METHODIST VILLAGE
SENIOR LIVING

# FAMILY NOTIFICATIONS

**Voice Friend-**

In the event of emergency situation, we have implemented a mass messaging system to keep in touch with all of our resident's families. This is a way to send out multiple text and phone messages all at the same time. Below are your options as to how you would like to receive your messages.

Please choose your preference.

- ☐ Phone Message
- ☐ Text Message

**Text and Email Notifications for Billing Purposes-**

I authorize MVSL to send Billing Reminders through text and/ or email notifications.

- ☐ Text Message
- ☐ Email _____

Residents name_____

Contact number _____

_____ _____

Resident/ Responsible Party Date

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619
Reviewed and Revised: 02/12/20, By: KJ

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# Medicare Insurance Benefits

I, _____ resident/responsible party for

_____ have been informed of the following insurance benefits:

Primary Payer Source:

SSN: _____Medicare ID #: _____

_____ ***days available***, as of _____, 20_____

Second Payer Source:

Insurance: _____Insurance ID #:_____

Benefits

| |
|---|
| |

***Please note days available are not a guarantee of payment from Medicare or secondary insurance sources. Days available are reflected per Medicare website upon admission. Days available may change depending on resident's previous hospital/facility stay. Resident responsibility for days 21-100 is $185.50 per day for co-insurance.***

_____ _____
Resident/Responsible Party Date

_____ _____
Administrator/Admissions Coordinator Date

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Reviewed and Revised: 1/06/21, By: KG

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## Admissions Agreement

This Agreement, made and entered into on the _____ day of _____, 20 ____ between _____ RESIDENT/ RESPONSIBLE PARTY and METHODIST VILLAGE SENIOR LIVING, herein after referred to as MVSL.

MVSL's room and board rates are billed on a per day basis. You are billed monthly, but if the resident is discharged for any reason, you will be reimbursed for the remainder of the month. All refunds are processed on the 10th of the month following discharge.

The purpose of this agreement is to provide for the medical, nursing and personal care of _____ subject to the following financial terms and patient care arrangement as set forth in this contract and the current or future operating rules of MVSL. MVSL will provide room, board and its customary general care of the RESIDENT, in accordance with the nature and extent of its facilities and services as may be available.

MVSL shall provide the services of a licensed physician for the RESIDENT. MVSL shall also obtain such medications as the physician may order; and to arrange for transfer of the RESIDENT to the hospital of the RESIDENT'S choice, when this is ordered by the attending physician. MVSL shall immediately notify the RESPONSIBLE PARTY of such transfer.

MVSL reserves the right to transfer or discharge the RESIDENT for medical reasons, for his/her welfare, for the welfare of other residents, or for non-payment for his stay (except as prohibited by Title XVII and XIX of the Social Security Act), with 30 days advance notice to ensure transfer or discharge.

The RESIDENT/RESPONSIBLE PARTY hereby certifies that he/she/they has/have read this agreement and has received a copy. The RESIDENT/RESPONSIBLE PARTY further acknowledges acceptance of the terms of this agreement; agrees to assume financial responsibility for the services rendered to him/her; and further agrees to abide by all operating rules of MH&R, both current and as modified in the future. The RESPONSIBLE PARTY further certifies that he/she/they assumes financial responsibility for services rendered to the RESIDENT.

_____

Resident/Responsible Party Date

_____

Administrator/Admissions Coordinator Date

METHODIST VILLAGE
SENIOR LIVING

# Door Safety

You have been provided with the code to use on the doors of the facility. Please be aware of your surroundings at all times when you open a door to the facility as you may inadvertently let a resident out! Many residents of our facility are cognitively impaired and by "opening the door to let them out" you are placing them in danger. Many times, it is difficult to determine if someone is a resident or a visitor, never assist anyone to exit the building.

- Here is some easy step to make sure everyone stays safe:
- Allow the door to close completely and lock before you walk away.
- Look around before you walk off to make sure residents don't follow you out the door!
- If a resident is near the door, ask a staff member to help you leave safely.
- If you think you may have let someone out, immediately call for help and stay with the resident until help arrives.

Should you have any additional questions, please contact any staff member for assistance.

I, _____ understand the door safety measures and agree to comply.

_____ _____

Signature Date

**NOTIFICATION OF NURSING FACILITY ADMISSION**
**Arkansas Department of Human Services**
**Division of Medical Services**
**Office of Long Term Care**

**NOTICE OF ADMISSION**

**FACILITY**

| |
|---|
| **Name of Facility Methodist Health & Rehab** |
| |
| |
| **City** |

**RESIDENT**

| | |
|---|---|
| **Name of Resident** | **Date of Birth** |
| **Contact Person and Title** | **Contact Person's Telephone Number** |
| **Contact Person's Home Address** | |
| **Resident's County of Residence** | **Resident's SSN** |
| **Referral Date** | **Medicaid ID # (or NA)** |
| **Type of Placement**<br>☐ Long Term NF(Permanent) ☐ Short Term NF (Convalescent not to exceed 6 months)<br>☐ NF Rehab (Also considered Short Term, but admission specifically related to Rehab)<br>☐ Hospice<br>☐ Other (Specify) | |
| **Date of Admission** | |
| **Payment Source**<br>☐ Medicaid ☐ Medicare ☐ Private Pay/Third Party | |

**DECLINATION FOR LONG TERM CARE OPTIONS COUNSELING**

**You are eligible to receive counseling on various options regarding long term care services. Your facility may be the most appropriate place to reside and to receive care. In other instances, you may find other programs that provide care in the home and in the community to be an alternative to nursing facility care. If you do not wish to receive counseling regarding these programs please check the following box:**

☐ **I DO NOT WISH TO RECEIVE LONG TERM CARE OPTIONS COUNSELING**

**LTC Options Counseling Form:** ☐ Read to Resident/Representative ☐ Not Read to Resident/Representative because the resident lacks decisional capacity and does not have a representative.

_____
Signature of Resident and/or Representative Date _____

_____
Signature of Facility Representative Date _____

Distribution: Complete and submit a COPY of this form to the Office of Long Term Care no later than 5:00 p.m. of the next business day following the contact. Maintain the original of this form in the individual's file at the Long Term Care facility.

DHS-9571 (02-01-10)

METHODIST VILLAGE
SENIOR LIVING

# Facility Authorization Form

Resident: _____

Please check the appropriate response to each question as listed below.

| YES | NO | |
|---|---|---|
| ____ | ____ | I authorize MVSL to photograph the resident during in-house planned activities. |
| ____ | ____ | I authorize MVSL to use photographs of the resident in the facility newsletter, on the website, on the Facebook page, and for advertising/marketing purposes. |
| ____ | ____ | I authorize MVSL to post the resident's birthday (month and day only) within the facility and in the facility newsletter. |
| ____ | ____ | I authorize MVSL to forward any business mail to the responsible party. |
| ____ | ____ | I authorize MVSL to take the resident on planned activity trips outside the facility, with prior notification. |
| ____ | ____ | I authorize MVSL to open and read mail to the resident, as needed. |

_____ _____

Resident/Responsible Party Date

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Reviewed and Revised: 2/12/20, By: KJ

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SENIOR LIVING

# Estimated Medical Liability

Resident: _____ Date: _____

Income:

1. Income (Social Security, Retirement, etc.):

a) _____
b) _____
c) _____
d) _____

Total Income: _____

2. Personal Allowance: _____40.00

Insurance: _____

Other: _____

Total Expenses: _____

Estimated Liability: _____

Residents will be allowed Medicaid-pending status for 90 days. If Medicaid approval has not been reached at that time, the resident pay status will change from Medicaid pending to Private Pay. Payment of those Private Pay charges will be expected at that time. It is the Responsible Party's responsibility to stay in contact with the DHS department and work towards getting financial approval in the 90-day period. If there is an unforeseen problem, this must be communicated to this Care Center.

_____ _____

Resident/ Responsible Party Date

_____ _____

Administrator/ Admissions Coordinator Date

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Reviewed and Revised: 2/12/20, By: KJ

METHODIST VILLAGE
SENIOR LIVING

# Skilled Bed Hold Policy

Resident: _____

If a resident is absent due to hospitalization or home visit, the daily rate continues until MVSL is notified of their discharge, and the resident's room is vacated of any and all personal belongings.

If a resident is on Skilled/Medicare Part A services and is in the hospital past midnight for three consecutive days the family will be notified and required to:

A. Pay bed hold charges during hospital stay (private pay daily rate or their portion of the Medicaid liability) to hold bed at facility.

OR

B. Discharge resident from facility completely to avoid paying bed hold charges.

If a private pay bed is held, the full private rate must be paid.

If a Medicaid bed is held the resident or family must continue to pay their liability according to the Medicaid Program.

There is no adjustment in room rate during the resident's absence and all payments are due the fifteenth of the month. By signing I understand that I am responsible to pay the charges to hold the bed OR if I choose to discharge, I understand that a readmit will be based on bed availability.

_____

Resident/Responsible Party Date

_____

Administrator/Admissions Coordinator Date

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619
Reviewed and Revised: 2/12/20, By: KJ

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SENIOR LIVING

# Long Term Care Bed Hold Policy

Resident: _____

If a resident is absent due to hospitalization or home visit, the daily rate continues until this facility is notified of their discharge, and the resident room is vacated of any and all personal belongings. In the event that a Medicare resident is hospitalized or absent past midnight while on Medicare days there will be a charge of the private pay daily rate for those days or their portion of the Medicaid liability.

If a private pay bed is held, the full private rate must be paid. A Medicaid bed will be held for five (5) days, after which the resident or family must continue to pay their portion due according to the Medicaid Program if the bed is to be held.

There is no adjustment in room rate during the resident's absence and payment is still due by the tenth of the month. If discharge is requested, readmission will be based upon availability of beds.

_____ _____
Resident/ Responsible Party Date

_____ _____
Administrator/ Admissions Coordinator Date

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# Room Moves within the Facility

Upon Admission, the Responsible Party/Resident will be asked if they will be here for Short Term Rehab only or if they will remain for Long Term Care.

If they will remain in the facility for Long Term Care the Responsible Party/Resident is notified that they will be moved off of the Rehab Hall either to a Private room or Semi Private room depending on their choice and our availability once Skilled Services have been completed.

If Long term care beds are not available at the time, Admissions and Social Services will help the family find placement in a different facility.

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# Telephone Service

Resident: _____ Room: _____

MVSL provides **free local** telephone service to all residents.

Each resident is responsible for bringing their own telephone to the facility.

_____ _____
Resident/ Responsible Party Date

_____ _____
Administrator/ Admissions Coordinator Date

## Long Distance

MVSL provides **long distance** telephone service for a flat rate of **$10/month**. If long distance service is chosen, the $10 fee will appear on resident's monthly statement.

___ I would like long distance service for $10/month.

___ I do **NOT** want long distance service.

_____ _____
Resident/ Responsible Party Date

_____ _____
Administrator/ Admissions Coordinator Date

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# Therapy Progress Acknowledgement

Resident: _____

Medicare requires that therapy patients make progress each week while in therapy. This includes the patient being cooperative, participation in therapy, and making continual gains. If a patient does not make progress, by the ethical and Medicare standards, they must be discharged from therapy. In some cases, this will mean that their Medicare Part A benefit will no longer be active until the next qualifying event. The decision as to whether or not a patient is making progress is determined by the skilled, licensed therapist. A 72- hour notice will be given when discharging from Medicare Part A services.

_____ _____

Resident Date

_____ _____

Responsible Party (If different from Resident) Date

_____ _____

Administrator/ Admissions Coordinator Date

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619
Reviewed and Revised: 2/12/20, By: KJ

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SENIOR LIVING

# Assignment of Medicare Benefit

Resident/ Responsible Party: _____

By signing below, I, the resident/ responsible party,

1. Authorize MVSL to render any and all therapy services under the Medicare Part B program: Occupational, Physical and Speech therapies that MVSL feels are necessary or advisable to the resident in conjunction with physician referral.

2. Authorize MVSL to render any and all therapy services under the Medicare Part A program: Occupational, Physical and Speech therapies that MVSL feels are necessary or advisable to the resident in conjunction with physician referral.

3. Authorize MVSL to request payment from Medicare for the authorized benefits. I also understand that any deductions and/ or co-insurance are the responsibility of the resident/ responsible party.

4. Assign MVSL to any and all benefits payable by Medicare, Medicaid crossover and private insurance. I also authorize MVSL to apply and file for all such benefits on the resident's behalf.

5. Understand that I will be responsible for any co-insurance fees not covered by Medicaid or insurance.

6. Acknowledge that the provisions in this document will continue in full force and effect until MVSL receives a notice of written termination signed by resident/ responsible party.

7. Certify that all information given by the resident/ responsible party in applying for payment under Title XVIII of the Social Security Act and provided to MVSL is true and correct in all respects.

(Turn Over)

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SENIOR LIVING

Medicare Part A: _____ Medicaid #: _____

Medicare Part B: _____ Private Pay: _____

Secondary Insurance: _____

_____ _____

Resident/ Responsible Party Date

_____ _____

Administrator/ Admissions Coordinator Date

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619
Reviewed and Revised: 2/12/20, By: KJ

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SENIOR LIVING

# Patient Self Determination Disclosure Acknowledgement

Resident's Name: _____

I acknowledge that upon my admission to MVSL or as soon as I was able thereafter, I received a copy of Arkansas Advance Directives: Legal Documents to Assure Future Health Care Choices.

I acknowledge that the information regarding state law is not meant to be legal advice. If I have questions concerning my rights in this regard, I will consult my attorney.

Any questions I may have had about MVSL's policies and procedures regarding Advance Directive have been answered, but I understand that I may always ask the Director of Social Services, Director of Nursing Services, Administrator, or my Physician, any additional questions that I may have.

OR

I provided a copy of my Advance Directive to MVSL.

_____

Resident (Print)

_____ _____

Resident (Signature) Date

Due to the condition of _____ when admitted, a copy of the above information could not be provided. However, the required information was provided to me as the resident's designated representative. I hereby acknowledge the above statement.

(Turn Over)

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SENIOR LIVING

OR

I provided a copy of my Advance Directive to MVSL.

_____

Designated Representative (Print)

_____ _____

Designated Representative (Signature) Date

_____ _____

Administrator/ Admissions Coordinator Date

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Reviewed and Revised: 2/12/20, By: KJ

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SENIOR LIVING

# Long Term Care Physician's Visit Policy

Date: _____

Long Term Care residents must be seen by a physician every 30 day for the first 90 days, then no less than every 60 days thereafter.

Dr. _____ does see patients here and will coordinate with MVSL to see (Resident) _____ in the Care Center.

In the event Dr. _____ no longer sees the resident, it will be your responsibility to obtain another primary physician. MVSL maintains a current list of physicians that visit patients here at MVSL and we will be glad to assist you. In the event that the resident has not been seen in the required time period, the Medical Director will intervene in order to meet the regulatory requirements.

Your signature below acknowledges that you have read the above and understand Long Term Care Physician's Visit Policy.

_____ _____

Responsible Party Date

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Reviewed and Revised: 2/12/20, By: KJ

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SENIOR LIVING

# Release of Responsibility for Valuables Kept by Residents

Resident: _____

The facility encourages the resident not to bring valuables with them. The facility is not responsible for valuables left in the possession of residents or for valuables brought in by visitors and left with residents. All due precautions are taken to safeguard the possessions of residents, however MVSL cannot assume responsibility for the valuables in possession of the residents.

*Valuables include, but are not limited to the following: Cash, checks, jewelry, remote controls, etc.

_____ _____
Resident/Responsible Party Date

_____ _____
Administrator/Admissions Coordinator Date

List Valuables Below:

_____

_____

_____

_____

_____

_____

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Reviewed and Revised: 2/12/20, By: KJ

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SENIOR LIVING

# Receipt of Notice of Privacy Practices Acknowledgement

Resident: _____

Medical Record Number: _____

I, _____, have received a copy of MVSL's Notice of Privacy Practices. This information is included in the Welcome Packet given to me by the Care Center.

I understand that the Care Center may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations.

The Care Center may update this Notice at any time and I have been informed that I may request the most current version at any time.

Please Print Name: _____ Date: _____

Signature: _____

---

**For Office Use Only:**

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency prevented us from obtaining acknowledgement

Other (Please Specify

_____

_____

_____

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SENIOR LIVING

# Do Not Resuscitate (DNR) Policy

DNR means that in the event of cardiac or respiratory arrest no Cardiopulmonary Resuscitation (CPR) will be initiated to revive the individual.

CPR, at MVSL includes the use of manual chest compressions and artificial respirations to attempt to preserve function while waiting for Emergency Medical Service (EMS) transportation to the nearest Emergency Room.

If a resident and/ or family member requests a DNR the following steps must be followed:

1. **The physician must write an order for DNR to be exercised in the event of death of that individual.**

2. **The resident and/ or responsible party acting on his/ her behalf must sign the acknowledgement (attached) that MVSL requires to ensure that full disclosure has been made to all parts.**

3. **A member of MVSL' s administration will be available to visit with the family to answer any questions regarding the DNR policy so that the family is certain what this order means, prior to signing the acknowledgement.**

When all of the above requirements have been met then the order for DNR will be exercised in the event of death.

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Reviewed and Revised: 2/12/20, By: KJ

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# Do Not Resuscitate (DNR) Acknowledgement)

Resident Name: _____

This acknowledges that I, _____ (Responsible Party), have been given the opportunity to ask questions regarding MVSL's policy regarding DNR.

**Do NOT initiate Cardiopulmonary Resuscitation (CPR) in the event of cardiac or respiratory arrest. (DNR)**

_____ _____

Resident/ Responsible Party Date

_____ _____

Witness Date

**Initiate Cardiopulmonary Resuscitation (CPR) in the event of cardiac or respiratory arrest.**

_____ _____

Resident/ Responsible Party Date

_____ _____

Witness Date

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Reviewed and Revised: 2/12/20, By: KJ

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SENIOR LIVING

# Beauty Shop Authorization Form

Note: Authorization Form Must Be Completed Before Services Are Rendered

Resident: _____ Room: _____

| SERVICE DESCRIPTION | CHARGE | FREQUENCY |
|---|---|---|
| Men's Haircut | $12.00 | |
| Women's Cut | $15.00 | |
| Women's Shampoo/Cut/Style | $20.00 | |
| Shampoo Set | $11.00 | |
| Hot Towel & Shave | $10.00 | |
| Hot Towel/Shave/Cut | $20.00 | |
| Beard Trim | $5.00 | |
| Full Color/Cut/Style | $40.00 | |
| Color Rinse (add-on) | $5.00 | |
| Color Only | $35.00 | |
| Perm/Style | $35.00 | |
| Perm/Style/Cut | $40.00 | |
| Relaxer | $35.00 | |
| Shampoo/Braid | $20.00 | |
| Press & Curl | $25.00 | |

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Reviewed and Revised: 2/12/20, By: KJ

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SENIOR LIVING

| | |
|---|---|
| Style | $5.50 |
| Manicure | $25.00 |
| Pedicure | $30.00 |
| Polish & Trim | $10.00 |

***All Salon Service Pricing includes chemicals, products, and equipment.***

Is the resident diabetic? ____ YES ____ NO

Known allergies:

_____

_____

_____ _____
Resident/ Responsible Party Date

_____
Responsible Party Phone Number

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619
Reviewed and Revised: 2/12/20, By: KJ

METHODIST VILLAGE
SENIOR LIVING

# Family Foot Care

Dear Resident, Family, or Responsible Party:

Our Care Center is offering Podiatry Services to our residents on a regular basis, through Senior Works.

Basic foot care (cutting or removal of corns or calluses and/ or trimming of nails) is considered routine care and not covered under normal Medicare guidelines. The fee for this service is typically $7.00.

If you are interested in having Senior Works provide this service, please give your authorization as stated below. All other services will be evaluated and filed appropriately with the resident's medical insurance.

Please Print

Resident's Name: _____

Care Center: Methodist Village Senior Living__

I give authorization for Senior Works to treat the above-named resident for services listed above. I understand that this service is not covered under Medicare and I will be responsible for payment. This will be performed every 14 weeks unless otherwise advised.

_____ _____

Signature of Responsible Party Date

Mail invoices to: _____

Street Address City, State, Zip

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# Medical Authorization

Resident Name: _____

## I. AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of my care and treatment to authorize or administer any medications or treatments, which may be deemed necessary, while I am a resident of MVSL.

## II. NOTICE OF RIGHTS, SERVICES AND RESPONSIBILITIES

I have received a copy of the Influenza, Pneumococcal, and COVID-19 Vaccine Statements.

## III. INFLUENZA AND PNEUMOCOCCAL VACCINE

I hereby authorize MVSL to administer an annual influenza vaccine once every year, and to administer a one-time pneumococcal vaccine.

_____ Yes, I give authorization for a yearly influenza vaccine.

_____ No, I deny authorization for a yearly influenza vaccine.

If already received:

Date: _____ Administering Facility: _____

If refused, provide reason: _____

(Turn Over)

METHODIST VILLAGE
SENIOR LIVING

_____ Yes, I give authorization for a Pneumococcal vaccine.

_____ No, I deny authorization for a Pneumococcal vaccine.

If already received:

Date: _____ Administering Facility: _____

If refused, provide reason: _____

**IV. COVID-19 VACCINE**

I hereby authorize MVSL to administer the COVID-19 vaccine.

_____ Yes, I give authorization for a COVID-19 vaccine.

_____ No, I deny authorization for a COVID-19 vaccine.

If already received:

Date: _____ Administering Facility: _____

If refused, provide reason: _____

_____ _____

Resident/ Responsible Party Date

_____ _____

Administrator/ Admissions Coordinator Date

METHODIST VILLAGE
SENIOR LIVING

# Preferred Pharmacy

Resident: _____

Methodist Village Senior Living has a contract with TruCare Pharmacy for all of its pharmaceutical needs. TruCare Pharmacy is a closed-door pharmacy in Fort Smith designed to meet the specific needs of long-term care residents in nursing facilities.

We respect the right of our residents and their responsible party to choose which pharmacy they would like to use, however, because ordering from many different pharmacies takes the time of our nurses from our residents there will be a **$20 monthly administrative fee** added for those who choose to use a different pharmacy other than TruCare.

If you choose to go with another Pharmacy, please choose one of the pharmacies listed below by initialing on the line provided by each name.

Central Discount: _____ Medisav Pharmacy: _____

Coleman Pharmacy: _____ Stonewood Village: _____

Health Depot: _____ TruCare Pharmacy: _____

MVSL will also accept other forms of pharmacy services because we do realize that insurances and veteran's services require mail order style delivery. If you choose mail order, MVSL will request that you select a pharmacy from the above list to be used as an alternate for emergency medication and medication unable to be obtained from mail order.

If any type of mail order medication is going to be used here at MVSL please, on the lines below, fill out the name of the program and any other pertinent information regarding medication delivery.

_____

_____

_____ _____

Resident/ Responsible Party Date

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619
Reviewed and Revised: 2/12/20, By: KJ
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SENIOR LIVING

# Inventory of Personal Items

Resident:_____

| Items Retained by Resident | | | | | |
|---|---|---|---|---|---|
| Qty. | Description | Qty. | Description | Qty. | Description |
| | Bathrobe | | Suits | | Razor |
| | Bed Jacket | | Sweaters | | Toothbrush |
| | Housecoat | | Vest | | Dentures: Total |
| | Nightgown | | Sports Jacket | | Upper |
| | Pajamas | | Coat | | Lower |
| | Slippers | | Belt | | Partial |
| | Bra | | Suspenders | | Wheelchair |
| | Underwear | | Gloves | | Walker |
| | Garters | | Handkerchiefs | | Bible |
| | Girdle | | Tie | | Other: Total |
| | Hose | | Scarf | | |
| | Slip | | Hat/Cap | | |
| | Socks | | Shoes | | |
| | T-Shirt | | Boots | | |
| | Shirt | | Wallet | | |
| | Blouse | | Purse | | |
| | Pants | | Luggage | | |
| | Shorts | | Comb/Hairbrus | | |
| | Skirt | | Glasses w/ | | |
| | Dresses | | Hearing Aid | | |

** Continue list on back if needed.

____Dentures Marked ____Glasses Marked ____Clothing Marked ____Other Marked

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Reviewed and Revised: 2/12/20, By: KJ

METHODIST VILLAGE
SENIOR LIVING

| Items Acquired After Admission | | | |
|---|---|---|---|
| Date | Qty. | Description | Initials |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Items Removed After Admission | | | |
|---|---|---|---|
| Date | Qty. | Description | Initials |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| On Admission | On Discharge |
|---|---|
| I/We take full responsibility for the articles retained in my possession and any others brought to me while a patient in the facility and acknowledge receipt of a copy of this form. This facility cannot assume any responsibility for valuables left in patient's possession. | I acknowledge receipt of all resident's personal items. |
| Responsible Party:<br>_____ Date: _____ | Responsible Party:<br>_____ Date: _____ |
| Care Center Rep:<br>_____ Date: _____ | Care Center Rep:<br>_____ Date: _____ |

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619
Reviewed and Revised: 2/12/20, By: KJ

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SENIOR LIVING

# Social History

**Please Return Within 5 Days**

Name: _____ Resident's Birth Order: _____

Place of Birth: _____ Number of Siblings: _____

Number Living: _____ Number Deceased: _____

Surviving Siblings Names:

_____

_____

Father's Name: _____ Occupation: _____

Mother's Name: _____ Occupation: _____

Resident Grew Up in What Town or State: _____

Level of Education: _____ School Attended: _____

Military Service: _____ Church Affiliation: _____

Marital Status: _____ Name of Spouse: _____

Number of Years Married: _____

Number of Children: Living: _____ Deceased: _____

Children's Names:

_____

_____

Grandchildren:

_____

_____

Resident's Occupation: _____ Spouse's Occupation: _____

Resided in What City: _____

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619
Reviewed and Revised: 2/12/20, By: KJ

METHODIST VILLAGE
SENIOR LIVING

Resident's Interests, Hobbies, Clubs, Organizations prior to Admission:

_____

_____

_____

Mood or Behavior Problems Prior to Admission:

____ Hostile ____ Combative ____ Wandering

History of Depression, Mental, or Emotional Problems:

_____

_____

Mental Status Prior to Admission:

____ Friendly ____ Alert ____ Non-Responsive ____ Other

_____

Anything Special about the Resident You Would Like to Share:

_____

_____

_____

_____

_____

_____

_____

_____

_____

METHODIST VILLAGE
SENIOR LIVING

# Voting Information

Resident: _____ Room: _____

____ YES ____NO Are you a registered voter?

____ YES ____NO Do you need an Arkansas Voter Registration Application?

____ YES ____NO Do you want vote in any upcoming elections?

____ General Election

____ Midterm Election

____ Other Local and State Elections

____ YES ____NO Do you want to vote by absentee ballot?

____ YES ____NO Do you want social services to arrange for the ballot?
(If NO, family will assume responsibility for providing ballot OR providing transportation to a voting poll.)

_____ _____
Resident Date

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619
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METHODIST VILLAGE
SENIOR LIVING
7425 Euper Lane, Fort Smith AR. 72903
479-755-6305 www.methodistvillage.com

Date

Name

Address

Dear

This letter is to inform you that Methodist Village Senior Living is discharging residents name 30 days from the date of this letter**.**

Due to the following reasons:

Denied by OLTC due to being over resourced.

If requested we will assist you by providing information about placement at alternate facilities. If you have other options you are free to contact us with this information or arrange placement status yourself. We will expect to hear from you before the 30 days are up with your plans to move residents name.

You have the right to appeal this decision with the State within seven (7) calendar days of this letter, by contacting:

**State Ombudsman**

Region VIII Representative

Cherry Jo Long, RN, BSN, RO
524 Garrison Ave.
P.O. Box 1724
Ft. Smith, AR 72902
1-800-737-1827

**Director Department of Human Services**

Carol Shockley

Office of Long Term Care, Slot 404
P.O. Box 8059
Little Rock, AR 72203-8059
(501) 682-8487

Reviewed and Revised: 2/12/20, By: KJ
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METHODIST VILLAGE
SENIOR LIVING
7425 Euper Lane, Fort Smith AR. 72903
479-755-6305 www.methodistvillage.com

Persons with Developmental Disabilities:

**Arkansas Division of Mental Health Services**
Department of Human Services 4313
West Markham St.
Little Rock, AR 72205-4096
1-(501)686-9164

We are enclosing a copy of the final bill; please make arrangements to pay this invoice.

We apologize for any inconvenience this will place on you; however, we can no longer take care of **Residents name** in this environment. We wish you and your loved one the best in your endeavors.

Sincerely,

Deanna Fears

Administrator

cc: Dr. Bradly Short, Medical Director
Melissa Curry, CEO

METHODIST VILLAGE
SENIOR LIVING
7425 Euper Lane, Fort Smith AR. 72903
479-755-6305 www.methodistvillage.com

Date

Name

Address

Dear,

This letter is to inform you that Methodist Village Senior Living is discharging (residents name) 30 days from the date of this letter**.**

Due to the following reasons:

Denied by OLTC for failure to provide necessary information.

If requested we will assist you by providing information about placement at alternate facilities. If you have other options you are free to contact us with this information or arrange placement status yourself. We will expect to hear from you before the 30 days are up with your plans to move Residents name.

You have the right to appeal this decision with the State within seven (7) calendar days of this letter, by contacting:

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Sincerely,

Deanna Fears

Administrator

cc: Dr. Bradly Short, Medical Director

Melissa Curry, CEO

METHODIST VILLAGE
SENIOR LIVING

Melissa Curry
Chief Executive Officer

Deborah Covitz
Accounting Director

Deanna Fears
Care Center Administrator

Alicia Hanson
Director of Nursing

Amy Parmenter
MDS Director
Assistnat Administrator

Carol Smith
Business Development
Director

Kate Jones
Executive Assistant

Samantha Coggin
Care Center
Administrative Assistant


Matthew Holloway
Security Director

Reviewed and Revised: 3/5/21, KJ
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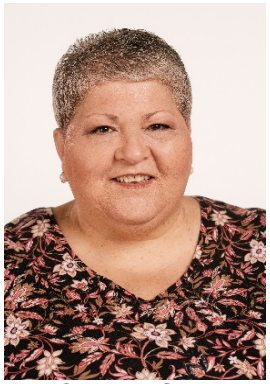
METHODIST VILLAGE
SENIOR LIVING

Kassie Hicks
Activities Director

Melynnda Dunn
Campus Education Director

Tracy Curlin
Director of Culinary Services

Ella Jones
Social Services Director



Susan Gill
HR Director

Brandie Simmons
Admissions Director

Tina Browder
Environmental Services Director

Reviewed and Revised: 3/5/21, KJ
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METHODIST VILLAGE
SENIOR LIVING

**Campus Administrative Office- 479-755-6305**

**Care Center Administrative Office- 479-452-1611**

**Front Hall Nurses Station- 479-755-6401**

**North Hall Nurses Station- 479-755-6402**

**Northwest Hall Nurses Station- 479-755-6302**

**West Hall Nurses Station- 479-755-6301**

**Beauty Salon- 479-452-1611 ext. 2114**

**Housekeeping- 479-452-1611 ext. 2113**

**Dietary- 479-452-1611 ext. 2119**