

CLEARVIEW ADMISSION AGREEMENT

Clearview
199 Home Road, Juneau, WI 53039
Phone: (920) 386-3400

<i>For Office Use Only</i>	
Admit Date: _____	CVN/CV: # _____
Admitted From: _____	
Voluntary/Protective Placement (Circle) MR#: _____	
Payment Source: _____	LOC: _____
County of Responsibility: _____	

Name _____
(first) (middle) (last) (likes to be called)

Previous Address/Phone Number

(street, city, state, zip, phone #)

D.O.B. _____ **Gender (Circle)** M F **Marital Status (Circle)** S D M W

Primary Contact Person(s):

1. Name _____ Phone (h) _____ (wk) _____

Address _____

Relationship _____ Legal Status _____ POA/HC; _____ Guardian of Person

2. Name _____ Phone (h) _____ (wk) _____

Address _____

Relationship _____ Legal Status _____ POA/HC; _____ Guardian of Person

Physician Choice(circle one): Clearview's **Other(Name/#)** _____

To Whom may Clearview tell specific medical information if they inquire?

Name/Address/Phone # of Funeral Home

Has the applicant been hospitalized in the past 30 days? ____yes ____no
If yes, where? _____; **when?** _____

Has the applicant ever lived in any retirement/nursing home/swing-bed unit? ____yes ____no
If yes, where? _____; **when?** _____

Do you have prescription drug coverage? ____Yes ____No; **If yes, please provide appropriate card and indicate the name of the organization/plan and the policy number:**

CLEARVIEW ADMISSION AGREEMENT

Resident Name _____ **Social Security#** _____

When paying for my stay at Clearview, I have the following sources of income: (provide copies)

_____ Medical Assistance; # _____ Long Term Care Insurance

_____ Medicare; # _____ Private Pay Status

_____ Pension _____ Social Security Benefits: \$ _____ /mo _____ Other: _____

Other Health Insurance or Supplement (if applicable) – Policy# _____ Name of Company _____

_____ Is this an HMO? ____yes__ _no

Spouse Health Insurance if different than above (including Policy # and Name of Company) _____

Are you or your spouse currently working? _____yes _____no

Choose ONE of the following options regarding the resident's finances (Initial Choice):

A. _____ The resident has:

_____ an activated Power of Attorney for Finances (POA) (Please provide copy.)

or

_____ been deemed incompetent by a Court of Law and has a Guardian of Estate

Therefore the resident's finances will be handled by the resident's POA or Guardian of Estate. Financial information and invoices should be mailed to:

Name: _____ Phone#: _____

Address: _____

B. _____ Clearview is delegated the responsibility of managing my financial affairs (including personal allowances under Federal and State programs) and may open an account at Clearview as Representative Payee. The following amount is the limit Clearview may spend towards my needs without prior notification to me/my legal representative: \$ _____. If left blank the amount will be at Clearview's discretion. As Rep. Payee, we will be receiving mail pertinent to financial matters; your initials here gives us permission to open it and manage it accordingly _____.

C. _____ I will personally be responsible for all of my financial matters and will agree to promptly pay the amount determined by Clearview and/or Department of Health & Family Services to be applied to the cost of care.

I am applying for admission to Clearview. OR

I am applying on behalf of _____ for admission to Clearview.

X _____
Signature: Resident/Guardian of Person/Power of Attorney for Health Care Agent Date

I authorize any holder of medical or other information about me to release to the Social Security Administration, Veterans' Administration, and/or the Medicare Program or its intermediaries or carriers or to the Professional Standards Review Organizations, any information needed for Medical Assistance, Medicare or other insurance claims. I request that payment of authorized benefits be made on my behalf, during my residence at Clearview.

X _____
Signature: Resident/Guardian of Estate/Financial Power of Attorney Date

CLEARVIEW ADMISSION AGREEMENT

Resident Name _____

Who will shop for resident's personal items? _____

Please put an "X" on the appropriate lines to indicate your receipt of the information:

- Application for Admission (Including the Financial Information and Agreement)
- Emergency Care, Do Not Resuscitate Order
- Advanced Directives Offered
- Daily Rates, Bed Hold Policy, Beautician/Barber Services Information
- Information about HIPPA/Notice of Privacy Practices
- Pre-Admission Consultation brochure "Considering Assistive Living or a Nursing Home: What You Should Know"

Clearview has the following services available within the facility, which may be at an additional cost. Please indicate with an "X" on the lines next to the ones you wish to utilize.

- PODIATRY SERVICES
- DENTAL SERVICES (Examinations are required within 6 months of admission.)
- OPHTHAMOLOGY SERVICES
- BEAUTY/BARBER SERVICES (Circle: Cut/Perm/Set - how often? _____)

If you wish to use your own service provider for any of these services, please indicate below by including an "X" on the line and the provider's name and contact number.

- Podiatrist: _____
- Dentist: _____
- Optometrist: _____
- Beautician/barber: _____

Place an "X" below only by those you wish to authorize.

- I will allow my name and/or photo to be published for public relations purposes.
- I wish to have staff assist me with mail that I receive while at Clearview (this may include opening it and reviewing it with me).
- I wish to open a resident account at Clearview to handle spending money.
- I wish to have all mail that may come to me at Clearview forwarded to the following:
person (Name/Address): _____
- *Specify any mail that could go to the resident:** _____

I have been given and I understand the above information received. An "X" indicates my receipt and/or authorization and I recognize that I can contact anyone in the social services department with questions.

Signature of Resident Date

X

Signature of Legal Guardian/Power of Attorney for Health Care agent (if activated) Date

CLEARVIEW PERSONAL HISTORY
Please provide information during their lifetime

Name: _____ Prefers to be Called: _____

Birthdate: _____ Birthplace: _____

Father's Name/Birth Date/Place of birth: _____

Mother's Name/Birth Date/Place of birth: _____

Are parents still living? _____ If no, when did they die? _____

Brothers and Sisters (Note order of birth, age and/or if deceased): _____

Education: _____ Former Occupation: _____

Veteran Status: _____

Religion _____ Name/ Phone # of Church _____

Contact Clergy if critical change in condition: Y N

Marital Status: (Circle One) Married Widowed Divorced Single

Marital History (Names of spouse(s), dates of marriages and dates of divorce or death of spouse)

Children (Note order of birth, age and/or if deceased): _____

Customary Routine: (Circle One)

Naps during the day: Y/N

Use of tobacco products at least daily: Y/N

Stays up late (after 9PM): Y/N

Use of alcoholic beverages at least weekly: Y/N

Goes out 1+ days during the week: Y/N

Distinct food preferences: Y/N

Involved in group activities: Y/N

Eats between meals all or most days: Y/N

Spent most time alone or watching TV: Y/N

In bed clothes most of the day: Y/N

Adjusts easily to changes in routine: Y/N

Wakens to toilet all or most nights: Y/N

Showers for bathing: Y/N

Bathing in PM: Y/N

Daily contact with relatives/close friends: Y/N Daily animal companion/presence: Y/N

Stays busy with hobbies, reading or fixed daily routine: Y/N

Faith is important: Attends church, temple, synagogue routinely: Y/N

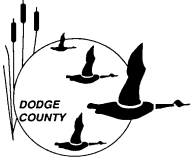
Where did person live previously?

Childhood (to age 12) _____

Young Adult (to age 21) _____

Adulthood _____

Describe resident's personality traits, hobbies and usual former daily routine: (This section is especially important for us, as it helps us get to know the resident and how to best individualize their activities, etc.)



Clearview LTC & Rehabilitation GENERAL DIRECTIVES FOR CRITICAL CARE

Resident Name: _____

The resident/legal representative may revoke or revise this document at any time

Due to scientific and medical advancements in life prolonging technology, some health care decisions need to be made in advance of an emergency or crisis situation. Decisions regarding treatment and hospitalization will be made between the physician, resident and/or responsible party. The expressed desire of a resident at Clearview, who is capable of making his/her own health care decisions, always supersedes the effect of an advance directive.

In all instances, comfort measures will be employed to alleviate suffering, promote comfort and preserve dignity. Such comfort measures may include emotional support, spiritual support, skin care, turning and positioning, grooming, bowel and bladder care, maintenance of sensory functioning, pain medications and/or oxygen.

CARDIOPULMONARY RESUSCITATION

Cardiopulmonary Resuscitation (CPR) is an emergency medical procedure used in an attempt to restore circulation and respiration which have stopped. The absence of circulation and respiration is referred to as a cardiorespiratory arrest. The infirmities of aging and significant medical conditions that are common among the elderly and/or medically fragile make chances of CPR survival almost nonexistent.

CPR consists of both basic and advanced life support procedures. Basic CPR involves rescue breathing and chest compressions. Rescue breathing is performed mouth-to-mouth or by using a special mask and bag. Chest compression, or external cardiac massage, is the compression of the chest at the lower part of the sternum with one's hands, using the weight of the body for pressure. It is done to force the circulation of blood through vital organs. The hazards of chest compression include the possibility of broken ribs, lacerated liver, punctured lung(s) and/or brain damage due to lack of sufficient oxygen to the brain.

I understand that Clearview's policy is that no CPR will be provided unless I request CPR and the arrest is witnessed by staff. Such a request will only be honored if my attending physician agrees that CPR is both desirable and reasonable and that a physician's order is written directing that CPR be provided. I understand that my physician retains the authority to deny the use of CPR in futile cases. To retain my autonomy, if I, or my lawful surrogate request the CPR be provided, but if my physician disagrees, he/she will chart the medical rationale for withholding CPR; will inform me or my surrogate of this decision and the rationale for this decision; and will offer me the options of a transfer to the care of another physician or my move to another long term care facility. I also understand that by requesting to receive CPR that I am signifying I understand the hazards associated with the use of chest compression. I understand the chances of success of CPR in the elderly and/or medically fragile is unlikely.

I, _____ (Name of Resident), being of sound mind, state my wishes willfully and voluntarily. **I desire to receive CPR in the case of my witnessed arrest. I understand that this decision will only be implemented if my physician agrees and writes a physician's order directing the use of CPR.**

Signature of Resident: _____ Date: _____

OR

I, _____ (Name of legal representative) as guardian or activated health care agent execute this directive on behalf of the following individual, believing these directives to be consistent with his/her wishes.

_____ (Name of Resident) **desires to receive CPR in the case of their witnessed arrest. I understand that this decision will only be implemented if their physician agrees and writes a physician's order directing the use of CPR.**

Signature of Legal Representative: _____ Date: _____

Witness Signature: _____ Date: _____

Reviewed and approved by attending physician at Clearview:

Physician Signature: _____ Date: _____

Medicare Secondary Payer Questionnaire
Initial Screening Tool

Use this preliminary questionnaire to determine if additional information is needed to determine Medicare as a secondary payer.

PATIENT NAME: _____

1. Was this illness/injury the result of any kind of accident? Yes No
2. Were you injured on the job? Yes No
3. Are you covered by the Black Lung Program? Yes No
4. Have you ever received treatment that has been covered under a Federal Grant? Yes No
5. Are you over 65? Yes No
What is your age? _____
When did you retire? _____
What is your spouse's age? _____
When did your spouse retire? _____
6. Are you covered by a group health plan of 20 or more employees based on your present employment or present employment of your spouse? Yes No
7. Are you under 65? Yes No
8. Are you receiving Medicare benefits due to a disability? Yes No
9. Are you covered by a group health plan of 100 or more employees from a present or former employer or from your spouse or a parent? Yes No
10. Have you ever had renal disease or been on kidney dialysis? Yes No
11. Are you covered by a Group Health Plan based on your present or former employer, or a parent's or a spouse's Health Plan? Yes No

If question 1, 2, 3, 4, 6, 8, 9, 10 or 11 are answered YES – complete Comprehensive Medicare Secondary Payer Questionnaire

Completed By: _____

Date: _____

Tommy G. Thompson
Governor



State of Wisconsin
Department of Health and Social Services

DIVISION OF HEALTH
1 WEST WILSON STREET
P. O. BOX 100
MADISON WI 53701-0100

DO-NOT-RESUSCITATE (DNR) INFORMATION

To whom it may concern:

Recently, 1995 Wisconsin Act 200 created new language in chapter 154 of the statutes establishing a system for issuance of do-not-resuscitate orders and do-not-resuscitate bracelets in certain circumstances. Enclosed is information about the new statutes and accompanying rules. Implementation steps and answers to common questions are summarized below.

Which do-not-resuscitate (DNR) orders are controlled by Act 200?

These do-not resuscitate orders are written orders issued by physicians under chapter 154 of the Wisconsin statutes to direct emergency medical technicians, first responders, and emergency health care facilities personnel not to attempt cardiopulmonary resuscitation (CPR) on a person for whom the order is issued if that person suffers cardiac or respiratory arrest. A person with a valid DNR order is identified by a standardized DNR bracelet. Specifications for DNR bracelets and the procedures for emergency medical technicians, first responder and emergency health care facilities personnel to use in following a DNR order are described in Administrative Code HFS 125.

Act 200 only applies to the entities identified above which are primarily prehospital and emergency department health care providers. Act 200 does not control DNR orders for inpatient hospital settings or other inpatient settings.

Who is eligible for a DNR order under Act 200?

A person must be a "qualified patient" to be eligible for a DNR order. A qualified patient is someone age 18 or older who has a terminal condition or a medical condition such that, were the patient to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful, cause significant harm or pain, or would be successful only temporarily. See the DNR order form completion guidelines for additional details.

Who can issue a legal DNR order under Act 200?

Only an attending physician may issue a DNR order under Act 200. The attending physician may issue a DNR order to a patient only if all of the following apply:

- The patient is a qualified patient.
- The patient requests the order.
- The order is in writing.
- The patient signs the order.
- The physician does not know the patient to be pregnant.

How does someone obtain a DNR order under Act 200?

After consulting with the attending physician, the patient must be provided with written information about DNR procedures. The physician or designee must also document in the patient's file the qualifying medical condition that warrants a DNR order. A copy of a DNR order form and information sheet can be obtained from the Department of Health and Family Services (608/267-7147). Other forms and written information are acceptable.

How does someone obtain a DNR bracelet under Act 200?

The physician or designee attaches a standardized DNR bracelet after all the prerequisites are met. Hospitals, clinics, etc. will supply the plastic bracelets and insert a standardized insert with the required patient information. The bracelet must be clear and at least 3/4 of an inch in width.

The insert will be distributed by the Department of Health and Family Services and have a preprinted logo of the State of Wisconsin and the words "Do-Not-Resuscitate" in blue. The required information must be printed in size 10 or greater font and includes the patient's name, address, date of birth, and gender on the left half of the form and the physician's name, business telephone number, and signature must be on the right half of the form.

Must the bracelet be plastic or are there alternatives?

The law at this time only allows for plastic bracelets.

What will happen when a DNR patient wearing a bracelet needs health care assistance?

Health care will be provided to DNR patients with only full resuscitative care being withheld. Comfort care will be given, but no life sustaining cardiac or pulmonary care will be provided.

What if the patient changes his or her mind and wants to revoke the DNR order?

The patient can revoke the DNR order by expressing to emergency health care personnel the desire to be resuscitated, or by defacing, cutting, removing, or asking someone to remove the bracelet. The attending physician shall be notified as soon as practicable of the patient's revocation of the DNR order and shall record in the patient's medical record the time, date, and place of revocation.

What if a family member or friend wants to revoke the order?

In the event the patient's family member or a friend wishes resuscitative measures be taken, their wishes do not supersede the wishes of the patient with a valid do-not-resuscitate bracelet. The do-not-resuscitate bracelet must be honored. Individuals with DNR orders should make family members and friends aware of their wishes to avoid problems.

What immunities are there with this law?

No physician, emergency medical technician, first responder, health care professional or emergency health care facility may be held criminally or civilly liable, or charged with unprofessional conduct, for any of the following:

1. Under the directive of a DNR order, withholding or withdrawing resuscitation from a patient;
2. Failing to act upon the revocation of a DNR order unless they had actual knowledge of the revocation;
3. Failing to comply with a DNR order if they did not have actual knowledge of the DNR order or if the person in good faith believed the order had been revoked.

What penalties are there for violations of the DNR laws of Act 200?

1. Any person who willfully conceals, defaces or damages the DNR bracelet of another person without that person's consent may be fined not more than \$500 or imprisoned for not more than 30 days or both.
2. Any person who, with the intent to cause the withholding or withdrawal of resuscitation contrary to the wishes of the patient, falsifies, forges or transfers a DNR bracelet to that patient or conceals a revocation shall be fined not more than \$10,000 or imprisoned for not more than 10 years or both. Any responsible person who withholds personal knowledge of a revocation faces the same penalties.
3. Any person who directly or indirectly coerces, threatens or intimidates an individual so as to cause the individual to sign or issue a DNR order shall be fined not more than \$500 or imprisoned for not more than 30 days or both.

EMERGENCY CARE DO NOT RESUSCITATE ORDER (DNR)

This form provides consistent language and documentation for emergency care DO NOT RESUSCITATE (DNR) orders and bracelet to direct emergency medical technicians, first responders and emergency health care facilities personnel in the field. By wearing a DNR bracelet a patient clearly notifies emergency medical personnel of the intent to have these orders followed. This form is the legal document that serves as the basis for affixing the do not resuscitate bracelet to the patient. The form also provides specific care instructions for health care providers responding to emergency calls. If this form is appropriately completed, emergency personnel should limit care as outlined. The patient has the right to revoke these restrictions on care at any time.

Action desired by patient:

May call 911 for urgent needs.

May call ambulance for routine transport: phone # _____

If this form has been completed, this is the type of care that will and will not be provided:

Emergency Provider as appropriate will:	Emergency Provider will NOT:
Clear airway. Administer oxygen. Position for comfort. Splint. Control bleeding. Provide pain medication. Provide emotional support. Contact hospice or home health agency if either has been involved in patient's care, or the patient's attending physician.	Perform chest compressions. Insert advanced airways. Administer cardiac resuscitation drugs. Provide ventilatory assistance. Defibrillate.

Gender: Male Female

Patient's Name: _____ Date of Birth: _____
(Please print or type)

Patient's address: Street: _____
City: _____ State: _____ Zip Code _____

I understand this document identifies the level of care to be rendered by an emergency medical technician, first responder, or emergency health care facility personnel in situations where death may be imminent. I make this request knowingly and I am aware of the alternatives as explained to me by my physician. I expressly release, on behalf of myself and my family, all persons who shall in the future attend to my medical care of any and all liability whatsoever for acting in accordance with this request. Furthermore, I direct that this order be enforced even though I may develop a diminished mental capacity at some future time. I am aware that I can revoke this order at any time by removing or defacing the identification bracelet or by requesting resuscitation.

Patient's Signature Date

Print Physician's Name

Physician's Signature Phone # _____ Date _____

THE ABOVE SIGNATURES AND DATES ARE REQUIRED FOR THIS FORM TO BE VALID AND ITS INTENT CARRIED OUT. See reverse side for background information and instructions on how to complete this form.

**BACKGROUND INFORMATION/INSTRUCTIONS FOR
COMPLETING DO NOT RESUSCITATE ORDER**

I. BACKGROUND INFORMATION

Cardiopulmonary resuscitation is a procedure employed after cardiac arrest in which cardiac massage, drugs, and artificial ventilation are used to restore breathing and circulation. It is standard medical practice to perform cardiopulmonary resuscitation (CPR) on all persons found to be in cardiac or respiratory arrest in the absence of directives from a primary physician to withhold such action. However, patients may legally and ethically decline these treatments. THE DNR order is used to implement their decision that CPR is not to be performed. This decision to limit CPR rests with the physician and his/her qualified patient as identified in 1995 Wisconsin Act 200. A qualified patient means a person who is at least 18 years old and to whom any of the following conditions applies.

1. The person has a terminal condition.
2. The person has a medical condition such that, were the person to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful in restoring cardiac or respiratory function or the person would experience repeated cardiac or pulmonary failure within a short period before death occurs.
3. The person has a medical condition such that, were the person to suffer cardiac or pulmonary failure, resuscitation of that person would cause significant physical pain or harm that would outweigh the possibility that resuscitation would successfully restore cardiac or respiratory function for an indefinite period of time.

This form and bracelet are intended to communicate the existence of a "Do Not Resuscitate" order to the emergency medical personnel who may be summoned in the event of an emergency. In addition, it provides guidelines for comfort and supportive care short of CPR that may be administered by emergency personnel.

II. GUIDELINES FOR FORM COMPLETION AND AFFIXING BRACELET

1. After discussing treatment options, the patient completes the DNR order. The types of care to be rendered and withheld should be carefully explained to the patient and family members by the physician or physician designee before the form is signed. After the form is completed, the physician or designee shall affix the Do Not Resuscitate Bracelet to the patient's wrist and record the decision in the medical record. (Information on how to complete the bracelet is included with the bracelet insert form). It is recommended that the written documentation include:
 - a. The rationale for the decision including qualifying medical condition.
 - b. The presence of decision making capacity on the part of the patient.
2. TWO DATED SIGNATURES ARE REQUIRED FOR THIS DOCUMENT TO BE VALID AND ITS INTENT CARRIED OUT.
 - a. Patient's signature and date signed by patient.
 - b. Physician's signature and date signed by physician.
3. Provide the patient with a copy of this form. An original signed form or a legible photocopy or electronic facsimile is presumed to be valid. Individuals may reproduce this blank form if they need additional copies.

III. REVOKING THE DNR ORDER

The patient can revoke the DNR order by any of the following methods.

1. The patient expresses to emergency personnel the desire to be resuscitated.
2. The patient defaces, burns, cuts or otherwise destroys the DNR bracelet.
3. The patient removes the DNR bracelet or another person, at the patient's request, removes the DNR bracelet.

The patient should also tear up the DNR order (and copies) and the patient's physician should be notified of the revocation. Family members or other individuals may not revoke this document. Only the patient may revoke an order issued under Chapter 154 Wisconsin Statutes. The DNR order is not revoked when an ambulance is called.

THE PATIENT MUST WEAR THE STANDARDIZED IDENTIFICATION BRACELET FOR THIS ORDER TO BE VALID AND HONORED BY EMERGENCY HEALTH CARE PERSONNEL. A PATIENT WITHOUT A BRACELET WILL BE PRESUMED TO HAVE REVOKED THE DNR ORDER BY REMOVING THE BRACELET.

