

**LEOFF Board Application for Payment of Services**Case No: 10-19Please Print Clearly & Legibly – Incomplete Form Will Be Returned**A) This Section To Be Completed by Member**

Member Name: \_\_\_\_\_ Active: \_\_\_\_\_ Retired: \_\_\_\_\_

Member Telephone: \_\_\_\_\_ Police: \_\_\_\_\_ Fire: \_\_\_\_\_

Member Address: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Alternate Contact Telephone: \_\_\_\_\_

Describe Your Condition and Why It Is Duty Related: He suffered a stroke on 7/30/19 that has significantly impaired his vision & mobility. His cognitive skills are variable from one day to the next as well.Describe the Service/Treatment Requested: Full time nursing assistance in an adult family home as my father is no longer able to safely live alone.Total Cost of Treatment/Service: \$ 8000/moAmount Paid by Insurance/Medicare: \$ 0Amount Requested from the Board \$ 8000/mo

Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the amount paid for this treatment/service.

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please attach a copy of the Power of Attorney if signed by the alternate contact.

**B) This Section To Be Completed by Member's Attending Health Care Provider**  
(attach additional pages as needed)Provider's Name: ERIC CHYN MD Provider's Telephone: 509 596 5395Clinic/Office Name: SR CareProvider's Address: 402 S 12th Ave Yakima WA

Describe the Patient's Current Condition and State Whether It Is Duty Related:

Stroke with R Hemiplegia  
not Duty Related

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary:

R hemiplegia resulting in him not having functional use of R side of his body resulting in all ADL Dependence

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome &amp; Costs:

No reasonable alternative plan except for feeding  
exceptProvider's Signature: ERIC CHYN MD Date: 10/28/19

Fax Completed Form to: (360) 709-2735 or mail to: City Of Olympia HR Dept, PO Box 1967, Olympia WA 98507-1967

**CWRCS INC.**  
ADULT FAMILY HOMES  
**CONTRACT & CARE AGREEMENT**  
226 S 16<sup>TH</sup> AVE  
YAKIMA, WA 98902  
PHONE (509) 453-1301  
FAX (509) 248-1332

10/30/2019

**Parties:** The first party is \_\_\_\_\_, who operates a licensed Adult Family Home. In this contract, Delbert Miles shall be referred to as the "Provider". The second party is \_\_\_\_\_, who is the person who will be residing in the Providers home and in this contract will be referred to as the "Residents". The third party to this contract is \_\_\_\_\_, whose relationship to the Resident is Daughter/POA. The representative has the authority and power to sign for the resident and to make decisions for the resident, which includes the ability to enter into this contract. A copy of Resident's Power of Attorney or Guardianship should be provided upon admission.

**Terms:** The Provider agrees to provide the Resident with a room, meals, snacks, laundry services, physical help with personal needs and companionship. For these services, the Resident and Representative agree to pay the sum of \$8000.00 per month. Due to the cost of admitting and AFH daily operations, the 1<sup>st</sup> months' rent will not be reimbursed. In the event that the resident goes on State, the family will need to make up the difference or move the resident within 30 days or move into a shared room. The resident also agrees to abide by the Rules and Policies of our adult family homes. This contract will begin on the 30<sup>th</sup> day of October, 2019. Payment for services shall be due by the 30<sup>th</sup> day of each month. Payments not made by the 30<sup>th</sup> day of each month shall be subject to a \$50.00 per day late fee.

On the annual anniversary of the Residents move in date, there will be a 3% increase to the monthly payment for services. This is due to the increase in costs of operating each year.

**Resident Responsibilities:** Medical bills, clothing, prescriptions, non-prescriptions medications, equipment, special soaps, or lotions, disposable incontinence pads and gloves, food supplements, vitamins, or other special items ordered by the residents, the representative or resident doctor, are not included in the month fee. These are paid for by the Resident or Representative. Likewise, transportation for the resident to, eating out and shopping, attending activities such as the local senior center, are also not included. Fees for initial and subsequent assessment (which are required by State Law) will be the responsibility of the Resident, and payment arrangements are to be between the Resident and the licensed nurse; this also applies to Nurse Delegation fees.

**Extra Services:** In the event the Resident becomes incontinent as to defecation or urination, becomes bedridden, or requires continuous nursing care, the level of care will be reassessed: and the monthly rate may increase to cover the cost of additional supplies and time to give quality care. The actual amount will be agreed upon between the Resident and care required, and will be agreed upon between the Resident and Representative and the Provider.

**Hospitalization:** It is assumed that from time to time the resident may be hospitalized for a short period of time, intending to return to the Providers AFH. In that even, the Resident's room will be held (and the fees will continue) until such time notice is given that the Resident will be returning.

**Liability:** The resident and or the Representative have had full opportunity to inspect the premises of the Providers home and find them to be satisfactory. The Provider agrees to exercise reasonable care in providing for the needs of the resident according to this contract. This provision acknowledges that the Resident is elderly and may not be able to guard against injuries from falls or from normal illnesses as a result of the aging process.

**Emergency Evacuation Drills:** The provider must ensure that all Resident's participate in at least one household emergency evacuation drill every calendar year involving full evacuation from the home to a safe location. The names of resident's and staff involved in the drill must be documented.

**Medications:** All medications out of date or stopped by the Dr. will be disposed of by the provider

**Provider agrees to provide the following services:** Personal hygiene/bathing, hair combing, teeth-brushing, denture care, nail care (fingernails and toenails should be trimmed by resident, if able. If he/she is not able to, Provider or other caregivers may do so if it is deemed safe; if not deemed safe, then the family is responsible for nail trimming. (Exceptions- NO NAIL CARE WILL BE PROVIDED FOR DIABETIC RESIDENTS)

- Dressing
- Eating
- Toileting
- Ambulation
- Transfer
- Positioning
- Medication ad distance (all medications will be logged)
- Body care

These tasks are provided to the Resident as needed according to the Resident physical and mental conditions. The provider may define and include additional tasks. All personal tasks will be performed following Universal Precautions in dealing with body fluids. This includes the use of gloves and good hand washing.

**Board:** Includes availability of three or more meals daily. Snacks are provided between meals as needed

**Bedroom:** Refers to a living space set apart by floor-to-ceiling walls on all sides with doors and windows. This may be a private or semi-private room.

**Negotiated Services Plan:** A written description of a Resident's needs and capabilities, which also specifies what care is to be provided, when and how often care services are provided and the expected outcome. This plan must be discussed, and dated by Provider, Resident and Family within 30 days of admission. The Resident, or his/her Representative will pay the cost and or fees for the assessment that must be performed by a licensed nurse, upon which this plan is based.

**Supervision:** Provider or staff is available to

- Help the resident with personal care task that cannot be scheduled. For example, toileting, ambulation, transfers, positioning, or some medication assistance.
- Provide protective supervision to a Resident who cannot be left alone because of confusion, forgetfulness, or lack of judgment. Caregivers are available for Residents needs 14 hours per day awake care. Covenant House, Lola/Kay, and Izzy's are 24 hour awake care.
- Intervene on a resident's behalf if a crisis arises.

All three of our homes, Covenant House, Lola/Kay, and Izzy's all have alarm systems.

**Housekeeping:** Clean sheets, adequate blankets, clean pillowcases will be provided. Resident's living space will be kept clean and tidy.

**Laundry:** Clothes and linens used by the resident will be washed and dried. Linens will be washed weekly and as needed. Dry cleaning is the resident's responsibility. As no ironing or pressing will be done, "wash to wear" clothes are strongly recommended.

**Personal Property and or Money:** We strongly discourage Residents from bringing large sums of money into the AFH (above \$25.00) and or valuable personal property such as expensive rings, watches, etc. If the resident desires and doesn't have a locked box, one will be provided. At no time will the

Provider receive cash money from Resident, or act as a money manager for Resident. Please do not ask that this be done. Changes in Resident's physical, mental or emotional functioning will be reported to the Provider by the staff. Provider will contact family and or physician, and case manager as needed. **Families should discuss all concerns with the Provider.**

**Emergencies:** In the event of an emergency, the Provider or caregiver will perform First Aid/ CPR and call 911.

**Advance Directives:** Residents have the right to make decisions about their health care. A copy of the Advanced Directive is strongly recommended upon admission. If resident has a: DO NOT RESUSITATE ORDER (DNR) THIS WILL BE HONORED.

**Activities:** Each resident will be evaluated for activities appropriate for his/ her needs. If Adult Day Services is used, the cost is not included in the monthly rate. Examples of our activates might include gardening, pet therapy, television, and games, playing with children, going out for walk, fairs, yard sales, Ice cream socials, feeding the ducks, summer BBQ'S.

**Notice to Move:** The provider shall give Resident and Representative a 30 day written notice to move, unless the circumstances require immediate attention where the health and welfare of the residents are at risk. Likewise, the Resident and or representative shall give Provider a 30 day written notice of intent to move. This notice is necessary to receive a refund of the security/ damage deposit, and to avoid additional room fees. If going into the next month payment can be prorated for the following month. This does not include the 30 day trial period starting on the admission date. During the trial period, either party may terminate the contract without notice. If the Resident or Representative terminated the contract during the first 30 days, damage/ security deposit will not be refunded.

- Provider will not refund any charges or the damage/security deposit if the Resident moves without notice.
- In the event of a Resident's need to move to a hospital or skilled nursing facilities, the room will be held away from AFH, a five day per diem charge may be assessed after notice is given.
- Provider will give advanced notice of charge of room roominate.
- Rate increase: A 30 day written notice of rate increase will be given prior to such increases taking effect. If Resident's condition changes, requiring increased care and or hospices, a rate increase of \$500.00 will be made.
- If this Resident is coming in at a hospice care rate and will not be increased.

We may invoice the daily rate for the number of days of Residents stay and care at our own discretion.

The undersigned, by the setting of their hands hereunto, agree to abide by the terms and conditions set forth in this contract.

**AFH PROVIDER:**

**DATE:**

**RESIDENT:**

**DATE:**

**REPRESENTATIVE:**

**DATE:**