Welcome to The Pines:

We emphasize dignity, privacy and care. Care not only for the body, but the mind, heart and soul as well. Residents are free to make their own choices and live in a comfortable environment... It is their life and their home.

With the information provided in these documents we can personalize a care plan to suit the physical and mental needs of our residents. Please take the time to fill out all of the included information and sign where indicated.

You may also find electronic copies of these documents on our website at www.FlagstaffCareHomes.com. Or email us and have these files sent directly to your computer.

In this packet you will find forms to be completed by the resident or resident's representative, as well as forms for their physician.

Resident / Resident's Representative Documents:

- Residency Agreement
- Admission Agreement
- Resident & Representative Information
- Inventory of Personal Items
- Food Preference Questionnaire
- Social, Recreational & Rehabilitative Activities
- Current Situation of Resident's Health
- Vaccination Authorization
- Resident's Rights
- Living Will Declaration
- Insurance Card Copies
- Home Rules
- Important Phone Numbers
- Evacuation, Disaster and Relocation Plan
- Grievance Procedures

Physician Documents:

- Physician's Report
- Physician's Consent for Administration of Medication
- Physician's Routine Orders
- Current Tuberculosis Test

Please be aware that every document in this packet must be signed before we are allowed to accept a resident into Pine Meadows Ranch Assisted Living Home. This is not only a company policy, but requirements of The Arizona Department of Health Services.

Thank You for Choosing Pine Meadows Ranch

The Pines
Residency Agreement

The Pines is an Assisted Living Home, intended to provide personal care to help our residents achieve, and maintain the goals, consistent with their RN's or Physician's Service Plan, enabling them to function at their highest level possible. Resident's residing in this home will be in a loving, family atmosphere.

The monthly charge of $___________ will be due on or before the _____________ day of the each month, payable in advance. For services at 6005 Abineau Canyon Dr, Flagstaff, AZ 86004 there is a one time charge of $350.00 for Needs Assessment and Care Plans performed by an RN. When a resident's service needs change as documented in the resident's service plan as required in R9-l0-7 1(A)(7) Updated Care Plans will be $100. Scheduled service plan updates take place every 12, six or three months depending on level of care and performed by the RN.

Residents will receive at least 30 days written notice before any increase becomes effective. Monthly payment must be received on or before the due date. There will be no grace period for paying late. A late charge of $50.00 per day will be assessed for late payments. The Pines does not hold any deposits or fees from any residents therefore there is no refund for any deposits or fees.

Refund Policy

If a resident or resident's representative terminates a residency agreement, with or without notice, as substantiated by a government agency for neglect, abuse, exploitation or conditions of imminent danger to the life, health, or safety of the resident, or for failure of The Pines to comply with the resident's service plan; a refund will be given for all days paid for that a resident does not reside at The Pines.

A full refund will be given for all days paid for that a resident does not reside at The Pines due to the death of the resident.

No refund will be given for any days paid for, that a resident does not reside at The Pines in the event of hospitalization if the resident plans to return to our facility.

No refund will he given in the event that the resident is absent from the facility for a period of time either for sickness or vacation if the resident plans to return to the facility, and chooses to have his or her room reserved until their return.

All refunds due, will be paid to the resident or the resident's representative within two weeks from the date of termination.

Services Include

Three nutritious meals plus snacks daily, housekeeping, laundry, vital checks, monitoring of medication, personal care as needed, daily exercise, planned activities, cable TV and local phone service.

Additional Charges

(for requested services, otherwise not provided)

Available services include: a hair dresser for services, long distance phone calls, licensed massage therapist, licensed nail technician, entertainment and transportation to outings or to and from doctors appointments, if transportation is available.

All residents must abide by the Internal Facility Requirements of The Pines which include but are not limited to (see home rules).

1. Smoking is not permitted anywhere on the property or in the home.
2. No alcoholic beverages on premises unless ordered by a physician for a resident.
3. All residents and staff are to be treated with respect.
4. Family and friends may visit anytime, but if before 8:30 am or after 8:30 pm, a phone call in advance is requested.
5. All clothing and personal items are to be marked with a laundry pen.
6. Radios, televisions and lights (except night lights) are to be off at 10:30 pm and remain off until at least 7:00 am.
7. No abusive language or combative behavior is permitted.
8. Everyone is to be up and dressed each day unless too ill.
9. Everyone comes to the table for each meal unless too ill.
10. Residents have access to the house phone. Residents have the option to have their own phone installed in their room at their own expense. Telephone privileges shall not be abused.

Resident or the Resident's Representative will provide the following upon admission (see Admission Agreement):

1. Transportation to and from doctors appointments, as well as personal errands.
2. Orders from the resident's physician, along with a recent history and physical. And a statement form the physician that states the resident is tuberculosis free.
3. All medications prescriptions and over-the-counter drugs.
4. Any needed equipment such as bedside commode, walker, wheelchair, etc.
5. All clothing and personal items.

Termination of Residency by Resident of Representative

The Pines requires a 30 day written notice for termination of residency. If no such notice is given there will be a prorated charge of 30 days following the date of departure. No written notice will be required if substantiated by a government agency for neglect, abuse, exploitation, or conditions of imminent danger to the life, health or safety of the resident, or failure to comply with the resident's service plan or residency agreement.

Termination of Residency Agreement

The Pines will provide the resident or the representative 30 days written notice of termination of the Residency Agreement, however The Pines may terminate the residency agreement after providing 14 days written notice to the resident or representative for one (1) of the following reasons:

1. Documentation of failure to pay charges.
2. Documentation of the resident's non compliance with the Residency Agreement or internal facility requirements.

The Pines may terminate residency of a resident without notice if:

1. The resident exhibits behavior that is an immediate threat to the health and safety of the resident or other individuals in The Pines,
2. The resident's urgent medical or health needs require immediate transfer to another health care institution.
3. The resident's care and service needs exceeds the services that The Pines is licensed to provide.

The Pines will ensure that a written notice of termination of residency includes the reason for the termination, the effective date of termination, the resident's right to grieve the termination, The Pines grievance procedure, and the refund policy regarding the termination of residency.

The Pines will, upon termination, provide the following to the resident or the representative:

1. A copy of the resident's service plan.
2. Documentation that the resident is free from pulmonary tuberculosis.
3. Phone numbers and addresses of the local area agency on aging and DES Long Term Care Ombudsman.
4. A written disposition of the resident's personal property.
5. An accounting of all monies.
6. A resident or the representative may terminate residency without written notice for one of the following, as substantiated by a governmental agency:
   - A. Neglect
   - B. Abuse
   - C. Exploitation
   - D. Conditions of imminent danger to life, health or safety.
   - E. The Pines fails to comply with the resident's service plan or residency agreement.

Grievance Procedures

All grievances may be submitted to The Pines, 6005 E. Abineau Canyon Dr., Flagstaff, AZ 86004 or call (928) 635-6750. All grievances will be discussed with the person filing the grievance immediately or as soon as feasibly possible. If the grievance cannot be resolved in a timely manner, between the management of The Pines and the person filing the grievance, the local Ombudsman will be contacted and asked to arbitrate. Any grievance that cannot be resolved by all parties concerned may call Adult Protection Services at (877) 767-2385 or the AZ Department of Health Services Division of Licensing Services (602) 364-2639.

Residents and family understand that the care at The Pines home will be given to the best of our abilities, using professional judgment, ethics, behavior, and instead of legal action an arbitrator will he called upon. In the event of emergency, illness or accident, the family will be notified immediately.

The Pines is not responsible for valuables of any kind, including jewelry or money and we are not responsible for lost or stolen items. Please take the time to write names on clothes in permanent marker and fill out an Inventory of Personal Items form in order to prevent confusion.

I acknowledge and accept all of the information presented on the first 4 pages of the Residency Agreement for:

Printed Resident Full Name: ____

Date of Birth: ______________

Signature of Responsible Party:

X____ Date: ____________

Printed Name of Responsible Party: ____

Relationship: __________________________ Phone: ______________________

Work Phone: __________________________ Cell / Pager: ___________________

Address: ____

____

____

Information Below This Line To Be Filled Out By The Pines Personnel

---

Representative of The Pines

Signature: ____ Date: ___________

Printed Name: ____

Download this form on our website: www.FlagstaffCareHomes.com

The Pines

Admission Agreement

The Resident or Representative provides:

1. Transportation to and from doctors appointments, as well as personal errands.
2. Orders from the resident's physician, along with a recent history and physical. And a statement form the physician that states the resident is tuberculosis free.
3. All medications prescriptions and over-the-counter drugs.
4. Any needed equipment such as bedside commode, walker, wheelchair, etc.
5. All clothing and personal items.

The Pines provides:

1. Transportation to and from events and outings sponsored by The Pines.
2. Twenty-four hour care and assistance with activities of daily living.
3. Three balanced meals per day with snacks.
4. Monitoring of medications.
5. Laundry service of washable items,
6. Semi-private or private room and housekeeping services.

Signature: ____ Date: ____________

Download this form on our website: www.FlagstaffCareHomes.com

The Pines

Resident and Representative Information

Resident's Full Name: ____

Nickname: ________________________________ **Date of Admission:** ________________

Emergency Contact: ____

Address: ____

Cell: ____________________ **Work:** ____________________ **Home:** ________________

Admitted By: __________________________ **Referred By:** __________________________

Resident's Representative / Legal Guardian: ______________________________________

Address: ____

Phone: _______________________________ **Relationship:** _________________________

Resident's Date of Birth: ________________ **Social Security #:** ______ - ______ - ______

Last Address of Resident: ____

Hospital: _______________________________________ **Phone:** _____________________

Physician: __________________________ **Business Name:** _________________________

Phone: ________________________________ **Fax:** _______________________________

Address: ____

Medicare #: ____

Insurance Company: __________________________ **Policy #:** _______________________

Allergies: ____

Home Health Agency / Community Health Nurse / Other Medical Provider:

Agency Name: ___________________________________ **Phone:** ____________________

The Pines

Current Situation of Resident's Health

Name: ______________________________________ Date: __________

Level of Self Care (please check the appropriate answer)

Task	Independent	Needs Help	Unable
1. Bathing			
2. Dressing			
3. Feeding			
4. Use of Toilet			
5. Care of Hair			
6. Care of Teeth			
7. Getting in/out of Bed			
8. Getting in/out of Chairs			
9. Care of Fingernails / Toenails			
10. Shaving			
11. Medications			
12. Personal Orientation (General)			
13. Behavior (Responding and Acting Individually with Others)			

14. Walking: ☐ Normal ☐ Unsteady ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutch

15. Bowel Control: ☐ Normal ☐ Occasional Loss ☐ Frequent Loss

16. Bladder Control: ☐ Normal ☐ Occasional Loss ☐ Frequent Loss

17. Does Resident Require Adult Diapers: ☐ Yes ☐ No

18. Can Resident's Needs Be Met in a Non-Medical Facility: ☐ Yes ☐ No

Resident or Representative Signature:

X ____ Date: ____________

Download this form on our website: www.FlagstaffCareHomes.com

The Pines

Preferences for Social, Recreational and Rehabilitative Activities

Resident Name: ____

Completed By: ______________________________________ Date: __________

This form is to be filled out upon admission by the resident or the resident's family.

Social, recreational and rehabilitative activities I really enjoy:

____

____

____

Social, recreational and rehabilitative activities I really dislike:

____

____

____

Social, recreational and rehabilitative activities that disagree with my body:

____

____

____

Social, recreational and rehabilitative activities I would like to try:

____

____

____

Signature: ____ Date: ____________

The Pines

Food Preference Questionnaire

Resident Name: ____

Completed By: ______________________________________ Date: __________

This form is to be filled out upon admission by the resident or the resident's family.

Food Allergies: ____

____

____

____

Foods I really enjoy: ____

____

____

____

Foods I really dislike: ____

____

____

____

Foods that seem to disagree with me: _____________________________________

____

____

____

Signature: ____ Date: ____________

The Pines

Home Rules

1. Smoking is not permitted anywhere on the property or in the home.
2. No alcoholic beverages on premises unless ordered by a physician for a resident.
3. All residents and staff are to be treated with respect.
4. Family and friends may visit anytime, but if before 8:30 am or after 8:30 pm, a phone call in advance is requested.
5. All clothing and personal items are to be marked with a laundry pen.
6. Radios, televisions and lights (except night lights) are to be off at 10:30 pm and remain off until at least 7:00 am.
7. No abusive language or combative behavior is permitted.
8. Everyone is to be up and dressed each day unless too ill.
9. Everyone comes to the table for each meal unless too ill.
10. Residents have access to the house phone. Residents have the option to have their own phone installed in their room at their own expense. Telephone privileges shall not be abused.

These Home Rules will be posted in The Pines for review at any time.

Signature: ____ **Date:** ___________

Download this form on our website: www.FlagstaffCareHomes.com

Important Phone Numbers

☆ **<u>CALL 911 FOR ALL IMMEDIATE EMERGENCIES</u>** ☆

The Arizona Department of Health Services' Office of Assisted Living Licensure
602-364-2639

D.E.S Adult Protection Services
877-SOS-Adult (877-767-2385) or 520-779-6141

D.E.S. Long Term Ombudsman
877-521-3500 or 928-213-5239

The Arizona Center for Disability Law
602-542-4331

The Governor's office for Americans with Disabilities
602-542-4331

Entities that provide information on health care directives:
Flagstaff Medical Center: 928-779-3366
Northland Hospice: 928-779-1227

The Pines Main Office Number
928-635-6750

Resident Signature: ________________________________ Date: __________

Inventory of Personal Items

Resident Name: ______________________________________ Date: ______________

Write total number behind item

☐ Bathrobe ___	☐ Bed Jacket ___	☐ Belt ___	☐ Blouse ___
☐ Bra ___	☐ Bracelet ___	☐ Bible ___	☐ Boots ___
☐ Chair ___	☐ Comb ___	☐ Coat ___	☐ Dresses ___
☐ Earrings ___	☐ Garters ___	☐ Girdle ___	☐ Glasses ___
☐ Glasses Case ___	☐ Gloves ___	☐ Handkerchief ___	☐ Hat or Cap ___
☐ Hose ___	☐ House Coat ___	☐ Hair Brush ___	☐ Lamp ___
☐ Luggage ___	☐ Make-up ___	☐ Medals ___	☐ Mirror ___
☐ Mouthwash ___	☐ Nightgown ___	☐ Pajamas ___	☐ Pants ___
☐ Purse ___	☐ Radio ___	☐ Razor ___	☐ Rings ___
☐ Rosary ___	☐ Scarf ___	☐ Shirt ___	☐ Shoes ___
☐ Shorts ___	☐ Skirts ___	☐ Slip ___	☐ Slippers ___
☐ Suspenders ___	☐ Sweater ___	☐ Toothbrush ___	☐ T-shirt ___
☐ Tie ___	☐ TV ___	☐ Underwear ___	☐ Vest ___
☐ Wallet ___	☐ Walker / Cane ___	☐ Wheelchair ___	☐ Money $_______

Dentures: ☐ Upper ___ ☐ Lower ___ ☐ Partial ___ ☐ Cleaner ___

Other: ____

Please write name on items with permanent marker or secure labels.

I acknowledge that The Pines Assisted Living Home is not responsible for damages, loss or theft of personal items. I am also the person responsible for taking this inventory of items, and bringing them to The Pines.

Signature: ____ Date: ____________

The Pines

Insurance Card Copies

Resident Name: ____ Date: ____________

The **LIVING WILL DECLARATION of**

Resident Name: ____

This LIVING WILL OF DECLARATION made this _______ Day of ____________, by

_____________________________________.

The undersigned declarant, whose resident address is The Pines Assisted Living Home.

WITNESSETH: That I, the undersigned declarant, being of sound mind, willfully and voluntarily make known my desires concerning my health care options below:
(Pursuant to A.R.S _36-3262, some general statements concerning your health care options are outlined below. If you agree with one of these statements, you should initial that statement on that statement on the line provided. Read al of these statements carefully before you initial your selection. You can also write your own statement concerning life sustaining treatment and other matters relating to your health care. You may Initial any combination of paragraphs 1,2,3, and 4 but if you initial paragraph 5, the others should not be Initialed)

_____ **1.** If I have a terminal condition, I do not want my life to be prolonged and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.

_____ **2.** If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I do not want the following:

- _____(a) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock and artificial breathing.
- _____(b) Artificially administered foods and fluids.
- _____(c) To be taken to hospital if at all avoidable.

_____ **3.** Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

_____ **4.** Notwithstanding my other directions, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

_____ **5.** I want my life to be prolonged to the greatest extent possible.

Other or Additional Statement of Desires (Attached Separate Sheet)

I have ______ I have not _____ attached additional special provisions or limitations to this document to be honored In the absence of my being able to give health care directions.

Any person honoring this LIVING WILL DECLARATION, whether a family member, a next friend, the attending physician; the health care institution and/or any licensed health care professional shall not incur any liabilities of any nature whatsoever in discharging those duties imposed by this LIVING WILL DECLARATION.

IN WITNESS WHEREOF, I, the undersigned Declarant, do hereby make and execute this LIVING WILL DECLARATION on the date first above written; that I understand the full importance of this Declaration, and I have the emotional and mental capacity to make this Declaration.

Signature of Declarant: ____

Witness Statement

The Declarant Is personally known to me; that I believe him/her to be Sound mind; that I am not related to the Declarant either by blood or marriage; that I am 18 years of age or older, that at the time of Declarant's execution of this Declaration, I am not entitled to any portion of the Declarant's estate under either a will, codicil to a will, or by the operation of Law, that I am not a claimant against any portion of the Declarent's estate; that I have no direct financial responsibility for the Declarant's medical care.

Witness 1

Signature of Witness 1: ______________________________ Date: ____________

Printed Name: ____

Address: ____

City/State/Zip Code: ____

Witness 2

Signature of Witness 2: ______________________________ Date: ____________

Printed Name: ____

Address: ____

City/State/Zip Code: ____

Download this form on our website: www.FlagstaffCareHomes.com

The Pines

Evacuation, Disaster, and Relocation Plan

1. In the event of a natural or other disaster where the home is rendered or considered unsafe for habitation, the staff of The Pines will implement the following procedures.
   a. If time permits a few belongings and the medications of each resident will be gathered together.
   b. The residents will each be notified that a temporary removal from the home is necessary.
   c. If time permits the person listed in the admission paperwork as the one to contact in an emergency will he contacted to come and pick up the resident.
   d. If time does not permit, all residents, their medications, and their records will be removed from the home and taken to a designated location until the disaster is considered past and the home declared safe for habitation.
2. There are two designated Locations for the relocations of the residents of The Pines. One is the Residence Inn, Continental Boulevard, Flagstaff, AZ. The other ll; The Peaks Assisted Living Facility/Long Term-Care.
3. In the event the entire town of Flagstaff needs evacuation, any resident whose family cannot come get them, will be transported by the staff of The Pines to Camp Verde AZ, to Cliff Castle Casino.

The following lists are the most common problems that may arise and could cause an evacuation of the residents. Also included are problems that may not require evacuation, but you might need to do a few things to ensure the safety and comfort of the residents.

INDOOR FIRE

Procedure:
1. In case of a fire that cannot be put out in 2O-3O seconds with a tire extinguisher, the home must he evacuated, Direct the residents to meet at the mailbox, unless it is necessary to exit the rear of the house. Then we will meet at the designated platform up the hill.
2. Evacuation of the least ambulatory residents will begin as the more mobile residents are asked to start outside the house,
3. Contact emergency services (911) as soon as safely possible with the mobile house phone.
4. In each resident’s room, an evacuation plan is hanging on the wall near the door clearly visible.
5. Account for all residents.
6. Call the The Pines management.
7. Regular fire drills will be conducted.

The Pines

Evacuation, Disaster, and Relocation Plan (Continued)

SNOWED IN

Procedure:
We have a snow plow service on call that will provide service by the end of the day. If it is an emergency, notify the supervisor and they will contact the plow driver immediately. Remember the heavier the snow, the busier they are.

FOREST FIRE

Procedure:
If an evacuation of the community is needed, chances are your supervisors will already be in contact with you. After notifying the families, we will then proceed to relocate the residents to a local hotel or in extreme circumstances move everyone to Cliff Castle Casino, located in Camp Verde.

POWER OUTAGES

Procedures:
There are numerous flashlights and night lights located in all homes. Residents on oxygen should be placed on portable oxygen tanks.

NO WATER

Procedures:
We will always have a week supply of water located on the premises.

I have read and understand the policy on evacuation, disaster and relocation plan on both pages. I have also been shown all fire exits as well as the designated meeting area.

Signature: ____ Date: ___________

The Pines
Resident's Rights R9-1O-710

1. To live in an environment that promotes and supports each resident's dignity, individuality, independence, self determination, privacy, and choice;
2. To be treated with consideration and respect;
3. To be free of abuse, neglect, exploitation, and physical restraints or chemical restraints;
4. To have privacy in correspondence, communications, visitations, financial, and personal affairs, hygiene, and related health services;
5. To receive and make private phone calls;
6. To participate or allow the representative or other individual to participate in the development of a written service plan;
7. To receive the services specified in the service plan, and to review and re-negotiate the service plan at any time;
8. To refuse services, unless such services are court ordered of the health, safety, or welfare of the other individual is endangered by the refusal of the services;
9. To maintain and use personal possessions, unless such use infringes upon the health, safety, or welfare of other individuals;
10. To have access to the common areas of the facility;
11. To request to relocate or refuse to relocate within the facility based on the resident's needs, desires, and availability of such options;
12. To have financial and other records kept in confidence. The release of records shall be written consent of the resident or representative, except as other provided by law;
13. To review the resident's own records during normal business hours or at a time agreed upon by the resident and the manager;
14. To review a copy of the rules and regulations during normal business hours or a time agreed upon by the resident and the manager;
15. To review the assisted living facility's most recent survey conducted by the Arizona Department of Health Services, and any plan of correction in effect during normal business hours or at a time agreed upon by the resident and the manager;
16. To be informed in writing of any change to a fee or charge at least 30 days before the change takes effect or is implemented unless the resident's service needs changes, as documented in the resident's service plan as required in R9-10-711(A)(7);
17. To submit grievances to employees, outside agencies, and other individuals without constraint or retaliation;
18. To exercise free choice in selecting activities, schedules, and daily routine;
19. To exercise free choice in selecting a primary care provider, pharmacy, or other service provider and assume responsibility for any additional costs incurred as a result of such choices;
20. To perform or refuse to perform work for the assisted living facility,
21. To participate or refuse to participate in social, recreational, rehabilitative, religious, political, or community activities; and
22. To be free from discrimination in regard to race, color, national origin, gender, sexual orientation and religion and to be assured the same civil and human rights accorded to other individuals.

Signature: ____________________________________ Date: _________

The Pines

Vaccination Authorization

Arizona Department of Health Services requires that all residents are offered the influenza and pneumonia vaccine on a yearly basis. The Pines Assisted Living Home will offer the pneumonia vaccine as well as the influenza vaccine to you if so desired in the fall of _________ as the vaccines are made available.

Please check YES or NO if you wish to receive the pneumonia and influenza vaccine coming this fall when the vaccine is made available, A physicians order from your doctor will be required before the vaccine can be administered. The Pines Assisted Living Home will obtain the necessary documents.

☐YES ☐NO

I ,____________________________, would like to receive the pneumonia vaccine by the RN as the vaccine is made available in the fall of _______________.

☐YES ☐NO

I ,____________________________, would like to receive the influenza vaccine by the RN as the vaccine is made available in the fall of _______________.

Representative or Resident Signature:

X ____ Date: ____________

Download this form on our website: www.FlagstaffCareHomes.com

The Pines

Grievance Procedures for The Pines

Please submit in writing or call management at 928-635-6750 with any concerns that you may have. It is the policy of our facilities to act immediately, within our power, to resolve any and all concerns that you may have.

Mail: 688 S. Garland Prairie Rd
Williams, AZ 86046

Fax Number: 928-635-6751

____

You do not need to provide your name and number if you wish to remain anonymous.

Name: ____________________________________ **Phone:** ____________________

Download this form on our website: www.FlagstaffCareHomes.com

The Pines

Acknowledgement

The undersigned hereby certifies that they have received a full explanation of the information listed below for The Pines Assisted Living Home. Furthermore, the undersigned also acknowledges receipt of the following documents:

1) Resident Rights
2) Home Rules
3) Residency Agreement
4) Discharge and Rate Change Information Found in the Residency Agreement
5) Admission Agreement
6) Evacuation, Disaster and Relocation Plan
7) Important Phone Numbers
8) Grievance Procedures

Resident Signature:_______________________________________ Date: ___________________

Representative Signature: __________________________________ Date: ___________________

For; ____
(Print Resident's Name)

Download this form on our website: www.FlagstaffCareHomes.com