Cozy Nest Care Home

New Resident Moving Package

304534 Township Road 350, RM of Dundurn, SK, S7C 0E2
admin@cozynestcare.ca www.cozynestcare.ca (306) 978 6266

Welcome

Cozy Nest Care Home, nestled in the tranquil setting of the Rural Municipality of Dundurn, offers a compassionate and welcoming environment for elderly residents in need of care and support. Located just outside of Saskatoon, this care home combines the serenity of rural livingwith the conveniences of nearby urban amenities, creating an ideal atmosphere for individuals looking for a safe, nurturing place to call home. The home is operated in partnership with Saskatchewan Health Authority.

At Cozy Nest Care Home, the focus is on providing personalized care that emphasizes the dignity, comfort, and well-being of each resident. The facility offers a range of services designed to meet the unique needs of seniors, from basic assistance with daily activities to specialized care for those with mobility challenges or cognitive impairments such as dementia.

The home features private rooms that are thoughtfully designed to foster a homelike environment, equipped with all the comforts and safety features needed to ensure residents feel at ease. The decor is warm and inviting, with a focus on creating a space that promotes both independence and relaxation. The spacious common areas encourage socialization and engagement, with comfortable seating and spaces for activities like games, crafts, and entertainment.

Cozy Nest Care Home values the close relationships it builds with both residents and their families. Open communication, regular updates, and a collaborative approach to care ensure that families are always involved in the well-being of their loved ones. The team at Cozy Nest is dedicated to creating a safe and supportive environment where residents are treated with the utmost respect and kindness.

Cozy Nest Care Home is a place where seniors can feel truly at home, receiving the care they need in a setting that promotes comfort, independence, and well-being.

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Valuables Policy at Cozy Nest Care Home

At Cozy Nest Care Home, we are committed to providing a safe and comfortable environment for all of our residents. We understand that personal items and valuables are important to residents and their families. To ensure the protection of these items, we have established the following valuables policy:

1. **Personal Property:** Residents are encouraged to bring personal items such as clothing, small personal effects, and familiar objects that contribute to their comfort. However, we ask that families be mindful of the volume and size of items brought into the home, considering safety considerations and space limitations.

2. **Valuables:** For high-value items such as hearing aids, dentures, glasses, jewelry, or electronics, we strongly recommend that families arrange for tenant insurance to protect these items. Cozy Nest Care Home will not be responsible for covering any lost, damaged, or stolen items, either financially or otherwise. Insurance provides added peace of mind and ensures that valuable items are protected.

3. **Labeling of Valuables:** To assist in identifying and recovering lost or misplaced items, we ask that all personal valuables brought into the home be clearly labelled with the resident's name. This makes it easier for staff to locate items if they go missing and helps prevent confusion.

4. **No Responsibility for Lost Items:** Cozy Nest Care Home is not responsible for the loss, damage, or theft of personal items, including valuables. While we strive to maintain a secure and safe environment, it is essential that families take precautions, such as labelling items and securing valuables with personal insurance, to ensure their protection.

5. **Assistance from Staff:** Our staff is available to assist residents and families with organizing and keeping track of personal belongings. If a resident's items go missing, staff will make every effort to locate them, but we cannot guarantee that lost items will be recovered.

In summary, we recommend that families arrange for tenant insurance for high-value items, ensure that items are clearly labeled with the resident's name, and understand that Cozy Nest Care Home will not be financially responsible for any lost or damaged valuables. By taking these steps, we can work together to provide a secure and comfortable living environment for all of our residents.

After reading & reviewing the above, I/ we have decided to *(write initial on box):*

☐ Take the following item(s) with me for safe- keeping: *(if listed on "Belongings List", indicate if taken)*

☐ Clothes:____ ☐ Jewelry: _____ ☐ Hearing Aid ☐ Denture ☐ Eyeglasses

☐ Other Items:_____

☐ Leave the following item(s) for me/ my family/ friend to use knowing fully well that it might get lost or damaged & that I will take full responsibility for the loss. Further, that Cozy Nest will not be obligated to replace the lost or damaged item:

☐ Clothes:____ ☐ Jewelry: _____ ☐ Hearing Aid ☐ Denture ☐ Eyeglasses

☐ Other Items:_____

Resident's Name	Resident's Signature	Date
POA/ SDM's Name	POA/ SDM's Signature	Date
On Behalf of Cozy Nest (Name)	Signature	Date

Resident Belongings Record Move In

Quantity	Item (Clothes & Clothing Items)	Description (Color, etc.)	Taken (Person's Full Name)
Total _____ (Move-In)			

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Quantity	Item (Eyeglasses, Hearing Aid, Dentures etc.)	Description (Color, etc.)	Taken (Person's Full Name)
Quantity	Item (Radio, TV etc.)	Description (Color, Type, etc.)	Taken (Person's Full Name)
Quantity	Item (Jewelry, Watch, etc.)	Description (Color, Type, etc.)	Taken (Person's Full Name)

Above Items Received From (name/date): _____Received By (name/date):_____

Sent to Laundry (name/date): _____Received from Laundry (name/date):_____

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TO BE FILLED BY NURSE OR DIETITION ONLY

COZY NEST CARE

Special Care Home Diet Order Form

A new form must be filled out and given to the kitchen before any diet changes can be implemented
Include all previous diet order(s) that are to continue

Resident's Name: _____

Room Number:_____Dining Room:_____ Table/Seat: _____

☐ New Admission ☐ Diet Change ☐ Supplement ☐ Temporary Until_____

Texture:

☐ Regular ☐ Soft ☐ Diabetic Regular ☐ Diabetic Soft
☐ Pureed ☐ Minced ☐ _____

Therapeutic Diet:

☐ Diabetic ☐ Renal ☐ Lactose-Free ☐ Gluten-Free
☐ Allergy_____ ☐ High Calorie/Protein ☐ Other_____

Fluid: (check only one)

☐ _____ ☐ _____ ☐ _____ ☐ _____

Special Considerations (bread, mixed consistencies, dry crumbly)**:**

☐ ☐

Nutritional Supplements (if applicable):

Supplements ☐ Yes Type: _____

☐ with meals ☐ AM ☐ PM ☐ Evening ☐ With Medications

Additional Information:

Order Obtained from: ☐ Physician ☐ Nurse Practitioner ☐ Registered Dietitian
Date: _____
Diet order updated on care plan: ☐ Yes Date: _____
Dietitian notified of change: ☐ Yes Date: _____

Signature:_____ **Printed Name & Title**: _____

NOTE: Please leave one copy for the Kitchen Team

TO BE FILLED BY RESIDNET FAMILY

COZY NEST CARE

Resident Diet Preference

Resident Name:

Likes:	**Dislikes:**

Specific Snacks

☐ AM_____ ☐ PM_____

☐ HS_____

Preferences:

☐ Coffee ☐ Tea ☐ Hot Water ☐ Cream/Milk ☐ Sugar ☐ Sweetener

☐ Hot Cereal ☐ Cold Cereal ☐ Milk:_____ ☐ Juice: _____

☐ Brown Bread ☐ White Bread

Serving Size: ☐ Small ☐ Regular ☐ Large

Additional Information:

Date & Signature:_____ Printed Name & Relation:_____ __

NOTE: Please leave one copy for the Kitchen Team

Photo Consent Form

We would like to request your consent to take and use photographs of your loved ones while they are with us. These photographs may be used for various purposes, including but not limited to:

- Our website and social media pages
- Newsletters, brochures, and other marketing materials
- Internal use for documentation or celebrations (e.g., events, activities)

We understand the importance of privacy and dignity, and we will always respect your loved one's preferences regarding photos.

Please review the following options and indicate your preference:

1. **Consent to Share the Photograph**
   I, the undersigned, grant Cozy Nest Care Home permission to share photographs that may include my loved one on public platforms, such as our website and social media pages.
   ☐ Yes, I give my consent.
   ☐ No, I do not give my consent.

Contact Information of the Person Providing Consent:
(Please complete this section if you are not the resident signing directly)

- Name of Family Member/Supporter: _____
- Relationship to Resident: _____
- Phone Number: _____
- Email Address: _____

Signature of Family Member/Supporter:
By signing below, you acknowledge that you have the legal authority to provide consent for your loved one to be photographed and that you understand the potential uses of these photographs.
Signature: _____
Date: _____

Thank you for your cooperation. We look forward to being part of your loved one's journey at Cozy Nest Care Home.

Sincerely,
The Management Team
Cozy Nest Care Home

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admin@cozynestcare.ca www.cozynestcare.ca (306) 978 6266 (306) 978 6425

Government of Saskatchewan

Drug Plan and Extended Benefits Branch

Please return to:
Drug Plan & Extended Benefits Branch
Income Assessment - Operations Unit
3475 Albert Street
Regina, Saskatchewan S4S 6X6
Phone: 1-800-667-4884 or 306-787-5023
Fax: 306-787-8679
Website: www.saskatchewan.ca

SIDE A

Institutional Supportive Care - Income-Tested Resident Charge
CRA Consent

- Provide a copy of your Notice of Assessment OR pages 1 to 4 of your Income Tax Return showing Line 150 (for both Resident and Spouse).
- If you do not file income tax, complete Side B and provide required income documentation.
- Incomplete applications will result in delays in processing. Please ensure you have provided all information.

RESIDENT INFORMATION (Please Print)		**SPOUSE INFORMATION (Please Print)**	
Resident's Surname	First	Spouse's Surname	First
Health Services Number	Date of Birth (YY/MM/DD)	Health Services Number	Date of Birth (YY/MM/DD)
Social Insurance Number		Social Insurance Number	
CONTACT INFORMATION (Please Print)			
Surname	First	Current Mailing Address	
Home Phone Number ( )	Work Phone Number ( )	City/Town/Village	Postal Code

DECLARATION AND CONSENT

Is the Power of Attorney (POA) signing on behalf of the resident? YES☐ NO☐
If YES, then copies of the POA documents MUST be attached. NOTE: If a Trustee, Guardian or POA is signing for the Applicant, a copy of the legal document must be attached to this consent form. Due to the variety of POA documents, some may not be considered acceptable for CRA, such as POA specific to or limited to a bank or financial institution.

I hereby consent to the release, by the Canada Revenue Agency to an official of the Saskatchewan Ministry of Health, of information from my income tax returns, and, if applicable, other required taxpayer information about me. The information will be relevant to, and used solely for the purpose of determining and verifying my/our eligibility and the general administration and enforcement of: the Income Tested Resident Charge pursuant to *The Housing and Special-care Homes Act* and regulations made thereunder, and will not be disclosed to any other person or organization without my approval.

This authorization is valid for the most relevant of the two taxation years prior to the year of signature. It is also valid for each subsequent consecutive taxation year during which my family unit seeks assessment under the Income-Tested Resident Charge requested by me or on my behalf. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to Saskatchewan Ministry of Health, Drug Plan and Extended Benefits Branch.

DATE

Signature of Resident, or if applicable, Guardian/Trustee/ Power of Attorney. A witness is necessary if resident signs with an "X" or a mark.

DATE

Signature of Spouse, or if applicable, Guardian/Trustee/ Power of Attorney. A witness is necessary if spouse signs with an "X" or a mark.

PRINT NAME OF Guardian/Trustee/ Power of Attorney/Witness.

PRINT NAME OF Guardian/Trustee/ Power of Attorney/Witness.

Government of Saskatchewan

Drug Plan & Extended Benefits

3475 Albert Street
Regina SK S4S 6X6

Phone 306-787-5023
or Toll-Free 1-800-667-4884
Fax 306-787-8679

LONG TERM CARE
OPTIONAL DESIGNATION FOR DETERMINING RESIDENT CHARGE

I, _____(name)

residing in _____(facility)

hereby wish to be designated as indicated below for purposes of calculating the income-tested resident charge. I understand that either designation does not automatically designate me in this way with other social safety net programs in the federal government (e.g. Guaranteed Income Supplement) and provincial government (e.g. Saskatchewan Assistance Plan and other Ministry of Health Programs).

Please check the designation applicable to your situation **(check only one box).** With this designation only the resident's income is considered in determining the resident charge.

- ☐ My spouse and I live in separate dwellings for reasons beyond our control. However, our marital status has not changed.*
- ☐ I am separated from my spouse pursuant to a separation agreement or a judicial separation.** Effective Date _____

Signed this _____ day of _____, 20 ____.

_____
Resident's Signature or Spouse's/Supporter's Signature

_____
Name of individual signing above (Please Print)

* Commonly called "involuntary separation"

** Sometimes called "legal separation"

H31-7797
2000/10

Pre-Authorized Debit (PAD) Plan agreement
I/we authorize Cozy Nest Care Home and the financial institution designated (or any other financial institution I/we authorize at any time) to begin deductions as per my/our instructions for monthly regular recurring payments and/or one- time payments from time to time, for payment of all charges arising under my/our Cozy Nest Care Home account. Regular monthly payments for the full amount of services delivered will be debited to my/our specified account on the 28th day of each month. Cozy Nest Care Home will obtain my/our authorization for any other one-time or sporadic debits. This authority is to remain in effect until Cozy Nest Care Home has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. I/we may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca. Cozy Nest Care Home may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to me/us. I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Please attach void cheque here.

Authorized Signature(s):_____ Date: _____

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Miscellaneous Consent Form

Resident Name: _____ Room #: _____

Contact Name(s): _____

Address: _____ Province:_____

Postal Code: _____ City/Town: _____

Phone (Main): _____ Email: _____

PRE-AUTHORIZED DEBIT (PAD) PLAN

Monthly invoices can be withdrawn automatically from your account. Initial to confirm that you have read and agree to the Pre-Authorized Debit (PAD) Plan agreement on the following page.

Financial Institute: _____

Account #: _____ **Transit #:** _____

Branch #: _____

Initial Here

EMAILED STATEMENTS

Cozy Nest Care Home offers emailed statements to save paper. Charges for hair care, transportation, cash withdrawals, incontinence products or other miscellaneous expenses will be itemized on monthly statements. Initial to email the monthly statement to reduce paper.
(Receipts will be available at Cozy Nest for up to 1 year from the statement date.)

Initial Here

TELEVISION PACKAGE (BELL)

Cozy Nest Care Home charges a mandatory $50 for cable, which cannot be waived.
Approximately 50 channels.

Initial Here

PHONE PACKAGE (SASKTEL)

Resident/support is responsible for contacting SaskTel directly to obtain a phone connection. Resident is billed directly from SaskTel

Initial Here

FORM A

RETURN TO:
Drug Plan and Extended Benefits Branch
3475 Albert Street
Regina, Saskatchewan S4S 6X6
PHONE: 1-800-667-7581 or 306-787-3317
FAX: 306-787-8679
EMAIL: dpeb@health.gov.sk.ca

SENIORS' DRUG PLAN APPLICATION CRA CONSENT

- If you do not file income tax, please complete FORM B.
- Please ensure you have provided all information. Incomplete applications will result in delays in processing.
- Coverage is effective the date complete information is received, subject to approval.

APPLICANT	
SURNAME	**FIRST NAME**
CURRENT ADDRESS	
CITY	**POSTAL CODE**
DATE OF BIRTH (DD / MM / YYYY)	**PHONE NUMBER**
HEALTH SERVICES NUMBER (HSN)	**SOCIAL INSURANCE NUMBER (SIN)**

This consent authorizes Canada Revenue Agency (CRA) to provide Saskatchewan Ministry of Health with Line 23600 for this and <u>future</u> years as long as you file income tax.

Is the Power of Attorney (POA) signing on behalf of the applicant? YES ☐ NO ☐
If YES, then copies of the POA documents MUST be attached. NOTE: If a Trustee, Guardian or POA is signing for the Applicant, a copy of the legal document must be attached to this consent form. Due to the variety of POA documents, some may not be considered acceptable for CRA , such as POA specific to or limited to a bank or financial institution.

I hereby consent to the release, by the Canada Revenue Agency to an official of the Saskatchewan Ministry of Health, of information from my income tax returns, and, if applicable, other required taxpayer information about me. The information will be relevant to, and used solely for the purpose of determining and verifying my eligibility and the general administration and enforcement of: the Seniors' Drug Plan pursuant to *The Prescription Drugs Act* and regulations made thereunder, and will not be disclosed to any other person or organization without my approval.

This authorization is valid for the most relevant of the two taxation years prior to the year of signature. It is also valid for each subsequent consecutive taxation year during which my family unit seeks coverage under the Seniors' Drug Plan requested by me or on my behalf. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to Saskatchewan Ministry of Health, Drug Plan and Extended Benefits Branch.

SIGNATURE OF APPLICANT	**DATE**
If applicable, SIGNATURE OF GUARDIAN / TRUSTEE / POWER OF ATTORNEY. **A Witness is necessary if Applicant signs with an "X" or a mark.**	**DATE**
PLEASE PRINT YOUR NAME IF GUARDIAN / TRUSTEE / POWER OF ATTORNEY	**DAYTIME CONTACT NUMBER OF GUARDIAN / TRUSTEE / POWER OF ATTORNEY**

Important Documents for Admission

Cozy Nest Care Home Intake Checklist:

- CRA Consent Form (Included in the move-in Package) ☐
- Pre-Authorized Debit Form (Included in the move-in Package) ☐
- Senior's Drug Plan Form (Included in the move-in Package) ☐
- Void Cheque ☐
- Power of Attorney ☐
- Latest Tax Return or Notice of Assessment ☐

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Supporting Natural Death in Long Term Care

Determine the resident's choice to resuscitate.

CPR guidelines indicate that CPR will not be started unless the cardiac arrest is witnessed.

What is CPR?

Cardiopulmonary resuscitation (CPR) is an emergency procedure to restart the heartbeat $ and breathing if these were to stop. The reality is very different from that portrayed in television programs Such as "ER." CPR is an aggressive and sometimes traumatic treatment

Risks & Side Effects of CPR on a Frail Person

Broken ribs Nerve damage Skin burns Bruising Broken sternum Collapsed lungs Stroke **Coma** Need for artificial ventilation

Ensure your wishes are recorded & known to your physician & care partners.

The chances of CPR restoring the heartbeat and returning a person to his/her previous health vary under different circumstances.

If the heart beat stops because of a sudden heart attack or abnormal heart rhythm in an otherwise healthy individual, the chances of restarting the heart are only 3% in the community & 12% if it occurs in hospital.

If CPR is successful, all that pounding on the body usually results in major physical trauma. This trauma often includes broken ribs, lung bruising, damage to the airway & internal organs, and internal bleeding.

On top of that, the existing health conditions that caused the heart failure in the first place make it even less likely that they'll recover at all or have a reasonably good quality of life.

Because of all this, some people argue that using CPR on seniors leads to an unnecessarily prolonged & painful death.

This doesn't mean that CPR isn't a valid choice for older adults. It means that it's important to understand the facts and realistic outcomes before making a choice.

In a study, when older adults over 85 years old were made aware of their chances of survival, only 6% chose to have CPR.

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MY STORY

My Legal Name	
Preferred Name	
Date of Birth	
My Position in the Family	
My Siblings (Name and where they live)	
Children (Name and where they live)	
My Grandchildren (Name and where they live)	
Other family/friends that are important to me?	
My Heritage, nationality/ culture is:	
Where I was born and raised	
Places I lived as a child	
Chores and responsibilities I had at home	
I played these games as a child	
The schools I attended	
The first job I had	
My first car was a	
MY ADULT LIFE	
These are some of my major life accomplishments &/or milestone.	
I Married (insert name)_____on (month/ day)____, (year)_____. We Got Married at (location)_____(Or Never Married. _____Divorced _____)	

This is how I met my spouse/partner	
People most likely to visit/ stay in touch with me	
The last job I had before I retired, which was	
After I retired, I occupied my time by	
My special interests/ hobbies/ sports	
I belonged to these clubs or groups (Past and present)	
OTHER THINGS YOU SHOULD KNOW ABOUT ME	
My favorite type/s of music	
I play (or played) a musical instrument.	
I had pets (please provide name & kind of pet; how it was with you).	
Religious preferences & spiritual practices that are important to me	
My family traditions are	
Things that I enjoy doing or being a part of My "simple pleasures",	
Ethnic foods that I enjoy are	
I have always wanted to (things you dream of doing)	

Saskatchewan Health Authority

Long-Term Care Agreement

Financial Responsibilities

This Long-Term Care Agreement is a legally binding agreement, which You (or Your Financially Responsible Person) must sign for residency in Our long-term care home or continuing care program:

COZY NEST CARE HOME INC.

Insert Name of SHA (or other) long-term care home or program above

This Agreement describes Your financial rights and responsibilities that are in place as long as You are a resident of Our long-term care home. If You have any questions or concerns about this Agreement, please ask Us for advice before signing it. If you transfer to a different Saskatchewan Health Authority, or other, long-term care home during your residency, this Agreement will follow You to Your new long-term care home.

In this Agreement, you or your Financially Responsible Person will be called "**You**" or "**Your**". Our long-term care home will be called "**We**", "**Us**" or "**Our**".

Your "**Financially Responsible Person**" means Your attorney or power of attorney, Your property guardian, or the Public Guardian and Trustee, as determined by Your situation.

We agree:

1. To charge You only the rates set by the provincial government in the *Program Guidelines for Special-care Homes* (as adjusted from time to time by the Ministry of Health).
2. To give You no less than one (1) month's written notice of any change in Your charges.
3. To provide greater convenience for You and Your Financially Responsible Person by providing You with the following options (where available):
   - If You desire, monthly statements can be sent by e-mail to eliminate wait time.
   - You have the following payment options:
     i. Pre-Authorized Debit – an automatic withdrawal will be made for Your long-term care and resident's trust fund charges. This option eliminates the concern of making timely payments and reduces cost of issuing and mailing payments; OR
     ii. On-line payments – Your monthly payments can be made on-line with Your specific financial institution.
     iii. Other payment options, i.e., cash or cheque, may be available.

   Please complete and sign the enclosed forms if You want to receive Your monthly statements by e-mail and/or sign up for pre-authorized debit.
4. Upon long-term care services being no longer required, to assist the long-term care home with necessary turnaround time to move the next resident in, You will be charged the equivalent of three (3) days, starting on the first day. These three days will be charged except for inter-home transfers within SHA (if applicable).

Saskatchewan Health Authority

You (or Your Financially Responsible Person) agree(s):

1. To pay Us the first month's resident's fees, or a pro-rated portion (if the first month is less than a full month) upon Move-In and to guarantee that financial arrangements are in place for the continuation of monthly payments on the first business day of each month thereafter.
2. To continue to pay Us Your monthly resident's fees during any short-term absence, while receiving treatment in another health care facility, or longer-term absence for any other reason approved in advance. Your room will be held exclusively for You until Your return or until you no longer require the room. If necessary, You (or Your Financially Responsible Person) will pay Us the equivalent of three (3) days of Your monthly charges if you no longer require the room.

Please review the most current version of the Special-care Home Resident Supply Charges (the "**Charges Document**") at Section 6.10 of "Program Guidelines for Special Care Homes" (updated from time to time by the Ministry of Health), available at: Program Guidelines 2016 .

You (or Your Financially Responsible Person) further agree(s):

3. To pay Us the monthly personal hygiene supplies charge as specified in Group "D" of the Charges Document.
4. To pay Us the cost of additional charges or expenses for non-insured goods or services that We provide to You, at Our cost as specified in Group "B" and Group "C" of the Charges Document, that are not included in any other fee or charge that You pay.
5. That everything else that We provide to you as specified in Group "A" of the Charges Document will be free of charge to You. Anything else not referred to in the Charges Document is Your responsibility.
6. To provide You with spending money as required from Your trust fund, if available at your location. The amount in Your trust fund at all times must be sufficient to pay for requested withdrawals and/or third-party services, and may be subject to a minimum amount.
7. That outstanding balances owed to Us may be subject to interest charges at the rate currently in effect. All cheques and pre-authorized debits returned from Your financial institution due to non-sufficient funds (NSF) are also subject to Our penalty charge then currently in effect. We may also start a collection or legal process to recover.
8. To submit income information to Us as requested annually to allow the Ministry of Health to determine Your income-tested resident's fee. Alternatively, You may choose to complete a form to give consent to Canada Revenue Agency to release Your income information to the Ministry of Health on a go-forward basis. If income information is not submitted, You will be charged the maximum monthly resident's fee after the first two (2) months.
9. We are committed to keeping all information in our possession relating to You confidential. This includes information related to Your financial affairs. However, Your information may need to be released, as necessary, to authorized personnel in order to enforce payment of Your fees if You are in default.
10. Your signature on this document indicates that You, or Your Financially Responsible Person, have/has read, understand(s) and agree(s) to all parts of this Agreement

Saskatchewan Health Authority

Date this: Click here to enter a date. (Day/Month/Year) Click here to enter text. (City/Town) Click here to enter text. (Province)

Signature for Care Home: Click here to enter text.

Signature of Designated Financially Responsible Person: Click here to enter text.

Resident's/Responsible Person's Signature: Click here to enter text.

**** As of 1 November, 2020, this Agreement supersedes the financial agreements of each of the former Saskatchewan health regions. ****

Saskatchewan Health Authority

Long Term Care Moving-In Agreement

Every long term care (LTC) home in Saskatchewan Health Authority (SHA) strives to create a sense of home, a community, where individuals with varied preferences, needs and abilities live together. Open communication, mutual respect and flexibility are some of the foundational principles that enhance life in LTC. These principles also contribute to healthy workplace environments for care team members. It is through mutual commitment to these principles that community is created.

This agreement is between SHA and:

_____ _____

Name of Resident

Name of Personal Guardian and Relationship (As applicable)

_____

Name of Proxy

_____

Name of Substitute Decision Maker and Relationship (As applicable)

_____ _____

Name of Two Treatment Providers
(In the absence of a Personal Guardian, Proxy and/or Substitute Decision Maker)

The LTC Moving in Agreement is considered a medical agreement. If a person requires long term care but lacks the capacity to make a health care decision, the Personal Guardian, appointed by court; Proxy, identified in the Health Care Directive; Substitute Decision Maker, determined by nearest relative list; or two Treatment Providers, in that order of priority, may sign on the Resident's behalf (The Health Care Directives and Substitute Health Care Decision Makers Act, 2015).

If the Personal Guardian or proxy sign this agreement on behalf of the Resident, as the Responsible Party, they agree to enter this agreement on behalf of the Resident.

THE RESIDENT AND/OR RESPONSIBLE PARTY acknowledge and agree to abide by our provincial SHA applicable policies as well as protocols and procedures in place at the LTC Home both now and in the future, including but not limited to the following:

GENERAL CARE

1. Medications
    - No pharmaceuticals/medications or other non-prescription treatments are to be kept in the Resident's possession or supplied by relatives or friends without the knowledge and consent of the Manager or designate.
    - Medications are to be dispensed and packaged by the pharmacy under contract with the SHA or LTC Home.

2. If the Resident needs new clothing, money or effects, the Resident/Responsible Party will be responsible to supply these. Staff at the LTC Home will not alter clothing without the consent of the Resident or the Responsible Party.
3. Damage or Loss of Property
    - Reasonable effort is made for the Resident's protection, but the SHA or LTC Home does not accept responsibility for damage or loss to the Resident's property.
    - The Resident/Responsible Party is encouraged to consider obtaining contents insurance (i.e. tenant's pack) for the Resident's belongings, which may include personal or valuable items such as dentures, hearing aids, jewelry, etc. Labelling of personal belongings is also encouraged.
4. Authorization for personal electrical appliances (example: fans, humidifiers, coffee makers, electric blankets, etc.) must be obtained before use.
5. Structural alterations or additions to the premises are not allowed.
6. The Resident is aware that the LTC Home may have registered pets that either visit or reside in the home. If the Resident does not want a pet to come into his/her room, the Resident will notify the care team and the care team will indicate this in the Resident's care plan.
7. Resident Room
    - The Resident is required to bring clothing and is encouraged to bring small personal items to personalize his or her room.
    - The Resident understands that after discussion with the Resident/Responsible Party, for sanitary or other safety reasons, the home has the right to request removal and/or disposal of any article by the Resident/Responsible Party.
    - Each home has a regular process for staff to review the environment of the home including resident rooms for infection control, safety and security reasons.
8. The SHA or LTC Home will take the Resident's picture for the purpose of identification by staff, medication administration and for resident safety purposes. See SHA-05-002 Informed Consent to Care Policy and SHA-08-009 Patient Identification Verification Policy.
9. Personal health information will be shared with:
    - Care team members, including but not limited to, therapies, social work, pastors, acute care staff, etc.
    - Elections Canada, Statistics Canada, Canada Census and Saskatchewan Provincial Elections, unless the Resident/Responsible party indicate otherwise.
10. Concern handling processes will follow SHA-02-013 Concern and Complaint Management Policy.
11. The SHA has zero tolerance for verbal, physical, emotional and psychological abuse of residents, staff, patient and family partners, physicians, etc. Situations of potential or actual abuse will be address by the SHA accordingly.

MEDICAL CARE

12. Health Care Directives
    - If the Resident has a Health Care Directive, a copy is provided to the home.
    - The Health Care Directive or Saskatchewan Medical Order for Scope of Treatment (SMOST) (CS-OS-0993) will inform the care team of the Resident's health care choices in the event of a serious illness, sudden collapse and/or cardiac arrest.

- The Resident will be invited to meet with the care team to review an existing Health Care Directive, or discuss and complete one.
    - If the resident does not have capacity to create a health care directive, their substitute decision maker will have an opportunity to engage in shared decision making with the resident's practitioner, to create a SMOST. (Physician or Nurse Practitioner).
    - If there is no Health Care Directive or SMOST at the time a decision is needed, the Substitute Decision Maker will be contact to make the decision.
- The care team will offer support and provide information to make informed health care decisions.

13. Resuscitative Services
    - In accordance with the Saskatchewan Ministry of Health Program Guidelines for Special Care Homes, staff at the LTC Home will provide resuscitative service to Residents indicating their wish to receive it in the event of a cardiac arrest.
    - Staff not certified in CPR will perform Hands Only CPR as directed by 911 dispatchers. Staff certified in CPR shall proceed as trained. Automated External Defibrillators (AEDs), where available, may also be used.
    - In the event the Health Care Directive or SMOST indicates a resident wishes further treatment, they may be transferred by staff to an acute care facility for further treatment.
14. The LTC Home will coordinate the purchase of medications, etc. with the community pharmacy contracted by the LTC Home (sharing of Personal Health Information with community pharmacies for this purpose will occur).
15. Medical treatment, nursing care, medication administration, immunization, and therapeutic services for the Resident will be supported by the home where indicated and appropriate consents reviewed.

TRANSFER/RELOCATION/END OF SERVICE PROTOCOL/DEATH

16. The SHA or LTC Home reserves the right to transfer/relocate a Resident to a different room or LTC Home. The SHA or LTC Home will discuss transfer/relocation with the Resident and/or Responsible Party. If the situation is urgent, contact with the Responsible Party will be made as soon as possible once the Resident's care needs are met and explanations will be provided. Under these conditions, the SHA or LTC Home accepts responsibility to move the Resident's personal belongings to the Resident's new location and the associated costs.
17. If it is determined by the SHA or LTC Home that relocation or end of service is appropriate because the Resident's health has improved sufficiently so that the Resident no longer needs the services of the LTC Home, the Resident's care will be assessed, coordinated, and planned in collaboration with the Resident and/or the Responsible Party and an SHA Assessor Coordinator.
18. The Resident's personal health information will be shared with the receiving home when resident is transferred from one LTC to another LTC Home, acute care facility, medical clinic, etc. including the return from acute care.
19. The Resident/Responsible Party may request a transfer to another room within the home. The SHA or LTC Home will strive to accommodate such requests taking into consideration space availability, appropriateness of the transfer, the care needs of the Resident and other residents and the capacity of the home. The Resident/Responsible Party will collaborate with the SHA or LTC Home to arrange timely relocation of the Resident's belongings.

20. Resident/ Responsible Party may appeal a decision following the former Regional Health Authority practices and where applicable SHA policies.
21. The Resident/Responsible Party may request a transfer to another home that is able to support the care needs of the resident and providing there is no balance owing on the account.
22. In accordance with the SHA Finance policy and the Resident's financial agreement, the Resident/Responsible Party must ensure all payments are made and up to date at the end of service. The SHA will take the steps required to address any overdue funds at end of service, per the Saskatchewan Ministry of Health Program Guidelines for Special Care Homes, the SHA Finance policy and the Resident's financial agreement.
23. End of Service/Discharge/Death
    - The circumstances surrounding Resident discharge/ end of service can be a sensitive and uncomfortable time for the Responsible party; ensuring end of service plans are arranged for removal of personal belongings can increase the Responsible party's ability to navigate the end of service with ease.
    - The Resident/ Responsible party will ensure a plan is in place to remove the Resident's personal belongings within 48 hours of the end of service, unless otherwise discussed and agreed upon by the Responsible party and the LTC Home Manager/Director.
    - If the Responsible Party does not reside within the same geographic area of the Resident, or if the Responsible Party encounters barriers to removing the Resident's personal belongings, the Responsible Party should discuss these barriers and review options with the LTC Home Manager/Director to have additional time to remove the Resident's personal belongings.
24. If the Resident and/or the Responsible Party fails to comply with this agreement
    - A meeting between the Resident/Responsible Party and the administrator/Manager will be scheduled to discuss the areas of concern.
    - Notice of end of service (exit from long term care services as a final option) may also be given by the LTC Home.

LTC HOME CONTACT INFORMATION

Open and honest communication, full disclosure and mutual respect are cornerstones of establishing and maintaining relationships between care providers and recipients of care. SHA and its affiliates support a culture of openness and willingness to learn from issues and concerns and are committed to working with you to seek resolution. In the event that questions or concerns arise, they may be directed to:

_____ _____

Name/Title Phone Number

AGREEMENT SCOPE

I, the undersigned Resident and/or Responsible Party, upon the Resident's move to a LTC Home within Saskatchewan Health Authority agree to the items outlined, as discussed, and I recognize that this agreement will remain in effect in the event of a subsequent move to another LTC Home.

DATED at _____ , Saskatchewan, this _____ day of _____, 20_____.

_____ _____

Signature of Resident, Responsible Party and/or PROXY Signature of Witness

_____ _____

Printed Name of Resident, Responsible Party and/or Proxy Printed Name of Witness

CHEETHAM'S PHARMACY

514 Queen Street, Saskatoon, SK, S7K 0M5
P (306) 653-5112
F (306) 653-1661
Email: cheethamspharmacy@gmail.com

Payment Authorization form

I authorize Cheetham's Pharmacy Inc. and its associated financial institution to begin regular deductions from my/our financial institution or credit card for my/our associated charges related to pharmacy services received from Cheetham's Pharmacy. Payments of the charges associated with received pharmacy services will be deducted within the first 3 days of each month. The charges will be for the pharmacy services that resident(s) received in the previous month, for example charges for services received in January will be processed in February and so on. **You have waived the right to receive pre notification of the PAD and have agreed that you do not require advance notice of the amount of PAD/PAP prior to processing the charges.** Cheetham's Pharmacy Inc. will seek prior authorization for any charges that are sporadic or non-pharmacy related.

This authorization remains in effect until Cheetham's Pharmacy receives a written authorization of change or termination. Once the notice is received I/we agree that Cheetham's Pharmacy will process the final charges and once the final charges are processed, the payment agreement is terminated. The change or termination notice can be provided to the Pharmacy by email or mailing to the address provided below.

Cheetham's Pharmacy Inc. may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to us. I/we have certain recourse rights if any debit/charge does not comply with this agreement. For example, I/We have the right to receive reimbursement for any PAD/PAP that is not authorized or is not consistent with this PAD/PAP Agreement. In case of non-sufficient funds, there will be a $10 charge per instance. Please fill the information below.

Name of the resident:_____ SK Health Card #: _____

Power of Attorney Full Name:_____ (Please provide POA Document)

POA Correspondence Name:_____, Email:_____

Address:_____ City:_____ Prov:____

Postal Code:_____ Ph # 1) _____ 2) _____

I, _____(resident or POA), authorize Cheetham's Pharmacy to transmit personal health information via email for the listed patient.

Authorized Signature: _____ Date: _____/_____/_____

CHEETHAM'S PHARMACY

514 Queen Street, Saskatoon, SK, S7K 0M5
P (306) 653-5112
F (306) 653-1661
Email: cheethamspharmacy@gmail.com

Payment Options:

Option 1:

Pre authorized debit: Please provide a copy of Pre Authorized Debit form from the Financial institution or a copy of a VOID cheque.

Option 2:

Credit Card Authorization (please be advised that there will be a 1.5% service charge applied to the payment when using the credit card for auto payment.)

Please fill in the information below and email mail or fax to the pharmacy.

Credit Card (Visa/ MasterCard/ Amex # _____ (16 digit or 15 digit for AMEX)

Card Expiration Date: ____(MM) _____(YYYY) CVV:_____ (3 or 4 digits)

Authorized signature: _____ Date:_____

Medication Change and Medication Review Authorization

I am aware that medications may be modified and changed for the resident by the physician/prescriber from time to time.

I am aware that Cheetham's Pharmacy will conduct medication reviews from time to time and suggest possible changes to the medications to the physician in order to ensure the most appropriate medications are being used, drug interactions are prevented, and the resident'/ patient's health is at the forefront of therapies. These reviews may be conducted in collaboration with physicians, the home's care staff, and any other health care professional involved in the care of the resident/ patient.

I am aware and agree that Cheetham's Pharmacy can and will make changes to the medication regimen according to the physician's orders.

Please complete this authorization and return to the above mentioned address or email address.

Authorized Signature _____ Date _____

Walking Stick Mobility
(By Marche Mates Mobility Inc.)

Unit # 40 – 510, Lauriston Street,
Saskatoon, SK S7K 0R5

Tel: (306) 242 – 7849
Fax: (306) 242 - 6849

Payment Authorization form – Incontinence Products

I / We authorize Marche Mates Mobility Inc. (DBA Walking Stick Mobility), hereinafter referred to as 'The Company', to begin regular deductionsfrom my/our financial institution or credit card for my/our associated charges related to Incontinence products received from the Company.

Payments for charges associated with Incontinence products received will be deducted within seven days of receipt.

By signing the Payment Authorization form, I / We agree to waive our right to receive pre-notification for the debit amount and confirm that I/we do not require advance notice of the amount of the Pre Authorization debit before processing the charges.

The company shall invoice incontinence products at the stated unit rates, which we understand are subject to change without prior notice.

This authorization remains in effect until the Company receives written notice of change or termination and all previous dues have been cleared. I/we may provide the change or termination notice to the Company via email or mailing to the address provided.

The Company may assign this authorization, fully or partially, by operation of law, change of control, or otherwise, by providing at least 10 days prior written notice. I/we have certain recourse rights if any debit/charge does not comply with this agreement. Further, the Company may impose a $10 charge per instance in case of non-sufficient funds.

Name of the resident:_____

SK Health Card #: _____

Power of Attorney Full Name:_____

Email:_____

Address:_____

City:_____Province:_____

Postal Code:_____Ph # 1)_____2) _____

I,_____(resident or Power of Attorney), authorize Marche Mates Mobility Inc. to transmit personal / health information via email for the listed patient.

Note: Please attach a copy of the Power of attorney, where a POA has been assigned

Walking Stick Mobility
(By Marche Mates Mobility Inc.)

Unit # 40 – 510, Lauriston Street,
Saskatoon, SK S7K 0R5

Tel: (306) 242 – 7849
Fax: (306) 242 - 6849

Payment Options

Option 1:

Pre-authorized debit: Please provide a copy of the Authorized Debit form from the Financial institutionor a copy of a VOID cheque.

Option 2:

Credit Card Authorization (Please be advised that a 1.5% service charge will be applied to the payment when using the credit card for auto payment.)

Please fill in the information below and email or fax it to Marche Mates Mobility Inc.

Credit Card (Visa/ MasterCard/ Amex #_____
(16 digits or 15 digits forAMEX)

Card Expiration Date:_____(MM)_____(YYYY) CVV:_____(3 or 4 digits)

Authorized signature:_____Date:_____