



EAGLES HOUSE LIVING CENTER

INTAKE PACKET CHECKLIST

RESIDENT: _____

STAFF INITIAL & DATE

- _____ NEW RESIDENT CHECKLIST COMPLETE
- _____ RESIDENT INFORMATION SHEET COMPLETE
- _____ ADDITIONAL CONTACTS COMPLETE
- _____ SPECIAL AUTHORIZATION(S) FOR RELEASE SIGNED
- _____ NONMEDICAL CONSENTS SIGNED
- _____ MEDICAL SERVICES CONSENT SIGNED
- _____ PROMOTIONAL/MEDIA COVERAGE RELEASE SIGNED
- _____ RESIDENT RIGHTS AND RESPONSIBILITIES SIGNED
- _____ FIRE EVACUATION PLAN SIGNED
- _____ RANDOM ROOM CHECK REQUEST
- _____ GENERAL PEDIATRIC CLINIC/TEENAGER VISIT COMPLETED
- _____ DENTIST VISITATION FORM COMPLETED
- _____ OPTOMETRIST VISITATION FORM COMPLETED
- _____ STREU'S PHARMACY INTAKE
- _____ CLOTHING AND POSSESSION INVENTORY COMPLETED
- _____ POSSESSIONS AT DISCHARGE SIGNED



EAGLES HOUSE LIVING CENTER

Resident Information

Resident: _____ Nickname: _____ County: _____ Male
D.O.B.: _____ S.S.# _____ Placement Date: _____
Height: _____ Weight _____ Eyes: _____ Hair: _____

Social Worker: _____ Phone: _____
Address: _____ Fax: _____
_____ E-Mail: _____

Attorney: _____ Phone: _____
Address: _____ Fax: _____
_____ E-Mail _____

Mother (Guardian): _____ Home Phone: _____
Address: _____ Work Phone: _____
_____ Cell Phone: _____
_____ E-Mail _____

Father (Guardian): _____ Home Phone: _____
Address: _____ Work Phone: _____
_____ Cell Phone: _____
_____ E-Mail _____

Other: _____ Home Phone: _____
Address: _____ Work Phone: _____
_____ Cell Phone: _____
_____ E-Mail: _____

Most recent school and grade level: _____

Religious Preference: _____

Medications (prescribing physician and start date): _____

Medical History (allergies, issues, reactions, limitations): _____

Doctor to notify in an emergency: _____

Dentist to notify in an emergency: _____



EAGLES HOUSE LIVING CENTER

ADDITIONAL CONTACTS

Name: _____

Phone: _____

Relationship: _____

Cell Phone: _____

Address: _____

Fax: _____

E-Mail: _____

Name: _____

Phone: _____

Relationship: _____

Cell Phone: _____

Address: _____

Fax: _____

E-Mail: _____

Name: _____

Phone: _____

Relationship: _____

Cell Phone: _____

Address: _____

Fax: _____

E-Mail: _____

Name: _____

Phone: _____

Relationship: _____

Cell Phone: _____

Address: _____

Fax: _____

E-Mail: _____

Name: _____

Phone: _____

Relationship: _____

Cell Phone: _____

Address: _____

Fax: _____

E-Mail: _____

MEDICAL SERVICES CONSENT

Use of form: Use of this form is voluntary, but completion will aid caretakers in ensuring that appropriate and timely health care is provided. The form is to be completed by the parent or guardian of a child placed in foster care or treatment foster care. Personally identifiable information on this form will be used for identification purposes and to assure appropriate medical care for the child. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions: If additional space is needed, attach a separate sheet or use reverse side of this form.

Name – Parent or Guardian (Last, First, MI)

Name – Child (Last, First, MI)

Birthdate – Child (mm/dd/yyyy)

A. Routine Medical Services Consent and Exclusions

For purposes of routine medical services for the above named child, I hereby give my consent for the child placing agency or its designee to approve the provision of routine medical services*, including medical and dental examinations and nonemergency prescribed treatments (e.g., tooth repair, immunizations, medications, reproductive health needs assessment), with the following exceptions:

* All medical services will be under the direction of a licensed dental care provider or physician or other licensed professional as appropriate.

B. Routine Emergency Medical Services Consent and Exclusions

In case of a medical emergency involving the above named child, I understand that the following procedures will be used. I hereby give my consent for the child placing agency or its designee to arrange for emergency medical services using the following procedures:

1. A reasonable effort will be made to contact me and secure my consent for needed medical services, including surgical procedures.
2. If I cannot be located within a reasonable time, the placing agency has the authority to consent to emergency surgery.
3. The juvenile court has the authority to consent to other medical services.
4. All medical services will be under the direction of a licensed dental care provider or physician or other licensed professional as appropriate.

I have no objections to the placing agency exercising its authority, with the following exceptions:

C. Parent / Guardian Information

Address – Home (Street, City, State, Zip Code)

Telephone Number – Home

Address – Work (Street, City, State, Zip Code)

Telephone Number – Work

Address – Other (Specify)

Telephone Number – Other (Specify)

Address – Other (Specify)

Telephone Number – Other (Specify)

SIGNATURE – Parent / Guardian

Date Signed

SIGNATURE – Child (age 14 and over only)

Date Signed



EAGLES HOUSE LIVING CENTER

PROMOTION/MEDIA COVERAGE RELEASE

I _____, understand part of the programming for the young men at Eagles House Living Center involves working with the public during community service or community events. Photographs may be taken during these events such as volunteering community service, sports teams, graduations, and general activities provided by the structure of the group home program. Boys, staff, and others involved with Eagles House Living Center, Inc. may be interviewed or photographed by the media or staff. Full names are not used and confidentiality is respected. I give my permission for Eagles House Living Center, Inc. to photograph or interview the young man named above for educational and/or promotional purposes, common examples could be, but not limited to newsletters, website, and brochures.

I _____, have read the above request for permission and give my approval.

PARENT/LEGAL GUARDIAN SIGNATURE

DATE

I _____, understand part of the programming the young men at Eagles House Living Center involves working with the public during community service or community events. Photographs may be taken during these events such as volunteering community service, sports teams, graduations, and general activities provided by the structure of the group home program. Boys, staff, and others involved with Eagles House Living Center, Inc. may be interviewed or photographed by the media or staff. Full names are not used and confidentiality is respected. I give my permission for Eagles House Living Center, Inc. to photograph or interview me for educational and/or promotional purposes, common examples could be, but not limited to newsletters, website, and brochures.

I _____, have read the above request for permission and give my approval.

CLIENT SIGNATURE

DATE



EAGLES HOUSE LIVING CENTER

RESIDENT RIGHTS AND RESPONSIBILITIES

All Eagles House Living Center residents have rights as well as access to a grievance procedure consistent with section 51.61 Wisconsin Statutes and DHS 94, Wisconsin Administrative Code. Residents are explained their rights and responsibilities upon admission and these rights are visibly displayed in each of the group homes. These rights include:

TREATMENT RIGHTS - Every resident has the right to:

- Receive prompt and adequate treatment
- Participate in their treatment planning
- Be informed of their treatment and care
- Refuse treatment and medications (unless court-ordered)
- Be free from unnecessary or excessive medications

RECORD PRIVACY AND ACCESS

- Staff must keep patient information confidential
- Records cannot be released without patient consent (with some exceptions)
- Residents may see their records
- They can always see records of their medications and health treatments
- During treatment, access may be limited if the risks outweigh benefits
- Residents may challenge the accuracy, completeness, timeliness or relevance of entries in their records

COMMUNICATION RIGHTS - Every resident has the right to:

- Have reasonable access to a telephone * Residents are allowed to make and to receive unlimited private calls to legal counsel.
- See (or refuse to see) visitors daily *
- Send or receive mail. If a staff member has probable cause to believe that a piece of mail contains contraband, the resident may open the mail in front of the staff member and shake the item to determine if there is contraband. Staff members may not read any of the resident's mail, unless the resident or resident's parent or guardian requests that staff read the mail to the resident.
- Contact public officials, lawyers or patient advocates

PERSONAL RIGHTS - Every resident has the right to:

- Have the least restrictive environment
- Not be secluded or restrained except in an emergency when necessary to prevent harm to self or others
- Wear their own clothing and use their own possessions *
- Have regular and frequent exercise opportunities
- Have regular and frequent access to the outdoors
- Have staff make reasonable (non-arbitrary) decisions about them
- Refuse to work – except for personal housekeeping tasks
- Be paid for work they agree to do that is of financial benefit to the facility
- All residents shall be provided with opportunities for voluntary religious expression and participation in religious education (except for documented security reasons) and attendance at services compatible with the religious preference of the resident, or a parent or guardian of the resident. A resident whose disruptive behavior interferes with other residents' right to worship may be removed from worship services.

PRIVACY RIGHTS - Every resident has the right to:

- Not be filmed or taped without his or her consent
- Have privacy in toileting and bathing *
- Have a reasonable amount of secure storage space for his or her possessions *

MISCELLANEOUS RIGHTS - Every resident has the right to:

- Be treated with dignity and respect by all staff of the provider
- Be informed of his or her rights
- Be informed of any costs of his or her care
- Refuse electro-convulsive therapy (ECT)
- Refuse drastic treatment measures
- File complaints about violations of his or her rights
- Be free from any retribution for filing complaints
- Personal Search - Staff members may conduct a personal search of a resident if the staff member has probable cause to believe that there could be a security or safety issue in the facility.

All residents at Prentice House also have the right to:

- Daily shelter, warmth, personal bed and bedding, and private space for possessions
- Food in sufficient quantities and quality, three regular scheduled meals and snack.
- Clothing sufficient in both quantity and quality and normative in appearance.
- Basic personal care articles to maintain health, hygiene, and grooming.
- Periods of time that allow for privacy.
- Personal respect and protection.
- A psychologically and physically safe and secure environment.
- Present personal concerns or grievances as they occur in a reasonable manner to staff.
- Contact social worker or attorney at any reasonable time upon request.
- Be consistently and accurately informed about treatment progress, rules, expectations, and any changes that might be made.
- Schedule individual therapeutic sessions with counseling staff upon request.
- Freedom from restraint, unless danger to self or others is imminent.
- Personal choice and decision making whenever possible, and the ability to do so positively increases.

Limitation or Denial of Resident Rights:

No resident may be denied their rights or have them limited, except for the following rights and only when medically or therapeutically contraindicated:

- Right to make telephone calls.
- Right to wear one's own clothing.
- Use of personal possessions.
- To have access to secure storage space.
- To have privacy in toileting and bathing.
- To have visitors daily.

If the resident's rights are going to be limited or denied, the facility must document the denial or limitation and put the documentation in the resident's treatment record.

Informed Consent

All treatment of residents requires consent unless there is a court order requiring specific treatment.

Grievance Procedure

Eagles House Living Center residents have the right to an informal and formal grievance process. It should always be preferred to have grievances resolved informally whenever possible.

Informal

When a resident feels that a right has been violated, they should notify a staff member immediately. The staff member will document the notice in the residents daily charting and inform their supervisor. The Program Director will then schedule a meeting with the resident and any staff members related to the grievance. The Director will determine whether a right has been violated. The resident and Director will then work toward resolution of the grievance. This process and resolution will be documented, signed by all parties, and stored in the resident's file.

Formal

If Eagles House Living Center residents feel that a right has been violated, and they were not able to resolve it informally, they have the right to a formal Grievance Resolution Procedure outlined in DHS 94, Wisconsin Administrative Code and Rights of Access to Court that has been explained to the resident at the time of admission and posted visibly in each of the group homes. Abbreviated levels of action are as follows:

- A. Notify your service provider within the specified time limits and cannot be threatened or penalized for informal or formally filing a grievance.
- B. A resident can appeal the service provider's decision to the county agency director if the placement is being paid by a county.
- C. If resident or any party of the grievance is dissatisfied with the county level decision or you are paying for the services through a private agency an appeal may be made at the state level to the State Grievance Examiner.
- D. If the resident or any party to the grievance is still dissatisfied an appeal can be made to the Administrator of the division of Supportive Living. This will be the final decision/review.
- E. Residents have a right to file suit in court if they feel there has been a violation of rights at any time and seek damages or other court relief. Residents may also file suit if they believe they are being placed against their will and ask a court to review their commitment or placement order.

Family Planning

All residents have access to confidential family planning services upon request.

Statement of Non-Discrimination

Eagles House Living Center LLC. does not discriminate against residents because of race or cultural identification, sex, sexual orientation, age, color, creed, ancestry, national origin, disability, political affiliations, or religious beliefs.

House Rules and Behavior Interventions

The overriding expectation for each of our residents is to show respect for themselves, other residents, and staff. It is the responsibility of our staff to assure that this respect is shown to each resident and staff member. Specific directives for dealing with the times and situations which are disrespectful may be found in the House Rules and Discipline section of the intake packet that all new residents agree to and understand (by signing the sheet) upon their admittance to the group home.

House Rules

- All residents will take part in cleaning and chores. Daily chores will be done after meals or upon request of the staff.
- Residents will be expected to eat all meals served at the house, unless a schedule has been worked out with staff.
- Residents will have a study period Sunday through Thursday evenings. The residents will study in areas assigned by staff.
- Residents will be allowed to have family visitors at the house through prior approval to be given by the resident’s social worker, and as indicated by their court order and/or personal treatment plan before family or any other guests will be allowed at the house. Eagles House Living Center staff has the right to request visitors to leave the premises if they feel there is a concern of safety for any of the residents or staff.
- Residents will have reasonable access to a telephone. Residents are allowed to make and to receive unlimited private calls to legal counsel.
- Residents will be responsible for their own laundry. Laundry will be done on their assigned day.
- Bedtime (lights out and quiet) will be at 9:00 PM on school nights. Bedtime on non-school nights will be determined by staff.
- Residents may be required to get haircuts (at staff discretion) if it becomes a treatment issue.
- Residents will be allowed to attend church, though staff supervision may be needed.
- Residents who stay a week or longer will receive a regular, base amount of spending money appropriate to his or her age and maturity. Older residents can be given opportunities to earn extra money above and beyond the base allowance.
- Residents will NOT be allowed to use ALCOHOL or DRUGS. This will NOT be tolerated in the program.
- Residents are expected to not be involved in any form of violence, including threats. This will NOT be tolerated in the program.
- Residents are expected to be respectful to other residents and staff at all times. Vulgar and obscene language or gestures are NOT tolerated.
- Residents are expected to respect themselves, their property, as well as the rights and property of others
- Any unauthorized absences from Eagles House Living Center will be considered running away. This will NOT be tolerated in the program. Violation of any curfews established with Eagle House staff will immediately be considered AWOL status and acted upon accordingly.
- Inappropriate sexual contact or harassment will NOT be tolerated.
- Residents will comply with staff directions and expectations as the need arises.
- Residents are expected to follow program expectations to the best of their ability.
- Residents who fail to comply with the rules of the program may be subjected to dismissal from Eagles House.

Eagles House Living Center staff members have the responsibility to set limits on behaviors, activities, expectations, provide care and supervise and carry out treatment plans.

Behavior Interventions/Consequences

Behavior interventions and consequences will be based on staff’s understanding of the youth’s intentions, motives and actions in regards to the rule infraction. Physical behavior intervention is only used as a last resort by employees trained in agency approved crisis intervention techniques as instructed by the Crisis Consultant Group. Physical behavior intervention is only used if the resident is presenting an immediate and immanent physical threat to himself or others. Eagles House Living Center staff will always carry out behavior interventions in a humane manner. Behavior Interventions and Consequences used and the behaviors they address will be documented in the residents Daily Charting.

Behavior Interventions/Consequences that may be used:

- **Television restrictions**
- **Assigning household chores or written therapeutic reports pertaining to specific behaviors**
- **Loss of extracurricular activities**
- **Loss of privileges**
- **Increased staff supervision**
- **Residents who fail to comply with the rules of the program may be subjected to dismissal from Eagles House Living Center Group Home**

Resident: _____

Date: _____

Social Worker: _____

Date: _____

Eagles House LC Staff: _____

Date: _____



EAGLES HOUSE LIVING CENTER

FIRE EVACUATION PLANS

Fire Evacuation Plan Eagles House Living Center

Evacuation routes for emergencies and drills:

- All occupants upstairs at time of emergency or drill will promptly go down the stairs to the main floor and out the front door (facing Floral Drive.). Immediately gather by the fence on the west side of the house.
- Shut the bathroom and bedroom doors as you leave. Knock on all doors you pass to make sure everyone is evacuating. Go quickly, with no pushing or shoving.
- All occupants in the kitchen of the house should promptly exit the kitchen area exit and gather by the fence on the west side of the house.
- If fire has blocked the prescribed exit, then those in the kitchen area should also exit the living room/foyer exit.
- If fire has blocked the living room exit, those on the main floor should exit through the kitchen exit. Those unable to reach this exit should exit the nearest window.
- If the stairway exit is blocked by fire, from the second floor, then a window must be used to exit.
- All occupants must report to the fence area on the west side of the house to make sure all persons are accounted for

If prescribed exits are blocked by fire the occupants:

- Second Floor, use the window connected to the garage and climb down the latter with assistance.
- In living rooms and dining room, use the closest unobstructed front door on the north side of the building.
- In kitchen, use the same exit as dining room and living rooms, the closest unobstructed front door on the north side of building.
- If fire has blocked both north doors, use the side exit located in the kitchen on the west side of the house. If all exits are blocked, use the nearest unobstructed window to exit the building.
- Go immediately to the fence on the west side of the house so all occupants can be accounted for.

Client Signature:

Date

Staff Signature:

Date



EAGLES HOUSE LIVING CENTER

REQUEST FOR RANDOM ROOM CHECK

RESIDENT _____

PLACING AGENCY _____

SOCIAL WORKER _____

JUST CAUSE FOR REQUEST

_____ History of drug and alcohol abuse

_____ Other (specify) _____

Signature of this request gives authorized personnel to conduct Random room check on the resident named above for the duration of his placement at Eagles House Living Center

Signature of Social Worker/Agency Representative

Date



EAGLES HOUSE LIVING CENTER

DENTIST VISITATION FORM

Name: _____

Date Seen: _____

Dentist Signature: _____

Comments: _____



EAGLES HOUSE LIVING CENTER

OPTOMETRIST VISITATION FORM

Name: _____

Date Seen: _____

Signature: _____

Comments: _____



NEW PATIENT INFORMATION FORM

Welcome to Streu's Pharmacy! We are pleased to have the opportunity to work with you to provide your medications and other medical supplies. As part of our admission process, please review the enclosed packet and complete the following forms as listed below:

- New Patient Information Form (below)
- Acknowledgment of Receipt of NOPP and Patient Bill of Rights
- HIPAA Release of Information Authorization
- Streu's Rx Savings Club

NOTE: The remainder of the forms are yours to keep. Please feel free to call us if you have any questions at (920) 593-2467.



PHARMACY NOTIFICATION OF NEW ADMISSION

Name _____ DOB _____

Facility Name _____ Address _____

Gender _____ M _____ F

Height _____ Weight _____
Serum Creatinine _____ mg/dL Date drawn _____

Allergies _____

Medical Condition(s) _____

YES, a copy of the prescription card is enclosed *(Please photocopy both sides of card)*

NO, a copy of the prescription card is not attached *(Please provide the following prescription insurance information)*

Name of Plan _____ Phone # _____

BIN # _____ ID # _____

Group # _____ Person Code _____ PCN # _____

Medicare Number _____ and/or **SSN** _____ - _____ - _____

Start date and time for blister packs: **DATE** _____ **TIME** _____



Streu's Pharmacy, Inc.
HIPAA Release of Information Authorization

Patient Name: _____ Date of Birth: __/__/__
Address: _____

SECTION A: To whom the information is being authorized for release:

Table with 6 columns: Name(s)/Relationship, Street Address, City, State, Zip, Phone Number. Rows (1) through (4) for listing authorized individuals.

Do NOT release information to anyone other than patient.

SECTION B: The use and/or disclosure being authorized (check boxes below).

- Billing Account (Including insurance information)
Prescription Information

SECTION C: Statement Information. (Please indicate where billing statements should be mailed):

Table with 6 columns: Name, Street Address, City, State, Zip, Phone Number for billing statements.

TO THE INDIVIDUAL
No Conditions: This authorization is voluntary.
Effect: The protected health information described below may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws.

Information will not be released without the appropriate consent form signed.

Name of Patient or Legal Representative (printed)

Signature

Date Time

**If you have signed this form as a legally authorized representative of the patient, please identify your relationship to the patient below:

Expiration and Revocation.

This authorization will remain in effect until I choose to revoke it. Right to Revoke: I understand that I may revoke this authorization at any time by providing written notice of revocation to Streu's Pharmacy, 635 Main Street, Green Bay, WI, 54301.



ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been offered/received a copy of and understand the following Streu's Pharmacy forms:

1. Notice of Privacy Practices (NOPP) / Patient Bill of Rights and Responsibilities
2. Billing Information Form / 30 Supplier Standards
3. Complaint Procedure
4. Red Cross Emergency Kit Information
5. Stop Germs! Wash Your Hands

I will notify the Pharmacist of changes in my PHI that could include, but are not limited to, the following: new medications, changes in directions for use of medication, allergies or drug reactions, address changes, insurance changes, or any health condition changes.

PRINT Patient Name or Attach Label

Date of Birth

Signature of Patient/Guardian/Power of Attorney
(please circle one)

Date



Streu's RX Savings Club

To save our customers money on the rising cost of prescriptions, we have developed a prescription savings club and have enrolled all of our valuable customers.

Please complete the bottom half of this form and return to Streu's Pharmacy Bay Natural or give to your delivery driver to continue your membership in the savings club. If you choose not to participate, you may see a cost increase in your prescriptions. This program will not be used for marketing or promotion of any kind.

I confirm my enrollment in the **Streu's Pharmacy Bay Natural "Streu's RX"** prescription savings club. There is no cost to join.

I decline membership in the **Streu's Pharmacy Bay Natural "Streu's RX"** prescription savings club. I understand I may see an increase in the cost of my prescriptions.

Name [Print]: _____ Date of Birth: ____/____/____

Signature: _____ Date: _____



NOTICE OF PRIVACY PRACTICE (PART 1)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES (PART 2)

Part 1 - SECTION A: Uses and Disclosures of Protected Health Information

The Pharmacy is required by law to maintain the privacy of Protected Health Information (PHI) and Electronic Protected Health Information (E PHI), to provide individuals with notice of our legal duties and privacy practices with respect to PHI and to notify affected individuals following a breach of unsecured PHI. PHI is information that may identify patients and that relates to past, present or future physical or mental health or conditions and related health care services. It may include electronic and computerized information, telephone and cell phone communications, verbal and faxed information. This Notice of Privacy Practices (Notice) describes how PHI may be used and disclosed to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes patient rights with respect to PHI about the patients.

The Pharmacy is required to follow the terms of this Notice and to maintain the storage and access to records to prevent loss, destruction or tampering of information. PHI is not used or disclosed about patients without written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI maintained. Upon request a revised Notice is provided.

The Pharmacy obtains written authorization from the patient before using or disclosing PHI for purposes not described in this notice or as otherwise required by law. This can include for psychotherapy notes, marketing purposes, and disclosures that constitute a sale of PHI. Authorization may be revoked in writing at any time by contacting the Pharmacy at the address listed in Section B. Upon receipt of a written revocation PHI is no longer used or disclosed, except to the extent that action was already taken in reliance on the authorization.

The Pharmacy is permitted to make certain types of uses and disclosures for treatment, payment, and healthcare operation purposes. For treatment purposes, such uses and disclosures are used in providing, coordinating, or managing healthcare and its related services by one or more providers, such as a pharmacist consulting with a physician regarding medications, treatments or conditions.

For payment purposes, such uses and disclosures are used to obtain or provide reimbursement for providing pharmaceutical care services, such as when a case is reviewed to ensure appropriate care was rendered. For reimbursement purposes, PHI may be disclosed to one of several intermediaries including, but not limited to, insurers, pharmacy benefit managers, claim administrators and computer switching companies.

For healthcare operation purposes, such use and disclosure includes for quality assessment and improvement, provider review and training, reviews and compliance activities. This is used in an effort to continually improve the quality and effectiveness of the health care and service provided.

In addition, the Pharmacy may contact patients to provide refill reminders, health screenings, wellness events, vaccinations, information about treatment alternatives or other health-related benefits and services that may be of interest, or by telephone concerning the furnishing of a Medicare-covered item that is to be purchased/received by the patient. The Pharmacy may contact patients for the purpose of fund raising activities, with patients having the option to opt out of such activities. Face to face marketing communications and promotional gifts of nominal value are permitted without authorization.

The Pharmacy may use and disclose PHI, without patient authorizations, when the Pharmacy needs to contact a physician or physician's staff and is permitted or required to do so without individual written consent or authorization. The Pharmacy may use and disclose PHI if contacted by another Pharmacy stating they have the patient's request and consent to transfer Pharmacy records on the patient's behalf.

Business Associates may be used to assist the Pharmacy in providing service for patients. PHI may be shared between the Pharmacy and the Business Associate. Business Associates are required to comply with all federal and state security and privacy rules and regulations.

The Pharmacy may disclose PHI without patient authorization to comply with workers compensations laws, as required by law enforcement, legal proceedings, public health requirements, health oversight activities (such as information necessary for licensure, for the FDA as related to adverse events/product defects, for coroners and medical examiners, correctional institutions when necessary for the health or safety of the patient and others, or to the Federal Department of Health and Human Services (DHHS) to determine our compliance with their standards, and as required by law).



Patients may request restricted uses and disclosures of PHI to carry out treatment, payment, or healthcare operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in the patient's care or payment for care. However, the Pharmacy is not required to agree to the request if the patient is in need of emergency treatment. If, however, patients request a restriction on a disclosure (unless the disclosure is otherwise required by law) of PHI to a health plan for purposes of carrying out payment or health care operations, and if the restriction applies to PHI that pertains solely to a health care item or service for which the Pharmacy has been paid out of pocket in full, the request will be honored.

Patients have the right to request the following with respect to PHI:

- (i) inspection and copying;
- (ii) amendment or correction (amendment requests may be denied if the records were not created by the Pharmacy, are not part of the Pharmacy's records, would not be available for inspection and copying under 164.524 (relating to grounds for denying access to PHI) or if in the Pharmacy's opinion the information contained in the record is accurate and complete);
- (iii) an accounting of disclosures of PHI by us; the Pharmacy is not required to account to patients for disclosures made for treatment, payment, health care operations, disclosures to patients or their personal representative, for notifications or as otherwise excluded by law;
- (iv) an electronic copy of PHI that is maintained electronically in designated record set(s). Pharmacy will provide access in electronic form and format requested, if it is readily producible, or, if not, in a readable electronic form and format as agreed to by the Pharmacy and patient;
- (v) for Pharmacy to transmit copy of PHI (not limited to electronic form) to patients' designee if request is in writing, is signed, and clearly identifies designated person and where it is to be sent;
- (vi) receipt of a paper copy of this Notice upon request.

Requests must be made in writing to the address listed in Section B. Requests must specify the time period of disclosure, which cannot exceed six years. Patients are notified of any cost involved (pharmacy may charge for supplies, cost of electronic media, labor and postage) in providing this information and may choose to withdraw or modify the request at any time. In addition, patients may request, and the request must be accommodated if reasonable, to receive communications of PHI by alternative means or at alternative locations. Contact the Pharmacy as described in Section B with such requests.

The Pharmacy may use patient names to reference prescriptions and pharmaceutical care services. Patients may be required to sign a signature log form or to acknowledge receipt of service, to acknowledge receipt of this Notice and the Patient Bill of Rights and Responsibilities, and the disclosure of PHI as outlined herein. The Pharmacy may disclose this information to other persons who ask for patient prescriptions by name. Patients may restrict or prohibit uses and disclosures by notifying the Pharmacy in writing. The Pharmacy is not required to honor these requests. The Pharmacy provides treatment services, even if patients object to signing the acknowledgement of receipt of this Notice or if the Pharmacy decides not to honor a request regarding the information in this Notice while documenting the patient requests and refusals. In the event of an emergency or patient incapacity, the Pharmacy uses reasonable judgment for what is consistent with patient known preferences, and what is determined to be in the best interest of the patient. Patients are informed of uses or disclosures under such circumstances and given an opportunity to object as soon as practical.

The Pharmacy may disclose to patient's family members, to a relative or close personal friend, or to any other person identified by the patient, PHI that is directly relevant to the person's involvement with care or payment related to care. In addition, unless the patient objects, the Pharmacy may use or disclose PHI to notify, identify, or locate a member of the family, the personal representative, another person responsible for care, or certain disaster relief agencies of the patient's location, general condition, or death. If patients are incapacitated, there is an emergency, or they object to this use or disclosure, the Pharmacy uses its judgment of what is in the best interest of the patient and discloses only information directly relevant to the person's involvement with the healthcare. The Pharmacy uses its judgment and experience regarding the best interest in allowing people to pick-up filled prescriptions or similar forms of PHI.

Patients believing their privacy or security rights have been violated may file a complaint with the Pharmacy at the location described in Section B, with the Office for Civil Rights Regional Manager, US Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601 (800-368-1019) or with the Accreditation Commission for Health Care (855-937-2242). Patients are not retaliated against for filing a complaint.

Section B: Contacting Us

For further information contact: Streu's Pharmacy, Inc., Privacy Officer, 635 Main Street, Green Bay, WI 54301, (920) 437-0206



Part 2 - PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

The Patient has the responsibility to:

Provide information regarding medical history, allergies, medication usage and other pertinent matters related to health status.

Take responsibility for requesting additional information or clarification about health status, treatment, or financial responsibilities when the information or instructions are not clearly understood.

Pay all outstanding financial charges.

The Patient has the right to:

Make decisions prior to and during the course of treatment and to refuse a recommended treatment to the extent permitted by law and to be informed of the medical consequences of this action. In case of such refusal, you are entitled to other appropriate care and services that the pharmacy provides or to receive services from another provider.

Be informed, both orally and in writing, in advance of service provided, of the charges, including payment for service expected from third parties and any charges for which the patient will be responsible.

Considerate and respectful care from your pharmacists, nurses and other pharmacy staff that does not discriminate against you and is in accordance with your physician's orders.

Have your property and person treated with respect, consideration, and recognition of patient dignity and individuality.

Be able to identify staff members through visible proper identification.

Be informed of pharmacy policies and practices that relate to patient service, treatment and responsibilities.

Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client/patient property.

Be informed of available resources for resolving disputes, grievances and conflicts (Refer to Notice of Privacy Practice, Streu's Pharmacy Complaint Form, Streu's Pharmacy Incident/Adverse Event Form).

Report and have investigated grievances/complaints regarding treatment or service, lack of respect of property, and may recommend changes in policy, staff or service without restraint, interference, coercion, discrimination or reprisal. Be informed of option to report Medicare complaints/questions to 1-800-Medicare.

A choice of healthcare providers, including choosing an attending physician.

Talk privately with staff and to have your health care information protected. You also have the right to read and copy your own medical information.

Expect that the pharmacy will maintain the confidentiality and privacy of your Protected Health Information (Refer to Notice of Privacy Practice (NOPP)).

Be advised of policies and procedures regarding the disclosure of information (Refer to NOPP).

Have your rights exercised by the person appointed to act on your behalf, or by the representative you designated to act on your behalf.

Accurate and easily understood information about your health plan, the pharmacy and pharmacy staff.

Have help provided if you speak another language, have a physical or mental disability, or have difficulty understanding the information, so you can make informed health care decisions.

Be informed of pharmacy service limitations and be informed of any financial benefits when referred to another service provider.

This notice is effective September 4, 2013.

3-27-2020



COMPLAINT PROCEDURE

The pharmacists, technicians, and nurses at Streu's Pharmacy pride ourselves in providing safe, accurate and timely pharmacy services to our patients. If you have a concern or complaint regarding our service, please don't hesitate to call a member of our management team. We would be glad to discuss the situation and determine the best possible solution to meet your needs.

Streu's Pharmacy Long-Term Care Hours of Operation:

Monday thru Friday: 7 AM – 10 PM
Saturday: 8 AM – 8 PM
Sunday: 8 AM – 4 PM
Phone: (920) 593-2467
Contact: Matt Ansay, Pharmacist Manager

Streu's Pharmacy Community Pharmacy Hours of Operation:

Monday thru Friday: 8 AM – 7 PM
Saturday: 9 AM – 1 PM
Sunday: Closed
Phone: (920) 437-0206
Contact: John Lemke, Pharmacist Manager

If your complaint has not been resolved adequately following contact with one of our management staff or owners, please refer to the contact information provided below to formulate a formal complaint with one of the following agencies.

Department of Health Services

1 West Wilson Street
Madison, WI 53703
(608) 266-1865
TTY phone number: 888-701-1251
Pharmacist Consultant: Doug Englebert (608) 266-5388 (M-F 8-4 PM CST)

Accreditation Commission for Health Care

139 Weston Oaks Court
Cary, NC 27513
855-937-2242
Hours of Operation: Mon-Fri 8-5 PM EST



BILLING INFORMATION FORM

PURCHASE AGREEMENT

The patient agrees to purchase the items described on the Medicare Billing Form or the Billing Permission Form.

Products sold to patient were inspected for defects, structural integrity and appropriateness for patient.

The patient agrees to pay Streu's for the equipment at the purchase price listed on the form.

If patient has a Streu's charge account-The purchase price and any other costs to be paid (taxes, etc.) are due and payable to Streu's within thirty (30) days of receipt of invoice. If no Streu's charge account- items are paid for at point of sale. If payments are not made in accordance with the terms and conditions of this document, Streu's may repossess the equipment without notice to the patient. A finance charge of 1.75% of unpaid balance per month may be added if full payment is not received on or before the payment due date.

Returns are subject to the following conditions:

- (vii) Returns must be made within 7 days of purchase.
- (viii) Returns are for substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and sold).
- (ix) All returns must be approved by the store manager or Medicare Specialist.
- (x) The customer's copy of the billing form must accompany all refunds or exchanges.

Additional manufacturer's warranties may be available on some products. Refer to the manufacturer's product warranty information for details.

FINANCIAL POLICY

It is the patient's responsibility to provide all insurance information including Medicare and Medicaid at the time of service rendered. The patient authorizes payment of benefits be made to them or directly to Streu's for products or services provided. The patient is financially responsible for any and all charges not covered by insurance. An installment account may be an option when payment of the balance due would present a financial hardship. Streu's does not guarantee coverage of any services.

RELEASE OF LIABILITY

Streu's assumes no responsibility for the suitability of the purchased equipment for any particular condition of or the success/failure of any treatment/therapy performed with the equipment. The patient does hereby release Streu's from any liability for damages that may occur as a result of the use of the equipment.

MEDICARE PRIVACY STATEMENT

The legal authority for the collection of information on the billing form(s) is authorized by section 1869 (a)(3) of the Social Security Act. The information provided is used to further document patient claims. Submission of the information requested on the form is voluntary, but failure to provide all or any part of the requested information may affect the determination of a claim. Information furnished on billing forms may be disclosed to the Centers for Medicare & Medicaid Services or another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.

MEDICARE CAPPED RENTAL AND INEXPENSIVE OR ROUTINELY PURCHASED ITEMS NOTIFICATION

Streu's does not provide capped rental items, or rent any inexpensive or routinely purchased items. Equipment can be rented from another provider; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount. Patient understands Streu's only offers the purchase option for equipment.



MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment. (The Pharmacy does not rent any equipment.)
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial, or control interest in the supplier.



18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics. (Last updated by CMS 2/8/16; Palmetto GBA



EAGLES HOUSE LIVING CENTER

POSSESSIONS AT DISCHARGE

_____ has received all personal possessions and does not have any personal items
Resident Name
remaining at Eagles Living Center

Client Signature

Date

Staff Signature

Date

Medications Released at Discharge:



EAGLES HOUSE LIVING CENTER

RESIDENT EXPECTATIONS (resident 16 and older)

Residents will be required to assist with maintaining and caring for their home

Residents must complete a total of 40 hours per week through a combination of the following activities:

- Community Services (therapy, medical appt, tutoring, mentor)
- Site identified Job
- Attending school
- Programing

Residents will be required to apply for the following:

- Employment
- Community Resources

Residents will be required to follow all household agreements as all intakes are a 30 day trial for permit placement

Residents will be required to participate in developing their individualized plan with goals that will be reviewed regularly for progress to include the following areas:

- Financial education and planning
- Interpersonal Relationships
- Cooking/home maintenance skills
- Transportation
- Health and Wellness
- Employment/job skills
- Education



The Eagles House Living Center program is voluntary and aims to prepare youth for success as they transition to adulthood. To be prepared for success in jobs, school and adult living participants will also be evaluated on the following every month:

- **Attendance and punctuality for scheduled meetings:** arrives on time, keeps appointments
- **Cooperation:** comes prepared to meetings, cooperates with suggestion and direction from team
- **Communication skills:** stays on task, able to interact appropriately, communicates in a respectful and positive manner.
- **House Responsibilities:** performs house duties regularly and timely.
- **Employment:** maintains a job, reports hours and shares work schedule
- **School:** attends all classes, maintains C grade or better
- **Program fees:** pays required fees on time
- **Financial Literacy:** meets with financial educator, follows financial plan, maintains and grows savings, pays bill on time



MEANINGFUL ACTIVITY

Eagles House Living Center requires all residents to participate in **40 hours of meaningful activity per week**. These activities may include employment, school, job searching, or working on your individual goal plan.

Meetings with probation or parole officers, case managers, mentors, participation in AODA recovery groups, and treatment court sessions also count toward the 40-hour requirement.

If you are not currently employed, you are expected to engage in **education, therapy, job searching and community service** to fulfill your hours. (Staff are available to help you identify suitable community service opportunities.)

Time sheets will be provided for you to record and track your weekly hours. I realize that Eagles House Living Center will give a 30 day notice if I do not show progress and towards my goals, consistently follow house rules or damage property.

Resident Signature

Date

Case Manger Signature

Date

Guardian or Parent Signature

Date