GraceManor
ASSISTED LIVING MEMORY CARE
PORT ORANGE

RESERVATION AGREEMENT

Suite Type/Suite Number: _____

Reservation Fee: _____

Projected Move-In Date: _____

Monthly Resident Fee: _____

This RESERVATION AGREEMENT is made _____, 20___, between Grace Manor Port Orange, LLC _____ and the Resident _____ _____.

APPLICATION: Resident/Sponsor wishes to place his/her name(s) on the waiting list to rent a suite. Resident/Sponsor will submit all required forms/reports, containing certain personal, health and financial information concerning the Resident. The approval of the Resident's application will be contingent upon the review and approval of all documentation, physicians report and personal interview with a representative of the 410 Group Senior Housing Community named above.

RESERVATION FEE: Resident/Sponsor shall pay a Reservation Fee in the amount stated above to reserve the Suite. Reservation Fee is fully refundable until move in. Upon move in the Reservation Fee becomes a non-refundable Community/ Application Fee.

MONTHLY RESIDENT FEE: The Monthly Resident Fee will remain unchanged for a period of twelve (12) months after the beginning of the date of the Resident Agreement. Grace Manor Port Orange, LLC reserves the right to adjust the Monthly Resident Fee annually by the consumer pricing index. Upon written notice to Grace Manor Port Orange, LLC, Resident/ Sponsor may terminate this agreement for any reason prior to executing a new Resident Agreement. Grace Manor Port Orange, LLC may terminate this Agreement if administration determines in its sole discretion that Resident does not meet the requirements for residency.

OCCUPANCY: Resident/Sponsors on Grace Manor Port Orange, LLC waiting list will be informed when a Suite becomes available. Resident/Sponsor will be given three (3) days in which to decide if he/she wants to rent said suite. If Resident/ Sponsor chooses to rent said Suite, Resident/Sponsor must execute a Resident Agreement and take occupancy within fifteen (15) days of said date. Should the Resident/Sponsor choose not to take occupancy upon availability of said Suite, Grace Manor Port Orange, LLC reserves the right to rent the Suite to another Resident/Sponsor. Resident/Sponsor will remain on the waiting list or they can request to have their reservation fee refunded.

RESIDENT/RESPONSIBLE PARTY:

By: _____

Date: _____

GRACE MANOR PORT ORANGE, LLC:

By: _____

Date: _____

Resident's Full Name _____

Address: _____

Phone: _____ Social Security Number: _____

Grace Manor Port Orange
Resident Information Sheet

State guidelines require that certain information be obtained from all residents. We understand that this information is private and wish to assure you that all information will be held in strict confidence.

Biographical Data							
Applicant's Name (Last name first)				DOB			
Address		City		State		Zip	
Birthplace City & State		Sex		Race			
Medical Data							
*Allergies							
Move-In Diagnosis	See Form 1823						
Dietary Restrictions							
Social Security #		Medicare #					
Insurance Company		Insurance #					
Insurance Co. Phone #		Medicaid #					
Primary Physician							
Name	Address		City/State		Phone		
Secondary Physician							
Name	Address		City/State		Phone		
Dentist							
Name	Address		City/State		Phone		
Podiatrist							
Name	Address		City/State		Phone		
Preferred Hospital							
Name	Address		City/State		Phone		
Social/Emergency Data							
Marital Status	Address		Spouse Name				
Emergency Contact	Address		Relationship		Phone		
Second Contact	Address		Relationship		Phone		
*Please attach a list of any other Emergency Contacts you wish to include							
Heath Care Surrogate*			Phone				
Funeral Home Preferred		Contact Name			Phone		
Father's Name		Mother's Name					
Place of Worship		Phone					
Religious Advisor		Address					
Previous Occupation		Hobbies/Interests					
Military Veteran?	Yes	No	Branch of Service				
Durable Power of Attorney for Health Care?*	Yes	No	Living Will?*	Yes	No	If No, would you like information regarding a Living Will?	
* If you have either of these documents a copy must be attached to this packet.							
Move-In Information (to be completed by Community staff)							
Date of Move-In		Move-In From					
Arranged By		Referral Contact					
Referral Source		Address			Phone		
Name of Employee Completing Information					Date		
Information Provided By	Resident_____	Family_____	Agency_____	Other (Specify)_____			
Sponsor/Responsible Party Billing Address							
Name			Phone				
Address		City/State		Zip			

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RESIDENT HEALTH ASSESSMENT for ASSISTED LIVING FACILITIES

TO BE COMPLETED BY FACILITY:
Resident's Name _____ DOB: _____

INSTRUCTIONS TO LICENSED HEALTH CARE PROVIDERS: *AFTER COMPLETION OF ALL ITEMS IN SECTIONS 1 AND 2 OF THIS FORM (pages 1 through 4), PLEASE RETURN TO:*

FACILITY NAME: _____

FACILITY ADDRESS: _____

TELEPHONE NUMBER: _____ CONTACT PERSON: _____

SECTION 1: HEALTH ASSESSMENT (*MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.*)

Known Allergies:	Height: Weight:
Medical history and diagnoses:	
Physical or sensory limitations:	
Cognitive or behavioral status:	
Nursing/treatment/therapy service requirements:	
Special precautions:	

TO BE COMPLETED BY FACILITY:
Resident's Name _____ DOB: _____

SECTION 1: HEALTH ASSESSMENT (*MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.*)

A. To what extent does the individual need supervision or assistance with the following?

Key	I = Independent	S = Needs Supervision	A = Needs Assistance

Indicate by a checkmark (✓) in the appropriate column below the extent to which the individuals is able to perform each of the activities of daily living. If "needs supervision" or "needs assistance" is indicated, please explain the extent and type of supervision or assistance needed in the comments column.*

ACTIVITIES OF DAILY LIVING	I	S*	A*	COMMENTS*
Ambulation				
Bathing				
Dressing				
Eating				
Self Care (grooming)				
Toileting				
Transferring				

B. Special Diet Instructions

__ Regular __ Calorie Controlled __ No Added Salt __ Low Fat/Low Cholesterol

____ Other, please describe: _____

C. Does the individual have any of the following conditions/requirements? If yes, please include an explanation in the comments column.

STATUS	YES/NO (Y/N)	COMMENTS
1. A communicable disease, which could be transmitted to other residents or staff?		
2. Bedridden?		
3. Any stage 2, 3, or 4 pressure sores?		
4. Pose a danger to self or others?		
5. Require 24-hour nursing or psychiatric care?		

D. In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or psychiatric facility? Yes ___ No ___ _____

Comments (Use additional page if necessary): _____

TO BE COMPLETED BY FACILITY:
Resident's Name _____ DOB: _____

SECTION 2-A: SELF-CARE AND GENERAL OVERSIGHT ASSESSMENT (*MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.*)

A. ABILITY TO PERFORM SELF-CARE TASKS:

Indicate by a checkmark (✓) in the appropriate column below the extent to which the individuals is able to perform each of the listed self-care tasks. If "needs supervision" or "needs assistance" is indicated, please explain the extent and type of supervision or assistance necessary in the comments column.*

KEY:	I = Independent	S = Needs Supervision	A = Needs Assistance

TASKS	I	S*	A*	COMMENTS*
Preparing Meals				
Shopping				
Making Phone Calls				
Handling Personal Affairs				
Handling Financial Affairs				
Other				

B. GENERAL OVERSIGHT:

Indicate by a checkmark (✓) in the appropriate column below the extent to which the individual needs general oversight. If other, please explain in the comments column*.

KEY	I = Independent	W = Weekly	D = Daily	O* = Other

TASKS	I	W	D	O*	COMMENTS*
Observing Wellbeing					
Observing Whereabouts					
Reminders for Important Tasks					
Other					
Other					
Other					
Other					

C. ADDITIONAL COMMENTS/OBSERVATIONS (Use additional page if necessary): _____

_____

_____

TO BE COMPLETED BY FACILITY:
Resident's Name _____ DOB: _____

SECTION 2-B: SELF-CARE AND GENERAL OVERSIGHT ASSESSMENT—MEDICATIONS (*MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.*)

A. Please list all current medications prescribed below (additional pages may be attached):

	MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

B. Does the individual need help with taking his or her medications (meds)? Yes ____ No ____. If yes, please place a checkmark (✓) in front of the appropriate box below:

	Needs Assistance with Self-Administration of Medications		Needs Medication Administration

C. ADDITIONAL COMMENTS/OBSERVATIONS (Use additional page if necessary): _____

NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION:

NAME OF EXAMINER (Please Print): _____

SIGNATURE OF EXAMINER: _____

MEDICAL LICENSE #: _____

ADDRESS OF EXAMINER: _____

TELEPHONE #: _____

TITLE OF EXAMINER (Please check the appropriate box): ☐ MD ☐ DO ☐ ARNP ☐ PA

DATE OF EXAMINATION: _____

TO BE COMPLETED BY FACILITY:
Resident's Name _____ DOB: _____

SECTION 3: SERVICES OFFERED OR ARRANGED BY THE FACILITY FOR THE RESIDENT (*MUST BE COMPLETED BY THE ALF ADMINISTRATOR OR DESIGNEE.*)

Note: This section must be completed for all residents based on needs identified in Sections 1 and 2 of this form, or electronic documentation, which at a minimum includes the elements below, except for residents receiving the following:

(a) Extended congregate care services (ECC) in a facility holding an ECC license; or
(b) Services under a community living support plan in a facility holding a limited mental health license; or
(c) Medicaid assistive care services; or
(d) Medicaid waiver services.

#	(Column 1) Needs Identified from Sections 1 & 2	(Column 2) Service Needed	(Column 3) Service Frequency & Duration	(Column 4) Service Provider Name	(Column 5) Date Service Began
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

NAME OF ADMINISTRATOR OR DESIGNEE: (Please Print) _____

SIGNATURE OF ADMINISTRATOR OR DESIGNEE: _____

DATE OF SIGNATURE: _____

Grace Manor Port Orange
Pharmacy Agreement

Pharmacy Name_____

Address_____

City, State, Zip_____

Phone_____ Fax_____

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*Resident:*_____*Suite #* _____

As the responsible party and/or Guardian, or POA, I authorize Grace Manor Port Orange, to purchase prescriptions and ~~medical supplies on this account in behalf of the named resident. My signature, attests that information provided is accurate~~ and complete to the best of my knowledge, and stipulates that I have read, understand and agree to:

1. Permit the release of medical records to determine liability for payment.
2. Authorization is given to _____Pharmacy to fill medications for said resident/ customer with authorization given to Community to order medications and supplies on behalf of said resident/customer.
3. Authorization is also given to submit claims to, exchange information with and receive payments from any and all third-party providers, with an assignment of benefits. The understanding that the co-pay amount and/or any rejected/ declined claims will be billed to the resident's account.
4. It is understood and agreed that should any third party insurance carrier refuse to pay for services rendered that the payment due is the sole responsibility of the customer and/or guardian.
5. HOSPICE - I understand that as a Hospice Patient, not all medications are supplied by Hospice. Authorization is given to continue to provide those medications NOT paid for by Hospice.
6. _____Pharmacy as a provider of pharmaceuticals and supplies is voluntary.
7. I understand and agree _____Pharmacy requires copies of the front and back of Medicare, Medicaid, and any other insurance cards.
8. I understand and agree that copies must be given of all legal documents, i.e.. P.O.A. , or Legal guardianship. Summary page and/or financial summation and signature page is required.
9. Per Medicare requirements, a Complaint Resolution form is available from the Pharmacy upon request.
10. HIPPA Disclosure: I acknowledge that I have been provided with a copy of HIPPA notification. I also acknowledge that unless stipulated in writing, I authorize _____ Pharmacy to provide information or discuss my account with whosoever contacts them regarding this account.
11. I understand that invoices/statements are processed on the 25th of the month and that payment is due within 15 days (approx. by the 10th of each month). It is also understood in order for the account to remain active, the account must be paid in full within 30 days of the invoice. After 30 days the pharmacy has the right to discontinue service and/or place the account on COD.

Name (Print):_____ ***Relationship:***_____

Signature:_____ ***Date:***_____

Continued

As the responsible party, please initial the selection of service you are willing to pay for. Your initials indicate your request to use _____ Pharmacy.

1._____ For ALL items: Prescriptions and Over-The-Counter (vitamins, laxatives, diapers)
2._____ For Prescriptions Only (whether covered by insurance or not). NO OTC Items
3._____ For Items ONLY COVERED BY INSURANCE (I understand that a co-payment may be required by the Insurance Company and that I am responsible for said payment.) I understand that items/prescriptions NOT covered by Insurance and OTC items WILL NOT BE SENT.
4._____ For Emergency Use ONLY. (Prescriptions are Mail Order or VA) Emergency Constitutes: items not available through Mail Order, Over-the-Counter Items, or Emergency Medications (such as antibiotics). It is understood that Authorization has been given to Grace Manor Port Orange to order medications and supplies on behalf of said resident/ customer.
5._____ DO NOT USE _____ PHARMACY at this time. Should I change my mind, I understand a new Pharmacy Agreement must be completed before medications can be provided.

Resident Information

Move-In Date:_____ Suite #:_____ Date of Birth:_____ Blister Pack ( ) Bottle ( )
Resident Name:_____ Male ( ) Female ( )
SSN#:_____ Allergies: _____

Billing Information

Name of Responsible Party:_____Relationship:_____
Billing Address:_____City:_____State:_____Zip:_____
Phone_____ Emergency or Cell:_____ Fax_____

Payment Options (please Initial One)

_____ I do not have/cannot provide a credit card. I understand in order for the account to remain active, the account must be paid in full within 30 days of the invoice. The Pharmacy has the right to discontinue service or to make the account COD.
_____ I Authorize _____ Pharmacy to bill my credit card on a monthly basis. I understand statements are generated on or about the 25th of each month, and my credit card will be charged the full amount, unless I contact the Pharmacy prior to this date.
_____ I authorize_____ Pharmacy to bill my credit card for EMERGENCIES. I understand my credit card will be charged for any amount that remains unpaid after 30 days from the most recent invoice/statement.

Credit Card Information (Please PRINT)

Credit Card (Circle One) American Express Discover Visa Master Card
Name on Credit Card: _____
Card #:_____ Expiration Date:_____ CSV #:_____
Signature of Card Holder: _____

I have read the terms and conditions stated herein and agree to said terms and conditions and authorize payment of past due balances as indicated above

Insurance/Prescription Coverage

_____ I understand that I must provide enlarged copies of the front and back of all applicable insurance cards, and that all numbers are legible. If copies are not provided or legible - insurance cannot be filed.I also understand that certain insurance companies will only allow a 30 day window to electronically process claims. At which time I may be responsible to pay the full amount and submit the claim with the insurance company myself.
_____ No Pharmacy Insurance
_____ Insurance with a pharmacy benefit
_____ Medicare Part D Company:_____
_____ Medicaid ID# _____ Social Worker: _____ Phone:_____

GRACE MANOR PORT ORANGE
RESIDENT AGREEMENT

This Resident Agreement (the Agreement) made this day of _____ between _____ (hereinafter referred to as the Community) whose address is _____ _____ and _____. (the Resident) residing at the Community and _____ (the Responsible Party).

DEFINITIONS:

Assistance with Self-Administration of Medication: This is defined as taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident; in the presence of the resident, reading from the container, and closing the container, removing a prescribed amount of medication from the container, and closing the container; placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth; applying topical medication; returning the medication container to proper storage; and keeping a record of when a resident receives assistance with self-administration under this section. Assistance with Self-Administration does NOT include: (a)mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed, (b) the preparation of syringes for injection or the administration of medications by any injectable route, (c) administration of medications through intermittent positive pressure breathing machines or a nebulizer, (d) administration of medications by way of a tube inserted in a cavity of the body, (e) administration of parenteral preparations, (f) irrigations or debriding agents used in the treatment of a skin condition, rectal, urethral, or vaginal preparations, (g) medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgement on the part of the unlicensed person, and at the request of a competent resident, and (h) medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (F.S. Part III Chapter 429.256)

Administration of Medication: This includes opening a container of medication, removing a prescribed dosage, and giving the medication to the person for whom it is prescribed via the route prescribed. (F.A.C. Chapter 58A-5.0131)

Activities of Daily Living: This means functions and tasks for self care, including ambulation, bathing, dressing, eating, grooming, and toileting, and other similar tasks. (F.S. Part III Chapter 429.02)

Personal Care Services: This means direct physical assistance with the 'activities of daily living' and other similar services. Personal Care Services shall not be construed to mean the provision of medical, nursing, dental, or mental health services. (F.S. Part III Chapter 429.02)

Supervision: This means reminding residents to engage in 'activities of daily living' and the self-administration of medication and, when necessary, observing or providing verbal cueing to residents while they perform these activities.

Effective April 15, 2010

1. Resident Admission - The resident will be admitted to the Community according to the admission guidelines in Chapter 58A-5 in the Florida Administrative Code and under the terms of this Agreement. These guidelines include but are not limited to:

   a. Nondiscrimination - Residents are admitted to the Community without regard to race, color, creed, national origin, sex or religion.

   b. Health Assessment - Residents will be required to have a "face-to-face' medical examination completed by licensed health care provider at least 60 days prior to admission or within 30 days following admission into the community and every 3 years thereafter, or after a significant change in condition. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities.

   c. Resident Function Evaluation - A health evaluation must be completed in full by the Community at the time of admission into the Community. Additional Personal Care Service charges, as defined in "Schedule A" attached, will be determined by the Resident Functional Evaluation outcomes.

2. Accommodations - The Community hereby grants the Resident the right to occupy suite number _____(the suite) as an unfurnished / furnished (Circle One) private / semi-private (Circle One) accommodation suite at the Community. All suite charges will be defined in Paragraph 3 and additional charges on attached "Schedule A."

3. The Monthly Resident Fee -

   a. The Resident (or Responsible Party) agrees to pay a Monthly Resident Fee (Resident Fee) of $_____ for the right to occupy the above listed suite. This rate will remain the same for twelve (12) consecutive months from the start date of this agreement. The Monthly Resident Fee on the Move-In Date, which will be no later than _____ (agreement start date). The Resident (or Responsible Party) will be sent a monthly itemized statement for the monthly Resident Fee and any additional charges; all sums due upon the first day of the month, with a grace period through the tenth(10th) of the month.

   b. A one time non-refundable Reservation Fee in the amount of $_____will be collected prior to move in.

   c. The monthly statement will include: (i) the monthly Resident Fee; (ii) additional charges that are defined in Paragraph 6 of this Agreement and itemized on attached "Schedule A."

   d. Upon entering into this Agreement, the Resident (or Responsible Party) shall pay one (1) month's Monthly Resident Fee. This Monthly Resident Fee, and any other prepayments, shall be credited to the remainder of the current month Resident Fee and additional charges and then to the next month's Resident Fee until applied in full. Any refund requested by the Resident (or Responsible Party) is subject to the provisions of Paragraph 23 of this Agreement. The Resident is responsible for full, prompt payment of all fees, charges and invoices from the Community unless a Responsible Party had been assigned, as detailed in the attached Guarantee (Attachment 2).

   e. The Monthly Resident Fee and all other payments are payable to Grace Manor Port Orange and are due by the first day of each month. Any sums that are not received by the Community within 10 calendar days of its due date shall be subject to a charge of 5% of the unpaid balance.

f. Thirty (30) calendar days prior to a change in your Monthly Resident Fee, the Community shall notify you in writing of the new Monthly Resident Fee.

g. The Community shall notify you in writing as an addendum of any modifications to this Agreement. A new Agreement will not be required.

4. Non-refundable Reservation/Community Fee - Resident has deposited with Grace Manor Port Orange the amount of $1500.00 herein above specified in this Resident Agreement as a Refundable Reservation Fee. Grace Manor Port Orange does not charge a security deposit. At the time of move-in, after the execution of the Resident Agreement, the Reservation Fee becomes a Non-Refundable Community Fee which covers all of the following services:

   a. Need Assessment that includes both medical and nutritional aspects to ensure the most appropriate level of care.

   b. Processing of all administrative documentation including state required health forms, pertinent personal information and medical reports for billing procedures.

   c. Establishment of medication protocol including control, delivery and billing.

   d. Preparation of all admission agreements.

   e. Orientation and introductions by the staff, including a resident handbook.

   f. All suite cleaning, refurbishing for all normal wear and tear, both prior to move-in and upon move-out.

5. Obligations and Responsibilities of the Community - The following services are provided to the Resident of the Community and included in the monthly Resident Fee:

   a. Private or Semi-Private accommodations with private or shared bathroom where available in the suite.

   b. Three (3) full service meals per day and snacks available daily.

   c. Supervision with Self-Administration of Medication.

   d. Supervision with Activities of Daily Living by Licensed Practical Nurses, Certified Nursing Aides or trained staff.

   e. Staff response to Emergency Response System when located in the suite.

   f. Scheduled group social/wellness/religious activities located in the Community per the posted Activity Schedule.

   g. Weekly suite housekeeping which includes vacuuming/mopping of all floor coverings, cleaning of the furnishings and counters, full bathroom clean-up, bed linen change, towel exchange, and surface dusting.

   h. In-House phone service.

   i. Utilities including water, sewer, electric, natural gas, and trash disposal.

   j. Suites include: air conditioning and heating unit, smoke alarm & fire safety sprinkler system.

   k. Transportation to scheduled outings per the posted Events Schedule.

l. Access and usage of all Community common areas.

m. Access to a private mail delivery.

n. Assistance with minor repairs and maintenance in the suite.

o. Personal Care Services as detailed in Attachment 1 of this Agreement.

6. Additional Charges/Services - The Community may provide services and/or products in addition to those itemized in Paragraph 5 of this Agreement. Such additional services and/or products shall be provided at an additional charge as detailed on 'Schedule A' attached to this Agreement. Services and charges outlined in 'Schedule A' are subject to change with a thirty (30) day advance notice to the Resident. The additional charges will be invoiced on a monthly basis in addition to the Monthly Resident Fee. All amounts are due and payable upon the first day of the month, and are subject to the terms of Paragraph 3 of this Agreement.

7. Medications - The Resident (or Responsible Party) hereby acknowledges, agrees, releases, indemnifies, and holds harmless the Community from any medication taken by the Resident, which is not administered or assisted by the Community and its employees, according to Paragraph 8 of this Agreement.

8. Medication and Medical Policies -

   a. Under the following conditions, the Resident is permitted to maintain and self-administer medication prescribed by the physician and properly labeled for the Resident, provided the attending physician has not ordered such medication to be controlled and administered by the Community's staff:

      i. The Resident shall not be permitted to use or take another Resident's medication.

      ii. All over-the-counter medication will be stored in a locked container, and not accessible to other Residents.

   b. The following information will be documented in the Resident file upon admission as more fully described in Paragraph 1 of this Agreement:

      i. The Resident's general physical and mental state.

      ii. Height and weight at time of admission; and

      iii. any drug or food allergies.

9. Access to Suite - Under normal circumstances the Resident's privacy is respected and entry to the suite requires the Resident's permission. However, the Community, its employees, officers and/or agents may enter the suite at reasonable times for purposes of inspection, safety and maintenance. In the event of an emergency, the Community, its agents, employees or officers can enter the suite at any time without notice or consent in order to safeguard the Resident and/or his/her property.

10. Religious Affiliation - The Community is not affiliated with any religious organization.

11. Transportation - The Community will schedule transportation or assist the Resident in obtaining transportation to appointments and activities located outside the Community. Additional fees for transportation may be charged according to 'Schedule A' attached to the Agreement. The

Resident is responsible for his or her own actions when outside the Community and not under the Community's care, custody or control.

12. Independent Contractors and Third-Party Provider - In the event the Resident (or Responsible Party) contracts with an independent contractor or third-party provider for the Resident's care, the Resident (or Responsible Party) shall be solely responsible for all charges and expenses incurred in connection therewith. The Community shall take action to assist in facilitating the provision of required services and coordinate with the third party provider to meet the specific service goals. The Community shall not have any responsibilities regarding the services or care provided to the Resident by any contractor or third-party provider. The Resident is responsible for his or her own actions when not under the Community's care, custody or control.

13. The Community's Right to Move the Resident - If the Community has determined that the Resident's safety and/or well-being of the Resident or others is in jeopardy, the Community reserves the right to move the Resident to another suite within the Community if it is in the best interest of the Resident and the Community. The Resident (or Responsible Party), by executing this Agreement, hereby agrees to such move.

14. The Resident's Right to Move Within the Community - In the event that the Resident requests a move to another suite within the Community, the Community will review and consider the request. Each time the Community accommodates the transfer request, the Resident (or Responsible Party), at the Community's sole discretion, may be charged a Transfer Fee of up to $250.00, which will be due to the Community along with the following month's Resident Fee. The Resident (or Responsible Party) will be responsible for all costs, fees and charges associated with the new suite. The Resident (or Responsible Party) is solely responsible for all transfer and relocation costs involved in moving Resident's personal belongings between suites.

15. Temporary and Limited Occupancy - The Residents (or Responsible Party) shall not allow any other person to temporarily stay or move into the suite or permanently occupy any portion of the suite without the Community's prior written consent, which consent may be withheld at the Community's sole discretion.

16. Obligations and Responsibilities of the Resident (or Responsible Party) - The Resident at all times during the Term of this Agreement shall:

    a. Conduct him or herself in a manner that does not unreasonably disturb the other Residents of the Community or constitute a breach of the peace. The Resident shall not alter, destroy, deface, damage, or remove any part of the suite or property belonging to the Community or to other residents, or permit any person to do so. The Resident is responsible for all costs associated with the repair, maintenance or replacement necessitated by any willful or negligent acts or inactions by the Resident or Resident's guests.

    b. Pay the Monthly Resident Fees and additional charges promptly.

    c. Comply with all present and future laws, orders and regulations of Federal, State, City, County and Municipal authorities, which affect the use or occupation of the suite and property, contained in it.

    d. Comply and follow the rules and regulations set forth in the Community's Resident Handbook.

    e. Resident may not sublet, transfer or assign the suite or any portion of the suite.

17. The Resident's Bill of Rights - Every Resident at the Community shall have all rights as enumerated in "Schedule B" attached hereto and incorporated herewith.

18. Insurance and Responsibility for Resident's Property - The Community shall not be liable for any loss or damage to the Resident's personal property from theft, fire, or other cause. Therefore, the Community suggests that the Resident (or Responsible Party) obtain appropriate insurance coverage for all personal property of the Resident, Resident guests, and invitees. The Community shall be responsible only for Resident personal money that is specifically delivered to the Community's Executive Director for safekeeping and for which shall be no more than $200.00 in cash or equivalent value. The Community's responsibility for any Resident money is only applicable when there is written documentation signed by both parties and when a receipt is issued to the Resident.

19. Bed-Hold Policy - The Community will hold the Resident's bed in the suite through the time period at which the Monthly Resident Fee is paid or guaranteed to be paid by the Resident (or Responsible Party).

20. Early Termination of Agreement -

    a. The Resident (or Responsible Party) is responsible to comply with all conditions in this Agreement through the Term of this Agreement. This Agreement may be terminated early if the following occurs:

        i. The Community may terminate this Agreement upon 45 days prior written notice upon the occurrence of, but not limited to, any of the following reasons or events:

            1. Failure of the Resident (or Responsible Party) to pay any or all Monthly Resident Fees or additional charges due and owing to the Community or

            2. Failure of the Resident (or Responsible Party) to comply with the terms of this Agreement

            3. Failure of the Resident to qualify as an appropriate Resident pursuant to Florida Statutes 429 and the Rules and Regulations of the Department of Health and Rehabilitative Services.

        ii. THE RESIDENT (OR RESPONSIBLE PARTY) MAY TERMINATE THIS AGREEMENT FOR ANY REASON AFTER PROVIDING THE Community WITH WRITTEN NOTICE OF TERMINATION AT LEAST THIRTY (30) CALENDAR DAYS PRIOR TO THE EARLY TERMINATION DATE.

    b. The early termination date, subject to this Paragraph, shall be the date the Resident (or Responsible Party) completely vacates the suite, including removal of all personal belongings. The Resident's (or Responsible Party's) obligation to pay for the suite shall end upon removal of all personal items from the suite.

21. Immediate Discharge of the Resident - If the Resident requires services that either the Community is not permitted to offer or is not able to offer, this Agreement will be terminated immediately, and all additional charges, including Monthly Resident Fees, will cease upon vacating the suite of personal belongings per Paragraph 20b.

22. Return of Prepayments - Upon the Resident's (or Responsible Party's) removal of all personal items from the suite, the Community shall have forty-five (45) days to return any prepayments, or in which to give the Resident (or Responsible Party) written notice, by certified mail, to the Resident (or Responsible Party)'s last known mailing address, of the Community's intention to impose a claim

on any prepayments and the reason for imposing the claim. The notice shall contain a statement in substantially the form required by Section 83.49(3) F.S. Unless the Resident (or Responsible Party) objects to the imposition of the Community's notice of intention to impose a claim within fifteen (15) days after receipt of the notice from the Community, the Community may then deduct the amount of its claim and shall remit the balance of any prepayments, if any, to the Resident (or Responsible Party) within forty-five (45) days after the date of the notice of the intention to impose a claim for damages. The Community may impose a claim against the Resident's prepayments for the following reasons:

a. Resident (or Responsible Party)'s outstanding balance due to the Community from any charges incurred or billed through the Resident's stay at the Community, or

b. Any damage to the suite and its furniture, fixtures or equipment during the Resident's stay at the Community, or

c. Any damage to the Community and its furniture, fixtures or equipment during the Resident's stay at the Community.

23. The Resident's Death or Relocation -

a. In the event the Resident dies or relocates due to health reasons, which necessitates service or care beyond the regulatory capacity of the Community, this Agreement shall automatically terminate without any financial penalty to the Resident (or Responsible Party). The date of termination in such instances shall be the date the suite is fully vacated of all the Resident's property and belongings. Resident (or Responsible Party) is responsible for all charges the Resident accrued and/or owed to the Community up until the date of Agreement termination. Payment for these charges is due upon receipt.

b. In the event of the death of the Resident with no spouse or no adult next of kin or such person cannot be located, funds due to the Resident (or Responsible Party)shall be placed in an interest bearing account, and all property held in trust by the Community shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the Community and other Residents of the Community. In the event the funds of the deceased Resident are not disbursed pursuant to the provisions of the Florida Probate Code within two years on the Resident's death, the funds shall be deposited in the Aging and Adult Licensure Trust Fund.

24. Records and Release of Information -

a. Resident health care records shall remain confidential and may be released only with the Resident (or Responsible Party)'s consent or consent of such other person duly authorized to release information or as authorized in "Schedule E" and "Schedule F" of this Agreement, except to the extent mandated by law or court order.

b. The Community is hereby authorized and directed to release information and health records concerning the Resident to other medical and health care facilities, insurance companies, federal and/or state agencies and regulatory bodies to the extent necessary to obtain payment and otherwise comply with applicable laws and regulations. The Resident (or Responsible Party) further authorizes release of information and/or records necessary for the Community to conduct reviews or audits of care rendered in the Community.

25. Closure of Community -

    a. Permanent Closure - In the event the Community is closed or ceases operating as a licensed Assisted Living Community according to Florida Statutes Chapter 429, the Resident (or Responsible Party) shall be entitled to a refund of all unused prepaid charges within seven (7) days of closure of Community.

    b. Temporary Closure - In the event of a flu, other communicable disease or epidemic, or as otherwise mandated by law, the Community may be closed to public visitation, should such be determined to be in the best interest of the Residents.

26. Responsible Party - In the event this Agreement is executed by an individual other than the Resident as detailed in the attached Guarantee (Attachment 2), the Responsible Party hereby warrants and represents that said party has full authority and power to enter into this Agreement on behalf of the Resident, and accepts full responsibility thereof. Additionally, under such circumstances, the term "the Resident" shall refer to and include the Responsible Party in all respects of fulfilling any terms of this Agreement.

27. Attorney's Fees - In the event that any party should initiate legal action to enforce any part of this Agreement, it is understood that each party will pay its own legal fees.

28. List of Attachments and Schedules to this Agreement:

"Attachment 1"	Personal Care Services
"Attachment 2"	Guarantee
"Attachment 3"	Second Person Occupant
"Attachment 4"	Informed Consent/Request for Assistance with Self-Administration of Medications by Unlicensed Personnel
"Attachment 5"	Release of Medical Records
"Attachment 6"	Assignment of Benefits and Authorization to Treat
"Schedule A"	Additional Services, Products and Charges
"Schedule B"	Resident Bill of Rights
"Schedule C"	Alternative Dispute Resolution
"Schedule D"	Photo and Media Release
"Schedule E"	Authorization for Release of the Community Health Services Records
"Schedule F"	Authorization for Release of Resident Health Care Records to the Community
"Schedule G"	Admission Packet Receipt
"Schedule H"	Resident HIPPA Consent Form
"Schedule I"	Statement of Policy on Advance Directives
"Schedule J"	Healthcare Advance Directives

"Schedule K" Statement of Policy on Do Not Resuscitate Orders

"Schedule L" Resident Elopement Response

"Schedule M" Third Party Provider Policy

Separate Attachment - Resident Handbook

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day, month and year first written above.

GRACE MANOR PORT ORANGE

_____ By:_____

Witness

RESIDENT

_____ By:_____

Witness

RESPONSIBLE PARTY

_____ By:_____

Witness

ATTACHMENT 1
PERSONAL CARE SERVICES FOR MEMORY CARE

Grace Manor Port Orange Living Services

Our Assisted Living Memory Care Program is designed for residents who require or prefer more or frequent and intensive assistance with activities of daily living. *Unlike other providers, however, your rates do not increase as your personal care needs increase. All Personal Care Services* are included in your Monthly Resident Fee.* Assessments are done on a quarterly basis or more often as needed. Our Assisted Living Memory Care Program is focused on nurturing residents to help them reach their maximum potential. Our team seeks to foster independence rather than dependence, and to be sensitive to the individuality, privacy and freedom of choice to which our residents are entitled. Caring is who we are, not simply a service we provide.

In the Assisted Living Memory Care Program we offer three levels of service and care designed to best complement the needs of our residents:

Grace Manor Port Orange Living Services:

Designed for residents who need minimal assistance with activities of daily living, but need the warmth and social environment offered by Grace Manor Port Orange. Includes the Residential Suite and all of the Basic Care elements listed under Basic Services.

Supportive Living (no additional fee):

Offers moderate assistance with the activities of daily living. Includes heavier assistance for activities of daily living including bathing, dressing, transferring, eating, ambulating, etc. Additional baths, housekeeping, linens, and personal laundry are included as needed. Also includes assistance with bladder and/or bowel incontinence using Grace Manor Port Orange's Continence Management Program. Frequent status checks are performed each day.

Enhanced Living (no additional fee):

Offers maximum level of assistance with activities of daily living. Includes the greatest assistance for activities of daily living with hands on assistance and support. Two hour status checks are performed throughout the day and evening hours. Incontinence management is provided by staff to include two hour toileting of the resident. Includes personalized care program including management of adult briefs or pull ups, skin moisturizing cream, sanitary wipes and gloves, and over the bed protection. Excessive baths and additional housekeeping are provided with this program.

** The only extra monthly expenses you may incur are for cable TV, beauty salon, private phones, medications, incontinent supplies or specialized medical needs.*

ATTACHMENT 2
GUARANTEE

In consideration of the Community accommodating and rendering services to _____ _____a Resident at Grace Manor Port Orange and other good and valuable consideration, the receipt, adequacy, and sufficiency of which is hereby acknowledged by the undersigned (aggregately now know as the Guarantor), the Guarantor jointly and severally hereby unconditionally and irrevocably guarantees the complete and prompt payment of the Resident's Fees, additional charges and any other incurred charges and due to the Community in accordance with the Agreement between the Community and the above named Resident as a primary obligation and not as a surety. This Guarantee shall survive termination of the Agreement and remain in full force and effect until all amounts owed are satisfied. This Guarantee acknowledges that this Guarantee is being accepted by the Community as a material inducement to enter into the above referenced Agreement with the Resident, and that the Community would not enter into this Contract in the absence of this Guarantee.

Dated this day of _____

Signed and delivered in the presence of:

_____
For the Community/Witness

_____
Resident/Responsible Party

Social Security # _____

Driver License # _____

_____
For the Community/Witness

_____
Guarantor

Social Security # _____

Driver License # _____

ATTACHMENT 3
SECOND PERSON OCCUPANT

Grace Manor Port Orange and Resident (or Responsible Party) has permitted _____(Second Person Occupant) to reside in the Resident's Suite for an additional fee of $_____(Second Person Fee) which is payable and due to the Community under the same terms and conditions of the Resident Fee. By signing this Attachment, the Second Person Occupant has become a party to this Agreement. Both the Resident and Second Person Occupant shall be jointly and severally responsible for complying with all terms and conditions of the Agreement.

Upon termination or discharge of occupancy of the Resident, the Second Person Occupant agrees to execute a new Agreement with the Community and agrees to be responsible for the Resident Fee for the suite.

Upon termination or discharge of occupancy of the Second Person Occupant this Attachment shall terminate, but the remainder of the Agreement shall continue in full force for the duration of the Term.

_____ _____

Second Person Occupant Signature Date

_____ _____

Resident (or Responsible Party) Signature Date

_____ _____

For the Community/Witness Signature Date

ATTACHMENT 4
INFORMED CONSENT/REQUEST FOR ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATIONS BY UNLICENSED PERSONNEL

Residents who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. For the purposes of this section, self-administered medications include both, legend and over-the-counter oral dosage forms, topical dosage forms and topical opthalmic, optic, and nasal dosage forms including solutions, suspensions, sprays and inhalers.

An Assisted Living Community (ALF), per F.S.429.256, is not required to have a licensed nurse on staff, and that the Resident may be receiving Assistance with Self-Administration of Medications from an Unlicensed Person, and that such assistance, if provided by an unlicensed person, may be overseen by a licensed nurse. An "Unlicensed Person" means an individual not currently licensed to practice nursing or medicine who is employed by or under contract to an ALF and who has received training with respect to assisting with the Self-Administration of Medication in an ALF as provided under F.S. 429.256 prior to providing such assistance as described in this section.

Assistance with Self-Administration of Medication by an unlicensed person may occur only upon this documented request by, and this written informed consent of, the Resident (or Responsible Party), surrogate, guardian, or attorney in fact.

I have been informed of this policy and agree to this informed Consent to have trained, unlicensed Community staff provide me with Assistance in Self-Administration of my Medications.

_____ _____

Signed (Resident or Responsible Party) Date

_____ _____

For the Community/Witness Date

ATTACHMENT 5
RELEASE OF MEDICAL RECORDS

Name of Company accepting assignment of Benefits

_____

_____

Resident Name:_____

I hereby authorize (i) any pharmacy which has dispensed prescription drugs to me, (ii) any physician or nurse who has treated me and/or (iii) any hospital, assisted living community, nursing home or healthcare Community at which I have been admitted or treated, to furnish (Pharmacy Name)_____

_____

and it's agents and representatives with copies of any and all records and information which they may request regarding my medical history (including medicines prescribed) and my current and prior physical, mental and/or emotional condition. A Photostat of this authorization shall be as valid as the original.

The information authorized for release may include records that may indicate the presence of communicable or venereal diseases, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS)

All information obtained will be maintained in a confidential manner.

_____ _____

Signature of Resident or Responsible Party Date

_____

Address

Attachment 6
Assignment of Benefits and Authorization to Provide Treatment

Name:_____

Social Security #:_____ DOB:_____

Medicare #:_____

Address: _____

_____, Florida _____

I authorize a Physician, or a Nurse Practitioner to assess and treat me in my home for medical problems.

I understand that both are licensed in the State of Florida.

I acknowledge and agree that I have received a copy of Notice of Privacy Information Practices (HIPPA).

I authorize the release to the Social Security Administration and Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related health care services claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to _____ _____, who accepts Assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature of Resident or Responsible Party Date

SCHEDULE A
ADDITIONAL SERVICES AND CHARGES

1. **Personal Care Services** - Grace Manor Port Orange will provide to the Resident appropriate assistance with Activities of Daily Living, which includes individual physical assistance with the following activities as determined by the Resident Functional Evaluation (RFE). The RFE scores Residents in all areas of Activities of Daily Living with four (4) levels of service available. The charges for each are as follows:

Score	Level	Additional Monthly Charge
0-15 points	Level I	$0.00
16-29 points	Level II	NC
30-44 points	Level III	NC
45-60 points	Level IV	NC
61+ points	Level V	NC

2. **Personal Care Supplies** - The Resident (or Responsible Party) is responsible for the purchase, possession and payment of any additional Personal Care Supplies that are not included in Paragraph 6 of the Agreement. At the Resident's sole cost, the Community will help coordinate and make available, but not limited to, the following supplies:

   a. Incontinence Supplies

   b. Laundry Bag

   c. Walkers/Canes

   d. Toilet Extensions

   e. Tub/Shower Equipment

3. **Transportation (Non-scheduled)** - includes round trip transportation at a charge of $30.00 within a 10 mile radius of the Community. Staff companion when necessary is available at the rate of $15.00 per hour, one-hour minimum. Staff companions are available for scheduled and non-scheduled trips/appointments.

4. **Room Service** - meals and/or snacks that are delivered to the Resident's suite at the request of the Resident. The service includes delivery and pick-up. Charge is $5.00 per delivery.

5. **Private Telephone Line, Telephone Service and Cable Service** - The Community will provide each suite with a telephone and cable jack, but it remains the responsibility of the Resident to activate the jack and pay for local and long distance services, as well as for cable services. When the Community provides an In-House phone and cable system, the Resident will be charged $_____ monthly plus applicable long distance tolls and fees for the phone and $_____monthly for the cable. Any charges for extended cable are to be paid to the cable service provider directly.

6. **Guest Meals** - Residents may invite guests to join them at the scheduled meal times. The charges per guest meal are:

   Breakfast $5.00 Lunch $5.00 Dinner $5.00

7. **Bank Charges** - Any returned check will result in a fee of $50.00. Returned checks will not be re-deposited, they must be replaced with a cashier's check. Any uncollected balance will be subject to late fees. Refer to Paragraph 3e of the Resident Agreement.

All "Additional Products and Service" prices are subject to change as deemed necessary by management.

SCHEDULE B
RESIDENT BILL OF RIGHTS

No Resident of the Community shall be deprived of any civil or legal rights, benefits or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States solely by reason of status as a Resident of a Community. Every Resident of the Community shall have the right to:

a. Live in a safe and decent living environment, free from abuse and neglect.
b. Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
c. Retain and use his own clothes and other personal property in his immediate living quarters, so as to maintain individuality and personal dignity, except when the Community can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other Residents.
d. Unrestricted private communication, including receiving and sending unopened correspondence, access to telephone and visiting with any person of his choice, at any time during waking hours.
e. Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
f. Manage his own financial affairs unless he or his guardian authorizes the Administrator of the Community to provide safekeeping for funds as provided in Florida Statutes Section 429.28.
g. Share a room with his/her spouse if both are Residents of the Community.
h. Reasonable opportunities for regular exercise several times a week and to be outdoors at regular and frequent intervals.
i. Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any Resident.
j. Access to adequate and appropriate health care consistent with established and recognized standards within the community.
k. At least forty-five (45) days notice of relocation or termination of residency from the Community unless, for medical reasons the Resident is certified by a physician to require an emergency relocation to a Community providing a more skilled level of care or the Resident engages in a pattern of conduct that is harmful or offensive to other Residents. In the case of a Resident who has been adjudicated mentally incompetent, the guardian shall be given at least forty-five (45) days notice of a non-emergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a Community to terminate the residency of an individual without notice as provided herein, the Community shall show good cause in a court of competent jurisdiction.
l. Present grievances and recommended changes in policies, procedures, and services to the staff of the Community, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. This right includes access to Ombudsman, volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

The contact information of the state Ombudsman Committee and Adult Abuse Register, where complaints may be lodged, is by telephone Toll Free 1-800-962-2873 or by fax Toll Free 1-800-914-0004.

_____ _____

Resident (or Responsible Party) Date

_____ _____

For the Community/Witness Date

SCHEDULE C
ALTERNATIVE DISPUTE RESOLUTION

1. Optional Arbitration Clause - Any controversy or claim between the Community and the Resident (or Responsible Party)shall be resolved by binding arbitration in accordance with the provisions of the Federal Arbitration Act (FAA), and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. If the arbitrator deems the FAA does not apply, then binding arbitration shall be undertaken in accordance with the Florida Arbitration Code. This optional arbitration clause is self-executing and any dispute over interpretation, scope, waiver or enforceability is exclusively for the arbitrator to decide. Parties are free to seek relief in Florida small claims court for disputes or claims within the scope of its jurisdiction. Terms below apply.

2. Parties to this Agreement acknowledge that the operation of this Community involves interstate commerce through insurance, Medicare, federal regulations, general operations and partners/ vendors.

3. Waiver of Jury Trial - Please read carefully. The Community and Resident(or Responsible Party) knowingly voluntarily and intentionally waive their respective right to trial by jury with respect to any dispute, claim, litigation or allegation which arises between Community and Resident (or Responsible Party).

4. Severability - Parties agree that, should any provision of this Agreement be deemed or declared invalid by a court (or arbitrator) of proper jurisdiction, or rendered invalid by any statute or regulation, then such provision shall be severed and the remainder of the Agreements shall remain binding and full force. Titles and captions are for convenience only.

5. Withdrawal - As it relates to this Agreement, and Party has three (3) days from execution of the Agreement to cancel any portion by timely delivering such notice in writing to the other Parties.

6. Aides/Visitors - The Community is not liable in any respect for the health and safety nor actions or inactions of any visitor, family member, private aide, assistant, sitter, or employee of/for the Resident. The Community does not provide background checks, works compensation, guarantees of any kind, nor liability for such individuals while on the Community property. The Resident (or Responsible Party) holds the Community harmless for the health, safety and actions/inactions of these individuals while visiting or providing services to the Resident at the Community. The Community reserves the right to exclude individuals from the premises.

7. Complete Agreement - Resident (or Responsible Party) acknowledge that they have the legal capacity and authority to sign this Agreement to admit the Resident to the Community and that this Agreement is the sole, exclusive and complete contract terms between the parties.

This document constitutes, the entire Agreement between the parties, and any provision of this contract which is not enforceable shall not affect the enforceability of any and all other terms of the contract.

_____ _____

Resident/POA/Legal Guardian/Responsible Party Date

_____ _____

For the Community/Witness Date

*Note: If document is not executed please X out the entire page.

SCHEDULE D
PHOTO & MEDIA RELEASE

I hereby authorize and consent to the release of my picture and/or name to the press or other news media during their coverage of any social or community function held at Grace Manor Port Orange.

_____ _____

Resident (or Responsible Party) Date

_____ _____

For the Community/Witness Date

SCHEDULE E
AUTHORIZATION FOR RELEASE OF THE COMMUNITY SERVICES HEALTH RECORDS

I, _____, do hereby consent to and authorize the Community to disclose to _____, information from the resident records relating to my identity, diagnosis, prognosis, or treatment for any health-related issue, including alcohol and/or substance abuse, HIV/AIDS and/or any psychiatric history. I understand that the specific type of information to be disclosed includes the Community Resident Care Record, and that the purpose or need for this disclosure is to determine resident needs. I also understand that unless revoked in writing, this consent will remain in force for the period of time necessary to effectuate the purpose for which it is given.

_____ _____

Resident/Guardian/POA/Responsible Party Date

_____ _____

For theCommunity/Witness Date

SCHEDULE F
AUTHORIZATION FOR RELEASE OF RESIDENT HEALTH CARE RECORDS TO THE COMMUNITY

I, _____, do hereby consent to and authorize _____ _____, to disclose to the Community, information from the resident records relating to my identity, diagnosis, prognosis, or treatment for any health-related issue, including alcohol and/or substance abuse, HIV/AIDS and/or any psychiatric history. I understand that the specific type of information to be disclosed includes any/all medical information and that the purpose or need for this disclosure is to evaluate the resident's health status for admission to the Community. I also understand that unless revoked in writing, this consent will remain in force for the period of time necessary to effectuate the purpose for which it is given.

_____ _____

Resident/Guardian/POA/Responsible Party Date

_____ _____

For the Community/Witness Date

SCHEDULE H
RESIDENT HIPPA CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their residents' consent for uses and disclosures of health information about the resident to carry out treatment, payment, or health care operations.

As our resident we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of you health care information and information about your treatment., payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not residents), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain resident consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

_____ _____

Resident (or Responsible Party) Date

_____ _____

For the Community/Witness Date

SCHEDULE I
STATEMENT OF COMMUNITY POLICY ON ADVANCE DIRECTIVES

The Community's policy on Advance Directives is to request upon admission a copy of the resident's Advance Directive documents. An "Advance Directive" is a witnessed written document with instructions given by the resident expressing their wishes concerning any aspect of their medical care. These documents could include a designation of a health care surrogate, a living will, or an anatomical gift.

For Residents having a Directive(s), the Community shall maintain a copy in the individual resident record and the Directive shall be presented to Health Care providers in compliance with HIPPA guidelines.

Residents not in possession of Advance Directives but requesting them will be directed to a professional resource for guidance and preparation of the documents requested.

I have read and understand this policy.

_____ _____

Resident (or Responsible Party) Date

_____ _____

For the Community/Witness Date

SCHEDULE J
HEALTH CARE ADVANCE DIRECTIVES

The Patient's Right to Decide
(Form SCHS-4-2006)

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's Disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and to indicate the desire to make an anatomical donation after death.

By law hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs)are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58a-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

Questions About Health Care Advance Directives

What is an advance directive?

It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:

A Living Will

A Health Care Surrogate Designation

An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a living will?

It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Which is best?

Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

What is an anatomical donation?

It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form (seen elsewhere in this pamphlet), or expressing your wish in a living will.

Am I required to have an advance directive?

No, there is not legal requirement to complete an advance directive. However, if you have not made an advance directive, decision about your health care or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, and adult relative, or a close friend.

The person making decision for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?

No, the procedures are simple and do not require an attorney, though you may choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnesses by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Where can I find advance directive forms?

Florida law provides a sample of each of the following forms: a living will, a health care surrogate, and an anatomical donation. Elsewhere in this pamphlet we have included sample forms as well as resources where you can find more information and other types of advance directive forms.

Can I change my mind after I write an advance directive?

Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive.

If your driver's license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?

An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

If you designate a health care surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.

Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.

Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.

Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.

If you change your advance directive, make sure your health care provider, attorney, and the significant persons in your life have the latest copy.

If you have questions about your advance directives you may want to discuss these with your health care provider, attorney, or the significant persons in your life.

More Information On Health Care Advance Directives

Before making a decision about advance directives you might want to consider additional options and other sources of information, including the following:

As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, health care provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available in the DOH website, www.doh.state.fl.us or www.MyFLorida.com (type DNRO in these website search engines) or call (850) 245-4440.

When you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.

If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors, must arrange with a local funeral home, and pay, for preliminary embalming and transportations of the body to the Anatomical Board located in Gainesville, Florida. After being used for medical education or research, the body will ordinarily be cremated. The cremains will be returned to the loved ones, if requested at the time of donation, or the Anatomical Board will spread the cremains over the Gulf of Mexico. For further information contact the Anatomical Board of the State of Florida at (800) 628-2594 or www.med.ufl.edu/anatbd.

If you would like to read more about organ and tissue donation to persons in need you can view the Agency for Health Care Administration's website http://ahca.MyFlorida.com (click on "site map" then scroll down to "organ donors") or the federal government site www.OrganDonor.gov. If you have further questions you may want to talk with your health care provider.

Various organizations also make advance directive forms available. One such document is "Five Wishes"that includes a living will and a health care surrogate designation. "Five Wishes" gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort such as what kind of music you might like to hear, among other things. You can find out more at:

Aging with Dignity
www.AgingWithDignity.org
(888) 594-7437

Other resources include:

American Association of Retired Persons (AARP)
www.aarp.org
(Type "advance directives" in the website's search engine)

Your local hospital, nursing home, hospice, home health agency, and your attorney or health care provider may be able to assist you with forms or further information.

Brochure: End of Life Issues
www.FloridaHealthStat.com (under Reports and Guides)
(888) 419-3456

LIVING WILL

Declaration made this _____day of _____, 20_____, I _____ _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

- _____(initial) I have a terminal condition
- or_____(initial) I have an end-stage condition
- or_____(initial) I am in a persistent vegetative state,

and if my attending or treating physician and other consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do_____, I do not_____ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name:_____

Street Address:_____

City:_____State:_____Phone:_____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions(optional): _____
_____
_____
_____
_____

(Signed) _____

Witness _____

Street Address_____

City_____State_____

Phone _____

Witness_____

Street Address_____

City_____State_____

Phone _____

At least one witness must NOT be a husband or wife or a blood relative of the principal.

Definitions for terms on the Living Will form:

"End-stage condition" means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

"Persistent vegetative state" means a permanent and irreversible condition of unconsciousness in which there is: The absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment.

"Terminal condition" means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

These definitions come from section 765.101 of the Florida Statutes. The Statutes can be found in your local library or online at www.leg.state.fl.us.

Designation of Health Care Surrogate

Name:_____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name:_____

Street Address:_____

City:_____State:_____Phone:_____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name:_____

Street Address:_____

City:_____State:_____Phone:_____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care Community.

Additional Instructions (optional):

_____

_____

_____

_____

_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care Community, I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name_____

Name_____

Signed_____

Date_____

Witnesses

1. _____

2. _____

At least one witness must NOT be a husband or wife or blood relative of the principal.

The card below may be used as a convenient method to inform others of your health care advance directives. Complete the card and cut it out. Place in your wallet or purse. You can also make copies and place anther one on your refrigerator, in your car glove box, or other easy to find places.

Health Care Advance Directives

I, _____
have created the following Advance Directives:

_____ Living Will

_____ Health Care Surrogate Designation

_____ Anatomical Donation

_____ Other (specify) _____

----------FOLD----------

Contact:

Name:_____

Address:_____

_____

_____

Phone:_____

Signature:_____

Date:_____

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SCHEDULE K
DO NOT RESUSCITATE ORDERS (DNRO)

It is the policy of the Community to only accept Do Not Resuscitate Orders (DNROs) from Residents who are admitted to a licensed Hospice program.

A DNRO is a physician's order to withhold or withdraw resuscitation if a patient goes into cardiac or pulmonary arrest. It is part of a prescribed medical treatment plan, is recorded on canary yellow paper and must have a physician's signature. It is usually written for patients who are terminally ill, suffering from an end-stage condition or who are in a persistent vegetative state.

For Residents under the care of Hospice who have a DNRO, the Community shall maintain an original yellow copy in the individual resident record and the Directive shall be present to EMS and other Health Care providers in compliance with HIPAA guidelines.

A Resident who has a DNRO always has the right to revoke it at ANY time. If the resident choose to revoke their DNRO they simply notify the Community and their physician and it will be removed.

The Community is a non-medical, social model of care that supports life. It is the policy of the Community to call 911 in all emergencies and allow EMS personnel to provide emergency medical care to our Residents.

I have read and understand this policy:

_____ _____

Resident (or Responsible Party) Date

_____ _____

For the Community/Witness Date

SCHEDULE L
RESIDENT ELOPEMENT RESPONSE

Policy: Resident elopement response policy is to be followed when a resident has been identified or observed as a risk for wandering and/or elopement. Every effort will be made to prevent and track wandering residents while maintaining the least restrictive environment for the residents who are at risk for elopement.

Purpose: To identify resident's risk of wandering and/or elopement

Definition of Elopement: Elopement is defined as "when a resident leaves the Community property beyond the perimeter of the parking lot or further and is missing without the Community's knowledge, and who have not signed out nor verbally informed the Community of their plans for returning."

Procedure:

1. The Health and Wellness Director or Executive Director will assess all residents for wandering and/or elopement at the time of moving in.

2. Upon admission a picture is taken of all Residents. The picture will be kept in a designated area.

3. The Executive Director and/or the Health and Wellness Director will re-evaluate resident per Resident Functional Evaluation Program to determine what changes have occurred that would trigger elopement episodes.

4. If the Resident's condition has changed since their initial admission to the Community, the services to be provided will be modified to reflect that the resident has been identified as a wanderer and/or is at risk for elopement episodes.

5. Interventions designed to mitigate elopement will be addressed and if appropriate for continued stay at the Community then the services plan will be modified to reflect these changes (i.e. secured suite).

6. Should an elopement episode occur, contributing factors, as well as the interventions and measures that are implemented to prevent this occurrence will be documented in the observation notes. Adverse incident reporting procedures will be followed.

7. The Executive Director will have a conference with the competent Resident and/or Responsible Party/ family member. If a Resident repeatedly leaves the Community without informing the staff or signing out, a mutual risk agreement must be implemented.

8. If a Resident with memory impairment wanders off the property a monitoring schedule will be updated to reflect the implementation of the monitoring schedule.

9. When/if a Resident is determined to be missing, a search shall begin immediately.

10. Resident, who do not return by the time designated or communicate with the Community, may be considered eloped and the Responsible Party, physician and authorities will be notified.

11. Residents evaluated to be at risk for elopement will be required to keep on their person, Community provided information including their name, Community name, address and phone number.

_____ _____

Resident (or Responsible Party) Date

_____ _____

For the Community/Witness Date

SCHEDULE M
THIRD PARTY PROVIDER POLICY

Scope: Residents who desire or require the services of a third party provider.

Policy: Ensure coordination and communication of services provided between Resident, Third Party Provider, and Community.

Procedure: Community will take action to assist in facilitating the provision of required services and coordinate with the third party provider to meet the specific services goals. If the Resident or their Representative decline assistance it will be noted in the Resident file and reviewed annually.

Resident will sign "Third Party Provider Policy" prior to the start of services.

All providers must comply with the following requirements:

1. Copy of License of company/agency and individual licenses of professional staff.
2. Copy of current Certificate of Insurance, including Liability Insurance with limits of $1,000000/$3,000000 and Workers Compensation.
3. Written acknowledgement by provider of compliance with the following:
   a. All staff screened for TB with up to date physicals.
   b. All staff submitted and cleared on criminal background checks.
   c. All staff up to date with current in-service requirements.
4. Sign and abide by Third Party Provider Agreement.
5. Abide by the Rules of Conduct.
6. Community has the right to terminate the Third Party Provider Agreement and execute a Third Party Provider from providing services within the Community for violation of Community policies, breach of the Third Party Provider Agreement or other disruption of Community operations.

Resident	Date
Responsible Party	Date
For the Community/ Witness	Date