

# Circle of Life Alzheimer's Homes, L.L.C.

5620 West Corliss

Prescott, Arizona 86305 Email: susan@circleoflifecare.com

(928) 237-4795

**CLIENT AGREEMENT/CONSENT FOR CARE AGREEMENT**

Note: Circle of Life Alzheimer's Homes, L.L.C. hereinafter referred to as "COLAH, L.L.C."

**Client's Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Individual with Power-of-Attorney (PoA) as Required\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, the undersigned, or the individual with the properly executed Power-of-Attorney (PoA) acting on my behalf, understand and hereby make the following acknowledgements and agreements regarding services to be provided by COLAH, L.L.C. at the location designated below.

**COLAH, L.L.C. Location for Services to be Provided to Client**

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# FREEDOM OF CHOICE

As of this date, I have chosen COLAH, LLC as the Direct Care provider of services. In order to receive care, I understand that I must have the approval of my physician, if required. I understand that I will continue to receive services until I no longer meet private insurance criteria of care, or until such time I elect to discontinue services, or until such time as resources are not available to meet my home care or hospice needs.

Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# II. CONSENT TO CARE

I authorize the employees of COLAH, L.L.C. to render care/services as prescribed by my physician. If required, I understand that I will be fully informed of the anticipated benefits, possible discomforts, and potential side effects prior to the performance of any medical treatment, and I release COLAH, L.L.C. from liability that may arise as the result of such treatment, unless due to sole negligence of its staff.

I consent to blood tests ordered by my physician, including blood tests for communicable diseases such as hepatitis and AIDS. I understand that State of Arizona law requires the reporting of certain positive results such hepatitis and the antibody for the AIDS virus to its health department.

I grant permission for COLAH, L.L.C. personnel to take photographs concerning treatment of my illness or injury with the understanding that such photographs are placed in my medical record and may be used for documentation and/or for teaching purposes.

Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# III. PROVISION OF SERVICES

I understand that COLAH, L.L.C. assigns staff based on client needs and considerations related directly to the care/services provided. I understand that services and employees are provided regardless of race, ethnicity, religion, sex, age, and veteran or handicap status.

Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# IV. RELEASE OF INFORMATION/PRIVACY RIGHTS

I have been provided by COLAH, L.L.C. with a written Notice of Privacy Rights that details the various ways that information about me may be disclosed for treatment, payment, healthcare operations and other purposes permitted or required by law as applicable.

Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# V. OBSERVATION/REVIEW CONSENT

I understand that medical, nursing, pharmacy, and dental students, supervisory staff, members of the Board of Directors, health care consultants, state and accreditation surveyors and representatives of any other certification/ accreditation/professional bodies may observe employees of COLAH, L.L.C. perform prescribed care. I understand the purpose is to provide a learning experience or for the evaluation of the quality of care and that all information will be kept confidential in accordance with the Notice of Privacy Rights. I hereby grant permission for the above individuals to observe COLAH,

L.L.C. employees performing prescribed care. I am aware that I may revoke permission for observation verbally or in writing at any time.

**Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# VI. CLIENT RIGHTS

My rights and responsibilities have been explained and I have received a copy of the Rights and Responsibilities.

I have received a Notice of Privacy Rights as applicable.

I have received information about State of Arizona laws and COLAH, L.L.C. policies concerning the Advance Directives.

I have been informed and received written information concerning the mechanism to voice grievances and recommend changes in policies/service

I understand that this mechanism may be accessed without coercion, discrimination, reprisal or unreasonable interruption of services.

Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# VII. CLIENT SERVICES

COLAH, L.L.C. offers awake service 24 hours care per day, 7 days per week, and 52 weeks per year. Its telephone number is 928 -862-2287.

Clients will be checked on during the night every two to four hours, an alarm will be set by caregiver every two to four hours) and times will be documented.

Annual Fire Drills, Disaster Training are conducted every three months and a Disaster Drill every six months.

COLAH, L.L.C. aids with ALL Daily Living Activities. Furthermore COLAH,

L.L.C. provides daily cognitive activities, daily exercise, assistance with medicine, cooking, cleaning, laundering and assistance with doctor appointment.

COLAH, L.L.C. is committed to offering superior quality service to its clients regardless of race, ethnicity, religion, sex, age, veteran or handicap status.

All Client's personal belongings brought into COLAH, L.L.C. homes will be itemized and kept in individual client binder. COLAH, L.L.C. is not responsible for lost or stolen items.

All clients will not be able to use BACK PORCH without their family members present OR CAREGIVER AT ALL TIMES as posted.

No personal money will be left on premises of all COLAH, LLC homes. If money is needed COLAH, L.L.C. will pay and bill for reimbursement on the next monthly billing statement.

# VIII. SERVICE COSTS, OTHER COSTS, REFUNDS AND PAYMENTS TO COLAH, L.L.C.

MONTHLY COST - $ 7,900.00 due each month (All inclusive – private room, all home cooked meals, including special diets, all personal care from caregiver, haircuts and sets, medications, hygiene needs, outside activities if able to join in, cognitive activities, doctor subscribed bandages, or wound care items.).

# THERE ARE NO ADDITIONAL COSTS FOR LEVEL OF CARE AND ADDITIONAL SERVICES.

ALL PAYMENTS ARE DUE each month on the date that the resident moved in:

Five days late - $100.00 service charge 10 days late - $200.00 service charge

30 day’s late – Notice of Termination will be sent/transfer procedures will commence.

# REFUND POLICY - COLAH, L.L.C. does not have a daily rate charge, all rooms are rented on a monthly basis. NO REFUNDS WILL BE GIVEN.

# IX. COLAH, L.L.C. POLICIES

**1. Move-in Policy**

YOU ARE NOT PERMITTED TO MOVE INTO COLAH, LL.L.C. WITHOUT:

FIRST MONTH'S RENT

 PROOF A TIMELY TB TEST/X-RAY

 PROOF OF A TIMELY FLU SHOT/PNEUMONIA

 SIGNED CONTRACT BY POA OR CLIENT ADMISSION FEE

 CALCULATION

 COPY OF FRONT & BACK OF ALL INSURANCE CARDS

 COPY OF SIGNED LIVING WILL

 COPY OF DNR

 COPY OF POWER OF ATTORNEY COMPLETED RESIDENT

 QUESTIONAIRE

 DIASTER AND EVACUATION PLAN SIGNED/ DISASTER AND

 EVACUATION DRILL SIGNED (See attachment directly below for your

 review and acknowledgement the COLAH. L.L.C. "Emergency Plan and

 Policies"

 ACKNOWLEDGEMENT OF RECEIPT OF THE FOLLOWING

 DOCUMENTS: ASSISTED LIVING RESIDENTS’ RIGHTS: ADULT

 PROTECTION SERVICES FLYER AND COLAH L.L.C.'S STANDARD

 GRIEVANCE POLICY

# ATTACHMENT

CIRCLE OF LIFE ALZHEIMER'S HOMES, L.L.C.

Emergency Plan and Policies

1. **Disaster and Evacuation**

In the event of a disaster in which the facility is considered uninhabitable or is ordered to evacuate COLAH, L.L.C. appropriate staffers will::

Remove all residents from the area of immediate danger

Call 911 (if applicable)

Contact the General Manager to notify her of the disaster

Contact’s “Out of town emergency number” 1-609-425-4877

(Mark Wielechowski)

Access Disaster Plan folder and resident medications if it is safe to do so and place in duffle bag/backpack

If it is not safe to gather medications the pharmacy on file will be notified to get replacement medications

Manager will contact the facility or family that will be receiving the residents and make arrangements for transfer of the residents

A copy of the medical records will be issued at the time of relocation of the Resident to the family or Facility

Take bottled water

Gather pre-pared duffle bag for each Resident -- duffle bag will contain two changes of clothes, briefs and 1one blanket

Place First Aid kit- Place in emergency duffle bag/backpack

Place in emergency duffle bag/backpack battery operated radio and two flashlights

Transport residents to designated evacuation site or sites -- transportation may be by the resident's representative, family member, and facility personnel or by transportation services

 Designated evacuation/relocation site is:

Holiday Inn Express

3454 Ranch Drive

Prescott, AZ 86303

 Notify family members and others significant to each resident's situation.

 (i.e. case managers, powers of attorney etc.)

 Family Members/POA can take Resident to town location.

 All Resident’s family will be notified first to see if able to take Resident

 before we move Resident to evacuation site

 If Client is receiving Hospice care, communication will be between

 COLAH/family/hospice provider. Hospice will set up transportation for

 residents on their service.

1. **Fire**

 Caregiver on duty will remain calm so as to focus on emergency

 actions and will: Call 9-1-1 and continue to evacuate while on phone

 Remove any residents in immediate danger, if possible

 Sound fire alarm and use fire extinguishers Confine the fire and smoke by

 shutting doors

 Remove residents from building following evacuation route

 Begin evacuation with residents that are capable of walking and direct

 them to exit, next will be those who are wheelchair bound and then

 bedbound

 Direct/move residents into a safe location and check all are accounted for

 If not safe to return into home, notify fire personnel if anyone is

 missing and last known location in the building

 Notify General Manager

 Transport residents to designated evacuation site:

Holiday Inn Express

3454 Ranch Drive

Prescott, AZ 86303

Note: Transportation may be by the resident's representative, family member, and facility personnel or by transportation services

Notify family members and others significant to each resident's situation. (i.e. case managers, powers of attorney etc.)

Family Members/POA can take Resident to town location.

All Resident’s family will be notified first to see if able to take Resident before we move Resident to evacuation site

If Client is receiving Hospice care, communication will be between COLAH’S

/family/hospice provider. Hospice will set up transportation for residents on their service.

 Shelter in place: In the event of a reverse 911 call or danger outside of

 home.

1. Power Outage

Caregiver on duty will:

Locate flashlight if needed

Immediately go to residents who are on oxygen

Connect to back up cylinder tank, assure it is working and note the time (Check these tanks every 15 minutes and change as needed)

Notify manager of time of outage

Manager will call electric provider to get estimate of time of outage

Resume normal schedule in order to not alarm or upset residents

If nighttime, places a flashlight in room next to bed.

Do not wake anyone up, but do help anyone who gets up

1. Drills

COLAH, L.L.C. will conduct a Disaster drill for Residents every six the facility will be oriented and have access to the disaster plan at any time. The plan will be followed in the

event of an internal or external disaster that could cause the facility to become uninhabitable.

Residents will be oriented to the emergency procedures of this facility within twenty-four hours of their admission. Caregivers will review the emergency procedures during their orientation sessions.

* 1. Hospitalization and Rehabilitation Policy

If client is admitted to the hospital or rehabilitation facility during their contract, the client's room with COLAH, L.L.C. will be theirs for as long as continued monthly payments are paid.

Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# X. Termination Policy -- Discharge

A resident may be terminated for any or all of the following and within the following time-frames:

1. Without written notice, if resident exhibits behavior that is an immediate threat to the health and safety of the resident or other individual in a COLAH residence;
2. With a 14-calendar day written notice of termination of residency:
	1. For non-payment of fees, charges or deposits’ or
	2. Under any of the conditions previously referred to in 1; or
3. With a 30-calendar day written notice of termination of residency, for any other reason determined by COLAH.

At the time of Termination, COLAH, L.L.C. will provide resident with a written Notice of Termination of Residency which will include:

a. Date of notice;

b. Termination reason

c. Policy for refunding fees, charges or deposits as applicable;

d. Deposition of resident’s fees, charges and deposits; and

e. Contact information of the State of Arizona Long-term Care Ombudsman.

Furthermore, at the time the resident receives written notice of residency termination, COLAH, L.L.C. will provide resident with:

 a. A copy of the resident’s current service plan, and

 b. Documentation of the resident’s freedom from infectious tuberculosis.

If COLAH, L.L.C. issues a written termination of residency notice, to a resident or the resident’s responsible party because the resident needs services that COLAH is either not licensed to provide or is not able to provide, COLAH, L.L.C.s hall ensure that the written notice describes the specific services that the resident requires that COLAH is either not licensed to provide or is not able to provide.

**XI. Medication Policy**

ALL CLIENT'S MEDICINE WILL BE LOCKED: Medicine will be counted daily and accounted for on a MEDICATION ACCOUNT FORM. All narcotics will be accounted for separately on their own MEDICATION ACCOUNT FORM. Each caregiver aide will date and sign form after they observe client taking their individualized doctor prescribed medication.

If resident refuses caregiver aide they, or their PoA, will mark and sign as well. If client cannot dispense their own medication the Manager /Nurse will dispense medication per doctor’s/nurse’s orders and sign and initial appropriate MEDICATION ACCOUNT FORM.

**XII. Daily Activities**

All clients will be encouraged to be self-sufficient. Along with being treated with dignity and self- respect. COLAH, L.L.C. will offer daily activities from 10:30 to 11:30 am and again 2:00 pm to 3:00 pm. Daily activities will be at the client’s level of Cognitive ability and participation, including but not limiting to: taking a walk, folding laundry, doing dishes, dusting, sweeping porches and walk ways, News events, music therapy, crafts, games, cards, puzzles, coloring, painting, writing letters to family, picnic, balloon therapy, etc. No client will be forced to participate. Activities are not just limited to those times.

COLAH, L.LC. believes in a Person Direct Care Approach, cognitive stimulation is offered constantly throughout the day to the best of the resident’s ability.

**XIII. Standard Grievance Policy**

IF YOU NEED TO VOICE A GRIEVANCE OR RECOMMEND CHANGES OF ANY TYPE, PLEASE FOLLOW THE STEPS LISTED BELOWS:

Notify COLAH, L.L.C. by phone at 928-862-2287 -- staff will take immediate action to resolve all problems brought to their attention and to keep the resident informed of the resolution.

If not satisfied, notify the Arizona State Hotline. Their phone number is 1-877-767- 2385. The hotline may be used for questions or complaints about care and concerns regarding implementation of advance directives.

Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# XIV. ACKNOWLEDGEMENTS

**Signature of Client or Their Power of Attorney Holder**

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**Printed Name of Client or Their power of Attorney Holder**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address of Client or Their Power of Attorney Holder**

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**Signature of Financially Responsible Party and/or Insured Party (or Their Power of Attorney Holder)**

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**Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address of Financially Responsible Party and/or Insured Party (or Their Power of Attorney Holder)**

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**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorized Acceptance by CIRCLE OF LIFE ALZHEIMER'S HOMES, L.L.C.**

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**Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Title General Manager**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**