Application for Admission
Rockingham County Nursing Home

Applicant's Name: _____
Primary Address: _____
Other Address (if living with someone): _____

(Referral from Hospital or Rehab Unit)
Hospital/Rehab Hospital being referred by: _____
Telephone No./Social Worker @ Hospital: _____

Personal Information Regarding Applicant:
Male ☐ Female ☐ DOB: _____
Marital Status: **S M W Sep. Div.**
Primary Physician: _____
_____
Specialist: _____
_____
(Address and Tel. No.)

Primary Language:
English: ☐ Other: _____
Any special needs required: _____

Contact Person Regarding this Application:
Name: _____
Address: _____
_____
Relationship: _____ Tel. No.: _____

2nd Contact: _____
Address: _____
_____
Relationship: _____ Tel. No.: _____

Responsible Person/Legal Guardian/DPOA:
Legal Guardian ☐
Durable POA (Health) ☐
Durable POA (Finances) ☐
Name: _____
Address: _____
Relationship: _____ Tel. No.: _____
Is DPOA for health activated? Yes ☐ No ☐
(Provide copies of above documents)

Advanced Directives in Place:
Living Will ☐
Do Not Resuscitate ☐
Do Not Hospitalize ☐
Organ Donor ☐
Feeding Restrictions ☐
Medication/Treatment Restrictions ☐
(Explain): _____

Living Arrangements:
Lives alone ☐ or Other: _____

Prior Hospitalizations/In-home Services:
Rehabilitation Services ☐
Home Health Services ☐
VNA Services ☐
Mental Health Services ☐

Insurance Information for Nursing Home Stay:
Private Funds (advance payment required) ☐
Medicaid No. _____ ☐
Medicare No. _____ ☐
Medicare Replacement Carrier: _____
_____ ☐
Social Security No. _____ ☐
VA No. _____ ☐
Supplemental Insurance:
Ins. I.D. No.: _____
Name/Address Supplemental Insurance:
_____
_____
_____

Enrolled in Medicare "D" Prescription Drug Program: Yes ☐ No ☐
Name: _____
(Provide copies of all cards; front and back)

Monthly Income Source(s)/Assets:
Social Security check $_____
Pension check $_____
Name/Address of Pension Company:
_____
_____
_____

Assets:	**Value:**
Real Estate:	$_____
Savings Account:	$_____
Checking Account:	$_____
Retirement Account:	$_____
Stocks/Bonds:	$_____
IRA/CD:	$_____

(Copies of most recent statements required)

Diagnoses (list all):

Medications (list all):

Comments/pertinent information explaining why this person needs to be placed in a nursing home:

PICTURE RELEASE

I hereby give designated staff of Rockingham County Nursing Home permission to take:

1. Photographs for identification purposes — Yes — No

2. Photographs for the purpose of publication in local newspapers and possible display in the facility. — Yes — No

Note to Hospital/Rehab Unit: **History and Physical, Discharge Summary and Transfer Forms along with PASARR Screening, if applicable, must be submitted upon acceptance to our facility**

Signature of Person Completing Application

Date of Application

ROCKINGHAM COUNTY NURSING HOME
POLICIES & PROCEDURES

RESIDENT CARDIAC ARREST

Whenever possible, early intervention to treat potential emergency situations will be followed through recognition of early warning signs, appropriate monitoring and transport to the hospital before the situation becomes a cardiac emergency.

In the event of a cardiopulmonary arrest, the American Heart Association (AHA) Heartsaver cardiopulmonary resuscitation (CPR) protocol will be provided to those residents with a signed affirmation of the "Resident Resuscitation Acknowledgement Statement" form provided by the facility. This care will be provided until the Emergency Medical Services (EMS) team arrives to provide the advanced life support and transport to the hospital.

All resident/responsible parties will be informed of their right to formulate an advance directive. At this time the Resident or Activated Durable Power of Attorney or Guardian will be required to indicate their preference on the "Resident Resuscitation Acknowledgement Statement" form provided by the facility. If the Resident is unable to affirm his/her choice and sign and the Activated Durable Power of Attorney or Guardian is not present at the time of admission and/or change in code status, a verbal acknowledgement may be accepted until a signature can be obtained. **Note: the facility must have a copy of the Durable Power of Attorney or Guardianship confirming the activated DPOA or Guardian prior to accepting any written or verbal directives.**
The original "Resident Resuscitation Acknowledgement Statement" form will be kept in the resident's medical record. A copy of the "Resident Resuscitation Acknowledgement Statement" form will be kept in the resident's file in the Nursing Office.

If the Resident is unable to affirm and sign, and in the absence of any legally documented clear directive (Living Will) and /or Durable Power of Attorney/Guardian, RCNH will initiate a "Provide CPR". Social Services will follow up with the family/surrogate to ensure that the wishes of the Resident are being followed.

Each resident will have in their medical record a physician's order stating

- Do Not Attempt Resuscitation – **DNR** – (PORT Form Required, see attached)
  OR
- Provide CPR (Full Code)

Resident's with a "Provide CPR" order will have a green "FULL CODE" sticker on the Condition Alert page in the front of their medical chart.
Resident's with a "Do Not Attempt Resuscitation" order will have a red "DNR" sticker on the Condition Alert page in the front of their medical chart

- The "Resident Resuscitation Acknowledgement Statement" is kept in the "Advance Directives/Consents" section of the medical chart

The facility policy is that CPR may be initiated by any employee of Rockingham County Nursing Home with a valid Heartsaver CPR certification.

In the event of a cardiopulmonary arrest of a resident with a physician's order for resuscitation, first staff on the scene, if not an employee of Rockingham County Nursing Home with a valid Heartsaver CPR certification, will dial "63" to page and state TWO TIMES "Supervisor 911, unit name and room number".

EX.: "Supervisor 911, Blaisdell 1, Room 109"
"Supervisor 911, Blaisdell 1, Room 109"

The nurse assigned to the paged unit should also respond to the location.

A staff member will be available to direct the supervisor when he/she arrives on the unit

If determination of a cardiopulmonary arrest emergency is made with a physician's order for CPR, the supervisor / first responder will direct staff to:

1. Have the unit nurse call 911.
   The nurse will provide the 911 dispatcher with the following information:
   Caller's name
   Name of facility
   Nature of emergency
   Location of emergency within facility
   Any additional information requested by 911
   Stay on line until instructed to hang up
2. If resident is on a soft surface (i.e. mattress), a backboard will be placed under resident's back before initiating the AHA Heartsaver CPR protocol. If the resident is on a low pressure air mattress, release the valve marked "For CPR"
3. Once initiated, CPR will continue until:
   - Resident regains cardiopulmonary function and is placed in a recovery position.
   - Performance of CPR with relief by additional Heartsaver CPR certified (current) staff is encouraged to sustain the rescue effort.
   - **If the resident is unresponsive AND not breathing, the AED (Automated External Defibrillator), located at the switchboard, may be utilized. The AED can only be used by RN's who are currently CPR certified AND have been trained in the use of the AED.**
   - The EMS personnel arrive to take over life support and transport to the hospital.
4. The supervisor will be responsible to give a brief history and summary to the EMS team regarding the rescue event.
5. Supervisor will call the doctor on call and the resident's responsible party to inform them regarding the rescue event.
6. **Supervisor** will document the rescue event in the resident's medical record and in the supervisor's 24 hour Report book.
7. Supervisor will re-stock the emergency cart, return it to its assigned location.

PORTABLE DO NOT ATTEMPT RESUSCITATION ORDER (P-DNR)

PORT FORM

PURPOSE

To ensure that the choice of residents regarding *Do Not Attempt Resuscitation* is clear not only while the resident is at RCNH but also if and when a resident is transferred to another facility or provider for care.

Effective January 1, 2007, Rockingham County Nursing Home will utilize the P-DNR – PORT Form authorized by the New Hampshire Legislature – NHL RSA 137-J to record the preference of facility resident who by themselves, if competent, or through their legally responsible representative in the case of cardiac arrest **DO NOT** want to have Cardio-Pulmonary Resuscitation initiated.

This document (PORT Form) will provide a portable record of the resident's choice **NOT to receive CPR** in the event of a cardiac arrest.

The PORT Form will accompany the resident to all out of facility providers to be presented to the appropriate parties in case of cardiac arrest.

PORT forms are kept in the resident's nursing office file. Whenever the PORT form is removed from the file, a PORT FORM REMOVED (see attached) sheet must be completed and placed in the resident's file **until** the PORT form is returned to the file (resident returns to facility).

RESPONSIBILITY

Social Services, upon admission (or as soon thereafter as possible), will have a PORT form completed, according to facility policy, for all residents who **DO NOT** want CPR initiated.

RESIDENT'S RESUSCITATION ACKNOWLEDGEMENT STATEMENT

Resident's Name _____

It is the policy of Rockingham County Nursing Home to have a documented directive regarding whether or not to attempt to perform Cardiopulmonary Resuscitation (CPR).

Please indicate your decision by marking with an "X".

_____ DO NOT ATTEMPT RESUSCITATION
(PORT form required)

_____ Provide CPR (FULL CODE)

_____ _____
Resident Date
or
Activated Durable Power of Attorney
or Guardian

_____ _____
Witness Date

Verbal Acknowledgement given by _____
Activated Durable Power of Attorney
or Guardian

to _____ Date _____

☐ Will come in to sign ☐ Mailed - __/__/__ ☐ Faxed - __/__/__

ROCKINGHAM COUNTY NURSING HOME

VACCINATIONS AND IMMUNIZATIONS

INFLUENZA VACCINE

PNEUMOCOCCAL POLYSACCHARIDE VACCINE

POLICY

It is the policy of Rockingham County Nursing Home that all residents are offered immunizations and vaccinations that help in preventing infectious diseases unless contraindicated per medical condition or otherwise indicated by the resident's attending physician.

PROCEDURE

1. ***All residents and / or legal representative are provided information regarding Influenza and Pneumococcal Polysaccharide Vaccines (VIS from the CDC) prior to or upon admission.***
   Updated information will be provided to residents and/or legal representative as it may become available from the CDC. This information may be hand delivered or mailed.

2. ***A consent form is completed and signed. The consent is good for the entire length of stay in the facility.***

3. ***If consent is NOT given, the consent form asks for the reason to be indicated. This provides more specific information for MDS coding.***

4. ***Completed Immunization Consent forms are maintained in the consent section of the resident's medical chart.***

5. ***Influenza Vaccine is provided annually, as appropriate, from October 1st – March 31st.***

6. ***Pneumococcal Polysaccharide Vaccine is provided as appropriate in accordance with PPV indicated use and CDC guidelines, a one time dose of PPV after the age of 65.***

7. ***The Head Nurses will ensure that consent forms are completed and appropriate MD orders are obtained.***

8. ***Vaccines administered are documented in the MAR and in the Immunization section in PointClick Care.***

VACCINE INFORMATION STATEMENT

Influenza Vaccine
Inactivated
What You Need to Know

2012 - 2013

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 http://www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease.

It is caused by the influenza virus, which can be spread by coughing, sneezing, or nasal secretions.

Anyone can get influenza, but rates of infection are highest among children. For most people, symptoms last only a few days. They include:

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

Other illnesses can have the same symptoms and are often mistaken for influenza.

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 – can get much sicker. Flu can cause high fever and pneumonia, and make existing medical conditions worse. It can cause diarrhea and seizures in children. Each year thousands of people die from influenza and even more require hospitalization.

By getting flu vaccine you can protect yourself from influenza and may also avoid spreading influenza to others.

2 Inactivated influenza vaccine

There are two types of influenza vaccine:

1. **Inactivated** (killed) vaccine, the "flu shot," is given by injection with a needle.

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

A "high-dose" inactivated influenza vaccine is available for people 65 years of age and older. Ask your doctor for more information.

Influenza viruses are always changing, so annual vaccination is recommended. Each year scientists try to match the viruses in the vaccine to those most likely to cause flu that year. Flu vaccine will not prevent disease from other viruses, including flu viruses not contained in the vaccine.

It takes up to 2 weeks for protection to develop after the shot. Protection lasts about a year.

Some inactivated influenza vaccine contains a preservative called thimerosal. Thimerosal-free influenza vaccine is available. Ask your doctor for more information.

3 Who should get inactivated influenza vaccine and when?

WHO

All people **6 months of age and older** should get flu vaccine.

Vaccination is especially important for people at higher risk of severe influenza and their close contacts, including healthcare personnel and close contacts of children younger than 6 months.

WHEN

Get the vaccine as soon as it is available. This should provide protection if the flu season comes early. You can get the vaccine as long as illness is occurring in your community.

Influenza can occur at any time, but most influenza occurs from October through May. In recent seasons, most infections have occurred in January and February. Getting vaccinated in December, or even later, will still be beneficial in most years.

Adults and older children need one dose of influenza vaccine each year. But some children younger than 9 years of age need two doses to be protected. Ask your doctor.

Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.

4 Some people should not get inactivated influenza vaccine or should wait.

- Tell your doctor if you have any severe (life-threatening) allergies, including a severe allergy to eggs. A severe allergy to any vaccine component may be a reason not to get the vaccine. Allergic reactions to influenza vaccine are rare.

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

- Tell your doctor if you ever had a severe reaction after a dose of influenza vaccine.
- Tell your doctor if you ever had Guillain-Barré Syndrome (a severe paralytic illness, also called GBS). Your doctor will help you decide whether the vaccine is recommended for you.
- People who are moderately or severely ill should usually wait until they recover before getting flu vaccine. If you are ill, talk to your doctor about whether to reschedule the vaccination. People with a mild illness can usually get the vaccine.

5 What are the risks from inactivated influenza vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small.

Serious problems from inactivated influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so you cannot get influenza from the vaccine.

Mild problems:

- 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 1-2 days.

Moderate problems:

Young children who get inactivated flu vaccine and pneumococcal vaccine (PCV13) at the same time appear to 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:

- Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.
- In 1976, a type of inactivated influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, flu vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current flu vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.

The safety of vaccines is always being monitored. For more information, visit:

www.cdc.gov/vaccinesafety/Vaccine_Monitoring/Index.html and **www.cdc.gov/vaccinesafety/Activities/Activities_Index.html**

One brand of inactivated flu vaccine, called Afluria, **should not be given** to children 8 years of age or younger, except in special circumstances. A related vaccine was associated with fevers and fever-related seizures in young children in Australia. Your doctor can give you more information.

6 What if there is a severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or unusual behavior. Signs of a serious 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** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form. Or you can file this report through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not provide medical advice.

7 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) was created in 1986.

People 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**.

8 How can I learn more?

- Ask your doctor. 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/flu**

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 ean 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

ROCKINGHAM COUNTY NURSING HOME

IMMUNIZATION CONSENT FORM

Resident _____

I have read the Vaccine Information Statement on Pneumococcal Polysacchride Vaccine (PPV).

I have read the Vaccine Information Statement on Inactivated Influenza Vaccine.

I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that the:

(Indicate your wishes by checking the appropriate box)
Note: All Vaccines require a physician's order

Pneumococcal vaccine to be administered ☐

Pneumococcal vaccine NOT be given ☐

If not to be given, please state reason: (Ex. Allergy, personal preference, etc.)

_____

_____

Resident received vaccine on _____(date)

Influenza vaccine to be administered annually ☐

Influenza vaccine is NOT to be given annually ☐

If not to be given, please state reason: (Ex. Allergy, personal preference, etc.)

_____

_____

Signature of Resident / Responsible Party: _____

Relationship: _____

Date: _____

Verbal consent given by _____ to _____ on __/__/__

Consent mailed for signature on __/__/__ by _____.

11/10

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, the undersigned, hereby voluntarily authorize that information (including psychiatric) from the medical record of:

Name of Person	D.O.B.	Social Security #

be exchanged (including facsimile) between Rockingham County Nursing Home and:

Name of Agency

Address

Telephone Fax Number

Information to be released covers the treatment dates of _____

The following checked items are being _____ released _____ requested:

___Adm. H & P ___Discharge Summary ___Immunization Record
___Consults ___Treatment Plans ___Laboratory Reports ___X-Rays
___Progress Notes ___Physician Orders ___Other – Specify _____
___Information from other providers received after May 1982 _____ Entire Medical Record

_____Psychotherapy notes (if this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.

INITIAL if you wish the following information to be released (if present).

_____Alcohol and/or Drug Abuse Treatment: (I understand that all related information is protected under Federal Regulation 42CFR and that I have the right to refuse the release.)

_____HIV Related Information: (I understand I have the right to refuse the release.

The purpose of the release is: _____ Evaluation for Admission
_____ Treatment Planning
_____ Other – (specify): _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release expires one year from the signature date below unless a shorter period is specified here: _____.

_____ _____

Signature of Resident or Resident's Legal Representative Date

_____ _____

Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Resident

ROCKINGHAM COUNTY NURSING HOME
117 NORTH ROAD, BRENTWOOD, NEW HAMPSHIRE 03833
TELEPHONE: 603-679-5335 FAX: 603-679-9307

cc: Resident/Legal Representative
File

ROCKINGHAM COUNTY LONG TERM CARE

117 NORTH ROAD
BRENTWOOD, NEW HAMPSHIRE 03833
Phone: 603-679-5335
Fax: 603-679-9307
www.co.rockingham.nh.us

STEVEN WOODS, NHA
LTC SERVICES DIRECTOR

Permission for Release of Information

RE:_____

I, _____ grant permission for medical information to be released to the following:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Resident or Resident's Legal Representative

Date

ROCKINGHAM COUNTY LONG TERM CARE

117 NORTH ROAD
BRENTWOOD, NEW HAMPSHIRE 03833
Phone: 603-679-5335
Fax: 603-679-9307
www.co.rockingham.nh.us

STEVEN WOODS, NHA
LTC SERVICES DIRECTOR

Permission for LOA with Responsible Person

RE:_____

I, _____(Activated DPOA/Guardian) grant permission for LOA from RCNH with the following responsible individuals.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Resident or Resident's Legal Representative — Date

ATTENDING PHYSICIAN UPON ADMISSION

Rockingham County Nursing Home has a medical staff made up of four staff physicians and one ARNP.

Karl Singer, MD – Medical Director
Core Physicians
9 Buzzell Ave.
Exeter, NH 03833
603-773-5200

Paul Gustavson, MD
19 Sudbury Rd.
Danville, NH 03819

L. Mark Reiner, MD
Exeter Executive Park
19 Hampton Rd.
Exeter, NH 03833
603-772-9371

Jeremy James, MD
Lamprey Health Care
207 Rt. 27
Raymond, NH 03077
603-895-3351

Holly Solie, ARNP
Rockingham County Nursing Home
117 North Rd.
Brentwood, NH 03833
603-679-5335

If you prefer your own personal physician to follow the resident after admission, that physician must be consulted and must contact the Medical Director of this facility to obtain the Rules & Regulations in order to be granted privileges to admit to this nursing home.

Contact Person: Dr. Karl Singer, Medical Director
Rockingham County Nursing Home
117 North Rd.
Brentwood, NH 03833
(603) 679-5335

RESIDENT:_____

Please indicate your choice of physician:_____

Signature:_____ Date: _____

ROCKINGHAM COUNTY NURSING HOME
PERSONAL NEEDS TRUST
AGREEMENT

I hereby authorize the center to hold, safeguard, manage and account for my personal funds that I deposit into its personal needs trust account. I understand that my personal funds in excess of $50.00 will be deposited into an interest bearing account that is separate from any of the center's other accounts. Such interest will be credited to my account.

I understand that the center will maintain an accurate accounting of all receipts and expenditures of my personal funds, which I shall receive at least quarterly in the form of a written statement. If I have a legal representative, such written statements shall be sent to them.

Except for the applicable deductible or coinsurance amounts, the center may not impose a charge against my personal funds for any item or service for which payment is made by Medicare or another health insurance plan. I authorize the center to charge my account for all other services that I request, including, but not limited to:

- Personal comfort items
- Cable Television
- Telephone
- Cosmetics
- Beauty and Barber shop services
- Personal reading materials
- Gifts purchased on my behalf
- Flowers and plants
- Social events and entertainment offered outside the scope of required activity programs
- Non-covered special care services
- Alternative food requested instead of the food generally prepared by the center

Within 30 days after my transfer or discharge, the center will convey my account balance along with a final written statement to me or, if I have one, my legal representative. In the event of my death, within 30 days thereafter, the center will convey my account balance along with a final written statement to the person responsible for settling my estate. If there is no such person, then the center will convey my account balance to the proper person as required by law. If I owe the center for unpaid items or services that I requested, I authorize the center to deduct from my account balance any such amounts owed before making final disbursement.

_____ _____
Signature of Resident/Legal Representative Date

_____ _____
Signature/Title of Center Representative Date

Send quarterly statements to: _____

_____

_____

Telephone #: (_____) _____

IMPORTANT INFORMATION – PLEASE READ BEFORE SIGNING YOUR NAME

My signature below indicates that I understand my rights of appeal and civil rights and that:

- **I certify** that all of the information I have provided on this renewal form is true and complete to the best of my knowledge.
- **I understand** that if I deliberately give any false information or withhold information related to my receipt of assistance, now or in the future, I may be prosecuted for fraud.
- **I understand** that the Department of Health and Human Services will keep any information on this renewal form confidential and only persons involved in administering the Department's programs or as otherwise permitted by State Law or Federal Regulations, will review it.
- **I understand** that as part of the administration of Department programs, the Department may verify information I have provided on this renewal form and any other information that would affect my eligibility, and that I may be required to provide proof of my statements. My signature below authorizes the Department to obtain verification and authorizes the release of such information to the Department. My authorization to release information remains in effect until the time of my next renewal of eligibility.
- **I understand** that, because I am in a nursing facility, the Department must be able to exchange eligibility information with the nursing facility in order to best administer the program. My signature below authorizes that exchange and remains in effect until the time of my next renewal.
- **I understand** that I am required to disclose to the Department any interest that my spouse or I have in any annuity.
- **I understand** that any annuity purchased or modified by my spouse or me on or after February 8, 2006 will be considered a transfer of assets for less than fair market value unless the State is named the beneficiary for at least the amount of Medicaid paid on my behalf.
- **I understand** that I may choose to allocate some of my income to my spouse and/or dependents who live in the community. If so, verification of my spouse's and/or dependent's income and shelter expenses must be provided.
- **I understand** that to change the amount of income allocated to my spouse and/or dependents who live in the community, I must first provide verification of their income and shelter expenses.
- **I certify** that I have read the information about my rights and responsibilities and have contacted my District Office for an explanation of any statement I did not understand.

SIGNATURE OF CLIENT/AUTHORIZED REPRESENTATIVE	PHONE #	DATE
SIGNATURE OF PERSON, OTHER THAN CLIENT/AUTHORIZED REPRESENTATIVE, WHO COMPLETED THIS FORM	PHONE #	DATE

PLEASE TEAR OFF THE ATTACHED *YOUR RIGHTS AND RESPONSIBILITIES AND NONDISCRIMINATION NOTICE* AND KEEP FOR YOUR INFORMATION

ROCKINGHAM COUNTY NURSING HOME

117 NORTH RD., BRENTWOOD, NH 03833

TELEPHONE: 603-679-5335 FAX: 603-679-9307

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. 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 (SSN)

Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b))(3)(A), and 1864 of the Social Security Act.

Skilled nursing facilities for Medicare and Medicaid are required to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity and health status. As of June 22, 1998 all skilled nursing and nursing facilities are required to establish a database of resident assessment information and to electronically transmit this information to the State. The State is then required to transmit the data to the federal Central Office Minimum Data Set (MDS) repository of the Health Care Financing Administration.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long Term Care System of Records.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing homes that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing homes to receive reimbursement for Medicare services.

3. ROUTINE USES

The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1516. Information from this system may be disclosed, under specific circumstances, to: (1) a congressional office from the record of an individual in response to an inquiry from the congressional made at the request of that individual; (2) the Federal Bureau of Census; (3) the Federal Department of Justice; (4) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health; (5) contractors working for HCFA to carry out Medicare/Medicaid functions, collating or analyzing data, or to detect fraud or abuse; (6) an agency of a state government for purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State; (7) another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds or to detect fraud or abuse; (8) Peer Review Organizations to perform Title XI or Title XVIII functions, (9) another entity that makes payment for or oversees administration of health care services for preventing fraud or abuse under specific conditions.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

For nursing home residents residing in a certified Medicare/Medicaid nursing facility the requested information is mandatory because of the need to assess the effectiveness and quality of care given in certified facilities and to assess the appropriateness of provided services. If a nursing home does not submit the required data it cannot be reimbursed for any Medicare/Medicaid services.

NOTE: Providers may request to have the Resident or their Representative sign a copy of this notice as a means to document that notice was provided. Signature is **NOT** required. If the Resident or their Representative agrees to sign the form it merely acknowledges that they have been advised of the foregoing information. Residents or their Representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions.

Resident Advocacy List

The New Hampshire Department of Health and Human Services
30 Maplewood Avenue
Portsmouth, NH 03801
Telephone: 603-433-8300 or 1-800-735-2964

The Social Security Administration
80 Daniel Street
Portsmouth, NH 03801
Telephone: 603-433-0716 or 1-800-772-1213

Nursing Home Licensure/Survey/Certification Agencies
Office of Program Support
129 Pleasant Street
Brown Building
Concord, NH 03301
Telephone: 603-271-4592 or 1-800-735-2964
TDD Access: 1-800-735-2964

Medicaid Fraud Unit
33 Capitol Street
Concord, NH 03301
Telephone: 603-271-1246
TDD Access: 1-800-735-2964

NH Long Term Care Ombudsman Program
129 Pleasant Street
Concord, NH 03301
Telephone: 603-271-4375 or 1-800-442-5640
TDD Access: 1-800-735-2964

Protection and Advocacy for Individuals with Developmental Disabilities and/or Mental Illness Disabilities Rights Center Inc.
18 Low Street
Concord, NH 03301
Telephone: 603-228-0432 or 1-800-834-1721

Servicelink
Telephone: 1-866-634-9412

Rockingham County Long Term Care Services

NOTICE OF PRIVACY PRACTICES

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.

The Purpose of this Notice

Rockingham County Long Term Care Services (RCLTCS) is required by law to maintain the privacy of your personal health information. We are now required by the federal Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, and HIPAA regulations, 45 CFR Part 160 and 164, to provide you with this Notice of our privacy practices, our legal duties, and your rights concerning your health information. This Notice will take effect on April 14, 2003 and will remain in effect until it is replaced. RCLTCS must abide by all terms of this Notice as long as it is in effect. RCLTCS reserves the right to revise or change this Notice at any time. Any such revision will affect information we already have about you and any information we receive in the future. If there is any significant change in our privacy practices, this Notice will be changed and the new Notice will be sent to you. You do not have to call or do anything in response to this Notice. If you do have any questions about this Notice, please direct your questions to:

HIPAA Privacy Officer
Rockingham County Long Term Care Services
117 North Road
Brentwood, NH 03833
1-603-679-5335

How RCLTCS will Use or Disclose Your Health Information

Rockingham County Long Term Care Services uses and discloses your health information for the following purposes:

Treatment: We may use or disclose your health information to provide, coordinate, or manage your health care treatment between health care providers. For example, this may include the co-ordination of treatment by your health care provider with a third party, consultation between health care providers relating to you, or referral for your health care from one health care provider to another.

Payment: We may use or disclose your health information to determine and remit proper payment for health care treatment or services you receive, or to receive payment for health care treatment provided to you at Rockingham County Long Term Care Services. For example, your health information may be used to determine eligibility for coverage, billing, claims management and collection activities.

Health Care Operations: We may use or disclose health information about you for operational purposes. For example, your health information may be used to conduct quality assessment and improvement activities, to conduct fraud and abuse detection programs, and for business planning and development. It may also be used for professional review of health care professionals, auditing services, claims adjudication, underwriting and general administrative activities of RCLTCS.

Other Possible Uses and Disclosures

Disclosures Required by Law: We may use or disclose information about you when we are required to do so by law. RCLTCS may disclose your health information to comply with a court order, an administrative order, a subpoena, a discovery request or other lawful process, report information related to victims of abuse or neglect, or to a law enforcement official for a law enforcement purpose.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability.

Health Oversight Activities: RCLTCS may use or disclose your health information for oversight activities authorized by law, including audits, civil, administrative or criminal investigations, or other activities necessary for appropriate oversight.

Direct Contact: RCLTCS may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Research: RCLTCS may use your personal health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Your health information may be used or disclosed to carry out specialized government functions, such as protection of public officials, for national security, to correctional institutions, or to another agency administering a public benefits program.

Worker's Compensation: Your health information may be used or disclosed in order to comply with the laws and regulations related to Worker's Compensation.

Decedents: Your health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Any Other Use and Disclosure: Any use or disclosure of your personal health information other than referenced above will require RCLTCS to obtain your written authorization. You have the right to revoke any such authorization.

Your Health Information Rights

You have the following rights regarding the medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information RCLTCS maintains about you. To inspect and copy your medical information, please submit your request in writing to the HIPAA Privacy Officer at the address given above. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances.

Right to Amend: If you feel that the health information we maintain about you is incorrect or incomplete, you may ask us to amend the information. You have the Right to request an amendment for as long as the information is kept by RCLTCS. Your request for an amendment must be submitted in writing to the HIPAA Privacy Officer at the address listed above.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for RCLTCS.

- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures," if any such disclosure was made for any purpose other than treatment, payment, healthcare operations (TPO) or certain other authorized disclosures.

To request an accounting of disclosures, you must submit your request in writing to the HIPAA Privacy Officer at the address listed above. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations (TPO). You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. ***We are not required to agree to your request for restrictions.*** To request restrictions, you must submit your request in writing to the HIPAA Privacy Officer listed above. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, at work or by mail, in your room or in another room that may provide more privacy. To request confidential communications, you must submit your request in writing to the HIPAA Privacy Officer listed above. Where possible, we will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may ask us to give you a copy of this Notice at any time. You may obtain a copy of this Notice by contacting the HIPAA Privacy Officer or RCLTCS Social Service Department.

How to File a Complaint

If you believe your privacy rights have been violated by RCLTCS, you may file a complaint addressed to the HIPAA Privacy Officer, Rockingham County Long Term Care Services, 117 North Road, Brentwood, NH 03833. Your complaint must be in writing. You may also file a complaint with the federal government by contacting the Secretary of the Department of Health and Human Services at 200 Independence Ave., SW, Washington, DC 20201. **You will not be penalized or retaliated against for filing a complaint.**

Rockingham County Nursing Home

Acknowledgement of Receipt of Notice of Privacy Practices

_____

Signature of Resident or Resident's Legal Representative

_____

Name of Resident or Resident's Legal Representative

_____

Description of Resident's Legal Representative's Authority

_____

Date