.5 % per month or the maximum rate permitted by law will accrue on all delinquent accounts beginning on the day after the payment is due. The Patient or their Legal Representative and/or Financially Responsible Party hereby authorize Omnicare to charge any credit card or bank account number identified above for any amounts owed.
5. **Fees and Expenses:** The Patient and Financially Responsible Party are responsible for paying all costs and expenses incurred by Omnicare in the collection of amounts owed and the enforcement of its rights under this agreement, including without limitation, attorneys fees, court costs and expenses.
6. **Assurance of Payment Termination at Services:** The Patient or Legal Representative and Financially Responsible Party acknowledge that if the Patient and Financially Responsible Party are delinquent on payment of any amount owed to Omnicare, Omnicare may, in its sole discretion, do either or both of the following: (a) condition its continued provision of products and services to the Patient upon Omnicare's receipt of assurance of payment acceptable to Omnicare, which may include, without limitation, a requirement that Omnicare receive authorization to charge all amounts owed, past and future, to a valid credit card number; and/or (b) suspend or terminate its provision of products and services to the Patient. Such suspension or termination will in no way affect the Patient's or Financially Responsible Party's obligations to pay all amounts owed under this agreement, including costs of collection.
7. **Reliance and Consideration:** Omnicare is relying upon the Financially Responsible Party's agreements herein in determining to provide products and services to the Patient, and Omnicare's provision of products and services to the Patient constitutes good and adequate consideration for Financially Responsible Party's agreements contained in this agreement.
8. **Disclosure or Use of Patient Information for Treatment, Payment, and Healthcare Operations:** The Patient or Legal Representative hereby authorizes Omnicare, its employees, agents, and sub-contractors to disclose to Medicare, Medicaid or any other third party payer any medical or other information needed for payment for all products and services provided by Omnicare to the Patient until payment has been made in full. The Patient or Legal Representative further authorizes Omnicare, its employees, agents and sub-contractors to use and disclose the Patient's medical and other information for the provision of products and services, for the business operations of Omnicare and for the review of Omnicare's services, including review by accrediting bodies or government agencies.
9. **Modification:** No modification or amendment of this agreement shall be effective unless agreed to in writing by Omnicare.

ARBOR NURSING CENTER

ADMISSION AND DISCHARGE SUMMARY

RESIDENT

RESIDENT NAME: PARVIN, MARY | SEX: F | STATION/ROOMBED: SOUTH 11A | MED REC NO.: | ORIGINAL ADMIT DATE: 6/29/13 | CURRENT ADMIT DATE: 7/10/14 | DISCHARGE:

NICKNAME: | DATE OF BIRTH: 03/16/1943 | AGE: 71 | MARITAL STATUS: W | SSN: 566-62-7161 | PAY TYPE: CARE | LEVEL OF CARE: SNF | PLACE OF BIRTH: | CITIZEN: US | RACE/ NATIONALITY: WHITE | RELIIGION:

MEDICAID/MEDI-CAL NO: N | COUNTY: | MEDICARE NO.: 566627161A | BC/BS: | VA: | INS.: OMAHA-33165599 | INS.:

SPOUSE: | ADDRESS: | CITY: | STATE: | ZIP: | PHONE: W H 625-8587

RESPONSIBLE PARTY (RELATION): ANDERSON, TIFFANY COUSIN | ADDRESS: 2 N. Avena Ave | CITY: Lodi | STATE: CA | ZIP: 95240 | PHONE: W H ~~(209) [illegible]~~

EMERGENCY CONTACT (RELATION): Kellee Cooper | ADDRESS: 2 N Avena Ave | CITY: Lodi | STATE: | ZIP: | PHONE: W H 707-718-6253

EMERGENCY CONTACT (RELATION): Barbara Ambern | ADDRESS: Rio Vista | CITY: | STATE: | ZIP: | PHONE: W H 707-410-8666

CLINICAL

PHYSICIAN: FREUND, EDMUND | ADDRESS: 1901 W. KETTLEMAN LN. #200 | CITY: LODI | STATE: CA | ZIP: 95240 | PHONE: (209) 334-8540

ALTERNATE PHYSICIAN: | ADDRESS: | CITY: | STATE: | ZIP: | PHONE:

DENTIST: | ADDRESS: | CITY: | STATE: | ZIP: | PHONE:

PHARMACY: OMNI | PHONE: | ALLERGIES: | REHAB POTENTIAL: | PROGNOSIS:

FUNERAL HOME / MORTUARY: | PHONE: | ADMITTED FROM: LODI MEMORIAL | PHONE: | HOW TRANSFERRED: AMBULANCE | DATES OF STAY: 6/28/14 to 7/10/14

DIAGNOSES

ADMITTING DIAGNOSES (PRIMARY AND SECONDARY)
PRIMARY:

AMS
HYPERAMMONEMIA
CHF

CODE STATUS: | RESIDENT IS AWARE OF PRIMARY DIAGNOSIS: | REASONS:

PERSONAL

HOSPITAL PREFERENCE: | PHONE: | AMBULANCE PREFERENCE: | PHONE:

NAME OF CHURCH: | PHONE: | CLERGY: | PHONE:

POWER OF ATTORNEY: | PHONE: | EDUCATION LEVEL: | PRIMARY LANGUAGE:

PREVIOUS OCCUPATION: | INDUSTRY: | NURSING ALERT:

PREVIOUS ADDRESS: 17 LOUIE AVE | CITY/STATE/ZIP: LODI, CA 95240 | COMMENTS:

DC DX

DISCHARGE DIAGNOSIS:

DISCHARGED: ☐ WITH APPROVAL ☐ AGAINST APPROVAL ☐ TRANSFERRED ☐ DIED: ____ (DATE AND TIME) NO. OF DAYS STAYED: ____

DISCHARGE TO: ☐ OWN HOME ☐ FRIEND / RELATIVE'S HOME ☐ HOSPITAL OTHER FACILITY: ____

REVIEWED BY: ____ (SIGNATURE) ____ (TITLE) DATE: ____

RESIDENT NAME: PARVIN, MARY | SEX: F | STATION/ROOM/BED: SOUTH 11A | ADMISSION NO: | ORIGINAL ADMIT DATE: 6/29/13 | CURRENT ADMIT DATE: 7/10/14 | DISCHARGE:

CALIFORNIA ADMISSION AGREEMENT CHECKLIST

Resident Name: PARVIN, MARY Admit Date: 7/10/14

	1.	California Standardized Admission Agreement for SNF's
	2.	Attachment A – Facility Owner and Licensee Identification
	3.	Attachment B-1 – Supplies and Services Included in Basic Daily Rate for Private Pay & Privately Insured Residents
	4.	Attachment B-2 – Optional Supplies and Services Not Included in Basic Daily Rate for Private Pay & Privately Insured Residents
	5.	Attachment C-1 – Supplies and Services Included in Basic Daily Rate for Medi-Cal Residents
	6.	Attachment C-2 – Supplies and Services NOT Included in the Medi-Cal Basic Daily Rate That Medi-Cal Will Pay the Dispensing Provider For Separately
	7.	Attachment C-3 – Optional Supplies and Services NOT Covered by Medi-Cal That May Be Purchased By Medi-Cal Residents
	8.	Attachment D-1 – Supplies and Services Covered by the Medicare Program for Medicare Residents
	9.	Attachment D-2 - Optional Supplies and Services NOT Covered by Medicare that may be purchased by Medicare Residents
	10.	Attachment E – Authorization for Disclosure of Medical Information
	11.	Attachment F – Resident Bill of Rights

Admission Completed By: KAMIRYN SUBEGA Date: ___________

Notes:

PRIOR STAY INFORMATION

Resident Name: PARVIN, MARY Admit Date: 7/10/14

HIC#: 566627161A

Most Recent Acute Hospital Stay:

Hospital Name: LODI MEMORIAL Inpatient Stay: ☑ Yes ☐ No

Hospital Admit: 6/28/14 Hospital Discharge: 7/10/14

Prior Stays:

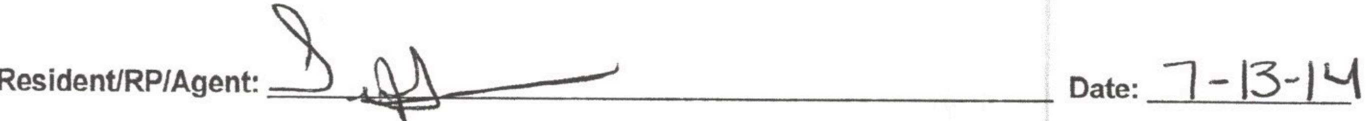
(Please Include: Acute, B&C, Assisted Living, and SNF stays including any prior stay at this facility)

Facility Name	*Type of Facility*	*From*	*To*	*Medicare Days Used*	*Last Covered Day*	*Date Custodial Level of Care*
ARBOR NURSING	SNF	07/10/14				
LODI MEMORIAL	ACUTE	06/28/14	07/10/14			
HOME		06/27/14	06/28/14			
ARBOR NURSING	SNF	04/16/14	06/27/14			
LODI MEMORIAL	ACUTE	04/11/14	04/16/14			
ARBOR NURSING	SNF	04/08/14	04/11/14			
LODI MEMORIAL	ACUTE	04/03/14	04/08/14			
HOME			04/03/14			

Please indicate Actual Days Available as determined by Prior Stay on the Financial Verification Form

Notes from calls to other facilities / Comments:

Verified By: ______________________ **Date:** __________



Resident/RP/Agent: ______________________ **Date:** 7-13-14

Lodi Memorial Hospital OE **LI
NURSING INTERVENTIONS
ORDER No.0710-0090
4TH FL SW CENTRAL NURSE STAT PRINTE

NAME: PARVIN,MARY JEAN
PHYS: Ali,Nazish Nawaz MD -HOSP
DOB: 03/16/43 AGE/SEX: 71 F
ADM NO: V025938127
ROOM: 466-A LOC: 4S

7-10-14
Physicians Orders

Code Status: Do not Resuscitate(DNR)

Allergies/ADRs: Sulfa (Sulfonamide Antibiotics),morphine,latex

HT: 5 FT 5 IN 165.1 CM WT: 214 LB 3.92 OZ 97.18 KG

Primary Diagnosis- CHANGE IN MENTAL STATE
Isolation type: Contact

Discharge Now Order (DCNOW)

SER DATE: 07/10/14
TIME: 0957
ORDER SOURCE: E - POM

Is physician discharge complete: Y
Discharge to- SNF
(H)ome, (S)NF, (HO)me w/home health, (B)&C, (A)PR, or other
DC Telemetry? Y DC NG/OG/FT? Y DC central line? Y (Mouse click to select)
DC Foley? Y DC IV? Y DC PICC? Y

DC Other
Comment

ORDERED BY: Ali,Nazish Nawaz MD -HOSP ENTERED BY: ALINAZ 07/10/14 0957 LMH22409.1
OTHER PROV: