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

METHODIST VILLAGE
SENIOR LIVING

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 based on the current medicare co-insurance rate.

_____ _____
Resident/Responsible Party Date

_____ _____
Administrator/Admissions Coordinator Date

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619
Reviewed and Revised: 1/06/21 KG; 720-22 KJ

METHODIST VILLAGE
SENIOR LIVING

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 MVSL, 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

METHODIST VILLAGE
SENIOR LIVING

Alarm & Restraint Policy

MVSL is a Bed/Chair Alarm and Restraint free campus.

By signing this form, I acknowledge that I was informed of MVSL's Alarm & Restraint Policy.

_____ _____

Signature – Responsible Party Date

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619

Created 2/14/24 KJ

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 ☐ Long Term NF(Permanent) ☐ Short Term NF (Convalescent not to exceed 6 months) ☐ NF Rehab (Also considered Short Term, but admission specifically related to Rehab) ☐ Hospice ☐ Other (Specify)	
Date of Admission	
Payment Source ☐ 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

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

METHODIST VILLAGE
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 Private Pay and fully responsible for all charges, until the resident has been approved by Medicaid or other payers. This includes providing ALL documents necessary for the Medicaid application in a timely manner, before all due dates and deadlines. **Preliminary Medicaid documents and applications must be completed with the business office within five (5) days of admission**. If Medicaid approval has not been reached, the resident pay status will remain Private Pay, with the resident or responsible party being fully responsible for paying all charges. If resident is applying for Medicaid, payment of those Private Pay charges will be expected at the time of admission for the first month of the calculated resident responsibility, and the 1st of the month for each following month. 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

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619
Reviewed and Revised: 2/12/20, By: KJ; 7/18/24 KJJ

METHODIST VILLAGE
SENIOR LIVING

Agreement to Provide Financial Documents

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

The purpose of this agreement is for the RESIDENT/ RESPONSIBLE PARTY to provide financial documents required for Medicaid applications to pay for the medical, nursing and personal care of _____.

A list of required documents for Medicaid applications is provided by MVSL, if MVSL is assisting in the application process. ALL of the required documents must be provided to MVSL, within 5 business days of the decision to apply for Medicaid. If the resident/responsible party fails to provide all required documents within 5 business days, a prepayment for the first 30 days of room and board is required. If the Medicaid application is approved, retro back to an effective date previously paid for by the RESIDENT/ RESPONSIBLE PARTY, the unused portion will be refunded on the 10th of the month following the notice of Medicaid approval.

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/her 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 MVSL, 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

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 KJ, 4/7/22 KJ

METHODIST VILLAGE
SENIOR LIVING

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.

METHODIST VILLAGE
SENIOR LIVING

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

METHODIST VILLAGE
SENIOR LIVING

Therapy Progress Acknowledgement

Resident: _____

Medicare requires that therapy patients make progress each week while in therapy. This includes the patient being cooperative, participating 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 48- 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 KJ; 7/20/22 KJ

METHODIST VILLAGE
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)

METHODIST VILLAGE
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

METHODIST VILLAGE
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

(TURN OVER)

METHODIST VILLAGE
SENIOR LIVING

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.

OR

I provided a copy of my Advance Directive to MVSL.

_____
Designated Representative (Print)

_____ _____
Designated Representative (Signature) Date

OR

I decline to provide a copy of my Advance Directive to MVSL at this time.

_____
Designated Representative (Print)

_____ _____
Designated Representative (Signature) Date

_____ _____
Administrator/ Admissions Coordinator Date

METHODIST VILLAGE
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

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

METHODIST VILLAGE
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:

_____

_____

_____

_____

_____

_____

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

METHODIST VILLAGE
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

_____

_____

_____

METHODIST VILLAGE
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.

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

METHODIST VILLAGE
SENIOR LIVING

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

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

METHODIST VILLAGE
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	$15.00	
Women's Haircut	$20.00	
Women's Shampoo/Cut/Style	$30.00	
Shampoo Set/Style	$20.00	
Beard Trim	$10.00	
Full Color/Style	$45.00	
Full Color/Cut/Style	$50.00	
Perm/Style	$45.00	
Perm/Style/Cut	$55.00	
Shampoo/Braid	$25.00	

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

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

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

METHODIST VILLAGE
SENIOR LIVING

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 (VIS) Statements.

Yes_____ (Please Initial) _____

III. INFLUENZA AND PNEUMOCOCCAL VACCINE

Have you had your Influenza Vaccine Yes_____ No_____
Have you had your Pneumococcal Vaccines Yes _____ No _____
If yes, when/where? _____

I hereby authorize MVSL to administer an annual influenza vaccine once every year.

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

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

If refused, provide reason: _____

I hereby authorize MVSL to administer Pneumococcal vaccines as recommended by ADH/CDC.

_____ Yes, I give authorization for a Pneumococcal vaccine.

_____ No, I deny authorization for a Pneumococcal vaccine.

If refused, provide reason: _____

METHODIST VILLAGE
SENIOR LIVING

IV. COVID-19 VACCINE

Have you had your COVID-19 Vaccine Yes_____ No_____

I hereby authorize MVSL to administer the COVID-19 vaccines as recommended by ADH/CDC.

_____ 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.

Health Depot: _____

Medisav Pharmacy: _____

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 KJ; 7/20/22 KJ

METHODIST VILLAGE
SENIOR LIVING

Continuous Glucose Monitor Policy

It is the policy of MVSL to allow diabetic residents access and use of Continuous Glucose Monitors (CGM) when ordered by a physician.

MVSL accepts the responsibility to monitor, record, and document values associated with the CGM.

MVSL WILL NOT be responsible for the following items-

- The cost of the CGM not covered by insurance (MVSL has fingerstick capabilities and supplies on hand).
- The supply of the “receiver” device, insulin pump, and/or smart device needed to monitor the CGM values.

MVSL will require access to the “receiver” device, insulin pump, and/or smart device to be able to monitor CGM values.

_____

Resident/Responsible Party Date

7425 Euper Lane Phone: 479-452-1611 Fax: 479-452-1619
Created 11/14/24 KJ

METHODIST VILLAGE
SENIOR LIVING

RESIDENT AND FACILITY MUTUAL ARBITRATION AGREEMENT

This Arbitration Agreement (the "Agreement") is hereby entered into between Methodist Village Senior Living (the "Facility"), and _____ (the undersigned "Resident" or the Resident's "Responsible Party on behalf of the Resident"), separately from the Admission Agreement. The "Responsible Party" is the Resident's legal guardian, if one has been appointed, or the Resident's attorney-in-fact, if the Resident has executed a power of attorney. If the Resident does not have an appointed guardian, and has not executed a power of attorney, the "Responsible Party" is another individual or family member who agrees to assist the Facility in providing for the Resident's health, care, and maintenance. The "Facility" shall collectively refer to the nursing Facility and all Facility's agents, assignees, including assignees' agents, employees, officers, directors, shareholders, direct and indirect parent, subsidiaries, affiliates, predecessors, and successors to the full extent permitted by applicable law. The Resident or Responsible Party and the Facility shall be collectively referred to as the "Parties". The Parties intend that this agreement shall inure to the benefit of and bind the Parties; their successors and assigns; the owners, agents, employees, and independent contractors of the Facility and any affiliated entities; all persons whose claim is derived through or on behalf of the Resident, including that of any parent, spouse, child, guardian, executor, administrator, legal representative, or heir of the Resident; and any person whose claim is predicated on conduct involving the Resident or the aforementioned individuals.

Arbitration assists in resolving claims more quickly and less costly than going to court. It is understood and agreed by the Parties that any legal dispute, controversy, demand, or claim that arises out of or relates to the Admission Agreement or any service or health care provided by the Facility that would constitute a cause of action in a court of law that the Facility may have now or in the future against the Resident or Responsible Party, or that the Resident or Responsible Party may have now or in the future against the Facility, shall be resolved exclusively by binding arbitration to the fullest extent allowed under local, state, and federal law. A neutral Arbitrator will be selected by the Parties to hear the dispute. Specifically, the Facility will provide the Resident or Responsible Party with a list of five individuals qualified to serve as the Arbitrator. The Resident or Responsible Party may select the Arbitrator from the list or propose an alternate list of five individuals qualified to serve as the Arbitrator to the Facility for its selection. The alternate list must contain the names of Arbitrators with five or more years of experience and be licensed Arkansas attorneys whose offices are located within the State of Arkansas. If the Parties cannot agree on an Arbitrator by mutual agreement, the American Arbitration Association will select an Arbitrator in accordance with American Arbitration Association Rules. The Facility will contact the selected Arbitrator and finalize the appointment. The Resident or Responsible Party and the Facility will

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have the right to be represented by any attorney at the arbitration hearing, which will be conducted at a venue that is convenient to the parties. Each party shall bear its own fees and expenses of preparing for and participating in the arbitration. The Facility will pay the Arbitrator's fee and the court reporter's fee. The decision of the Arbitrator binds both parties and is final. The Arbitrator's written decision shall state the reasons supporting the Arbitrator's decisions and shall be based upon on governing law and evidence cited.

This Arbitration Agreement is executed separately from, the Admission Agreement, and is not a condition of admission. The Resident or Responsible Party has the right not to sign this Agreement. Failure to sign this Agreement is not a requirement to continue to receive care at the Facility. Once signed, this Arbitration Agreement governs the resolution of all claims to the maximum extent permitted by all local, state and federal law by all Parties and all their successors and assigns; the owners, agents, employees, and independent contractors of the Facility and any affiliated entities; all persons whose claim is derived through or on behalf of the Resident, including that of any parent, spouse, child, guardian, executor, administrator, legal representative, or heir of the Resident; and any person whose claim is predicated on conduct involving the Resident or the aforementioned individuals The Resident or Responsible Party has the right to rescind this Agreement within thirty (30) calendar days of signing it by providing written notice to the Facility.

The Arbitrator shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability, or formation of the Agreement, including, but not limited to, any claim that all or any part of this Agreement is void or voidable.

The Resident or Responsible Party understands that nothing in this Agreement prevents the filing of any grievance under the Facility's grievance policy; communicating with federal, state, or local officials, including but not limited to federal and state surveyors, other federal or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman regarding any matter relating to the Facility; appealing an involuntary transfer or discharge to the appropriate state or federal agency; or any making complaint with an appropriate state or federal agency concerning resident abuse, neglect, or misappropriation of resident property.

This agreement to arbitrate includes, but is not limited to, any claim for payment, nonpayment, or refund for services rendered to the Resident by the Facility, violations of any right granted to the Resident by law or by the Admission Agreement, breach of contract, fraud, or misrepresentation, negligence, gross negligence, malpractice, or claims based on any department from accepted medical or health care or safety standards, as well as any and all claims for equitable relief or claims based on contract, tort, statute, fact, or inducement. All actions or claims must be brought within the statute of limitations established in the applicable state or federal law pertaining to the underlying claim.

All claims based in whole or in part of the same incident, transaction, or related course of care or services provided by the Facility to the Resident shall be arbitrated in one proceeding. A claim shall be waived and forever barred if it arose and should reasonably have been discovered prior to the date upon which notice of arbitration is given to the Facility or received by the Resident or Responsible Party and such claim is not presented in the arbitration proceeding. Any award of the Arbitrator may be entered as a judgment in any court having jurisdiction. The Parties agree that

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Revised 2/15/24 Resident or Responsible Party Initials _____

damages awarded, if any, in an arbitration conducted pursuant to this Agreement shall be determined in accordance with the provisions of the state or federal law applicable to a comparable civil action filed in the State in which the Facility is located, including any prerequisites to, credit against, or limitations on such damages. The Parties also agree that they will not seek representative, consolidated, or class treatment of any claim. For arbitration disputes that are resolved under this Agreement, the Facility agrees to maintain records of the Arbitrator's decisions for a period of five (5) years after the resolution of the dispute.

Acknowledging and agreeing that the Facility regularly engages in such interstate commerce transactions and that the services provided by the Facility to the Resident involve interstate commerce, the Parties expressly agree that arbitration conducted under this Agreement shall be governed by the Federal Arbitration Act, 9 U.S.C § 1-16 et seq.

The Parties agree that all the provisions contained in the agreement are severable. In the event any portion of this agreement is deemed unenforceable, that portion shall not be effective, and the remainder of the agreement shall remain in full force and effect to the maximum extent permitted by law. The Parties agree that this Agreement is to be construed as if drafted by all Parties to this Agreement. This agreement to arbitrate shall not fail because any part, clause, or provision hereof is held to be indefinite or invalid.
The Resident or Responsible Party further understand and acknowledge that (1) the execution of this Arbitration Agreement, in conjunction with the Admission Agreement, is not a condition of admission to the Facility; (2) he or she has been advised that this Agreement will affect his or her legal rights; (3) the Resident or Responsible Party is not required to use the Facility for his or her healthcare needs and that there are numerous other health care providers in the State where the Facility is located that are qualified to provide such care; (4) the Resident and/or Responsible Party has been given an opportunity to seek legal advice concerning the Agreement; (5) this Arbitration Agreement shall remain in effect for all care and services rendered at the Facility subsequent to the date the Agreement was signed, even if such care and services are rendered during a subsequent admission; (6) the Resident or Responsible Party has read, or has had the Agreement read to him or her, and the Resident and/or Responsible Party acknowledges that he/she understands this Agreement; and (7) this Agreement is signed voluntarily and with full knowledge of its terms.

THE PARTIES UNDERSTAND AND AGREE THAT BY ENTERING INTO THIS ARBITRATION AGREEMENT, THEY ARE KNOWINGLY AND VOLUNTARILY GIVING UP AND WAIVING THEIR CONSTITUTIONAL RIGHT TO HAVE THEIR DISPUTES DECIDED IN A COURT OF LAW BEFORE A JUDGE AND A JURY AND ARE INSTEAD MUTUALLY AGREEING TO AND ACCEPTING THE USE OF ARBITRATION.

INITIALS of Resident and/or Responsible Party: _____

By signing below, I acknowledge that I have read and understand the terms of this Arbitration Agreement, which is executed separately from the Admission Agreement, and have had its terms explained to me in a form and manner that I understand, including in a language that I understand, and have had an opportunity to ask questions and to consult any person before signing, including an attorney. I am signing this Arbitration Agreement voluntarily and with full knowledge of its terms.

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If I am acting as the Resident's Responsible Party and am not the Resident's Guardian or if I do not hold a Power of Attorney over the Resident, and have not otherwise been authorized by the Resident to act on his/her behalf, I affirm that I am entering into this Arbitration Agreement in my individual capacity, and on my own behalf, for the benefit of the Resident. by the Resident and to act on his/her behalf.

IN WITNESS WHEREOF, the Parties hereto have executed this Arbitration Agreement, included as part of the Admission Agreement, this _____ day of _____, 20_____.

_____
Resident

_____
Responsible Party/Representative of Resident/Power of Attorney

_____
Responsible Party's Relationship to Resident

_____
Witness if executed by Responsible Party

_____
Address of Witness

_____
Phone Number of Witness

_____ (Check if Applicable): A copy of guardianship papers, durable power of attorney, or other documentation of the Resident has been provided to the Facility and is attached.

_____
Facility Representative

Please identify the signatory *
☐ Resident
☐ Guardian
☐ Power of Attorney
☐ Spouse
☐ Adult Children

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