GF0000671114 GX00051806
HALL,ANNIE D
06/03/1950 65 F 07/11/15

[illegible]

GUARANTEE OF PAYMENT/ASSIGNMENT OF BENEFITS

[illegible] consideration of the hospital's [illegible] assign and transfer to Southwest Georgia Regional Medical Center all benefits and payments [illegible] payable [illegible] to become due and payable to me or anyone legally responsible for me or on my behalf under [illegible] policy or policies, under any replacement policies thereof, under any self-insurance program [illegible] any other benefit plan or program including [illegible] Medicare [illegible]

I understand and acknowledge that this assignment does not relieve me of my financial responsibility for all hospital charges incurred by me or anyone on my behalf, and I hereby accept such responsibility, including but not limited to payment of those fees and charges not directly reimbursed to the Hospital by any Benefit plan or program. I understand and agree that in order to service my account or to collect any amounts I may owe, the Hospital and/or any contractors working on its behalf may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. I further understand and agree that the hospital or any contractors working on its behalf may contact me using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Furthermore, I agree to pay all costs of collection, reasonable attorneys' fees and court costs incurred in enforcing this payment obligation.

AUTHORIZATION TO PROCESS CLAIMS AND RELEASE OF INFORMATION:

I authorize Southwest Georgia Regional Medical Center to process claims for payment by my insurance carrier on my behalf for covered services provided to me by Southwest Georgia Regional Medical Center. To the extent permitted by law, I authorize any overpayments made on my behalf to be applied to other outstanding accounts for which I am responsible. I authorize the release of necessary information, including medical information, regarding medical services rendered during this admission or any related services or claim, to my insurance carrier(s), including any managed care plan or other payor, past and/or present employer(s), Medicare, CHAMPUS/TRICARE, authorized private review entities and/or utilization review entities acting on behalf of such insurance carrier(s), payers, managed care plans and/or employer(s), the billing agents and collection agents or attorneys of, Southwest Georgia Regional Medical Center my employer's Worker's Compensation carrier, and, as applicable, the Social Security Administration, the Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency for the purposes(s) of satisfying charges billed and/or facilitating utilization review and/or otherwise complying with the obligations of state or federal law. Authorization is hereby granted to release health record data and/or copies to my attending and/or admitting healthcare professional and/or any consulting healthcare professional and/or any healthcare professional I may be referred to for follow-up care. I further authorize Southwest Georgia Regional Medical Center to obtain from any source medical history, examinations, diagnoses, treatments and other health or insurance authorization information for the purpose(s) of satisfying charges billed and/or facilitating utilization review, providing medical treatment and/or the evaluation of such treatment, and/or otherwise complying with the obligations of state or federal law. I consent to the use of an automatic telephone dialing system and/or pre-recorded messages in contacting my home and cell phones. A photocopy of this Authorization may be honored.

AUTHORIZATION OF REPRESENTATION:

To the extent authorized under my insurer or other third party payor or benefits agreement and by applicable law, in order to assist me in obtaining my benefits, I authorize and appoint Southwest Georgia Regional Medical Center to act as my representative, when it consents in writing to so act, in appealing any adverse benefit determination and to receive notices on my behalf with respect to same. I agree that I will comply with procedures established by the benefit plan relating to this authorization, if any.

SIGNED: Annie Hall by [signature] Hall — Daughter — 7-11-15
Patient/Patient's Representative — Relationship if other than self — Date

WITNESS: [signature]

Reason If Unable to Sign: ______________________

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ACKNOWLEDGEMENT FORM FOR NOTICE OF PRIVACY PRACTICES

If someone calls or visits and asks about you can we acknowledge that you are here?

Yes ✓ No ______

Who can we communicate with regarding your bill and other financial information necessary for us to get paid for providing services to you?

1) ______________________ 2) ______________________

Patient Signature: X Annie [illegible] Hall by [illegible]

Patient Name (Printed): Annie Hall

Date: 7-11-15

If patient is unable/unwilling to acknowledge receipt or is a minor, complete the following:

Patient is: ____ A minor

____ Unable to acknowledge receipt

____ Unwilling to acknowledge receipt

Signature of Personal Representative (if applicable): ______________________

Personal Representative's Name (Print): ______________________

Relationship to Patient: ______________________

Reason Patient Is Unable to Sign: ______________________

By initialing, you have indicated that you want to receive a paper copy of this form.

______________________ (Initials)

______________________ (Date)

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1. CONSENT AND TREATMENT AUTHORIZATION:

[illegible] (SGRMC).

This consent to receive medical treatment includes, but is not limited to, examinations (by imaging or otherwise), laboratory procedures, medications, infusions, anesthesia, surgical procedures and medical treatment, radiation therapy, and other services which Patient may require. The undersigned also consents to the disposal, at the hospital's discretion, of any tissues, specimens or body parts which may be removed.

The undersigned understands that Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals ("Healthcare Professionals"). While routinely performed without incident, there may be material risks associated with each of these Procedures. The Healthcare Professionals participating in the patient's care will rely on documented medical history, as well as other information obtained from the Patient or Representative in determining whether to perform or recommend the Procedures; therefore, the undersigned agrees to provide accurate and complete information about the Patient's medical history and conditions and to advise if any information requested is unknown to the undersigned. The undersigned understands that consent for any test or procedure may be withdrawn.

This consent to receive medical treatment includes, but is not limited to, transfusions of blood and blood products.

AH by [illegible] (Initial)

2. PHOTOGRAPHS, VIDEOTAPE AND RECORDINGS:

Physicians or staff may take photographs, videotapes or other recordings of the Patient for purposes of ensuring proper patient identification or for medical documentation or treatment purposes. The undersigned consents to such photographing, videotaping, and/or recording for these purposes. The undersigned further acknowledges that such photographs, videotapes and recordings and related information may be used for internal operations purposes including, but not limited to, medical education, training programs, quality assessment and improvement activities, outcomes evaluation, case management, and related functions that do not include treatment. The undersigned understands that such photographs, videotapes and recordings will be maintained in a secure manner and will not be disclosed for external use, except upon written authorization from the Patient or an authorized representative or as otherwise permitted by law.

3. RISKS AND DISCLAIMER OF GUARANTEES:

The undersigned hereby acknowledges that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risk of adverse results and injury. The undersigned hereby acknowledges that no guarantees have been made as to the result of procedures, which Patient may undergo while hospitalized at SGRMC or receiving services as an outpatient of SGRMC. The undersigned also acknowledges that he/she may be asked to sign separate consents for certain procedures or treatments.

4. ACKNOWLEDGEMENTS BY PATIENT/AUTHORIZED DECISION MAKER:

The undersigned understands that:

(a) It is customary, absent emergency or extraordinary circumstances, that the undersigned will have an opportunity to discuss Procedures with the physician or other health professionals so that the undersigned may be informed of the contemplated procedures and determine whether to accept the recommended course of treatment.

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[illegible]

5. STATUS OF PRACTITIONERS/INDEPENDENT CONTRACTOR:

[illegible]

6. TEACHING ACTIVITIES:

The undersigned recognizes that among those who may attend Patient at SGRMC are medical, nursing and other health care personnel who are in training and who, unless specifically requested otherwise, may be present and participate in Patient care activities as part of their medical education.

7. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

Authorization is hereby granted to SGRMC to release to Patient's insurance company or other companies, their agents, or other third party payors, confidential or other information concerning the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the patient or any minor children (including copies of records) as may be requested or necessary for the purpose of claim processing relating to Patient's hospital bills.

This authorization shall include information about drug/alcohol/chemical addiction or treatment, psychiatric conditions, AIDS, HIV and other privileged information.

8. RELEASE FROM RESPONSIBILITY FOR PERSONAL EFFECTS:

The undersigned understands that SGRMC provides facilities for the safekeeping of valuables, available upon request, and hereby releases SGRMC from any responsibility due to loss or damage of any personal effects that Patient may keep in his or her possession, or that may be brought to Patient by other persons.

9. PATIENT/REPRESENTATIVE CERTIFICATION:

Patient, or the undersigned representative authorized to act on Patient's behalf, hereby certifies that this form has been understood and read and that satisfactory explanations have been given for any questions asked. If this form is signed by Patient's representative then such representative hereby certifies that he/she has the legal right to consent for the Patient, and agrees to indemnify (hold harmless) SGRMC from any liability to Patient arising from such representative's actions in signing this form on Patient's behalf.

10. VALIDITY OF FORM:

Patient hereby authorizes that a copy of this document may be used in place of and is as valid as the original.

7-11-15 [illegible]
Date and Time of Registration

X Annie Doris Hall by [signature]
Patient/Representative

☐ Patient's Mark

[signature]
Witness

Daughter
Relation to Patient

MFP Authorization For Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Georgia and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Member Name: Annie Hall

Medicaid ID #: 222112296795

Health Plan Name: Medicaid

Persons/Organizations authorized to *receive, use or disclose* the information [i] are:

- ☑ MFP Field Personnel *
- ☑ Waiver assessment/case management staff *
- ☑ My Representative (Legal, etc.) *
- ☑ MFP service providers (Peers, Ombudsman, etc.) *

* *Personnel located in Georgia and in the state to which you are transitioning.*

Purpose of requested use or disclosure: [ii] for screening and assessment and participation in MFP. This Authorization applies to the following information (select ***only one*** of the following):[iii]

☑ All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] **Except:** ______________________________

☐ **Only** the following records or types of health information (including any dates). This may consist of psychotherapy notes, if specifically authorized:

____

____

EXPIRATION

All information I hereby authorize to be obtained from this inpatient facility will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for: (PLEASE CHECK ONE)

☐ ninety (90) days unless I specify an earlier date here: ______________________________

☐ one (1) year

☑ the period necessary to complete transactions related to my participation in Money Follows the Person on matters related to services provided to me through Money Follows the Person.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Money Follows the Person
Informed Consent for Participation

I, Annie Hall, (print name) voluntarily agree to be screened and assessed as part of my application for participation in the Money Follows the Person (MFP) project[i]. MFP Field Personnel will determine my appropriateness for the project. If approved for the MFP project, my participation may be in segments or consecutive days, but for a total period not to exceed 365 calendar days[ii].

By signing this Informed Consent, I agree to participate in all aspects of the MFP project, including completing the *Quality of Life Survey*. My responses to the *Quality of Life Survey* and other program information will be shared with the Centers for Medicare and Medicaid Services (CMS) as well as Georgia and national evaluators.

I have been given information about the MFP project; a copy of the MFP Brochure and a copy of the *Home and Community Services, A Guide to Medicaid Waiver Programs in Georgia* booklet. I understand the MFP project guidelines including enrollment requirements. I understand that MFP one-time transitional services are provided under the MFP demonstration project.

I understand that if I qualify for and am enrolled in an appropriate waiver program, waiver services will continue for as long as I need them and I continue to meet eligibility requirements. If I am no longer eligible for the Medicaid waiver program, I will be provided with other service options that may assist me in a community setting. I understand that certain circumstances will make me ineligible for a waiver and for MFP. If the total cost of providing my care under the waiver exceeds the cost of providing care in an inpatient facility, I will become ineligible for the waiver and for the MFP project. If my condition improves and I don't continue to meet the waiver Level of Care criteria, I will become ineligible for the waiver program and may become ineligible for the MFP project.

[signature] 2/23/15

Signature **Date**

If signed by Responsible Party, State Relationship and Authority to Sign

Melissa Pence 2/23/15

MFP Field Personnel Sign **Date**

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[i] Deficit Reduction Act of 2006, Money Follows the Person Demonstration P.L. 109-171, Title VI, Subtitle A, Chapter. 6, Subchapter B, Sec 6071, 120; as amended by the Affordable Care Act of 2010, P.L. 111-148, Title II, Subtitle E, Sec 2403(a), (b)(1), 124 Stat. 304

[ii] If the MFP participant needs to be readmitted to an inpatient facility for a period of 30 days or less, the participant remains enrolled in the MFP demonstration. As soon as the participant's condition stabilizes, the participant can return to the community and resume services. When an MFP participant is readmitted into an inpatient facility for a period of time greater than 30 days (31 days or longer), the participant is discharged from the MFP demonstration and is considered an institutional resident. However, the discharged MFP participant will be re-enrolled, prior to the completion of 365 days, back into the demonstration without re-establishing the 90-day institutional residency requirement. The individual is considered an MFP participant when discharged from the inpatient facility, and is eligible to receive MFP services for any remaining days up to 365. MFP field personnel determine if any changes to the participant's Individualized Transition Plan are needed to prevent a re-admission to an inpatient facility. If the participant is readmitted to an inpatient facility for a period of longer than six months, the participant will be re-evaluated like a "new" MFP participant.

MFP Authorization For Use or Disclosure of Health Information

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: ______________________________

____

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.[iv]

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.[v]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

X Lee Nola West 2/23/15

Signature of Member or Authorized Representative Date

____

If Signed by Representative, State Relationship or Basis of Authority

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[i] If the Authorization is being requested by the entity holding the information, this entity is the Requestor.

ii The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

[iii] This form may not be used to release both psychotherapy notes and other types of health information *(see 45 CFR § 164.508(b)(3)(ii))*. **If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.**

[iv] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see 45 CFR § 164.508(d)(1), (e)(2))*.

[v] If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. **Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.**

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

JOE ANNE BURGIN NURSING HOME

PATIENT NAME: Annie D. Hall TELEPHONE: ____________________

DOB: 06/03/1950

ADDRESS: ____

I hereby authorize Joe Anne Burgin Nursing Home to release information concerning the diagnosis, treatment, and prognosis with respect to any physical condition or mental condition and/or treatment of me or my minor child to:

NAME: ____

ADDRESS: ____

The following information to be used or disclosed:

( ) HISTORY AND PHYSICAL
( ) DISCHARGE SUMMARY
( ) OPERATIVE NOTES
(✓) LABORATORY REPORTS
( ) PATHOLOGY
( ) X-RAYS
( ) DOCTOR ORDERS
( ) PROGRESS NOTES
( ) EMERGENCY ROOM RECORDS
( ) OTHER ________________

APPROXIMATE DATE OR DATES OF SERVICE: April and May 2015

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

I understand the information obtained by use of this authorization will be used for the purpose of

( ) CONTINUITY OF CARE
( ) LEGAL SERVICES
( ) MY PERSONAL RECORDS
( ) BILLING/INSURANCE
( ) DISABILITY
( ) OTHER ________________

This authorization is subject to revocation. Without prior revocation, this authorization will automatically expire 90 days from the date thereof. I understand that once the above information has been disclosed, it may be re-disclosed by the recipient and the information may not be protected by laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

[signature] May 29, 2015

Signature of patient or legal representative Date

[signature] 5/29/15

Witness Date

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Nathan Deal, Governor | Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

December 8, 2014

Lee Nola West
P.O. Box 441
Georgetown, GA 39854

Joe-Anne Burgin Nursing Home
321 Randolph Street
Cuthbert, GA 39840-3129

RE: ANNIE HALL/ROSA HALL
Complaint #: GA00146318

Dear Lee Nola West:

This is to acknowledge receipt of your complaint. The complaint has been referred to the Long Term Care Section of the Healthcare Facility Regulation Division (HFRD) for review. First, we must determine if your complaint raises issues that are within our regulatory authority to oversee as outlined in state and/or federal regulations. If so, a member of our staff will investigate the complaint. If we do not investigate your complaint for some reason, we will write you and let you know why. If we determine that your complaint would be more appropriately addressed by another entity, we will provide contact information.

If a determination is made that an on-site investigation is required, the visit will be unannounced and your identity will remain confidential, unless you have granted permission to us to divulge your identity. Investigations are conducted by professional surveyors who are qualified to interpret the rules and regulations that apply to the facility. The surveyors will, as appropriate, review records, conduct interviews, and observe activities related to your concerns. If the surveyor/s are able to find evidence to support your concerns or evidence that similar situations have occurred with others receiving similar services, state and/or federal violations may be cited. When HFR cites a facility for failing to meet state and/or federal rules and regulations, the facility submits a plan of correction, and depending upon the severity of the violation, follow-up surveys may be conducted and enforcement actions considered.

After the investigation is completed, you will be notified in writing of the outcome of the investigation. However, because of federal confidentiality laws, personal health information will not be provided.

The surveyor may attempt to contact you during the course of the investigation. In the meantime, if you have any additional information or questions regarding this complaint, please call the Long Term Care Section at 404-657-5850 or send written reports to:

Long Term Care Section, Complaint Unit
Healthcare Facility Regulation Division
Two Peachtree Street, N.W. Suite 31-447
Atlanta, Georgia 30303-3167
Fax Number (404) 657-8935

Thank you for notifying us about your concerns. Be assured that our office is committed to monitoring facilities to ensure that individuals are receiving care in accordance with applicable regulations.

Sincerely,
Complaint Intake and Referral Unit
Healthcare Facility Regulation Division

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Clyde Reese, Commissioner **Nathan Deal, Governor**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

March 12, 2015

Lee Nola West
P. Box 441
Georgetown, Ga. 39854

RE: GA00146318/ Joe-Anne Burgin Nursing Home

Dear Ms. West,

The Georgia Department of Community Health (DCH) acknowledges receipt of your Open Records Act Request, 33703, dated March 9, 2015. You have requested a report of the findings on complaint # GA00146318. You have requested certain federal records that we are not authorized to release, pursuant to O.C.G.A. Sec. 50-18-72(a)(1) and Section 1864 of the Social Security Act and the CMS state operations manual. Specifically, we are not authorized to release complaint face sheets, because we investigated these complaints on behalf of CMS for federal certification and survey activity, you must file a freedom of information act (FOIA) request with CMS to obtain them. Here is the link to the web site where you can obtain contact information for region IV; http://www.cms.gov/center/freedom-of-information-act/regional-comtacts.html. You may access additional information concerning FOIA issues by visiting www.cms/gov/FOIA. Click on region IV. If you have questions regarding the FOIA process, you may contact Bobby Cobb at 404-562-7445. This concludes fulfillment of your Open Records Act Request 33703.
Please contact us at HFRDOpenRecords@dch.ga.gov if you have any questions about this request.

Thank you,

Rochelle Stembridge
Healthcare Facility Regulation Division