Founded on the idea of offering holistic-based residential care paired with integrative medical options, Living Well Care Home is quickly becoming the recognized model for sustainable eldercare. A licensed, non-profit facility located in Bristol, Vermont, Living Well provides a place for elders who are no longer able to live alone but who are still active and independent enough to enjoy a variety of interaction.

What sets Living Well apart from traditional eldercare facilities is our home-like atmosphere. Whether it's the made-from-scratch nutritious meals, the family-style setting and close-to-nature approach to wellness, or the unique activities and opportunities available to our elders, Living Well strives to create surroundings that nurture the mind, body and spirit of each of our residents.

From inviting in yoga instructors, local students and musicians, to providing an environment where residents can participate in basic life tasks, such as laundry, cooking and gardening (if they choose!), Living Well believes in creating a vital atmosphere that engages our residents to their fullest potential.

In addition, Living Well is a focal point for community involvement. Businesses, youth groups, schools and churches promote quality-of-life activities and volunteer for special projects that support our elders. This interaction not only benefits residents, but it fosters a sense of connectedness throughout our community.

With our focus on organic nutrition, our emphasis on community and interactive activities—including our award-winning Drumming Circle—Living Well provides a true experience of aging with dignity. We want to thank you for choosing Living Well Care Home as your elder-care partner.

In the following pages you will find all the forms you need to begin the process of admission to Living Well, along with some other information for you to keep on file. It may seem like a lot of paperwork, but many of these forms are required by our regulatory agencies. If you have already filled out some of these forms, there is no need to fill them out again. Please include copies of your forms with those from our Admission Packet. Why not use our Table of Contents as your checklist! If at any time, you have questions or need help with completing this application, please don't hesitate to contact me at info@livingwellvt.org.

Sincerely,

Dee DeLuca
Administrator

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Policies and Procedures

Admission Policy

LIVING WELL encourages all inquiries, however, admission to our facility is based on criteria and guidelines set out by the State of Vermont. LIVING WELL requests that a potential resident visit the facility, if possible, before admission. Before a new resident arrives at LIVING WELL the following forms must be completed by the resident or legal representative:

- A referral packet including
    1. Release of medical records
    2. Release of health-related information
    3. A financial assessment
- A copy of a current problem list from the primary physician including any physiological history and any known allergies
- A list of doctors (specialists, dentist, etc.) and their phone numbers whom the resident visits
- An original script of all medications routine or as needed
- Any advanced directives, such as Power of Attorney, Living Will, etc.
- Any list of large personal belongings that they will be bringing with them
- Any dietary restrictions
- Any special care procedures that the resident needs.

LIVING WELL assesses residents before admission to confirm the resident fits within our level of care. The house Nurse will have 72 hours from the time of admission to speak with any new resident and complete their assessment.

On arrival a resident should bring with them:

- Any toiletries currently used in their daily routine.
- Any current medications being taken (must be in original pharmacy bottle).
- Any other personal belongings that will be needed for a resident's daily routine, such as walkers or canes.

Before admission, a designated staff member of LIVING WELL sits down with the new resident and/or their legal representative to complete the following forms and review these policies:

1. The Admission Agreement, which includes our daily rate and any additional charges.
2. House rules regarding smoking, Quiet Hours, etc.
3. Discharge Policy.
4. A resident assessment.
5. Any advance directives that need to be completed or changed.
6. Resident's rights and the long-term ombudsman.
7. Responsible parties and emergency contact sheet.

LIVING WELL strives to become the last home away from home for our residents. The facility's staff works closely with outside agencies to ensure their compatibility with other residents and the staff of LIVING WELL. Thirty days from your admission, the resident, legal representative and our resident care coordinator will meet to discuss and firm up the care plans.

LIVING WELL accepts emergency placements as necessary. In these cases the facility, resident and their legal representative have 72 hours to complete everything listed above.

I, ______________________________ have read, asked questions and seen the posting of the Residents Rights in the facility. By signing this document, I understand my rights and whom to contact with any grievance I may have. I understand that I can retain a copy of this form and ask for additional copies as needed.

____

Patient/Responsible Party Signature Date

____

Patient/Responsible Party Printed Name Date

____

Administrator Date

Admission Agreement

This is an agreement between LIVING WELL and ____
(*name of resident and/or their legal representative, herein after referred to as resident or you*).

The purpose of this agreement is to explain what services LIVING WELL provides, how they are paid for, and what the rights and responsibilities of the resident are.

I. SERVICES

LIVING WELL is licensed by the State of Vermont as a Level III residential care home and, as such, may provide room, board, personal care, general supervision, and medication management. The scope of the services provided by LIVING WELL is outlined below.

The State of Vermont regulates most of the services provided in a residential care home. The State regulations contain much more detail about how care must be provided, and a copy of the regulations can be obtained from our manager.

A. Room

Under this agreement, you are provided with a private or semi-private room depending on availability. You may bring personal possessions to the home as space permits, unless the possessions infringe on the rights of others or create a fire or safety hazard.

It is expected that upon discharge you remove all personal possessions immediately. We will temporarily hold your room for you if you are hospitalized, but only if you are expected to return to Living Well. If you are unable to return to LIVING WELL for any reason, and fail to notify us, we will remove your possessions and store them, if possible until you are able to retrieve them. The effective date of discharge will be the date the possessions are removed. Before bringing personal items into the home, please discuss with our manager how you might be affected by this policy for those possessions.

We do your personal laundry unless you ask otherwise. We provide you with clean bed and bath linens and with typical housekeeping services.

B. Board.

You are provided with three attractive and satisfying meals, in accordance with State regulations and dietary standards, and with consideration of your dietary needs.

We offer snacks mid-morning, mid-afternoon, and before bed. And we offer therapeutic diets when ordered by the physician.

C. Personal Care provided includes:

1. Assistance with bathing and personal hygiene including shaving, combing and shampooing hair, brushing teeth
2. Assistance with eating such as cutting food and feeding
3. Assistance with toileting, including transferring on and off the toilet, and incontinence care
4. Assistance with dressing
5. Assistance with movement, including walking, transporting by wheelchair, transferring from bed to chair

D. Transportation.

State regulations provide that you are entitled to up to four trips per month (up to 20 miles, round trip) at no cost to you for any activity, including medical appointments. After 20 miles for any trip, or after four trips per month, we charge you ________per mile.

If you are eligible for Medicaid, after up to 20 miles round trip or the fourth trip of the month, we attempt to utilize available Medicaid transportation if appropriate. Medicaid transportation is available only for necessary medical appointments.

F. Nursing Care.

State regulations prohibit us from providing full-time nursing care, except in limited situations. We offer the following types of services directly through the local Home Health Agency.

1. Availability of a nurse. A nurse is available at least 5 hours each week to review assessments of each resident, oversee the administration of medications, and coordinate care with physicians. We call on our nurse as necessary if your condition warrants it, including illness, a change in doctors' orders, or if your ability to care for yourself appears to be deteriorating.

2. Hands-on nursing care. If you require the hands-on care of a nurse, such as changing a dressing or receiving an injection, such care is provided by the local Home Health Care Agency. This Agency bills you directly for extended care above and beyond LIVING WELL's regular provided services.

3. We work with the local Home Health Agency who offer Hospice services to residents who are terminally ill and wish to remain at LIVING WELL.

G. Medication Management.

State regulations require that we determine if you are capable of self-administering your medications.

1. We offer both assistance with and administration of medications. As long as you are able to direct the administration of your medications in accordance with State regulations, we provide you with necessary assistance such as reminding you of medication times or helping you take a medication.
2. If you are not able, or when you are no longer able, to direct administration of medications, we administer them for you. We do this by having our staff administer under the direction of our nurse at no additional cost to you.

H. Personal Needs.

We provide the following personal needs items as part of the monthly charge: toilet paper, tissue paper, hand soap, body soap, and mouth wash. All others have to purchased by you. For residents who are eligible for SSI, the personal needs funds available are discussed in the next section of this agreement.

II. CHARGES AND FINANCES

A. The daily charge for room, board, and services is $__________, and is due on or before the first of each month.
The daily charge for room, board, and Respite services is $__________, and is due before arrival for Respite care.

B. Non-payment of charges is cause for discharge in accordance with State regulations. For non-payment, we may discharge you after 30 days notice or less if we can locate another placement to which you agree.

C. It is not considered non-payment if you exhaust your funds and can no longer pay the private rate, but must rely on SSI.

D. We do not assist with managing residents' finances. If assistance with finances is required, you must obtain that assistance with your finances from an individual or entity outside the home.

III. RIGHTS AND RESPONSIBILITIES

A. Each resident retains all their civil rights while residing here. Furthermore, State regulations list specific rights of all residents of residential care homes. That list is attached to this agreement, and other copies are available upon request. We explain these rights before or at the time of admission.

B. If you are not satisfied with services or conditions in the home, we want you to tell us so we can try to resolve the concern. Our grievance procedure is attached.

C. As part of this agreement, we expect you to adhere to the reasonable rules established by us for the orderly management of the home. These rules are:

1. Residents may not keep or use weapons or illegal drugs of any kind at LIVING WELL.

2. Residents understand quiet hours are from 8 p.m. to 8 a.m.

3. Residents may have visitors. Overnight visits need to be scheduled in advance. Visitors may be limited at residents' request and may be asked to leave if they become disruptive and/or disturb other residents. Visitors may use common areas in the house as well as residents' rooms.

4. Residents may not bring pets to live with them.

5. Residents have access to the house telephone, provided that weekday usage is limited from 9 a.m. to 5 p.m. There is also the option for a private line in a resident's room at the resident's expense.

6. Residents may smoke in our smoking area, which is in the backyard. There is no smoking in the house.

IV. AGREEMENT

The undersigned agree to abide by the terms of this agreement and in accordance with the regulations for residential care homes set forth by the State of Vermont.

You may terminate this agreement voluntarily with 30 days notice. If you discharge yourself voluntarily without providing 30 days written notice to us, we are not obligated to provide you with any refund.

If there are any subsequent changes to the terms of this agreement, such as change in the monthly charge, we will notify you in writing 30 days in advance of the change.

Signed____ Date ____________________
Resident or Authorized Legal Representative

Signed____ Date____________________
Administrator / Manager

Financial Assessment

The daily charge at LIVING WELL is __________. The fee includes the resident's room, meals, personal care services, maintenance of the house and utilities. This fee is billed every month. The fee does not include medical care or nursing care such as home health services, hospice services, or nursing registry services. Those providers to the resident, or resident's third party payer source, as determined by the provider bill such fees.

If residents are not able to pay LIVING WELL per day, they are expected to pay 90% of their adjusted net income every billing period. Such fees are determined by the following worksheet. LIVING WELL has a policy of billing the estate of residents who use our sliding scale while living in the house for the difference between the daily charge and what was paid.

ADJUSTED NET INCOME WORKSHEET
To be used for determination of LIVING WELL daily charges only if a sliding scale needs to be determined.

Monthly Income		Monthly Expenses		Assets	
Source	Amount	Item	Amount	Item	Amount
SSI		PRESCRIPTIONS		STOCKS & BONDS	
STOCKS & BONDS		PHYSICIAN		SAVINGS	
PENSION		CHILDCARE		REAL ESTATE*	
DIVIDENDS & INTEREST		MEDICAL TRANSPORT		OTHER	
RENTAL INCOME		INSURANCES			
SALARY		HEALTH			
DISABILITY		LIFE		TOTAL	
OTHER		TOTAL			
TOTAL					

TOTAL MONTHLY INCOME $__________________

TOTAL MONTHLY EXPENSES $__________________

ADJUSTED NET INCOME** $__________________

TOTAL DAILY ROOM AND BOARD CHARGE $__________________

Effective 11/12/2008 does not include family income **90% adjusted net income plus consideration of assets over $2,000

Resident Agreement

AUTOMATIC RENT ENROLLMENT FORM

Name: ____ Room Number: ___________________

By my signature, I authorize the amount of $ _______________ to be withdrawn from the account indicated below. The withdrawal will be executed on or about the fifth day of the month for which rent is due.

Starting Date: ______________________

Withdrawal to be made from checking account (attach a voided check).

Please fill in the following information:

Account Number: ____

Name of Bank: ____

Address of Bank:
____

____
Signature of resident or legal representative Date

Information Release Form

I, ______________________________________ , give permission to Living Well to obtain information from all necessary parties; including my physician, hospital, social worker, mental health worker, and any other agency directly involved with my care.

____
Resident or Legal Representative Date

____
Facilities Manager Date

I, ____ , give permission to Living Well to provide / supply information to all necessary parties; including my physician, hospital, social worker, mental health worker, home health worker, Nursing agencies and any other service directly related to my care.

____
Resident or Legal Representative Date

____
Facilities Manager Date

Restrictions:

Request for Release of Medical Records

To:

I hereby request that my medical records be released to:

Tricia Bunal
Client Care Coordinator
c/o LIVING WELL
71 Maple Street
Bristol VT 05443
Phone: (802) 453-3946
Fax: (802) 453-6661
E-mail tricia@livingwellvt.org

Date: ______________________________________

____
Patient's signature

____
Designated Responsible Party

Patient's Date of Birth: _______________________-

Restrictions:

RESIDENT APPLICATION: Durable Power of Attorney

Durable Power of Attorney for Finances

I confirm that ____________________________ (Name) has accepted responsibility as my durable power of attorney to make decisions and to handle pertinent financial matters after admission to Living Well. I confirm that this individual is not a member of the staff or volunteers of Living Well.

Durable Power of Attorney for Health Care

I confirm that ____________________________ (Name) has accepted responsibility as my durable power of attorney for health care to make medical / health care decisions for me should I be unable to make my own. I confirm that this individual is not a member of the staff or volunteers of Living Well.

Designated Family Member / Support Person

I confirm that ____________________________ (Name) is my designated family member / support person and is to be informed of any change in my condition or any wishes / needs that I express. (S)he has accepted responsibility to see that the bills I have incurred while living at Living Well will be paid.

Address and telephone numbers(s) of person(s) designated above:

POA FOR FINANCES:
POA FOR HEALTH CARE:
DESIGNATED FAMILY/SUPPORT:

____

RESIDENT'S SIGNATURE / PRINTED NAME DATE

____

DESIGNATED OTHER'S SIGNATURE / PRINTED NAME DATE

71 Maple Street • Bristol, Vermont 05443 • 802-453-3946 • livingwellcarehome.org

Resident's Rights

YOU HAVE RIGHTS

You have the right:

- To be treated with Dignity, Respect, and as an individual to make your own choices.
- To be given information about the ruiles of the facility, about your rights, and of the services available, what they cost/how to pay for them.
- To exercise your rights without fear of reprisal, to make complaints and contact outside agencies, and to vote.
- To access your own medical and financial records.
- To be informed of your health status.
- To participate in your care plan.
- To know who your doctor is.
- To manage your own money.
- To be free from abuse and restraints.
- To be given notice of a room change or discharge from the facility if asked to leave.
- To go on leave from the facility.
- To look at the facility's survey results.
- To visit with anyone you choose to visit.
- To retain and use your personal belongings; to know your personal belongings are safe and secure.
- To meet as a Resident Council.

Resident's Rights Policy

The rights outlined below belong to all residents of Vermont Residential Care Homes. These rights are protected by State regulations and adhered to by LIVING WELL.

_____You are treated with consideration, respect, and full recognition of your dignity, individuality, and privacy. LIVING WELL may not ask you to waive your rights.

_____You may retain personal clothing and possessions as space permits, unless to do so will infringe on the rights of others or would will create a fire or safety hazard.

_____ You are not required to perform work for LIVING WELL. If you choose to perform specific tasks for LIVING WELL, you receive reasonable compensation which will be specified in a written agreement between you and LIVING WELL.

_____ You are allowed to associate, communicate and meet privately with persons of your choice. Visiting hours are from at least 8 am to 8 pm, or longer. Visiting hours are posted in a public place.

_____ You have the right to send and receive personal mail unopened.

_____ You have the right to reasonable access to a telephone for private conversations. You have reasonable access to the telephone except when restricted because of excessive unpaid toll charges or misuse. Restrictions are in writing. You may, at your expense, maintain a personal telephone in your room.

_____ You have the right to voice complaints or grievances without interference, coercion or fear of retaliation. LIVING WELL has a written grievance procedure for resolving residents' concerns or complaints that is explained at the time of admission. The grievance procedure includes time frames, a process for responding to residents in writing, and a method by which each resident filing a complaint are made aware of the Office of the Long Term Care Ombudsman and Vermont Protection and Advocacy as an alternative or in addition to LIVING WELL grievance policy.

_____ You have the right to manage your own personal finances. LIVING WELL may assist you in the management of your finances only if requested in writing. If we are to assist you with your finances, we will keep a record of all transactions and make the record available, upon request, to you or your legal representative, and provide a quarterly report. Your personal funds must be kept separate from LIVING WELL funds.

_____ Your right to privacy includes records and personal information about you. Personal information is not discussed with anyone not directly involved in your care. Release of any recore, or information must be approved by you in writing, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law. You have the right to review your records at any time.

_____You have the right to be free from mental, verbal, or physical abuse, neglect, and exploitation. You also have the right to be free from physical or chemical restraints.

_____ If you are adjudicated mentally disabled, such powers as have been delegated by the Probate or Family Court to your guardian devolve to the guardian.

_____ If you are asked to leave LIVING WELL, you have the right to

1) Be allowed to participate in the decision-making process in selecting an alternative placement.
2) Receive adequate notice of a pending transfer; and
3) Be allowed to contest the transfer by filling out a request for a fair hearing before the Human Services Board.

(There are limited reasons as to why a home may ask you to leave when you have not requested to leave. If you need help, call your local Ombudsman.)

_____ You have the right to refuse care to the extent permitted by law. This includes the right to discharge yourself from LIVING WELL. We must fully inform you of the possible consequences of your decision. If you refuse care, or decide to discharge yourself from LIVING WELL, we must fully inform you of the possible consequences of your decision. If you make an informed decision to refuse care or leave, LIVING WELL is absolved of further responsibility. If your refusal of care causes you to need more care than we are able or are licensed to provide, you may be legally asked to leave LIVING WELL within thirty (30) days of written notice.

_____ You have the right to formulate advance directives as provided by State law and to have those directives followed.

_____ The enumeration of residents' rights is not construed to limit, modify, abridge, or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A summary of the obligations of LIVING WELL to its residents is written in clear language, in easily readable print, is given to residents on admission, and is posted conspicuously in a public place in LIVING WELL. Such notice is also summarized in the grievance procedure. Directions for contacting the Ombudsman Program and Vermont Advocacy Network are included.

IF YOU HAVE QUESTIONS ABOUT YOUR RIGHTS, CONTACT YOUR LOCAL OMBUDSMAN.

Advance Directive

VERMONT ADVANCE DIRECTIVE FOR HEALTH CARE
Prepared by the Vermont Ethics Network
Explanation and Instructions

You have the right to give instructions about what types of health care you want or do not want. You also have the right to name someone else to make health care decisions for you when you are unable to make them yourself. You may do either of these by telling your family or your doctor, but it is generally better for you and your family if you write down your wishes. You may use this form in its entirety or you may use any part of it. For example, if you simply want to choose an agent in Part One, you may do so and go directly to Part Five to sign this in the presence of appropriate witnesses. You are also free to use a different form as long as it is properly signed and witnessed.

Part One of this form lets you name a person as your "**agent**" to make health care decisions for you if you become unable to make your own decisions. You may also name alternate agents. You should choose as your agent (and alternates) people you trust, who are going to be comfortable making what might be hard decisions on your behalf. They should know you and be guided by your values in making choices for you.

You should notify your agent and alternates that you have named them, and they need to agree to act as your agent if asked to do so. Your agent does not have authority to make decisions for you until you are unable to make your own decisions.

If you do not appoint an agent, and then become unable to make your own decisions, someone will be found to make health care decisions for you.

Part Two of this form lets you state **Treatment Wishes**. Choices are provided for you to express your wishes about having, not having or stopping treatment necessary to keep you alive under certain circumstances. Space is also provided for you to write out any additional or specific wishes based on your values, health condition or beliefs.

Part Three of this form lets you express your wishes about **organ or tissue donation**.

Part Four is for you to express your wishes about autopsy and **funeral arrangements**.

Part Five of this form is for **signatures**. You must sign and date the form in the presence of two witnesses. The **following persons may not serve as witnesses**: your agent and alternate agents; your spouse or partner.

You should **give copies of the completed form to your agent and alternate agents**, to your physician, your family and to any health care facility where you reside or at which you are likely to receive care. You should keep a list of those who have copies in case you revoke or revise the document in the future. You have the right to revoke all or part of this advance directive for health care or replace this form at any time. If you do revoke it, all old copies should be destroyed.

You may wish to read the booklet **Taking Steps** that includes worksheets to help you think about and discuss different choices and situations with your agent or loved ones. You may also use this section to nominate a guardian of your person, should someone need to be appointed at some future time to make decisions for you. Also, if you have a specific illness or condition and wishes that relate to it, this is a good place to note that.

ADVANCE DIRECTIVE

My Name ____Date of Birth __________

Address ____

____

Part One: Appointment of My Health Care Agent

I appoint ______________________________ Address ________________________________

____

Tel. #s(days) __________________________ cell phone: _____________________________

(eves.)__________________________ email:____________________________________

as my Health Care **Agent** to make any and all health care decisions for me, *except to the extent that I state otherwise in this document.*

If this health care agent is unavailable, unwilling or unable to do this for me, I appoint

____to be my **Alternate Agent.**

Address: ____

Tel. #s____

cell phone and email____
(Use additional sheet to appoint additional agents or alternates.)

Others who can be consulted about medical decisions on my behalf include:
____

____

Those who should NOT be consulted include:

____

Your agents should have been notified that you appointed them, they should understand your wishes and they should agree to make health care decisions for you when you can no longer make them for yourself.
(Optional space below is to identify your doctor or health care provider:) *Your doctor cannot also serve as your health care agent.

Primary care physician __________________________________ Address ____________________

____

(or other health care professional) Office Telephone:______________________________________

Name____________________________ Date of Birth__________ S.S.#____________________

Part Two: Treatment Wishes

Please express your preferences that follow by checking or initialing the statements. You may check or initial more than one choice. If you do nothing, your agent or others such as family members and doctors treating you will assume you want them to decide for you. If you do not state a preference for withholding or withdrawing artificial food (tube feeding) and hydration, your agent may not have authority to withhold or withdraw it, without a court order, if you are being treated in a New York or New Hampshire hospital.

____ **A. My Choice is to Limit Treatment** - I do not want to be kept alive if:
(Please, initial those statements below that you agree with)

1. ______I am so sick that I will die within a relatively short time (I cannot get better and have only weeks, days or hours left to live)
2. ______I become unconscious or unaware of my surroundings and most doctors agree that I will never regain consciousness,
3. ______I become unable to think or act for myself (and won't get better), or
4. ______The likely risks and burdens of treatment would outweigh the expected benefits. (For example: I will be in pain, or I will be unable to do things for myself, or the costs of caring for me will be beyond my willingness to pay.)
5. ______If it is possible that I might recover with treatment and more time is needed to determine if I can get better or not, I wish my medical team to start the necessary treatments to keep me alive. If, over time, these treatments do not improve my chances of living or my physical condition, I wish to have life-sustaining treatment stopped.
6. ______If I have initialed or checked any of the situations above and am also unable to swallow enough food and water to stay alive, I do want food and water to be given to me by vein or by feeding tube.
7. ______If I have initialed or checked situations 1-5, I do not want food and water to be given to me by vein or feeding tube, but I will accept medication for pain and agitation through an intravenous line.
8. ______Other specific instructions are as follows:

_______**B. My Choice is to Sustain Life** - I want to be kept alive as long as possible through any means possible regardless of my condition or awareness.

Specific Care Wishes Near the End of My Life

_______ If it becomes clear to my doctor, my agent and those caring for me that I am dying, I want palliative care for my pain, worries, nausea and other conditions that bother me. I want sufficient pain medication even though it may hasten my death.

________ I want hospice care when I am dying, if possible and appropriate.

________ I prefer to die at home, if this is possible.

Spiritual and Other Care Concerns:

I am of the ___________________________________faith. Below is the contact information (if known).

Church, Synagogue or Worship Center:____

Address:____

Leader____ phone # _________________________

Other people to notify if I have a life-threatening illness:

The following items or music or readings would be a comfort to me:

Part Three: Specific Instructions about ORGAN DONATION

I want my agent (if I have appointed one), family, friends and all who care about me to follow my wishes about organ donation if that is an option at the time of my death. (Initial below all that apply.)

_____ I do not wish to be an organ donor.
_____ I wish to donate the following organs and tissues:
_____ any needed organs or tissues
_____ major organs (heart, lungs, kidneys, etc.)
_____ tissues such as skin and bones
_____ eye tissue such as corneas

______ I desire to donate my body to research or educational programs. (Note: you will have to make your own arrangements through a Medical School or other program.)

It is very important that you talk with your family and your health care agent about your wishes regarding organ donation.

________ If an autopsy is suggested for any reason, I give my permission to have it done.

Part Four: My Wishes for Disposition of my Remains after my Death:

I. The person I want to serve as my agent for disposition of my body:

a.)_____ I want my health care agent to decide arrangements after my death.
_____ If he or she is not available, I want my alternate agent to decide.

b.)_____ Regardless of my appointment of a health care agent in Part One, I appoint the following person to decide about and arrange for the disposition of my body after my death:
Name _______________________ Address________________________________

Telephone _____________ Cellphone___________ Email_____________________
(or)
c.) ______ I want my family to decide.

II. My preference for Burial or Disposition of My Remains after Death:

_______ I want a funeral followed by burial in a casket at the following location, if possible (please tell us where the burial plot is located and whether it has been pre-purchased):

_______I want to be cremated and have my ashes buried or distributed as follows:

______ I want to have arrangements made at the direction of my agent or family.

I have a pre-need contract for funeral arrangements with the following Funeral Service:

____Tel.___________________________

Part Five: Signed Declaration of Wishes

Signed ____ Date_______________

The witnesses below confirm the signature of the maker of this document and that it is being signed by that person as a free and voluntary act. Appointed agents, family members, heirs, health care providers, funeral service staff and anyone to whom you owe money may not be witnesses.

Witness (and address)____

Witness (and address)____

If the maker is a current patient or resident in a hospital, nursing home or residential care home, the following additional witness confirms the maker's capacity, understanding, and freedom from undue influence (Hospital Explainer or Long-term-care Ombudsman or clergy, attorney, probate court designee):

Name __________________________Address _______________________________________

Title/position__________________ Date ________

Important!

Please list below the people and locations that will have a copy of this document:

______Vermont Advance Directive Registry (anticipated available by 2006)

_____ Health care agent

_____ Alternate health care agent

______ Family members: (List by name all who have copies)

Name________________________________ Address___________________________

____

______ MD (Name)________________________Address_________________________________

____

______ Hospital (s) (Names)____

______ Other individuals or locations: (list by name on added pages):

EMS Pre-hospital DNR Protocol Implementation

Background - Vermont's existing efforts on advanced directives have not provided an effective tool for EMS personnel and organizations to limit resuscitations in some cases where those efforts were not indicated or requested by the patient. This project is intended to identify a practical approach to limit inappropriate resuscitations by EMS personnel and organizations in the pre-hospital setting.

Approach - Develop a statewide EMS protocol that allows EMS providers to honor a physician's written do-not-resuscitate order for a patient in a health care facility or program. This would include hospitals, nursing homes, hospice, home care, VNA or similar programs. The program does not require a standardized DNR order form (although one is available based on local preferences) or any identifying bracelet for the patient. The program does not place any limitations on patients who can receive a physician's DNT order.

Rationale - Patients who are in a health care facility or program represent the most common encounters that EMS has with patients who have DNR orders. These patients are already within the formal health care system and in most cases their resuscitation status is well known by their caregivers and documented in their medical records. Because the resuscitation status of these patients tends to be unambiguous, allowing EMS to have a standing order to honor existing DNR orders has been viewed as a reasonable first step.

Work to date -

- A committee involving representation from EMS, Hospice and Home Care, Physicians, and the VT Ethics Network has been assembled as the primary workgroup for this project
- A protocol has been drafted
- A standardized DNR order form has been created
- Brattleboro was identified as the field test area for the protocol
- Involved agencies in Brattleboro were enlisted for a 90-day trial
- the 90-day trial was conducted and the results were reviewed with the participating agencies
- Based on the results in Brattleboro, modifications have been made to the standardized DNR form
- Local implementation is being planned on a county-by-county basis during the coming year. Participation is voluntary.

DO NOT INITIATE RESUSCITATION (DNR)Vt. EMS Protocols 5-00

General Considerations

A. This protocol is intended to cover patients in the health care system who have valid do-not-resuscitate (DNR) physician orders. This can include patients in health care facilities or under care in an out-of-facility setting (e.g. hospice care at home).

B. In cases where the patient is competent, EMS personnel should attempt to verify the patient's desire for no resuscitation attempts.

C. Emergency medical services must be provided to all persons regardless of resuscitation status, so that terminally ill patients have access to emergency palliative care and patients who decline CPR have access to other life-sustaining treatments.

D. DNR simply means do not initiate CPR (ventilations or compressions), defibrillation, advanced airway techniques (e.g. ET or EOA), resuscitation drugs or other resuscitation measures. It does not affect other EMS care. Comfort care measures may include positioning, temperature/environmental control, oral or nasal airways, suctioning, splinting, oxygen, IVs by on-line medical direction, assisted medications, etc.

Procedure

A. Care other than resuscitation measures should be initiated for patients with known DNR orders.

B. EMS Personnel should verify the physician's written order. Where possible, the name of the physician and the date the order was created should be obtained and noted on the EMS run report. Hospice or the Home Health Agency involved may be able to provide assistance.

C. If possible, EMS personnel should attempt to verify with the patient, patient's legal guardian or the patient's durable medical power of attorney that the DNR order is still in effect (i.e. has not been revoked).

D. Seek on-line medical direction for circumstances not specifically covered by this protocol.

Do Not Resuscitate Order

Do Not Resuscitate Order

Name of Person ______________________________

Date of Birth ______________________________

Physician's Signature ______________________________

Physician's Name ______________________________

Physician's Phone ______________________________

Date of Order ______________________________

Do not resuscitate the person named above on this order.

It is the physician's responsibility to assure that this order continues to be appropriate on an ongoing basis. Issuance of a new form is *not* required after a specific period of time. This order should be viewed as valid unless it appears to have been altered or voided.

The signed original of this form is on file at: ______________________________

Durable Power of Attorney for Health Care Vermont

Standard Form
(Please print clearly, except where signature is required)
I, ………………………………………………………….. of ……………………………...……., hereby appoint
………………………………………………… of ………………………………….., as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions. Should the person I have appointed be unable, unwilling or unavailable to act as my health care agent, I hereby appoint
.... of ……………………………………………. as my alternate agent.

A. **STATEMENT OF DESIRES, SPECIAL PROVISIONS AND LIMITATIONS REGARDING HEALTH CARE DECISIONS**. Here you may include any specific desires or limitations you feel are appropriate, such as when or what life-sustaining measures should be started or withheld; directions whether or not to use artificial nutrition and hydration; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. (If you want to include instructions about life-sustaining treatment, read Part B before filling out this section.) (attach additional worksheets or pages as necessary)
B. **THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE**. For your convenience in dealing with this subject, some general statements concerning life-sustaining treatment are set forth below. IF YOU AGREE WITH ONE OF THE STATEMENTS, YOU MAY COPY IT IN THE SPACE PROVIDED ABOVE.

If I suffer a condition from which there is no reasonable prospect of regaining my ability to think and act for myself, I want only care directed to my comfort and dignity, and authorize my agent to decline all treatment (including artificial nutrition and hydration) the primary purpose of which is to prolong life.
If I suffer a condition from which there is no reasonable prospect of regaining the ability to think and act for myself, I want care directed to my comfort and dignity and also want artificial nutrition and hydration, if needed, but authorize my agent to decline all other treatment the primary purpose of which is to prolong my life.
I want my life sustained by any reasonable medical measures, regardless of my condition.

I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this document. I have read, or had read to me, and understand the information contained in the disclosure statement. The original of this document will be held by my agent, and photocopies of the original will be given to my alternate agent and the following:

In witness whereof, I have hereunto signed my name this date of ……………………, 20….
Signature ………………………………………………. Date of Birth ………………………..
Address ……………………………………………………………………………………….
I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.
Witness: ………………………………….. Address: ……………………………………. Witness: …………………………………..
Address: …………………………………….
The following is required only if this document is being signed while the principal is in or being admitted to a hospital, nursing home or residential care home.
Statement of ombudsman, hospital representative, recognized member of the Vermont clergy, Vermont-licensed attorney or other person designated by the county Probate Court: I declare that I have personally explained the nature and effect of this durable power of attorney to the principal and that the principal understands the same.
Date: ……………….
Name: …………………………………………. Address: ………………………………….

Assistive Community Care Program

LIVING WELL agrees to serve you under the Medicaid Assistive Community Care Services (ACCS) Program as long as you are verified ACCS eligible and need Level III Residential Care Home Services.

** For Residents who are ACCS eligible without meeting a spend-down:
For as long as you are verified ACCS eligible, you are responsible for paying LIVING WELL directly for your room, board, shopping, and transportation (as defined in the Residential Care Home Licensing Regulations). You retain a Personal Needs Allowance of at least $ _________ a month. Your room and board payment is $ _________ a month.

** For Residents who become ACCS eligible meeting a spend-down:
If you must meet a spend-down to become ACCS eligible, you are responsible to pay LIVING WELL at the private rate of $ __________ per day/month ($ ________ for care,
$ __________ for room, board, shopping, and transportation) until the spend-down has been met. This rate pays for your room, board, shopping, transportation, and care services. Once the spend-down is met, LIVING WELL bills the Medicaid ACCS Program for your care services, and you are responsible for paying your room and board payment of $ __________ per month.

** For as long as you maintain ACCS eligibility, LIVING WELL bills the Medicaid ACCS Program for your Level III care services covered by the program at the daily rate established by the Medicaid program. LIVING WELL bills the Medicaid ACCS Program at this rate for each day of service provided to you. As of the date of the agreement, that rate is $ __________ per day. A day of service is a day on which you are ACCS eligible, reside at the home, and have not been absent for the entire 24-houir day or admitted to another facility. Under the terms of the Medicaid ACCS Program, the home may not ask or require you or anyone else to pay the home for days you are absent from the home.

** Covered services are the following services up to the Level III level care: help with activities of daily living; medication assistance (monitoring and administration); twenty-for-hour on-site assistive therapy; restorative nursing; nursing assessment; health monitoring; case management; and routine nursing tasks.

** LIVING WELL agrees that your room, board, shopping, and transportation payment, plus the funds LIVING WELL receives from the Medicaid ACCS Program is the sole and complete payment to LIVING WELL for required services except in the following two instances: First, if your care needs to increase to the point where you qualify for nursing home care, the home many increase its daily rate if the home can adequately meet your needs. Second, if your financial situation changes and you are required to meet a Medicaid spend-down that involves the ACCS Program, the home reserves the right to charge its customary rates during the spend-down period.

Enhanced Residential Care Medicaid Waiver Services & Payment

LIVING WELL agrees to accept you as a resident under the Vermont Enhanced Residential Care Medicaid Waiver (ERC) Program. You are responsible for paying LIVING WELL directly for your room and board, shopping, and transportation as defined in the Vermont Residential Care Home Licensing Regulations.

You will retain a Personal Needs allowance of at least $ _____________ per month.

LIVING WELL will bill Medicaid (ERC) for our enhanced care services each day LIVING WELL provides you with covered services. In addition, LIVING WELL will bill Medicaid (ACCS) for each day of service provided to you;

LIVING WELL agrees that your room, board, shopping, and transportation payment, plus the funds received from Medicaid, will be the sole and complete payment for required services. The home may continue to charge you the above room and board rate during absences from the home. Under the terms of the Medicaid Program, the home may not ask, require or accept from you or anyone additional payment on days that you are absent from the home or are admitted to another facility.

You will receive all of the above-mentioned services, as well as the services listed in the ACCS section. In addition, you will receive the following ERC services as needed: one (1) hour of RN services per week, two (2) hours of personal care assistance per day, and daily social and recreational activities.

LIVING WELL will work with your Medicaid Waiver case manager to coordinate your service package.

Resident's Activities and Interests

Resident Name ____________________________________ Date_____________

Check the appropriate blank to indicate those activities or interests you either have done in the past, currently do, and/or haven't done but would be interested in trying.

Physical Activities:	PAST	CURRENT	INTERESTED
Walking			
Swimming			
Bike riding			
Golf			
Fishing			
Strength Training			
Dancing			
Bowling			
Croquet			
Yoga			
Tai Chi			
Other:			
Games	**PAST**	**CURRENT**	**INTERESTED**
Bingo			
Pinochle			
Chess			
Rummy			
Scrabble			
Bridge			
Pool			
Puzzles			
Other:			
Crafts:	**PAST**	**CURRENT**	**INTERESTED**
Sewing			
Embroidery			
Knitting			
Crochet			
Needlepoint			
Quilting			
Weaving			
Basketry			

Other:			
Art:	**PAST**	**CURRENT**	**INTERESTED**
Painting			
Calligraphy			
Drawing			
Ceramics			
Pottery			
Sculpting			
Woodworking			
Other:			
Spiritual:	**PAST**	**CURRENT**	**INTERESTED**
Church services			
Bible studies			
Hymn sings			
Other:			
Intellectual:	**PAST**	**CURRENT**	**INTERESTED**
Reading			
Book review groups			
Poetry			
Writing			
Languages classes			
Computers			
Geneaology			
Current events			
Crossword puzzles			
Intellectual:	**PAST**	**CURRENT**	**INTERESTED**
Museums			
Other:			
Sporting Events:	**PAST**	**CURRENT**	**INTERESTED**
Basketball			
Baseball			
Football			
occer			

Tennis			
Golf			
Other:			
Social/Cultural:	**PAST**	**CURRENT**	**INTERESTED**
Movies			
Live theatre			
Opera			
Symphony			
Concerts			
Musical instrument			
(type ____________)			
Listening to music			
(type ____________)			
Travel			
Parties			
Other:			
Other:	**PAST**	**CURRENT**	**INTERESTED**
Cooking/baking			
Gardening			
Pets			
Collections, (stamps, coins, etc.)			
Volunteer activities:			
Occupation-related activities:			

Consent to Use Photographs, Testimonials, Video and Artwork

I, ________________________________, give LIVING WELL permission to use my Photographs, Testimonials, Video and Resident Artwork on their website, in print ads and in other marketing materials. I understand that there may be more than one use and that I will receive no remuneration.

____

Name of resident in Photographs, Testimonials, Video and Resident Artwork — Date

____

Administrator/House Manager

APPENDIX
The following information is for you to keep on file

Geriatric Massage

Gentle & Caring Massage

Offered at Living Well Care Home; Believing in Quality and Compassionate Care.

Did You Know?

Massage is considered to be among the oldest of all treatments used by man. Hippocrates wrote papers recommending the use of rubbing and friction for joint and circulatory problems..Today, massage is an accepted part of many physical rehabilitation programs.

Massage has proven beneficial to many chronic conditions such as low back pain, arthritis and bursitis. Massage helps relieve the stress and tension of ever day living.

What Are the Benefits to Receiving a Massage?

- Increase Blood Circulation
- Reduce Arthritis Pain
- Combat Depression
- Increase Joint Mobility
- Improve Balance
- Improve Posture
- Encourage Overall Well-Being