

**SARATOGA COUNTY MAPLEWOOD MANOR
ADMISSION AGREEMENT**

AGREEMENT made this ____ day of _____ 20__ between Saratoga County Maplewood Manor, 149 Ballston Avenue, Ballston Spa, New York 12020 (hereinafter referred to as SCMM), and _____ (hereinafter referred to as Resident), and _____ (hereinafter referred to as Designated Representative).

IN CONSIDERATION OF THE MUTUAL COVENANTS HEREIN CONTAINED, THE PARTIES HERETO HEREBY AGREE AS FOLLOWS:

The "Responsible Party" is the person who is primarily responsible to assist the Resident in meeting his/her obligations under the Financial Agreement.

A "Designated Representative" is the Resident's primary contact person with SCMM. This person may be the same person who serves as the Responsible Party. In some situations, a person other than the person assisting with the Resident's financial affairs may be better suited to serve as the Designated Representative.

The individual signing this Agreement may be either the Responsible Party or the Designated Representative.

SCMM'S RESPONSIBILITIES

1. Admits and treats all residents without regard to Race, Religion, Color, Blindness, National Origin, Sex, Handicap, Source of Payment, Marital Status, Sexual Preference or Sponsorship. There is no distinction in eligibility for, or in the manner of providing any resident service provided by or through the facility. All persons and organizations that have occasion to either refer residents to, or recommend the Saratoga County Maplewood Manor, are advised to do so in compliance with the Federal and State Antidiscrimination Law.

Federal and State Law prohibit this facility from denying admission to anyone because of race, creed, color, national origin, sex, handicap, source of payment, age, marital status or sexual preference.

2. Admits residents only on a physician's order.

3. Agrees to provide services covered in the appropriate area of Section II of the Financial Agreement.

4. Agrees to arrange for the transfer of the resident to the hospital when ordered by the physician and to notify the designated representative prior to hospitalization unless the transfer is for a medical emergency.

5. Agrees to maintain a record of all financial transactions between SCMM and the Resident. These records will be available upon request to entitled persons.

6. Shall promptly notify the resident and resident's designated representative when there is a change in room except when the medical condition of the resident requires an immediate room change or an emergency situation develops. Such change in room requires prior notice and consultation with the resident as well as reasonable accommodation of the resident needs or preferences.

In the event of a change in roommate assignment, SCMM will provide prompt notice to the residents involved and their designated representatives.

7. Agrees to provide the Resident or/and Designated Representative with a copy of the Resident's Bill of Rights (simplified version) with a detailed copy available upon request. If the Resident is not able to read the Bill of Rights, the simplified version will be read to him/her.

8. Agrees to notify the Resident and Designated Representative of changes in Resident's Bill of Rights.

9. Agrees to provide the name, address and telephone number of the attending physician to the Resident and/or Designated Representative upon admission.

10. Agrees to notify the Designated Representative of accidents involving injury to the Resident, significant change in status or need to alter the Resident's treatment significantly within 24 hours of discovery, if reasonably practicable.

11. Has a procedure in the event a Resident, family member or other individual wishes to file a complaint about the services provided by SCMM or its staff. This procedure has been developed in order to help residents, family members and/or designated representatives bring a problem to the attention of staff so that the issue can be resolved in an appropriate manner. Please notify the head nurse on your unit, the nursing office or social services if you have any complaints or issues.

12. Agrees to provide the Resident/Designated Representative with Guidelines for Resident Rooms.

13. Follows the following restrictions to the admission and retention of residents:

a. Admits residents 16 years of age or older;

b. Does not admit prenatal, intrapartum or postpartum, or maternity patients;

c. Admits only those residents that SCMM is able to care for medically.

Individuals who manifest such a degree of behavioral disorder that he/she is a danger to him/herself or others or whose behavior is socially unacceptable or disturbing as to interfere with the adequate care or comfort of other residents shall not be admitted. When transferred or discharged, the Resident and family will be given reasonable advance notice to ensure timely transfer or discharge, and such actions shall be documented in the Resident's medical record.

d. Does not admit or retain a Resident suffering from a communicable disease unless a physician certifies in writing that transmissibility is negligible, and poses no danger to other residents, or SCMM is staffed and equipped to manage such cases without endangering the health of the other residents.

RESIDENT/DESIGNATED REPRESENTATIVE'S RESPONSIBILITIES

The ensuing responsibilities are agreed to and undertaken by Resident and Designated Representative:

1. Agrees to be responsible for any personal property and/or money left in his/her possession while a resident at SCMM.
2. Agrees to have a physician visit in accordance with the regulations of the state health code or more often when medically indicated.
3. Agrees that all medical and dental services, which are provided at SCMM, will be provided by practitioners who have an affiliation with SCMM. If SCMM receives a request by the Resident's personal attending physician or dentist to care for the Resident, SCMM will promptly evaluate such requests.
4. Understands that the Resident may seek a second opinion if he/she disagrees with the diagnosis or treatment provided, and may call in a specialist selected by the Resident or Designated Representative for medical consultation. The expense of such consultation shall be the responsibility of the Resident/Designated Representative.
5. Authorizes the medical staff and consulting physicians of SCMM to administer treatment as may be necessary or advisable in the diagnosis and treatment of the Resident. In case of an emergency, allows SCMM to summon a physician, who is authorized to administer any appropriate treatment and to transfer to a hospital when necessary.
6. Authorizes SCMM staff and consultants to provide care as identified in the resident's plan of care for the resident
7. Agrees to pick up personal belongings of Resident within ten days of discharge. The Receptionist should be contacted to make arrangements for picking up belongings. If arrangements are not made, the Resident/Designated Representative understands that the belongings will be disposed of.
8. Understands that pets may be brought in to visit the Resident provided:
 - a. There is proof of immunization;
 - b. The animal is on a leash and its behavior is well controlled by the person bringing it in.
9. Agrees that all diets are prescribed by a physician.
10. Agrees that smoking is not permitted at Maplewood Manor due to health and safety reasons. This non-smoking requirement will be strictly adhered to.
11. Agrees that no contract for lifetime nursing care is established.
12. Agrees to hold SCMM harmless for any and all harm, injury, damage, or loss suffered by the Resident while away from SCMM.
13. Acknowledges receipt of the Resident's Bill of Rights.

14. Acknowledges that the doors are locked daily from 8:30 p.m. to 7:00 a.m. due to safety concerns. There is a doorbell at the front entrance that can be used to call for staff assistance in entering the building in the late evening or early morning.
15. Acknowledges that SCMM provides a locked secure area in each resident's room. The top drawer of each resident's nightstand is equipped with a lock. A resident may request a key for this lock in the drawer of his or her nightstand through the Unit Ward Clerk. There is also a safe in the Business Office that is available to store Residents' valuables temporarily until their family is able to pick up such items during business hours.
16. Agrees that appointments for family conferences or telephone contact with the physician are initiated through the head nurse on the unit. The Social Work Department of SCMM will confirm the physician appointment time and date with the resident or designated representative.
17. Authorizes SCMM to request medical information on the Resident from other facilities or physicians of the Resident and authorizes, without further notice, use of the Authorization to Release PHI form (enclosed) to obtain same.
18. Hereby agrees and grants SCMM permission to release any medical and social information to other health providers and facilities for treatment, payment and health care operations and agrees to hold harmless and covenants not to assert any claim or cause of action against SCMM, the County of Saratoga and any officer, director, agent or employee by reason thereof. Understands that the law requires disclosure of resident assessment information to Federal and State sources and that the resident does not have the right to refuse consent to these disclosures. (Addendum #1)
19. Agrees and acknowledges that SCMM does perform cardiopulmonary resuscitation. If the Resident/family desires resuscitation in the event of a cardiac or respiratory arrest, CPR is initiated and an ambulance is called so that the Resident can be transferred to the hospital as soon as possible. Resident/Designated Representative acknowledges that they understand that CPR is not generally effective with this type of population but may still want it performed.
20. Acknowledges receipt of information regarding New York State Do Not Resuscitate Order and Health Care Proxy Law.
21. Acknowledges that the Resident/Designated Representative was informed of SCMM's Notice of Privacy Practices.
22. Acknowledges that the Resident/Designated Representative was informed of the right to attend the Comprehensive Care Plan Committee meeting. If interested in attending, arrangements should be made prior to the meeting with the MDS Coordinator.
23. Acknowledges receipt of the SCMM Resident Handbook that outlines the Resident's privileges and obligations of SCMM. The information in this booklet constitutes the policies of SCMM and the Resident is governed by it. The policies outlined in this booklet are subject to change.
24. Acknowledges the receipt of information on administration of immunization, to protect residents against the flu, annually. It is the responsibility of the Resident/Designated Representative at the time of immunization to make any objections to the flu vaccine known to the Nursing Department. The resident is also educated regarding the possible complications of influenza.

MUTUAL

1. SCMM provides training for nurses aides. The nurse aide trainees are evaluated on skill performance. They demonstrate skills, following classroom instruction under the supervision of the Program Coordinator, Program Instructor or Trainee Supervisor.

Residents may participate by receiving care during the evaluation of skills, if the following criteria are met:

- a. The Resident is informed of the procedure and its purpose.
- b. The Resident's permission to participate is obtained.
- c. The trainee is directly supervised by a Registered Professional Nurse.
- d. The Resident's explanation of care and its' desired effects are given.
- e. The Resident's right to refuse or accept care, right to privacy, and right of confidentiality are all maintained.

2. It is agreed that if the Resident's physical condition should improve or change, so that the Resident no longer requires skilled nursing care, the Resident will be transferred to the appropriate level of care, as determined by the attending physician or medical director.

3. Both SCMM and the Resident are obligated under law to adhere to all applicable State, Federal and local regulations that govern the conduct and procedures of all aspects of nursing home operation.

DEPARTMENTS AND SERVICES PROVIDED AT SCMM

A. Nursing Services

The Saratoga County Maplewood Manor provides a twenty-four hour nursing services. A registered nurse is available at all times to address the needs of the resident.

B. Beauty and Barber Services

There is a beauty shop and barbershop in the facility. There is a barber who works at her convenience and gives hair cuts as needed. Aides shave residents. Charges for beauty and barber services are additional.

C. Dental Services

SCMM assists residents to obtain regular and emergency dental care. A consulting dentist provides this service. There is a Dental Laboratory at the facility. When it is necessary for residents to leave Maplewood Manor, transportation is provided to and from the dentist's office. Nursing personnel assist residents in carrying out dentist's recommendations. A dental evaluation is done on all admissions and yearly thereafter.

D. Diagnostic Services

Laboratory

This service is provided by Saratoga Hospital. The Resident is responsible for payment for these services through his/her insurance or privately.

EKG and Radiology Services

The outpatient x-ray services are provided through the radiology departments of Adirondack Imaging and Saratoga Hospital. Appointments are made by the facility, and the Maplewood Manor transport vehicle transports residents. Portable x-ray services for simple x-rays as well as EKG services are obtained from Summit Imaging. The Resident is responsible for payment for these services through his/her insurance or privately.

E. Consultant Service

The Medical Staff of SCMM requests consultant opinions from area specialists whenever they consider it advisable. The residents are transported by the Maplewood Manor vehicle to and from consultant physician's offices. Written reports and recommendations become a part of the resident's chart. Residents are transported to consultants in the Saratoga Springs/Ballston Spa area except that if, in the event consultant services are not available in the area, the facility will schedule an appointment at the nearest consultant service. Residents who want to go to a consultant outside of the above designated area when there is a local consultant available will be responsible for their own transportation. The Resident is responsible for payment of any and all consultant services through his/her insurance or privately.

F. Dietary Services

The SCMM Dietitian is responsible for menu planning which provides a daily general diet that contains the basic foods according to nutritional requirements. Protein intake is adequate and a reasonable variety of foods are offered to satisfy individual appetites. These menus are planned in advance of a minimum of 4 weeks. Upon request, kosher food is available to residents.

G. Emergency Service

The Saratoga County Maplewood Manor provides twenty-four hour medical service to its residents for emergency care.

H. Housekeeping and Maintenance

SCMM is structurally sound and provides a favorable environment for residents. The facility provides sufficient housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment.

I. Linen Services

Fresh bed linen is provided daily including sufficient quantities of necessary bed linen or appropriate substitute changes as often as required for incontinent residents. Personal laundry service is available at SCMM. Family members/responsible parties may choose to do the personal laundry of resident. If this is designated, the resident's family member/responsible party must provide a clothes hamper with a lid.

J. Resident Activities

Activities suited to the needs and interests of residents are provided as an important part of the active treatment program. The residents are encouraged, but not forced, to participate in activities. Suitable activities are provided for residents unable to leave their rooms. As part of our ongoing effort to provide a variety of activities for our residents, they will occasionally be offered the opportunity to go on outings. Transportation will be provided by the facility.

K. Residents' Association

The Resident Association is composed of persons living in the SCMM. All residents of the facility automatically become members of the association. The association operates independently but in partnership with Administration. The purpose of a Residents' Association, therefore, is to serve as a vehicle for residents to exercise their rights and protect their interests by participating in the decisions and tasks, which affect their everyday lives, both in the home and the outside community.

L. Pharmaceutical Services

SCMM has contracted with a Pharmaceutical firm, Royal Care Pharmacy (Omnicare) to provide all pharmacy related services. They have sole responsibility for ordering and dispensing all medications with the approval of the Medical Director. Royal Care (Omnicare) bills all private paying residents or their insurance directly for prescription drugs.

M. Physician Services

SCMM provides physician services through a Medical Director and Assistant Medical Director. They are responsible for and in charge of the medical care; supervision and needs of all residents in Maplewood Manor; maintain all records related to medical care; and visit each resident in accordance to NYS regulations. A medical doctor is available to treat residents that exhibit symptoms between their regular visits. Every resident is under the supervision of a physician, and receives an evaluation of individual needs and a prescribed, planned regimen of medical care. This plan covers medication, treatment, restorative services, diet, safety measures, activities, and continuing care with specific goals and recommendations, plans for discharge (if appropriate). The facility does provide for a doctor on call 24 hours per day 7 days per week.

N. Social Work Services

The Social Work Department is provided to meet the medically related social needs of the Resident during admission procedures, in the course of treatment and care in the facility, and in planning for discharge.

O. Podiatry Services

Podiatry services are provided through a licensed and qualified consultant podiatrist. This service is rendered only under consultation request of the attending physician. The Resident is responsible for payment for Podiatry services through his/her insurance or privately. The Podiatrist bills the Resident or the Resident's insurance directly.

P. Physical Therapy Services

Physical therapy services are provided to all residents, and are ordered by the Medical Director in the standing orders of each resident. Both restorative and maintenance programs are available depending on the need at any given time. A Physical Therapist performs evaluations, establishes treatment plans and directly and indirectly supervises Physical Therapist Assistants. The goals of such services (the nature and extent of which vary in each individual case) include: increase ambulation/gait skills, restore muscle function and joint range of motion, increase transfer/ADL skills, provide relief of pain, promote healing of skin ulcers, maintain function and prevent deterioration of physical skills as feasible and evaluate/address positioning needs in and out of bed. Periodic reviews of all residents are done in preparation of the CCP meetings to determine whether or not physical therapy services are needed.

Q. Occupational Therapy Services

Occupational therapy services are provided to identified residents with a physician's order. The Occupational therapist performs evaluations and treatments, provides splinting devices for the residents as needed, and directly and indirectly supervises certified occupational therapy assistants.

R. Speech Therapy Services

Swallowing evaluations, speech evaluations, and treatment are provided to identified residents with a physician's order.

S. The facility shall bill the resident's insurance or resident privately for therapy services if the resident does not have Medicare Part B or if therapy services exceed the annual Part B allowable amount. (Refer to Financial Agreement for additional information)

IN WITNESS WHEREOF, the parties have executed this Agreement on the date written below:

Signature of Resident/Responsible Party

Date

SCMM Representative

Date

**SARATOGA COUNTY MAPLEWOOD MANOR
ADMISSIONS AGREEMENT**

AUTHORIZATION FOR PROVISION OF EMERGENCY TREATMENT

I, the undersigned, give advance written consent to Saratoga County Maplewood Manor to provide any emergency medical care deemed necessary. I understand that _____ may also be transported via ambulance to another health care facility and any costs associated with any care and services provided by any agency other than Saratoga County Maplewood Manor will be billed by that agency.

Signature of Resident/Responsible Party

Date

Signature of SCMM Representative

Date

ASSESSMENT ROOMS

An assessment room is a specifically designated private room used for a temporary period of time by residents with specific needs and/or problems.

The purpose of the assessment room is to attempt to meet the resident's need for physical and emotional security by decreasing the number of room changes of residents through the availability of assessment rooms to:

1. Receive residents upon admission if available;
2. Place residents whose symptoms and/or diagnoses warrant the use of isolation technique in a private room to prevent the spread of infection;
3. Adequately care for a resident with an acute problem or illness that requires the use of special equipment or increased visual or auditory supervision of the nursing staff.

Resident/Designated representative was notified of above on _____

by _____.

Signature Resident/Designated Representative

**SARATOGA COUNTY MAPLEWOOD MANOR
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RELEASE FOR PHOTOGRAPH

I, the undersigned, do / do not give permission to Saratoga County Maplewood Manor to include my _____ name, photograph, portrait, picture, voice in any news releases concerning the facility and its' resident activities, whether or not same be deemed for advertising purposes or for purposes of trade. This release extends to all rights and remedies otherwise available under Article 5 of the Civil Rights Law and any successor laws and rules and any similar law and rules of this or any other state.

Signature of Resident/Responsible Party

Date

Signature of SCMM Representative

Date

RUGS II CLASSIFICATION

I have been notified by Maplewood Manor of my RUG II classification and the process by which a resident is classified for reimbursement purposes into the RUG II classification system. Also, that my designated representative or I will be informed semi-annually of this continuing process.

Signature Resident/Designated Representative

Date

DIVISION OF VETERANS' AFFAIRS SERVICES

I have received written information for contacting the Division of Veterans' Affairs and local veterans' service agencies regarding benefits.

Signature Resident/Designated Representative

Date

**SARATOGA COUNTY MAPLEWOOD MANOR
PRIVACY ACT STATEMENT - HEALTH CARE RECORDS**

ADDENDUM #1

REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.

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

Medicare and Medicaid participating long term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by the Federal Health Care Financing Administration (HCFA) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the HCFA contractor in the State government, which in turn transmits the information to HCFA.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures.

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

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

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

3. ROUTINE USES

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

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

4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

The information contained in the Long Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

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

Signature Resident/Responsible Party

Date

SARATOGA COUNTY MAPLEWOOD MANOR **RESIDENTS' RIGHTS**

This document outlines your Rights as a resident of a Residential Health Care Facility.

If you would like a detailed copy of the Bill of Rights, please notify the Social Work Department.

You Have...

1. The right to be fully informed, orally and in writing, of your rights;
2. The right to be fully informed, orally and in writing, of your responsibilities to the facility;
3. The right to receive written copies of any change(s) in rules and regulations that may affect your rights, obligations, or responsibilities to the facility;
4. The right to inspect and purchase photocopies of your records;
5. The right to be fully informed of your total health status, including your medical condition;
6. The right to refuse your nursing care and medical treatment after being informed of the consequences, and to refuse to participate in any experimental research;
7. The right to be informed of services available to you, and the related charges for such services;
8. The right to file a grievance, and/or complaint, with the facility, state survey and certification agency, ombudsman, or other advocates concerning abuse, neglect, or misappropriation of your personal property;
9. The right to be informed of the name, specialty, and way of contacting the physician responsible for your medical care;
10. The right to be informed on how to apply for and use Medicare and Medicaid benefits;
11. The right to be informed on how to receive a refund for previous payments covered by Medicare and/or Medicaid;
12. The right to exercise your rights as a resident of the facility and as a citizen or resident of the United States;
13. The right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising your rights;
14. The right to have your family and physician promptly notified of significant changes in your medical condition and/or status;
15. The right to be notified of a change in your room assignment or roommate;
16. The right to manage your own financial affairs;
17. The right to choose a personal attending physician;
18. The right to be fully informed in advance of your medical care and treatment, and any changes in such care and treatment;

19. The right to personal privacy;
20. The right to privacy in receiving and sending written communications;
21. The right to have regular access to the private use of a telephone;
22. The right to receive visitors at any time;
23. The right to confidentiality of your personal and clinical records;
24. The right to examine the most recent survey report and the facility's plan of correction;
25. The right to contact and receive information from agencies acting as client advocates;
26. The right to perform or not perform services for the facility;
27. The right to retain, store securely, use of your personal possessions, and locked storage space in your room;
28. The right to privacy with your spouse should both of you be a resident in the facility;
29. The right to self-administer your drugs and medications;
30. The right to receive a thirty (30) day notice before being transferred or discharged from the facility;
31. The right to be free from physical or chemical restraints;
32. The right to be free from verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion;
33. The right to choose activities, schedules and care consistent with your interests, assessments, and plan of care;
34. The right to interact with members of the community;
35. The right to organize and participate in established Residents' Council and resident groups;
36. The right to make choices about aspects of your life in the facility;
37. The right to participate in social, religious, and community activities;
38. The right to receive services with reasonable accommodation of individual needs and preferences; and
39. The right to be informed of the facility's bed-holding policy.

Signature Resident/Designated Representative

Date

Witness

Date

**SARATOGA COUNTY MAPLEWOOD MANOR
ADMISSIONS AGREEMENT**

IMMUNIZATION OF THE FLUOGEN

I have been provided information on the benefits and the potential side effects of the fluogen vaccine and

I, _____, give / do not give permission for my _____,
_____ to receive the flu shot if/when needed.

IMMUNIZATION OF THE PNEUMOVAX

I have been provided information on the benefits and the potential side effects of the pneumovax vaccine and

I, _____, give / do not give permission for my _____,
_____ to receive the pneumonia shot if/when needed.

IMMUNIZATION OF THE ADULT D/T -- TETANUS

I, _____, give / do not give permission for my _____,
_____ to receive the adult D/T--tetanus shot if needed.

Signature Resident/Designated Representative

Date

Witness

Date

If you have any questions or concerns regarding the above please contact our infection control practitioner through the nursing office