RESIDENT AGREEMENT
Assisted Living with Dementia Care

SUMMARY OF IMPORTANT TERMS

Resident(s): **Effective Date:**_____

_____ **Occupancy Date:**_____

_____ **Apartment No.:** _____

Apartment Address (Check One):
[ ] Mendota Manor - 659 Mulberry Lane, Mendota Heights
[ ] Hilltop Manor - 595 Mendota Road, Mendota Heights
[ ] Mendakota Manor - 2351 Pagel Road, Mendota Heights
[ ] Lake Manor - 2370 Rogers Avenue, Mendota Heights

Designated Representative (Name/Contact) **Legal Representative (Name/Contact)**

_____ _____

_____ _____

_____ _____

If Resident declines to name a Designated Representative, Resident please initial here: ☐

Term: Month-to-Month

Fees (Check All That Apply):	**Monthly Amount:**
Private Suite Monthly Base Fee (Rent & Included Services):	[ ] $ 13,700
Shared Suites Monthly Base Fee (Rent & Included Services):	[ ] $ 11,700
Meal Plan Monthly:	[ ] $ 100
Medication Set Up Non-Preferred Pharmacy Monthly:	[ ] $ 300
Medication Set Up Preferred Pharmacy Monthly:	[ ] Included

Total Monthly Fees: $ _____

Monthly Fee First Due:_____, 20____
Late fees may apply

One-Time Community Fee (Due on Admission): $850

[Office Use:] **Date Initial Service Plan finalized and placed in Resident file:** _____/_____/_____
Fill in date above **or** *check here if receiving Included Services only:* ☐

1. PARTIES TO THE AGREEMENT

This Resident Agreement (the "**Agreement**") is a contract between the Resident(s) named on the first page of the Agreement and Heart to Home Incorporated. Throughout this Agreement, the terms "**we**" and "**our**" refer to Heart to Home Incorporated and the terms "**you**" and "**your**" refer to the Resident(s) and the Designated Representative if one is named.

This Agreement describes the terms on which we will provide you with housing and services at Heart to Home Incorporated (the "**Community**"). Please read it carefully. It contains important information about our responsibilities and obligations to you, and your responsibilities and obligations to us and to other residents of the Community.

The Community is an equal opportunity provider of housing intended for and solely occupied by persons aged 65 and over in compliance with the Fair Housing Act and its implementing regulations.

2. IMPORTANT CONTACT INFORMATION

Facility (Check One): [ ] 659 Mulberry Lane, Mendota Heights, MN 55118. Tel 651-454-4550 [ ] 595 Mendota Road, Mendota Heights, MN 55118. Tel 651-994-9191 [ ] 2351 Pagel Road, Mendota Heights, MN 55120. Tel 651-994-2020 [ ] 2370 Rogers Ave, Mendota Heights, MN 55120. Tel 651-528-7883 **Person authorized to accept service of notices and orders:** Joshua Cesaro-Moxley, LALD 659 Mulberry Lane Mendota Heights, MN 55118	**Assisted Living Licensee:** Heart to Home Incorporated 659 Mulberry Lane Mendota Heights, Minnesota 55118 Tel. 651-454-5250 Fax 651-433-7117 **AL License No. (Check One):** [ ] 659 Mulberry Lane HFID 25756 [ ] 595 Mendota Road HFID 31990 [ ] 2351 Pagel Road HFID 26147 [ ] 2370 Rogers Ave HFID 33531

3. ACCOMMODATIONS

A. **Apartment.** Subject to the terms of this Agreement, you may occupy and use the apartment or suite identified on the first page of this Agreement (the "**Apartment**").

B. **Furnishings.** Your Apartment will be provided furnished with a commode and twin hospital bed.

The parties named below have executed this Agreement as of the date indicated.

HEART TO HOME INCORPORATED

By:_____

Its:_____

_____
(Signature)

Date:_____

RESIDENT

_____
(Printed Name)

_____
(Signature)

_____
(Date)

RESIDENT'S LEGAL REPRESENTATIVE

_____
(Printed Name)

_____
(Signature)

_____
(Date)

_____
(Street Address)

_____
(City, State, Zip)

_____
(Phone)

_____
(Email)

RESIDENT'S DESIGNATED REPRESENTATIVE

_____
(Printed Name)

_____
(Signature)

_____
(Date)

_____
(Street Address)

_____
(City, State, Zip)

_____
(Phone)

ATTACHMENT B
UNIFORM CHECKLIST DISCLOSURE OF SERVICES (SEE ATTACHED)

ATTACHMENT C
MEAL PLAN OPTIONS

Please make your selection by checking one of the boxes below:

☐ **Option 1—Three Meals a Day Plus Snacks**
Monthly Cost: $100

☐ **No Meal Plan.** I do not wish to participate in a meal plan through the Community at this time.

My selection of meal plan noted above revokes and replaces any prior meal plan selection. I understand that the fees associated with my selection will be added to my monthly fees.

Resident Signature: _____

Date: _____

ATTACHMENT D
SERVICE PLAN (SEE ATTACHED)

ATTACHMENT E
ASSISTED LIVING BILL OF RIGHTS (SEE ATTACHED)

ATTACHMENT F
DISCLOSURE OF SPECIAL CARE STATUS

1) The philosophy of Heart to Home is to care for those needing supervision and supportive services 24 hours a day while providing oversight to vulnerable areas in their day-to-day living. Residents who have dementia will be supported by our staff to ensure quality care for the needs and safety of these residents. .
Our Values:

- We believe in the inherent dignity and worth of the individual.
- We believe in the right of all people to live their lives to the fullest extent possible.
- We believe Heart to Home is responsible for assisting an individual to become aware of his/her potential by offering services for physical support and promoting psychological adjustments.
- We believe that Heart to Home has been established to promote an environment conducive to the health, safety and wellbeing of the Resident.
- We believe that employment in our Home can provide job satisfaction for the personnel.
- We believe Heart to Home is an integral part of the community.

Our Objectives:

CONTACT INFORMATION - Heart to Home Directory

Main Office -	651-454-5250
Mendota Manor (Ashley) -	651-454-4550 | mendota@hearttohomeinc.com
Mendakota Manor (Rane) -	651-994-2020 | mendakota@hearttohomeinc.com
Hilltop Manor (Minellie) -	651-994-9191 | hilltop@hearttohomeinc.com
Lake Manor (Abbey) -	651-528-7883 | lake@hearttohomeinc.com
Nurse Fax -	651-433-7117
Office Fax -	651-686-5295
General Email -	team@hearttohomeinc.com

Administrator / Co Owner
Josh Cesaro-Moxley, LALD (Primary Licensed Assisted Living Director)
651-485-8738 (cell) (Available 24/7 in Emergency)
josh@hearttohomeinc.com

Clinical Nurse Supervisor (South Campuses - Mendakota Manor & Lake Manor)
Misty Burnette, RN, LALD
651-888-0573 (cell)
misty@hearttohomeinc.com

Clinical Nurse Supervisor (North Campuses - Mendota Manor & Hilltop Manor)
Priscilla Amankwah-Akuffo, RN
651-888-9364 (cell)
priscilla@hearttohomeinc.com

Operations Manager & Dementia Specialist
Angie Burnette, CAEd, CAC, CFM, LALD
651-888-0573 (cell)
angie@hearttohomeinc.com

Staffing Coordinator & Activities
Susan Heutmaker, LALD
651-888-9364 (cell)
susan@hearttohomeinc.com

Facilities Maintenance Manager
Robert Heutmaker
robert@hearttohomeinc.com

CONTACT INFORMATION - Ancillary Service Providers

Bluestone Physician Services (Visiting Doctor)
Cheryl Vukmanich, CNP
651-342-1039 (office)
info@bluestonemd.com / www.BluestoneMD.com

Thrifty White Pharmacy (Pharmacy Provider)
1-800-642-3275
www.thriftywhite.com

Minnesota Hospice
952-898-1022
www.minnesotahospice.com

Our Lady of Peace Hospice
651-789-5030
www.OurLadyOfPeaceMN.org

Brighton Hospice
651-731-7894
www.brightonhospice.com

Ecumen Hospice
1-877-311-4997
www.ecumenhospice.org

APA Medical Equipment (Equipment Provider)
(612) 722-9000

Midwest Medical Supply (Equipment Provider & O2)
(763) 780-0100

TLC Special Transportation (Wheelchair Van Transport)
(952) 882-0535

Assisted Transport (Wheelchair Van Transport)
(612) 729-1156

Allegiance Transportation (Wheelchair Van Transport)
(651) 207-5211

Additional Information

Sixty days before the facility plans to reduce or eliminate one or more services for a particular resident, the facility must provide written notice of the reduction. Refer to 144G.55 Subd. 1(d) (www.revisor.mn.gov/statutes/cite/144G.55).

Residents may choose to obtain services from an outside service provider at their own cost. Residents may also obtain services from an outside service provider if the resident's assessed needs exceed the scope of services the facility can provide as agreed upon in the contract and are not included in the checklist. If this occurs and the resident is not able to obtain services from an outside service provider, then the facility may require the resident move to another facility or care setting that is able to meet the resident's needs. In the event this occurs, the facility will assist in a coordinated move of the resident to a safe and appropriate location.

Prospective Residents need to call the Senior LinkAge Line to discuss their housing options before signing a contract with a licensed assisted living facility. The Senior LinkAge Line is available Monday through Friday from 8am to 4:30pm at 1-800-333-2433.

You can get further information, at no cost, about advocacy or care options from:

- Office of Ombudsman for Long Term Care (https://mn.gov/board-on-aging/direct-services/ombudsman/); 1-800-657-3591
- Office of Ombudsman for Mental Health and Developmental Disabilities (https://mn.gov/omhdd/); 1-800-657-3506
- Minnesota Directory for community resources: www.MinnesotaHelp.Info
- Minnesota Senior LinkAge Line (www.seniorlinkageline.com/); 1-800-333-2433

By signing below, I acknowledge that I have reviewed this document. This is NOT a contract to receive services.

_____ _____

Date (MM/DD/YYYY) Individual or Legal/Designated Representative

MN 55401-1780 1-800-292-4150
mndlc@mylegalaid.org (http://mylegalaid.org/)

MINNESOTA DEPARTMENT OF HUMAN SERVICES
(Medicaid Fraud and Abuse-payment issues)
Surveillance and Integrity Review Services
PO Box 64982 St Paul, MN 55164-0982
1-800-657-3750 or 651-431-2650
DHS.SIRS@state.mn.us

SENIOR LINKAGE LINE (Aging and Disability Resource Center/Agency on Aging)
Minnesota Board on Aging
PO Box 64976 St. Paul, MN 55155
1-800-333-2433
senior.linkage@state.mn.us
www.SeniorLinkageLine.com

_____ _____

Individual or Legal/Designated Representative **Date Signed**

Prepared and Distributed by LeadingAge Minnesota July 2022
2550 University Avenue West, Suite 350 South • St. Paul, MN 55114
651.645.4545 • www.LeadingAgeMN.org

RESIDENT ACKNOWLEDGEMENT & RELEASE FORM

Resident Name:_____ Room #:_____ Move In Date:_____

Please initial to acknowledge that you have received the following documents:

_____I have received and signed the Resident Agreement for Heart to Home.

_____I have received a copy of the Resident Handbook.

_____I understand that if I am no longer able to meet the financial obligations for care and room/board that I may be given the option to move into a semi-private suite (if available) to continue to meet the Residency Requirements of Heart to Home.

_____I have received a copy of the following: Uniform Checklist Disclosure of Services, Assisted Living Bill of Rights, Notice of Privacy Practices, Disclosure of Special Care Status and the following Policies and Procedures; Philosophy of Services, Evaluation of Behavioral Symptoms, Wandering and Egress Prevention, Medication Management, Staff Training on Dementia, Life Enrichment Programming, Family Support Programs, Transportation Coordination and Safe Keeping of Resident Possessions.

_____I have received and signed a copy of the home care service plan/agreement.

_____I have been shown the emergency exit map, the location of the emergency exits and where I can obtain a copy of Heart to Home's disaster plan.

_____ We understand that the care staff of Heart to Home are not trained in CPR and that in the event of an emergency "911" may be contacted to provide such services.

_____ We understand policies on absences and continued financial obligations from Heart to Home per the Resident Agreement.

_____In the event a resident passes away they or their estate will remain financially obligated to pay for the Base Fee for a minimum of 15 days after their passing. If Heart to Home has rented the suite to another individual before the end of those 15 days the fees will be prorated to that date.

_____I may request a copy of Medication and Side Effects and Adverse Effects and was informed that I can contact Misty Burnette, Clinical Nurse Supervisor with medication Questions.

_____ We operate a restraint free facility. This means we do not use bed rails, wheelchair seat belts, alarms that may restrict a residents movement or other such devices that may restrict the movement of a resident.

_____ You have the right to name anyone as your “Designated Representative.” A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney (“attorney-in-fact”), or health care power of attorney (“health care agent”), if applicable.

_____ We provide dementia care in a non-secured home environment that utilizes standard residential door locks.

Initial those that apply;

_____I have received information about advance health care directives and a brief description of Heart to Home’s policy regarding advance health care directives.

_____I have executed a Health Care Directive and have provided a copy to Heart to Home.

_____I have executed a Health Care Directive and have not provided a copy to Heart to Home.

_____I have not executed a Health Care Directive.

Photo release; I consent without consideration or compensation for the use (full or in part) of any photographs taken of me or statement made by me for the purpose of illustration on Heart to Home website, brochures, newsletters, or other printed materials, videotape, slides, computer digital presentations, or distribution in any manner with no restriction in time.
□ Yes □ No

Is it OK if Heart to Home posts your name on the memory board outside of your room?
□ Yes □ No

Is it OK if Heart to Home takes me on supervised walks in the neighborhood or on resident outings?
□ Yes □ No

Is it OK if Heart to Home posts your Birthday in the common areas for activity purposes?
□ Yes □ No

_____

(Signature of Home Care Client or Responsible Party) (Date)

_____

(Signature and Title of Heart to Home Staff) (Date)

Updated 2/1/2024

Patient Enrollment Form

All information must be completed

Bluestone Physician Services

Patient Information: Please use full legal name.

☐ *Memory Care* ☐ *Assisted Living* ☐ *Group Home* ☐ *Independent Living*

First Name: _____ Last Name: _____ M.I.: ____

Date of Birth: ____/____/____ Social Security #: _____ Gender: ☐ M ☐ F ☐ Other

Facility Name: _____ Phone Number: _____ City/State: _____

Patient Room #: _____ Patient personal cell or direct phone only *(if applicable):* _____

Marital Status *(choose one)*: ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Single

Race/Ethnicity: *Choose one or more*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

Primary Language: _____ Country of Origin: _____ ☐ Interpreter Services Needed

Drug Allergies ***(required)***: _____

Insurance: Please submit a copy of insurance cards.

Medicare ID #:_____ (If on Medicare, ID ***required*** for enrollment.)

Primary Plan: _____ Policy ID #: _____ Group #: _____

Secondary Plan: _____ Policy ID #: _____ Group #: _____

Prescription Drug Coverage Name: _____ Plan ID #: _____

Legal Representative

I understand that a patient may voluntarily designate or appoint an individual other than the patient to make medical decisions on the patient's behalf. The individual may be referenced on the applicable authorizing paperwork using the following terms or other similar terms: Power of Attorney, Healthcare Surrogate, Healthcare Proxy, Healthcare Power of Attorney, Guardian, etc. (collectively referred to here as the "Legal Representative"). I acknowledge and agree that by signing this form as Legal Representative, I swear and attest that I am legally authorized to act and make decisions on the patient's behalf. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative in order to receive related communications, including verbally and via the Bridge. The Bridge is where you can electronically contact Bluestone's care team 24 hours a day, 7 days a week for questions, and is where the care team will connect with you about the patient's care. Upon signing this form or any other required documentation from Bluestone as a Legal Representative for the patient, I hereby release and hold harmless Bluestone Physician Services and its representatives from any claims or damages arising from Bluestone's reliance on my attestation that I am the patient's Legal Representative. If there is a/you are the Legal Representative, please provide their/your contact information below:

Name: _____ Relationship to Patient: _____

Mobile Phone #: _____ Secondary Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Billing Contact:

☐ Same as Healthcare Decision Maker ☐ Self ☐ Other _____

Name: _____ Relationship to Patient: _____

Mobile Phone #: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Updated 8/17/2022

Authorization for Release of Health Information

Bluestone Physician Services

Patient Information: Please use full legal name.

First Name: _____ Last Name: _____ M.I.: _____ Date of Birth: _____/_____/_____

Community and Room #: _____

Release Information From (Required):

Clinic Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Release Information To:

Bluestone Physician Services
Attn: Medical Records Dept.
270 Main Street N., Suite 300
Stillwater, MN 55082

FAX: 855-490-4045 **PHONE:** 877-599-1039

Information To Be Released (Required): Indicate ONLY the information that you are authorizing to be released.

☐ Notes from **four** most recent provider visits ☐ Labs and imaging within last two years

☐ Hospital discharges within **last two years** ☐ Other: _____

By law, you must specifically request the following information for it to be released:

Chemical dependency program: ☐ Yes ☐ No Behavioral health notes: ☐ Yes ☐ No

I hereby authorize the release of my individually identifiable health information described above for treatment and payment purposes. I understand that this authorization to release health information is voluntary. I understand that the information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing of this form. I understand I may request a copy of this form after I sign it. I understand that this authorization may be revoked by me by written notice to Bluestone Physician Services. I understand that if I revoke this authorization it will not have any effect on any actions taken by Bluestone Physician Services before receiving my revocation. This release covers past, present and future encounters/visits unless I write in specific treatment dates here: _____ to _____. This consent does not expire unless I write in a specific expiration date here: _____.

I acknowledge and agree that by signing this form as a Legal Representative for the patient, I swear and attest that I am legally authorized to act and make decisions on behalf of the patient. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative in order to receive related communications. Upon signing the form or any other required documentation from Bluestone as a Legal Representative for the patient, I hereby release and hold harmless Bluestone Physician Services and its representatives from any claims or damages arising from Bluestone's reliance on my attestation that I am Legal Representative.

_____ _____

Patient or Legal Representative Signature ***Date***

_____

Legal Representative Printed Name and Authority to sign for patient *(i.e. Health Care Directive, Medical POA; must include documentation)*

Updated 8/17/2022

Consent for Services

Bluestone Physician Services

Patient Full Name: _____ Date of Birth: _____/_____/_____

Community and Room #: _____City/State: _____

Consent for Services and Disclosure of Information for Treatment: I consent to any and all medical evaluation and treatment, preventative care services and procedures which are deemed necessary or advisable by Bluestone medical providers and designees. I consent to the use of telemedicine services in the course of my diagnosis and treatment with my Bluestone Provider Team. Telemedicine involves the use of audio, video or other electronic communications to interact and consult with the healthcare provider(s). I also consent to the use and disclosure of my health information by Bluestone for my treatment, including disclosure of my health care information to health care providers and facilities unrelated to Bluestone that may be involved in care.

Health Information Exchange: Bluestone may disclose my health information to and access my health information from other providers using a record locator service or patient information service of a health information exchange unless **I object by checking here:** ☐

This applies to health information Bluestone already has about me, information about future care I may receive from Bluestone and information Bluestone receives from third parties. This consent will continue unless I cancel by giving written notice to Bluestone or it expires as required by law. Cancellation will apply after the date when the notice to cancel is received. It will not affect information that is used or disclosed before cancellation.

Notice of Privacy Practices and Consent (Acknowledgment of Receipt): I received a copy of Bluestone's Privacy Practices and understand I have a right to review these before signing this consent form. I understand that Bluestone may change its privacy practices in the future, that any changes will be posted on Bluestone's website and that I may request a copy of the new privacy practices at any time. I understand I can contact Bluestone's Privacy Officer with any questions I may have about the Notice of Privacy Practices. In addition to the other uses and disclosures described in this document, I consent to the use and disclosure of my health information for the purposes described in the Notice of Privacy Practices, including Bluestone's health care operations.

Patient Financial Consent: I understand that it is my responsibility to know what the terms of my insurance are, and in compliance with those terms, I understand I will pay all applicable co-pays or co-insurance and outstanding account balances as they become due. I understand that it is my responsibility to read and review the Bluestone Physician Services (BPS) Patient Financial Consent policy located online at BluestoneMD.com and agree to be bound by its terms.

Use of Health Care Records in Program Evaluations and Training: I give Bluestone permission to use and disclose information gathered during the course of my treatment from Bluestone, including information from my treatment records, for the purposes of program evaluation and training and for overall quality review, including staff performance and outcomes at Bluestone.

Chronic Care Management: I give Bluestone permission to enroll me in the Bluestone program which includes chronic care management (CCM) when appropriate. The program and CCM include practitioner/ care management visits and activities, which will be billed to my insurance with normal deductibles and copays. I understand that only one practitioner may furnish and be paid for CCM services during a given calendar month and that I have the right to stop CCM services at any time. I understand information concerning this program is available on the website at BluestoneMD.com/forms.

Consent for Use of Medical Records in Academic Research: I authorize Bluestone Physician Services to use or disclose my health records for medical or academic research, including health records created at any time by Bluestone and records Bluestone received from other health care providers, unless I object by checking here: ☐ **I request that Bluestone tell me the dates on which my health records are released for research and how to contact external researchers who have received my records.**

Consent to Email or Text Usage: I authorize Bluestone to communicate with me, including potentially sensitive information about me like billing, payment, and appointment- related information, via text message (also known as SMS) and e-mail.

☐ **I would like to opt-out of receiving text messages**
☐ **I would like to opt-out of receiving e-mails from Bluestone**

If Legal Representative signing this form: I acknowledge and agree that by signing this form as a Legal Representative for the patient, I swear and attest that I am legally authorized to act and make decisions on behalf of the patient. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative in order to receive related communications. Upon signing the form or any other required documentation from Bluestone as a Legal Representative for the patient, I hereby release and hold harmless Bluestone Physician Services and its representatives from any claims or damages arising from Bluestone's reliance on my attestation that I am Legal Representative.

Patient signature: _____ Date: _____

Legal Representative signature *(if authorized to sign for patient):* _____ Date: _____

Legal Representative printed name: _____ Relationship to patient: _____

Updated 8/17/2022

Consent for Access to Protected Health Information (PHI)

Bluestone Physician Services

Patient Full Name: _____ Date of Birth: _____/_____/_____

The Bridge and the Patient Portal are HIPAA compliant communication and health record systems where you and/or people you authorize can stay updated or access important health information online and access the Bluestone care team anytime. Both are very important tools for delivering high quality healthcare and keeping everyone informed. The primary way to reach your provider team is through the Bridge!

If patient is signing this form: I can authorize a personal representative to access my health care information and communicate with my Bluestone Provider Team electronically through the Bluestone Bridge and/or the Bluestone Patient Portal by filling out the PHI form with the **appropriate information.**

If Legal Representative is signing this form: I acknowledge and agree that by signing this form as a Legal Representative for the patient, I swear and attest that I am legally authorized to act and make decisions on behalf of the patient. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative in order to receive related communications with the Bluestone Provider Team electronically through the Bluestone Bridge and/or the Bluestone Patient Portal. Upon signing the form or any other required documentation from Bluestone as a Legal Representative for the patient, I hereby release and hold harmless Bluestone Physician Services and its representatives from any claims or damages arising from Bluestone's reliance on my attestation that I am Legal Representative.

If you are the patient and have signed the Consent for Services form yourself, please complete the below section to consent to authorizing access to Protected Health Information for those who you want to have access to your medical information and care providers. Return via fax to the number listed below or use our secure upload feature.

If you are the Legal Representative for someone who is not able to consent themselves, you will need to fax or email this form **and the supporting legal documents** (Health Care Directive, Healthcare Power of Attorney forms, proof of guardianship, etc.) to our office as soon as possible. ***Receiving this paperwork is the only way we can provide access to Protected Health Information to someone other than the patient.***

FAX: 855-306-1167 **Secure Upload: bluestonemd.sharefile.com/filedrop**

This consent applies to health information Bluestone already has about me, information about future care I may receive from Bluestone and information Bluestone receives from third parties. This consent will continue unless I cancel by giving written notice to Bluestone Physician Services or it expires as required by law. Cancellation will apply ***after the date*** *when the notice to cancel is received. It will not affect information that used or disclosed before cancellation.*

People who the signer of this consent grants access to Bridge and Patient Portal: please ensure accuracy of this info or there will be delays

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

REQUIRED: By signing below, you acknowledge the above and that you are giving the following individuals access to your health care records maintained by Bluestone, including updates on your health care status.

Patient signature: _____ Date: _____

Legal Representative Signature *(if authorized to sign for patient):* _____ Date: _____

Legal Representative printed name: _____ Relationship to patient: _____

For IT questions about Bridge or patient portal registration, please contact the IT Help-Desk Line: 855-794-9476
For questions about enrollment or about Legal Representative forms, please contact the Enrollment Team at: 877-599-1039

Updated 8/17/2022

A POLST FORM MAY BE DISCLOSED IN A MEDICAL EMERGENCY WHEN PATIENT CONSENT CANNOT BE OBTAINED

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

PATIENT LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH

PRIMARY MEDICAL CARE PROVIDER NAME | PRIMARY MEDICAL CARE PROVIDER PHONE *(WITH AREA CODE)*

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

CHECK ONE

☐ **Attempt** Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).

☐ **Do Not Attempt** Resuscitation / DNR (**Allow Natural Death**).

When not in cardiopulmonary arrest, follow orders in B.

B MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

CHECK ONE (NOTE REQUIREMENTS)

☐ **Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.

☐ **Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Provide basic medical treatments aimed at treating new or reversible illness.

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

TREATMENT PLAN: Maximize comfort through symptom management.

C DOCUMENTATION OF DISCUSSION

CHECK ALL THAT APPLY

☐ **Patient** (*Patient has capacity*) ☐ **Court-Appointed Guardian** ☐ **Other Surrogate**

☐ **Parent of Minor** ☐ **Health Care Agent** ☐ **Health Care Directive**

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE ***(STRONGLY RECOMMENDED)*** | NAME *(PRINT)* | DATE

RELATIONSHIP *(IF YOU ARE THE PATIENT, WRITE "SELF")* | PHONE *(WITH AREA CODE)*

Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.

D SIGNATURE OF PHYSICIAN / APRN / PA

ALL ITEMS REQUIRED

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

NAME *(PRINT)* | CREDENTIALS (MD, DO, APRN, PA) | PHONE *(WITH AREA CODE)*

SIGNATURE | DATE

GIVE POLST FORM TO PATIENT WHENEVER TRANSFERRED OR DISCHARGED. *FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.*

INFORMATION FOR

PATIENT NAMED ON THIS FORM

A POLST FORM MAY BE DISCLOSED IN A MEDICAL EMERGENCY WHEN PATIENT CONSENT CANNOT BE OBTAINED

E ADDITIONAL PATIENT PREFERENCES *(OPTIONAL)*

OPTIONAL SECTION. IF COMPLETED, CHECK ONE FROM EACH CATEGORY

ARTIFICIALLY ADMINISTERED NUTRITION *Offer food by mouth if feasible.*

- ☐ **Long-term artificial nutrition by tube.**
- ☐ **Defined trial period of artificial nutrition by tube.**
- ☐ **No artificial nutrition by tube.**

ANTIBIOTICS

- ☐ **Use IV/IM antibiotic treatment.**
- ☐ **Oral antibiotics only (no IV/IM).**
- ☐ **No antibiotics. Use other methods to relieve symptoms when possible.**

ADDITIONAL PATIENT PREFERENCES *(e.g. dialysis, duration of intubation).*

F HEALTH CARE PROFESSIONAL WHO PREPARED DOCUMENT

REQUIRED: CHECK BOX OR COMPLETE ALL ITEMS

☐ **Same as signing provider (see Section D)**

NAME *(PRINT)* TITLE PHONE *(WITH AREA CODE)*

SIGNATURE DATE

NOTE TO PATIENTS AND SURROGATES

The POLST form is always voluntary and is for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. A Health Care Directive is recommended for all capable adults, regardless of their health status. A Health Care Directive allows you to document in detail your future health care instructions and/or name a health care agent to speak for you if you are unable to speak for yourself.

DIRECTIONS FOR HEALTH CARE PROVIDERS

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- POLST should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of a Health Care Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/APRN/PA in accordance with facility/community policy.
- A surrogate may include a court appointed guardian, health care agent designated in a Health Care Directive, or a person who the patient's health care provider believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known, such as a spouse, domestic partner, adult child, sibling, parent of a minor, other relative or close friend, or closest available relative.

Reviewing POLST

This POLST should be reviewed periodically, and if:

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

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through F and write "VOID" in large letters if POLST is replaced or becomes invalid.
- If included in an electronic medical record, follow voiding procedures of facility/community.

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Omnicare®
a ♥CVSHealth company

Pharmacy Intake Fax Cover Sheet

Complete and fax one cover sheet per patient upon admission or readmission. Missing information may delay medication delivery.

Do NOT send prescription orders with this cover sheet.

Facility/Community Name	Name of Person Completing Form

☐ **Check if a Face Sheet is attached. If ALL required information listed below is provided, STOP here. If required information is not included, fill in any fields below that are not included in the attachment.**

Resident Name (FIRST and LAST)	Date of Birth	Gender ☐ Male ☐ Female

Move-In/Admit Date	Select One: ☐ New Admission ☐ Re-Admission

Nursing Station/Wing or Floor/Room Number/Bed Number	Prescriber/Primary Care Physician Name (FIRST and LAST)

Allergies ☐ NKDA

Diagnoses

PAYOR INFORMATION

☐ Copies of insurance card attached. **Please include copies of all applicable insurance cards (front and back).**

☐ Medicare Part A	☐ Medicaid Managed Care (specify state):
☐ Medicare Advantage (MA Plan) Part C	☐ Medical Managed Care (specify):
☐ Medicare Part D	☐ Private Health Insurance (specify):
☐ Workers' Compensation/No Fault	☐ Other (specify):
☐ Medicaid (specify state):	☐ Hospice Name: Date Active:

Medicare (HICN/MBI) Number (if applicable)	Medicaid Number (if applicable)

Other Insurance Plan Number (if applicable)

Workers' Comp/No Fault Case #	Company	Injury Date	Phone Number

REQUIRED FOR NON-SKILLED NURSING FACILITIES, PREFERRED FOR SKILLED

Select Pharmacy (select one): ☐ Uses Omnicare ☐ Uses Outside Pharmacy

Financially Responsible Party (FIRST and LAST Name)
(Person responsible for a portion or all of the patient's health care expenses, not a health insurance plan)

Address

Phone	Email	Relationship

Please provide as much of the following information as possible.
Do not delay fax submission if the information below is not immediately available.

Social Security Number (if available)	Facility Medical Record (if available)

To preserve fax quality and integrity, please DO NOT make copies of this sheet. Contact your account representative or local Omnicare pharmacy to order additional pads.

CONFIDENTIAL HEALTH INFORMATION ENCLOSED: Health information is personal and sensitive information related to a person's health care. You, the recipient, are required to maintain this information in a safe, secure and confidential manner. Re-disclosure without appropriate authorization or as permitted by law is prohibited.

This information transmitted is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material, the disclosure of which is governed by applicable law. Any review, retransmission, dissemination or other use of, or taking of any action in reliance upon, this information by persons or entities other than the intended recipient is prohibited. If you received this fax in error, please contact the facility or person who completed this form and destroy materials contained in this message.

AUGUST 2021 / 3804611322R1018

HEART TO HOME INC.
AUTHORIZATION AGREEMENT
FOR DIRECT PAYMENTS (ACH DEBITS)

COMPANY NAME: HEART TO HOME INCORPORATED

I (we) authorize the COMPANY (named above) to initiate debit entries and, if necessary, to initiate any credit entries to correct an erroneous debit entry to my (our) account at the DEPOSITORY (identified below), for the purpose of automatically debiting funds from my (our) account. I (we) acknowledge that the origination of these transactions must comply with the provisions of U.S. Law.

DEPOSITORY / FINANCIAL INSTITUTION NAME _____

BRANCH_____PHONE NUMBER _____

CITY_____ STATE_____ZIP_____

ROUTING NUMBER_____See Attached Voided Check _____

BENEFICIARY / ACCT HOLDER NAME_____

ACCOUNT NUMBER_____ ☐Checking ☐Savings

TRANSFER FREQUENCY: **Monthly** AMOUNT OF TRANSFER: **Per Monthly Mailed Invoice**

DATES OF TRANSFER (Circle One):

15th of the Month ($100 Discount)

or

1st of the Month (No Discount)

☐ New Authorization ☐ Change to Previous ☐ Termination

I (we) understand that this authorization replaces any previous authorization and will remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and in such manner as to afford the COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME(S) (Print)_____

_____

Signature **Date**

Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name _____ Middle name _____ Last name _____

Patient date of birth ___ / ___ / _____ (MM / DD / YYYY) Previous name(s) _____

Home address _____

City _____ State _____ Zip code _____

Daytime phone _____ E-mail address (optional) _____

Medical Record/patient ID number (optional) _____

2 Contact for information about how this form was filled out (optional):

I give permission for the organization(s) listed in section 3 permission to talk to

First name _____ Last name _____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional) _____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name Heart to Home Inc.

And/or person: First name Misty Last name Burnette

Mailing address 659 Mulberry Lane

City Mendota Heights State MN Zip code 55118

Phone (optional) 651-454-5250 Fax (optional) 651-433-7117 (Preferred Method)

Information needed by (date) ___ / ___ / _____ (MM / DD / YYYY) (optional)

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☑ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental health	☐ HIV/AIDS testing
☐ Laboratory report	☐ Discharge summary	☐ Radiology report
☐ Emergency room report	☐ Progress notes	☐ Radiology image(s)
☐ Surgical report	☐ Care plan	☐ Photographs, video, digital or other images
☐ Medications	☐ Immunizations	☐ Billing records

☐ Other information or instructions _____

The following information requires special consent by law. Even if you indicate **all health information,** you must specifically request the following information in order for it to be released:

☑ Chemical dependency program *(see definition in instructions)*

☑ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

Minnesota Standard Consent Form to Release Health Information

Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

- ☑ Patient's request
- ☑ Review patient's current care
- ☑ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☐ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount_____)
- ☐ Sale (payment or compensation to entity maintaining the information? ☐ NO ☐ YES)
- ☐ Other (please explain) _____

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9 Patient's signature

_____ Date ___ /___ /_____
MM DD YYYY

OR legally authorized representative's signature _____ Date ___ /___ /_____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.) _____

PRINT FORM

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of any individual or family member of the individual, except as specifically allowed by this law.

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015.

Resident History & Preferences

Heart to Home, Inc.

Resident Name:_____

Name of Person Completing Form: _____

Religion: _____

Hospital Preference: _____

Funeral Home: _____

Veteran Status: _____

Food Preferences

Birthday Cake or Pie? What kind? _____

Ok for Alcohol? Provided by family _____

Disliked Foods? _____

_____

Favorite Food and Drinks? _____

_____

Portion Size? Small, Regular or Large _____

Activities and Hobbies

Games? Card, Board, Puzzles, Bingo, Trivia, Word _____

_____

Fine Arts and Hobbies? Painting, Flower Arranging, Crafting _____

_____

TV or Movie Preferences? News, Sports, Musicals, etc. _____

_____

Food Preparation? Cooking, Baking_____

_____

Gardening? Houseplants, Vegetable, Flower _____

_____

Musical Instruments? Piano, Guitar, Singing _____

_____

Musical Preferences? Style or Favorite Singers/Bands _____

_____

Pet Therapy? Dog and Cat Visits _____

Social Interests? Social Hours, Parties, Current Events _____

_____

Resident History

Preferred Name of Resident? _____

Marital Status and Spouse/Significant Other's Name: _____

Names of Children: _____

_____

Names and Relationships of anyone else important to that person: _____

_____

What was their past occupation(s)? _____

_____

Where was this person born or where did they grow up? _____

Describe the "home" they remember (small town, farm, city, white picket fence, large yard or garden): _____

_____

What makes this person feel valued? Talents, Occupation, Accomplishments, Family, Hobbies _____

_____

What is their exact or preferred morning and evening routine? _____

_____

_____

_____

What is their exact or preferred bathing routine? _____

_____

_____

What are other “habits of a lifetime”? _____

_____

_____

What causes stress? Noise, People, Certain Subjects, Bathing _____

_____

_____

What calms this person down? Poetry, Favorite Song, Massage, Hug _____

_____

What items are significant (familiar) to them? (Favorite Chari, Jewelry, Purse, Wallet, Family Photos, Heirlooms) _____

Describe a fond memory you have with this person: _____

_____

_____

Other information that would help us bring joy to this person:

_____

_____

_____

_____