The Lexington
You're home.

5550 Pioneers Blvd. | Lincoln, NE 68506 | 402.486.4400 | Fax 402.486.4441 | julie@thelexington.com

Thank you for choosing The Lexington Assisted Living for your new home!

As you begin to prepare for your move, let us know if you have questions or need a floor plan for room measurements. The Lexington has been long-standing members of the College View Neighborhood in the Lincoln community and we are located on the Star Tran Southpointe #53 bus route. We are exceptionally proud to be an accredited member of the Business Bureau with an A+ Rating. We have also been nominated one of the TOP 5 Senior Living Communities in Lincoln! We're here to help you! Below is a list of suggested items to bring with you to make your move as smooth and as comfortable as possible.

1. Shower curtain to help personalize your bathroom. If you bring a bath mat, be sure it is slip resistant. Showers are standard size and are walk-in. We suggest you use a shower chair or bench during showers.
2. Two (2) sets of sheets. We can change and launder the sheets weekly. Residents can have assistance with bathing twice a week and laundry once a week. We strongly recommend that you bring size appropriate bed spread or comforter. If the bed is a double size, please use double-size spread or comfortable. Bedding that hangs over the bed onto the floor is a serious tripping hazard.
3. Two (2) sets of bath towels, hand towels and washcloths so that you have a clean set when the other set is being laundered.
4. Personal toiletries. The General Store also carries personal care items you can purchase such as toilet paper, Kleenex, paper towels, etc.
5. Light bulbs for personal lamps. We furnish and replace bulbs for the built-in light fixtures in the apartment.
6. Curtains for the windows. We suggest a tension rod so you can hang curtains right away. We provide the blinds for the windows. **Windows measure 48" wide by 60" high.**

We appreciate your interest in The Lexington Assisted Living and we look forward to the opportunity to be of service to you. If you have any questions about the application packet or our admission policies and procedures, please do not hesitate to contact me.

Sincerely,
Eldonna Rayburn, Executive Director

FEDERAL CIVIL RIGHTS NOTICE OF NON-DESCRIMINATION

(APPLICANT COPY)

The Lexington Assisted Living Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Lexington does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Lexington provides free aids and services to people with disabilities to communicate effectively with us, such as Qualified sign language interpreters, Written information in other formats (large print, audio, accessible electronic formats, other formats) and Provides free language services to people whose primary language is not English, such as Qualified interpreters and information written in other languages. If you need these services, contact Candice Herzog, Administrator. If you believe that The Lexington has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

- **Candice Herzog, Administrator**
- **5550 Pioneers Blvd, Lincoln, NE 68506**
- **Phone: (402) 486-4400 or Fax: (402) 486-4441**
- **Email: Candice@TheLexington.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Candice Herzog, Administrator, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-308-995-4493 (TTY: 1-800-833-7352).

Language Assistance Taglines

State of Nebraska

Language (Ranking)	In-Language Translation
Spanish Español (1)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-308-995-4493 (TTY: 1-800-833-7352).
Vietnamese Tiếng Việt (2)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-308-995-4493 (TTY: 1-800-833-7352).
Chinese 繁體中文 (3)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-308-995-4493（TTY：1-800-833-7352）。
Arabic العربية (4)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-833-7352 (رقم هاتف الصم والبكم: 1-308-995-4493).
Karen unD (5)	[illegible] 1-308-995-4493 (TTY: 1-800-833-7352).

Language Assistance Taglines

State of Nebraska

Language (Ranking)	In-Language Translation
Nepali नेपाली (10)	ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-308-995-4493 (टिटिवाइ: 1-800-833-7352)
Russian Русский (11)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-308-995-4493 (телетайп: 1-800-833-7352).
Laotian ພາສາລາວ (12)	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-308-995-4493 (TTY: 1-800-833-7352).
Kurdish کوردی (13)	ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆرایی، بۆ تۆ بەردەستە. پەیوەندی بە 1- 800-833-7352 TTY (1-308-995-4493) بکە.
Persian (Farsi) فارسی (14)	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-308-995-4493(TTY: 1-800-833-7352) تماس بگیرید.
Japanese 日本語 (15)	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-308-995-4493（TTY:1-800-833-7352）まで、お電話にてご連絡ください。
English	ATTENTION: If you need language assistance services, it is available to you free of charge. Call 1-308-995-4493 (TTY: 1-800-833-7352).
Karen unD (5)	ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်ဆယိ, နမၤစ့ိာ်ဆတၢ်မၤစၢၤလၢတလၢာ်ဘွဉ်လာ်စု၊ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-308-995-4493 (TTY: 1-800-833-7352).
French Français (6)	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-308-995-4493 (ATS: 1-800-833-7352).
Cushite (Oromo) Oroomiffa (7)	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-308-995-4493 (TTY: 1-800-833-7352).
German Deutsch (8)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-308-995-4493 (TTY: 1-800-833-7352).
Korean 한국어 (9)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-308-995-4493 (TTY: 1-800-833-7352) 번으로 전화해 주십시오.

The Lexington

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Application for Residency

Please use BLACK INK ONLY!

Name_____ Date _____

Address_____

City, State, Zip_____ Phone (____)_____

Date of Birth_____/_____/_____ Age_____ Social Security #_____-_____-_____

Gender: ❑ M ❑ F Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Ethnicity: ❑ Hispanic or Latino ❑ Non-Hispanic or Latino Birthplace: _____

Race: ❑Caucasian ❑African American ❑Hispanic ❑Native American ❑Asian ❑Other:_____

Disabled: Yes ❑ No ❑ U.S. Citizen: Yes ❑ No ❑ Student: Yes ❑ No ❑

Former Occupation: _____

Present Living Arrangements: ❑House ❑Apartment ❑Alone ❑Other: _____

Primary Contact for Application

Name_____ Relationship_____

Address_____ City, State, Zip_____

Phone _____Work _____

Email _____

*Financial Power of Attorney (POA): _____*Medical POA: _____

*Guardianship: Name: _____ Phone: _____ ❑ NA

*Conservatorship: Name: _____ Phone: _____ ❑ NA

***PLEASE ATTACH COPIES OF POA, GUARDIANSHIP, AND/OR CONSERVATORSHIP, IF APPLICABLE.**

Who will receive the bill each month? Prefer: ❑ Email ❑ Mail ❑ Deliver to Resident Apartment

Name _____ Address_____ City, State, Zip_____

Phone _____ Work _____

Email _____

Emergency Contacts

Please list below, in the order you want us to contact them, the names of individuals you want us to contact in case you experience an emergency while living at The Lexington. 1st Contact should be the POA.

1st Contact Name: _____ Relationship_____

Address_____ City/State/Zip_____

Home _____ Work _____ ❑ I consent to text notifications.

Email _____ ❑ I consent to email notifications.

Release Confidential Medical Information to 1ST Contact: Yes ❑ No ❑

2nd Contact Name: _____ Relationship_____

Address_____ City/State/Zip _____

Home _____ Work _____ ❑ I consent to text notifications.

Email _____ ❑ I consent to email notifications.

Release Confidential Medical Information to 2nd Contact: Yes ❑ No ❑

Physician Information

Primary Care Provider: _____ MD PA NP

Clinic Name _____

Address_____

Phone _____ Fax _____

Specialty Physician & Clinic_____

Address_____

Phone _____ Fax _____

Insurance Information

Medicare #_____ Medicaid #_____

Medicare Part B $_____ Medicare Supplement Plan $_____ Prescription Drug Plan $_____

Medicaid Waiver Coordinator_____ Phone_____

Veteran's Administration # (if applicable) _____

Supplemental Health Insurance Carrier _____Policy#_____

Prescription Drug Insurance Plan _____Policy#_____

Religious Preference_____Clergy Name_____Phone _____

Funeral Home _____ Address_____

Hospital Preference (Circle one): ❑ Bryan East ❑ Bryan West ❑ Saint Elizabeth's ❑ VA

Diagnoses_____

Allergies _____

II. PHYSICAL STATUS

1. Are you able to walk without assistance? Yes ❑ No ❑

Cane: Yes ❑ No ❑ Walker: Yes ❑ No ❑ Wheelchair: Yes ❑ No ❑ Power Chair: Yes ❑ No ❑

Explain difficulties_____

2. Are you able to bathe without assistance? Yes ❑ No ❑

Explain difficulties_____

3. Are you able to dress without assistance? Yes ❑ No ❑

Explain difficulties_____

4. Are you able to eat without assistance? Yes ❑ No ❑

Explain difficulties_____

5. Are you able to handle all of your toileting needs without assistance? Yes ❑ No ❑

Explain difficulties_____

6. Other information regarding physical status: _____

III. FINANCIAL / OTHER INFORMATION

1. Do you have any outstanding debts that exceed $500? Yes ❑ No ❑

Please explain _____

2. Have you ever been evicted? Yes ❑ No ❑

Please explain _____

3. Have you ever been convicted of a felony? Yes ❑ No ❑

Please explain _____

Conduct Declaration: I declare that I have disclosed any conduct and/or behavior that may impact other Residents and/or staff at The Lexington. Conduct/behavior may include wandering, smoking/vaping, criminal conduct, aggression, inappropriate dress outside of one's apartment, inappropriate and/or discriminatory language, hoarding, refusing to comply with rules and guidance, etc. Furthermore, I certify that all information contained on this application is correct and complete to the best of my knowledge, and that any misrepresentation of material will result in my being ineligible for admission or possible eviction after admission. I agree to give The Lexington Assisted Living Center the authority to investigate any income and/or asset sources necessary to determine eligibility and to verify the above stated information.

_____ _____

Applicant/Responsible Party/POA Signature Date

****

It is illegal to discriminate against any person(s) based on race, religion, sex, national origin, familial status, sexual orientation or handicap.

Apartment Cable Verification

The Lexington Assisted Living Center purchases a bulk rate for cable. We pass on the reduced rate of **$** to Residents who would like to receive the cable service for their TV. Residents choosing this Cable, will have the rate added to the monthly statement. Cable rates are subject to change with notice. The Lexington will alert Residents when cable rates will change. We will connect cable and program the remote for you.

Please check the appropriate box indicating your choice.

☐ I **WANT** cable services in my apartment. Apartment #

☐ I **do NOT want** cable services in my apartment.

If you **do not want** cable services you will need to purchase an analog converter for your television if you DO NOT have an HD television.

If you want the cable TV service billed to someone else, please provide the following information.

Print Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Applicant/Responsible Party/POA Signature: _____

Date: _____

1/2020

Medical and Personal Consents

Instructions: Please check the following items you consent to and sign below.

☐ **Release Medical Information:** I hereby authorize any physician, clinic, hospital, healthcare provider, or related entity to answer fully any request from The Lexington Assisted Living for medical or psycho-social information concerning me while I am an applicant for residency, or while I am a resident at The Lexington.

☐ **Resident Consent to Release Medical Information:** I hereby authorize The Lexington Assisted Living to release my condition to the following people IF THEY INQUIRE ABOUT MY HEALTH STATUS. Please **PRINT NAME** and **RELATIONSHIP**. Use back of page if necessary.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

☐ **Photo Release:** I consent to The Lexington Assisted Living to take photographs of me and, in such cases, use them for advertisement purposes which may include but are not necessarily limited to magazines, news-papers, brochures, and The Lexington website or Facebook page. A photograph of the Resident will be taken for the chart and medication records.

☐ **Signature Authorization:** I consent to The Lexington Assisted Living to allow staff to sign for deliveries and then deliver the appropriate package and/or supply to the Resident. Deliveries may include flowers, mail and/or packages, Federal Express and UPS deliveries, oxygen and/or medical supplies, and medications that need to be signed for to show that delivery has been made. Delivery drivers do not deliver to the apartment.

☐ **Telehealth Authorization**: I consent to the delivery of healthcare services via Telehealth originated by my licensed provider in lieu of going to the provider's office. I understand that if non-public facing remote communication is not available, telehealth cannot be used.

☐ **Reference Check:** I understand that as a condition of my admission, a reference check of my current and prior living arrangements may be completed.

_____ _____
1st Reference Name Phone

_____ _____
2nd Reference Name Phone

I consent to the items checked above.

PRINT Name: _____ Date: _____

_____ _____ _____
Signature Date of Birth Social Security #

Direction of Health Maintenance Activities

I _____ (please print name) direct the unlicensed staff of The Lexington Assisted Living Center to perform the following health maintenance activities during my residence:

_____ Vital signs (monitored and performed at least monthly or as ordered by physician).

_____ Weight checks (monitored and performed at least monthly or as ordered by physician).

_____ Glucose monitoring (as directed by physician).

_____ Skin monitoring (monitored on a daily basis by medication aides and/or resident assistants).

_____ Application of TED hose/compression stockings, leg wraps.

_____ Assist with filling of oxygen tanks/CPAP

_____ Other _____

ACCEPTANCE OF DIRECTION AND MONITORING

Direction and monitoring means the ACCEPTANCE OF RESPONSIBILITY for observing and taking appropriate action regarding desired effects, side effects, interactions, and contraindications associated with medication. Direction and Monitoring can be done by:

a. Recipient with capability to make informed decision about the medications for himself/herself.
b. Recipient – specific caretaker
c. Licensed Healthcare Professional
d. The person taking responsibility for providing direction and monitoring of my medication will be:

_____ Self (resident)

_____ Care Taker _____

_____ The Lexington Certified Healthcare Professional_____

_____ _____

Applicant/Responsible Party/POA Signature Date

_____ _____

Facility Representative (signature and title) Date

Rev. 1/2019

Consent for Criminal Background Investigation Report

I understand that as a condition of my admission, a criminal background and sex offender investigation shall be completed. My name will be checked against law enforcement or related entity registries. A check of these registries is necessary to ensure that I meet provider standards.

To the best of my knowledge, I do not have any misdemeanor or felony convictions, or any prior criminal history; nor have I been convicted of a crime involving moral turpitude or a crime of sexual offense.

I hereby state the information contained below is accurate. Additionally, I authorize The Lexington Assisted Living Center to obtain a criminal background and sex offender history as well as authorize any and all law enforcement or related agencies to release such information to:

The Lexington Assisted Living Center
5550 Pioneers Blvd | Lincoln, NE 68506
(402) 486-4400 Phone | (402) 486-4383 Fax

PRINT Full Name of Applicant _____

Date of Birth _____ _____
Social Security Number

_____ _____
SIGNATURE Applicant/Responsible Party/POA Date Signed

Request authorized by: Julie Andresen, Leasing Director, or Eldonna Rayburn, Executive Director

Signature: _____ Date Submitted _____

Please complete and return to The Lexington.
The Lexington will contact Nebraska State Patrol.

Nebraska State Patrol:
*** PLEASE RETURN RESPONSE VIA FAX TO 402.486.4383 ***

The Lexington House Rules Policy

1. **Apartments** are unfurnished except for window blinds, mini refrigerator/freezer, microwave and the emergency call system receiver. Families are responsible for placement of wall hangings. Maintenance can assist with heavy items that need to be anchored, i.e. mirrors, etc. **NO NAILS IN THE DOORS.** Self-stick hooks or door hangers may be used. A coffee maker and toaster are allowed in the apartment if they are in excellent working order. No irons, heaters or other electrical appliances. **If these appliances are older than one (1) year, we will inspect them.** Moving to another apartment may be accommodated under rare circumstances and with permission only from the Executive Director. The Resident is responsible for all costs associated with the move and the physical moving of all possessions.
2. **Cable**. Apartments are equipped with cable TV hook-ups offered at a bulk rate. Residents subscribing to this service will be billed monthly by The Lexington. Please be considerate of your neighbors by keeping your volume at a moderate level. If the volume is too loud for the comfort of Residents, you will be asked to use a headset. The Lexington will handle the cable installation. Upon moving out, the cable box and remote must be left in the apartment or the Resident will be billed for replacement.
3. **Phone**. Apartments have hook-ups for a landline phone. This is an optional service and the Resident must contact a local carrier for service. Telephones in common areas are available for local calls at no charge. Direct, long-distance calls cannot be made from the common area phones. We offer free Wi-Fi for cell phone calls. No phone calls are permitted in the Lobby/Reception Desk area unless the call is an emergency. Please use your cell phones quietly and discreetly in other public areas.
4. **Video, Photography Or Other Imaging**. Due to the Health Information Portability and Accountability Act (HIPAA), photography or other means of imaging is prohibited. If The Lexington becomes aware of the presence of video cameras or any other recording devices being placed in a Resident's apartment either by the Resident or the Resident's responsible party, notice must be posted outside the Resident's apartment to notify staff and visitors of the presence of a recording device.
5. **Security**. The front doors lock 8:00 pm to 7:30 am. Staff are available to allow entry outside those hours.
6. **Leaving the building.** All Residents **must notify** Reception when leaving and returning to the building. We will collect your Arial call button unless you left it in your apartment. We will also ensure any medications are given to you during the time you are away. Please inform Reception at least 24 hours in advance whenever possible. If the Resident leaves the building, we highly encourage that she or he have an escort. If there are any memory or cognitive deficits, an escort will be required.
7. **Visitors.** All visitors are required to sign in at Reception upon arrival. All visitors are subject to all rules, regulations, policies and procedures. One overnight visitor is allowed for up to three (3) nights during a thirty (30) day period. The visitor must comply with all rules and regulations and submit an "Overnight Visitor Form" (*Resident Handbook* or Reception) for each stay. Please notify the Reception of the visit and meal order 24 hours prior to the stay and sign in and out at Reception. The visitor will be required to pay for his/her meals. The visitor can join the Resident in the Dining Room or reserve the private dining room, if available. If a room tray is preferred, the visitor must pick up and return the room tray to the Resident Dining Room.
8. **Laundry** articles (clothing and linens) must be labeled with apartment number at time of move in. Clothing brought to Resident after move in must be labeled before being sent to our laundry for cleaning.
9. **Meals** will be served at the following times: Breakfast at 8:00 am; the noon meal at 12:30 pm and the evening meal at 5:00 pm. Snacks will be available during morning hours in the 2nd floor Activity Room and evening hours after supper in the front lobby area. Coffee will be available between 8:00 am and 4:00 pm. It is necessary to notify Reception when you are planning to be absent for a meal. Except for holidays, visitors can join the Resident for a meal. See the Reception Desk for meal costs.

The Lexington House Rules Policy continued

10. **Food** kept in apartments must be kept in covered metal, plastic or glass containers.
11. **Meal Services.** Residents are expected to eat meals in the Resident Dining Room unless they are not feeling well or are quarantined to their apartment. If you are not feeling well, please let staff know and we will bring a "sick tray" to your apartment. If you are in quarantine, we will bring you a regular meal. If you choose to eat a meal in your apartment, obtain your meal that has been prepared for you in the Dining Room and we'll box it up for you to take back to your apartment. **If you request the meal to be delivered to your apartment, you will be charged a $3.00 fee per delivery that is added to your monthly bill.**
12. **Dining & Etiquette**. Please use good manners that your Grandmother would approve of at all times. Don't use cell phones during meals; keep voices at a conversational level; if you must disagree, be polite; a peck on the cheek or holding hands are acceptable forms of consensual public affection; wear appropriate attire to the Resident Dining Room and outside your apartment. Examples of inappropriate attire include pajamas, robe, slippers, lack of undergarments, soiled clothing, offensive words and images, etc. Keep grooming behaviors in your apartment.
13. **Private Dining.** The Private Dining Room is available for use by reservation, except on holiday weekends. You can bring food in or order from the Lexington Dining Room's menu up to a maximum of ten (9) meals for your event. We require a seven-day notice in order to have the amount of food you requested. Please contact Reception at least seven (7) days prior to your event to make arrangements and for meal costs.
14. **Smoking is NOT PERMITTED.** The Lexington provides a smoke-free environment for Residents. Smoking—cigarettes, cigars, pipes, or any other smoking device, such as vaping—by any person is NOT permitted on anywhere in our building or on our campus. Any violation of the smoking policy is grounds for **immediate** termination of residency.
15. **Pets** are not permitted to live with the Resident. Pets are welcome for visits with a current vaccination record provided to the Receptionist on duty.
16. **Valuables & Money**. The Lexington will not be responsible for handling any money belonging to residents. **For your safety and security, it is recommended that residents not bring expensive jewelry, large amounts of money, or other personal valuables into the facility.** ***The Lexington does not accept responsibility for lost or stolen items.***
17. **Solicitation**. The Lexington has a policy of no solicitation. No organization or individual is allowed to distribute literature within the building or canvas door-to-door.
18. **Nursing intervention**. Effective June 1, 2019, although authorized by state law, the policy of this Facility is not to provide part-time or intermittent Complex nursing interventions by facility staff.
19. **Billing.** The Lexington will submit to each resident or responsible party, a bill for the monthly rent, board and services, including special charges through the 25th of the previous month. Bills are due in full on the first of each month. Rent, board and services are paid in advance. All **special charges** such as room tray service or purchases in the General Store will appear on the Resident's monthly statement. Beauty/Barber Shop charges will be handled directly with the Beauty Shop Operator on the day of service. Any bill that is not paid within thirty (30) of the due date is grounds for termination of the lease.
20. **Arial** personal emergency devices are used by Residents during their stay at The Lexington**.** If the Resident should lose or damage an Arial, he/she will be charged a $200 replacement fee.
21. **Quarantine/Infection Control.** In the event of a pandemic or like event, Residents must follow precautions established by The Lexington. Failure to do so could result in immediate termination of residency. Anyone who refuses COVID testing will be treated as if they are positive. In the event of an exposure, if you are not up to date with vaccinations/boosters, you will be subject to quarantine protocols.
22. **Parking** spaces are available for Residents and guests in the parking lot at the front of the building. Fire lanes are clearly marked, and no cars are to be parked in these lanes at any time.

The Lexington House Rules Policy continued

23. **Vehicle.** A Resident is allowed to have one (1) vehicle in the parking lot with a current driver's license, insurance and registration. It must be in running order and be moved at least once a week. The Resident must notify The Lexington prior to moving in if parking their vehicle in the parking lot or if the Resident plans on obtaining a vehicle after moving. If The Resident is not following this policy, a warning will be given. If after 30 days the Resident is still non-compliant following the warning, The Resident will be given a 48-hour notice to comply or the vehicle will be towed and impounded at expense of The Resident.
24. If Residents use **alcohol** (in apartments only, other than at a Lexington-sponsored Happy Hour), **tobacco or other legal drugs**, appropriate use is expected at all times. Abuse of any substance is not acceptable and may be cause for termination of residency.
25. In the event of serious **illness**, The Lexington will call for emergency services, and then call the family. In the event of death, The Lexington will immediately call the coroner and then contact the family.
26. Each unit has **fire sprinklers** and **smoke detectors** that must not have anything hanging on it or attached. **No open flames are allowed.**
27. **Walker**. Residents that use a walker are required to have "skis" instead of the rear rubber feet. This helps with mobility. The Lexington can install the skis at a nominal fee, which can be added to the monthly bill, or the skis may be purchased form a medical supply company where they can be installed.
28. **Wheelchairs**. Manual wheelchairs are permitted. Motorized wheelchairs/scooters must be approved by management accompanied by a signed Safety Contract.
29. **Lifts/Transfers.** The Lexington is a **no-lift** facility. Residents must be able to access all areas of The Lexington (using a walking aid if necessary) and to perform all transfers (in and out of chairs, bed, transportation van, etc.) independently. Individuals with a history of frequent falls may not be admitted. In the event of a fall, staff will call 911 for paramedics to evaluate and lift a Resident who has fallen.
30. **Transportation** to medical appointments is available family or friends is unavailable. The Resident is allowed up to **five (5) trips per month** for medical appointments within the Lincoln city limits, Monday through Friday. The van is available on a first-come, first-serve basis and we can't guarantee the van will be available. It is recommended that even if The Lexington transports the Resident to a medical appointment, a family member meet and escort the Resident to the appointment. We can accommodate appointments between 8:00 am and 3:00 pm. Monday through Friday, with the exception of holidays.
31. **Moving in.** Our apartments are designed for Residents to live comfortably and safely in their home. We do check that pathways are clear and safe for Residents, Staff and emergency services personnel. If Resident and Staff safety are compromised, we will ask the Resident to remove any items that are unsafe.
32. **Moving out**. A daily rent charge (about $35 per day for a standard apartment) will continue to be charged until ALL belongings are removed. A fee of $100 may be charged if there is any trash, belongings or furniture left in the apartment or at the outside trash dumpster. Please see Moving Out instructions available at Reception. Employees are not allowed to accept donations from Residents or families.
33. **Discrimination**. The Lexington does not allow and shall not discriminate in regards to residents and staff on the basis of race, color, religion, gender, gender expression, age, national origin, ancestry, disability, marital status, sexual orientation or military status in any of its activities or operation. These activities include, but are not limited to, hiring and firing staff, selection of vendors and provision of services. We are committed to providing an inclusive and welcoming environment for all.

_____

Print Name Apt. #

_____

Applicant/Responsible Party/POA Signature Date Rev. 1/2023

Resident's Rights

The individual residing in an Assisted Living Facility in the State of Nebraska shall have the right to:

1. Be treated with dignity and provided care by competent staff.
2. Be an equal partner in the development of the resident service agreement, while retaining final decision-making authority.
3. Be informed in advance about care and treatment and of any changes in care and treatment that may affect the resident's well-being.
4. Be informed in writing of the pricing structure and/or rates of all facility services.
5. Self-direct activities, participate in decisions which incorporate independence, individuality, privacy and dignity and make decisions regarding care and treatment.
6. Choose a personal attending physician.
7. Voice complaints and grievances without discrimination or reprisal and to have those complaints/grievances addressed.
8. Examine the results of the most recent survey of the facility conducted by representatives of the Department.
9. Refuse to perform services for the facility.
10. Refuse to participate in activities.
11. Privacy in written communication including sending and receiving mail.
12. Receive visitors as long as this does not infringe on the rights and safety of other residents of the facility.
13. Have access to the use of a telephone with auxiliary aides where calls can be made without being overheard.
14. Have the right to have a telephone in his/her room at the resident's expense.
15. Retain and use personal possessions, including furnishings and clothing, as space permits, unless to do so would infringe on the rights and safety of other residents.
16. Share a room with a person of his or her choice upon consent of that person.
17. Self-administer medications if it is safe to do so.
18. Be free of chemical and physical restraints.
19. Exercise his or her rights as a resident of the facility and as citizen or resident of the United States.
20. Form and participate in an organized resident group that functions to address facility issues.
21. Review and receive a copy, within two working days, of their permanent records, as referred to in 175 NAC 4-006.12.
22. Be free from abuse, neglect, and misappropriation of their money and personal property and
23. Be free from involuntary transfer or discharge without 30-days advance written notice except in situations where the transfer or discharge is necessary to protect the health and safety of the resident, other residents or staff.

I _____ (print name) have read and understand these "Resident Rights."

Applicant/Responsible Party/POA: _____ Date: _____

Advance Directive Information

In Nebraska, adults who are capable of making healthcare decisions generally have the right to say "yes" or "no" to medical treatment. They also have the right to prepare a document known as an Advance Directive. This document tells what medical treatment the individual would want in the event he/she is unable to communicate that decision due to illness or injury. Every healthcare provider is expected to honor that decision. This means an individual can sign a legally binding document which identifies exactly what a healthcare provider is to do if the individual is in a terminal or vegetative state from which there is no hope of recovery. There are two common types of Advance Directives:

1. **Living Will**: states the kind of medical care the individual wants or does not want if he/she becomes unable to make his/her own decision.
2. **Power of Attorney for Health Care Decisions**: names someone else to make those decisions if she/she becomes unable to make his/her own decisions.

- An Advance Directive generally takes effect only after the individual is no longer able to make decisions.
- As long as the individual is able to make personal decisions, the healthcare provider will rely on him/her, not the Advance Directive.
- The document can be changed or canceled at any time.
- An Advance Directive is not required for admission to this facility. The facility does, however, request to be informed about any directives that do exist.

Resuscitation Preference

Please check one of the following:

- ❑ I DO have an Advance Directive. A copy is filed with: _____
- ❑ I do NOT have an Advance Directive and would like more information about them.
- ❑ I do NOT have an Advance Directive and do not want one.

No Heartbeat and/or No Breathing: What would you like us to do in the event facility staff find you without a heartbeat and/or you are not breathing?

- ❑ I **WANT** facility staff to begin CPR (Cardiopulmonary Resuscitation) and/or call 911.
- ❑ I do **NOT** want the facility staff to begin CPR.

Print Name: _____

Facility: **The Lexington Assisted Living Center**

Applicant/Responsible Party/POA Signature:_____ Date:_____

Physician Signature:_____ Date:_____

Facility Representative: _____ Date:_____

The Lexington will provide a copy of this signed document to the Resident.
File the ORIGINAL in Resident chart.

Medical Transportation Policy (Non-Emergency)

5/25/2022

Transportation to medical appointments is available if the Resident doesn't have access to transportation from family, friends or other means. The Resident is allowed up to **five (5) trips per month** for medical appointments within the Lincoln city limits, Monday through Friday. The van is not available on holidays. The Lexington transportation is a courtesy and is first-come, first-serve and we can't guarantee the van will be available when you schedule your appointment. It is recommended that even if The Lexington transports the Resident to a medical appointment, that a family member meet and escort the Resident to the appointment. We can accommodate appointments between 8:00 am and 3:00 pm. Monday through Friday, with the exception of holidays.

DIALYSIS/OUTPATIENT PHYSICAL THERAPY

If the Resident requires dialysis or outpatient physical therapy several times a week, then family will need to provide/arrange for transportation to and from the offsite location once the five (5) trips are reached within the month.

RESIDENT TRANSPORTS

If you are arranging for your own transportation, please notify Reception at least **48 business hours in advance** so that we can have the correct medical and insurance documentation for your provider and/or the correct medications needed while you are out of the building.

THE LEXINGTON TRANSPORTS

For best results, allow our Front Desk/Concierge staff to schedule your medical appointment and The Lexington Van at the same time. If you schedule the appointment, please contact Reception Staff to schedule the van. If the van is already booked, you may need to reschedule your medical appointment.

_____ _____

Applicant/Responsible Party/POA Signature Date

_____

PRINT NAME

Emergency Services Policy

It is the policy of The Lexington Assisted Living Center to initiate the emergency service response system (contact 911) for any resident experiencing an emergent situation such as signs and symptoms of a heart attack, stroke, loss of consciousness, profuse bleeding, or any other medical event that is deemed emergent by the administrator, resident services director, or other management personnel in the absence of the Administrator.

If a resident refuses treatment due to religious beliefs, cultural beliefs, or any other related or non-related beliefs, The Lexington Assisted Living Center will still initiate the emergency service response system (contact 911) to assess and/or provide emergency treatment and/or transportation to the nearest medical facility.

I _____ (PRINT NAME) have read and understand The Lexington Assisted Living Center Emergency Services Policy.

_____ _____
Applicant/Responsible Party/POA Signature Date

_____ _____
Resident Services Director Date

_____ _____
Administrator/Executive Director Date

Disaster Information

In the event that The Lexington suffers an internal (flood, electrical, etc.) or an external (tornado, wind damage, fire, etc.) disaster, all reasonable attempts will be made to make the Resident comfortable and appropriately housed.

In the event that there is an actual emergency, we will make every attempt to notify the Resident's family member or representative.

We also ask at this time in the event of an emergency, and there is not placement available in another facility, would a family member be able to accommodate the Resident?

In the event of an emergency:

Yes ❑ No ❑ My family would be able to accommodate me at my home or at another family home.

Yes ❑ No ❑ If there is an emergency that we can keep our Residents in house, would the Resident be willing to temporarily share his or her apartment?

Yes ❑ No ❑ If there is a city-wide evacuation from another facility, would you be willing to share your apartment temporarily?

_____

Print Name

_____

Applicant/Responsible Party/POA Signature

_____

Date

Grievance/Complaint Policy

It is the policy of The Lexington Assisted Living Center to provide quality care and immediate response to all Resident, family and employee complains and concerns. The Grievance/Complaint Report below will be used to document any problem experienced along with all documentation in the Resident chart or other supplementary information received and reported. Any Resident, family or staff concern should be documented on a Grievance/Complaint Report form and brought to the attention of the Administrator immediately. Reporting forms are available at the Reception Desk. The Administrator will investigate the complaint by interviewing the parties involved for further information. Documentation will include individuals in attendance, action taken to resolve the concern, results of action taken, update to plans of care, disciplinary action if necessary and methods used to notify the party with the grievance/complaint. Employee concerns may also be brought to the attention of the Administrator using the same form. The same procedure will be followed with documentation being place in the appropriate personnel files. I have read and understand the procedure of the Grievance/Complaint Policy.

_____ _____ _____

Print Signature Date

1/2020

Reduced

THE LEXINGTON ASSISTED LIVING
Grievance/Complaint Report

This form shall be utilized to provide written documentation of any concern expressed by a resident or resident representative and to record the follow-up action taken and results thereof.

RECEIPT OF GRIEVANCE/COMPLAINT

Date received: _____

Individual initiation complaint: ☐ Resident ☐ Resident representative; relationship: _____

Print individual's name: _____

Concern reported to: _____

Describe concern using factual terms: _____

_____

_____

_____

Complaint Signature: _____

DOCUMENTATION OF FACILITY FOLLOW-UP

Individual(s) designated to take action on this concern:

_____

_____

Date assigned: _____

Was group meeting held? ☐ Yes If yes, identify all individuals in attendance. ☐ No

_____

_____

Results of action taken: _____

Plan or Care Updated? ☐ Yes ☐ No Date: _____

Staff Member: _____
Name and Title

RESOLUTION OF GRIEFANCE/COMPLAINT

Was grievance/complaint resolved? ☐ Yes, describe resolution. ☐ No, explain why not.

_____

_____

_____

_____

Identify the method(s) used to notify the resident and/or resident representative of the resolution:

☐ Written notification ☐ Phone conversation ☐ One-to-one discussion

Date of notification: _____

This form was completed by: _____ _____
Signature and Title Date

08-09-19kfa

HIPAA Notice of Privacy Practices

Effective April 14, 2003

Information about your health and your health care is very personal and should be protected against unnecessary use and disclosure. As you would expect, The Lexington receives, creates, and maintains health care information about you while you live here. We need this information in order to provide you the quality care you deserve. However, we are required to use that information for limited purposes, unless we get your permission otherwise.

This notice applies to all the records of your health care that we have, and it describes the ways we use that information and how we disclose it to other parties. This notice also describes your right to get copies of the health care information we have about you, and describes certain obligations we have regarding the use and disclosure of your health care information. Finally, this notice describes how you can amend your health care information and your right to submit a complaint if you feel The Lexington has violated its duty to keep your health care information private.

We are required by law to:

- Maintain the privacy of your covered health care information
- Provide residents and their personal representatives with this Notice of Privacy Practices
- Abide by the terms of this Notice

The following categories describe different ways we might use your health care information and reasons we would disclose your health care information to other third parties without getting your consent first:

For Treatment: We use your health care information to help us decide which services you need while at The Lexington. The information would be the basis for your care plan that describes the services we will provide for you. We could also use that information to coordinate with your doctors, nurses, or other medical service providers who provide medical care to you.

For Payment: We may use and disclose your health care information so we can receive payment for the services we provide you. For example, we may have to provide an insurance carrier or a governmental agency with information about the services you receive so they can authorize payment to us.

For Health Care Operations: We may use and disclose your health care information so we can conduct studies about our services in an effort to improve the service to our residents. We need to do this to continually evaluate the performance of our staff in meeting the needs of our residents. We use and disclose the information to computer software designers who create database software for us to help us track and monitor our care plans.

Other Uses of Your Health Care Information: There are several other broad categories in which we might use or disclose your health care information:

1. Under rare circumstances we might participate in research projects that would require use and disclosure of the information. For example, we might be involved in a study to determine if exercise in our wellness center improves the length of time a resident with Parkinson's Disease could live at The Lexington;
2. If we were required by law i.e., a lawsuit in which you were a party, we might have to use or disclose your information;
3. If disclosing your information to a third party would be helpful to prevent a serious threat to the general health or safety of the community, we would make that disclosure;
4. If you are a military veteran, we might have to release your information to the Veterans Administration;
5. We might have to release your information in a Worker's Compensation claim;
6. We might disclose your information to public health agencies to help address public health risks or to comply with audits by the state agencies; and
7. We might contact you to remind you of appointments.

HIPAA Notice of Privacy Practices continued

Consent Required for Other Uses or Disclosures: For any uses or disclosures other than those listed above, we will first obtain your written authorization before engaging in such uses or disclosures. We must comply with the terms of that authorization, and you may revoke the authorization in writing at any time.

You have the following rights regarding your health care information that we maintain about you:

1. You have the right to request restrictions or limitations on the health information we use or disclose. We may not agree with the limitations if they would negatively impact the care we provide to you;
2. You have the right to receive confidential communications from us about your health information. You must tell us in writing what items you want confidential, and how that confidentiality is to be accomplished;
3. You have the right to have access to your health care information that we have;
4. You have the right to request an amendment to your health care information that we have if you think the information is incorrect. We will review the requested amendments with you and other care providers, and determine if the amendment is appropriate; and
5. You have the right to request an accounting of any disclosures of your health care information we have made to anyone.

You or your personal representative may complain to The Lexington or to the Secretary of Health and Human Services (DHHS) if you believe your privacy has been violated. Any time you intend to enforce one of your rights listed above (including the right to lodge a complaint), you must do so in writing, addressed to Administrator, The Lexington Assisted Living Center, 5550 Pioneers Boulevard, Lincoln, Nebraska 68506, phone (402) 486-4400.

The Lexington reserves the right to amend or change the terms of this Notice, or to make a new Notice at any time in the future.

I have read and understand the information contained within this notice. I further understand a copy of this notice will be made available to me upon my request.

Print Name:_____ Apt. # _____

_____ _____

Applicant/Responsible Party/POA Signature Date

Name and Title of Facility Representative: Eldonna Rayburn, Marketing Director

_____ _____

Facility Representative Signature Date

Admission and Discharge/Transfer Policy

Project Specific Requirements: The Lexington Assisted Living Center (The Lexington) provides living arrangements which integrate shelter and services for elderly persons. An elderly person is a household composed of one or two persons at least one of whom is 55 years of age at the time of initial occupancy and who need assistance with Activities of Daily Living. To that end, The Lexington provides the following primary functions and/or services:

- Safe physical and social environment.
- Three meals daily.
- Personal care assistance.
- Housekeeping and laundry assistance.
- Medication administration

Income Limits: Social Security Numbers; Citizenship Requirements: The Lexington participates in the federal low income housing tax credit program (referred to as the "Restricted Income Program") and as a result, some of the Residents at The Lexington will be required to meet income eligibility requirements (such residents are referred to as ("Restricted Income Applicants") which will require proof that their gross annual income does not exceed 60% of the Area Median Income. The Restricted Income Applicants must provide authorization permitting the facility to obtain third party verification of their income. This occurs with some of the Restricted Income Applicants prior to moving into the facility. However, it also applies to some current residents who did not qualify for the Restricted Income Program when they initially moved into the Facility, but can qualify after living here for some period of time. Restricted Income Applicants must disclose social security numbers so their social security benefit can be verified by the facility. All other residents provide their social security numbers along with their initial application for residency. Although we do not have a citizenship or residency requirement, if we chose to have one, we could check the Social Security Administration to make sure the social security number the resident submitted to us actually belongs to that resident.

Preferences:

Payment Source Preference: The Lexington has 98 apartments, 94 of which are one bedroom, and the other 4 are two (2) bedroom. Our HUD loan documents require The Lexington to have at least 25 one bedroom apartments occupied by individuals who are on the Nebraska Medicaid Waiver program (referred to as "Medicaid Waiver Residents"), and to market the two bedroom apartments to Medicaid Waiver Residents as well (but we are not required to hold the two bedroom apartments solely for Medicaid Waiver Residents). Our Restricted Income Program documents require the facility to have at least 52 apartments occupied by residents who meet the requirements of that program ("Restricted Income Residents"). The balance of our apartments are available for eligible elderly applicants regardless of their income (these are referred to as "Market Rate Residents"). As long as we have the required number of Medicaid Waiver Residents and Restricted Income Residents, we will give preference for available apartments to Market Rate Residents. The Administrator will continuously monitor the facility's compliance with the number of required Medicaid Waiver Residents and Restricted Income Residents, and will make the final admission decision after considering the Payment Source Preference.

Activities of Daily Living Preference ("ADL Preference"): In order for an individual to qualify for the Medicaid Waiver Program, he or she must be frail enough to quality for nursing home placement under the Medicaid Program, but Medicaid officials must determine that he or she will be able to function well enough to live in the assisted living setting. That is, he or she does not need 24 hour nursing care, but certainly cannot live independently any longer. Therefore, since Medicaid Waiver Residents qualify for nursing home placement, they are as a general rule usually more frail than Restricted Income Residents or Market Rate Residents, and therefore require a higher level of care which results in heavier staffing requirements. Consequently, as long

_____ Initials

as we are meeting the required number of Medicaid Waiver Residents and Restricted Income Residents, we will give preference for available apartments to applicants who are less frail than others on the Wait List, regardless of Payment Source and regardless of the date the applicant with the ADL Preference goes on the Wait List. The Healthcare Coordinator is responsible to conduct a physical evaluation of each applicant to determine both the applicant's physical eligibility for residency and the ADL Preference. The Administrator will continuously monitor the facility's staff levels necessary to provide the required levels of care to current residents, and will make the final admission decision for applying the ADL Preference.

Procedure for Accepting Applications and Selecting From Waiting List: Applicants who are elderly and need assistance with Activities of Daily Living may submit an application for residency at The Lexington. Applications may be mailed if requested by the Applicant, or may be obtained at the facility. When the application has been properly completed and returned to the facility, the Applicant will be scheduled for a physical evaluation. Based on the physical evaluation, the applicant may be placed on the Wait List if he or she requests. In the event an applicant is approved for residency, but there are not vacant apartments, the applicant will be placed on a wait list.

A prospective Resident will be added to our Prospect Wait List when the Resident submits a completed application to The Lexington. The application will be date stamped and that date/time will establish the prospect's position on the wait list with general priority given based on chronological order with the earliest date given highest priority. However, the administrator can give preference to a prospect who pays privately and for a prospect based on health care requirements. In addition, a prospect may be advanced ahead of an earlier prospect if the advancing prospect fully completes the admission process before the earlier prospect.

If the facility has a suitable apartment immediately available, the Applicant could be accepted into residency at The Lexington (after application of the Payment Source Preference and/or the ADL Preference) on a first-come first-serve basis without regard to race, color, religion, gender, creed, ancestry, sexual orientation, marital status, veterans or military status, or disability (so long as the facility is able to accommodate the disability under the existing facility staffing and the regulations governing the operation of assisted living facilities in the State of Nebraska as determined by the Department of Health and Human Service System Licensure and Credentialing).

Applicants placed on the Wait List will be contacted in order of their placement on the Wait List (after application of any applicable Preference). In the event an applicant is unable (for any reason other than subsequent ineligibility) to move into the facility at such time as a unit becomes available, the next applicant on the list waiting for the particular size unit will be contacted. Any applicant who is unable to move in as vacancies occur (for any reason other than subsequent ineligibility) will remain in his or her respective place on the Wait List and will be contacted accordingly as units come available. Persons may be placed on the Wait List at any time; however, the facility will contact those applicants on the existing Wait List monthly to determine continue interest and eligibility. The Wait List will not be closed.

Screening Criteria: All applicants will be evaluated using a standard functional test to determine if the criteria for admission are met. Periodic re-evaluations will be done to determine if The Lexington can continue to meet the applicant's and/or resident's needs. For an individual to become a resident and/or remain in residency at The Lexington, the following criteria must be met (but the Administrator may waive or modify the criteria as necessary so long as the facility still complies with applicable regulations for licensing):

1. Must have the ability to ambulate independently in their apartment (using a walking aid if necessary) and to perform all transfers (in and out of chairs, bed, on and off the toilet, etc.) independently. Individuals with a history of falls shall not be admitted to this facility. Those individual requiring consistent and/or long-term assistance shall be evaluated for continued residency.
2. Must have the ability to dress independently with assistance with zippers, buttons, shoelaces, etc. Additional minor dressing assistance may be provided.
3. Must have the ability to bathe and complete personal care independently or with limited supervision and assistance getting in and out of the shower.

_____ Initials

Admission and Discharge/Transfer Policy continued

4. Must have the ability to take care of all toileting needs without assistance and maintain a sanitary, odor-free environment and person. This includes the ability of the resident to manage incontinent products.
5. Must have the ability to self-administer medications or be willing to have both prescription and non-prescription medications administered by staff of The Lexington. All residents shall be evaluated for self-administration of medications. Those residents who are competent and physically capable of self-administration of medications shall be evaluated for continued self-administration on an annual basis.
6. **One-Person Transfer:** The Lexington can provide "one-person transfer assistance" to five (5) private pay residents for an addition charge. This service is limited both to the number of residents we can assist for staffing reasons, and to the payment source for those residents since Medicaid prohibits charging Medicaid residents for additional services. This service is also limited to residents whose bodyweight does not exceed 225 pounds for safety reasons (both to the resident and the staff). If a private pay resident who is receiving the one person transfer assistance gains weight in excess of the 225 pound limit while receiving this service, then that resident will be discharged from The Lexington. If a private pay resident who is receiving the one person transfer assistance eventually goes onto the Medicaid program, we will continue to provide the one person transfer to that person but in no event will we provide the service to more than five (5) residents.

A Resident will be considered no longer appropriate for residency for any of the reasons listed above as well as any of the following reasons:

a. Falsified information was provided on the application or any other pertinent documents used to determine admission eligibility at The Lexington.
b. Non-payment of rent, board, and service charges.
c. The Lexington is no longer able to meet the resident's needs on an ongoing basis.
d. Failure of the resident to comply with written policies and/or rules of operation at The Lexington.
e. A resident exhibits behavior which poses a physical threat to self, other residents, staff members, volunteers, or guests, including violent, abusive, and/or disruptive behavior.
f. A resident participates in verbally, abusive, intimidating or other inappropriate behavior toward another resident or staff members.
g. A resident requires tray food service on a continuous basis due to inability or refusal to come to the dining room for meals.

The Lexington will not admit or retain an applicant and/or resident who:

a. Is consistently and uncontrollably incontinent of bowel or bladder unless able to take care of all needs independently and maintain an odor free environment and person.
b. Is bedfast for a period of longer than three (3) days.
c. Requires skilled nursing care on more than an intermittent basis.
d. Has a communicable disease or infection unless the Resident is receiving medical or drug treatment for the condition.
e. Is consistently disoriented to time, person, and place to such a degree a Resident poses a danger to self or others, including wandering. Individuals eloping from the facility shall not be retained after one (1) elopement episode. If the resident does not have the capability of understanding the situation and creates an unpleasant atmosphere for staff and residents, the situation will be evaluated and resident removed from the incident. Family will be notified to assist with possible solutions.
f. Requires chemical or physical restraints as treatment for a disease.
g. Has difficulties with mobility that require assistance from staff of The Lexington.
h. Is unwilling and/or unable to abide by the smoking policy of The Lexington.
i. Any person on a special or therapeutic diet prescribed by a physician (supplement, Ensure, excluded).
j. Insulin-dependent diabetics can be admitted to The Lexington on a case-by-case basis.

_____ Initials

Residents requiring complex nursing interventions or whose conditions are not stable or predictable will not be admitted, readmitted, or retained unless:

a. The resident, if the resident has sufficient mental ability to understand the situation and make a rational decision as to his or her needs or care or the resident's designee, and the resident's physician agree that admission or retention of the resident is appropriate;
b. The resident or his/her designee assumes responsibility for arranging for the resident's care through appropriate private duty personnel, a licensed home health agency; and
c. The resident's care does not compromise the facility operations or create a danger to others in the facility.

If The Lexington is unable to admit and/or retain a resident, every effort shall be made to refer the individual to an appropriate facility.

Screening for Drug Abuse and Other Criminal Activity: The Administrator may deny admission to those individuals who have engaged in illegal drug-related and/or criminal activity. Specifically, those who may not be admitted included:

1. Any individual who was evicted in the last three years from federally assisted housing for drug-related criminal activity. The facility may, but is not required to, consider two exceptions to this provision:
    a. The evicted individual has successfully completed an approved, supervised drug rehabilitation program; or
    b. The circumstances leading to the eviction no longer exist (e.g., the household member no longer resides with the applicant household).
2. A household in which any member is currently engaged in illegal use of drugs or for which the owner has reasonable cause to believe that an individual's illegal use or pattern of illegal use of a drug may interfere with the health, safety, and right to peaceful enjoyment of the property by other residents;
3. Any individual who is subject to a state sex offender lifetime registration requirement; and
4. Any individual if there is reasonable cause to believe that individual's behavior, from abuse or pattern of abuse of alcohol, may interfere with the health, safety, and right to peaceful enjoyment by other residents. The screening standards must be based on behavior, not the condition of alcoholism or alcohol abuse.
5. Other criminal activity (**including but not limited to criminal background reports of a felony offense from the Nebraska State Patrol)** that threatens the health, safety, and right to peaceful enjoyment of the property by other residents or the health and safety of the owner, employees, contractors, subcontractor, or agents of the owner.

The Lexington reserves the right to transfer residents from one unit to another as appropriate under special circumstances, i.e. death of a spouse, change in Payment source, or change in physical condition. IN the event vacancies occur within the facility, those individuals already in residence and awaiting the availability of a different type of unit will be given preference.

Compliance with Civil Rights, Fair Housing and Section 504 of the Rehabilitation Act of 1973: The Administrator will be responsible for implementation of these laws, and will schedule appropriate training for staff to insure compliance.

Occupancy Standards: There are three (3) apartment sizes: standard one bedroom, large one bedroom, and two bedroom apartments. The one bedroom apartments are generally leased to individuals, but a couple could easily live in a large one bedroom apartment. The standard one bedroom apartments are available for Medicaid Waiver Residents, Restricted Income Residents and Market Rate Residents, depending on location within the building. The large one bedroom apartments are planned for two Medicaid Waiver Residents who are either married or related or who request the two bedroom apartment. The Administrator may permit modifications to this rental scheme as necessary to meet the needs of various residents and/or the facility. For example, a single applicant may lease a two bedroom apartment while waiting for a one bedroom apartment to come available.

_____ Initials

PHARMACY Admission Information

RelyCare PHARMACY
Your prescription for health

Print Name: _____ M / F Birthdate:_____

Allergies: _____

Following Physician: _____Social Security #: _____

Community: The Lexington Assisted Living Apt. #: _____ Bed: A/B Arrival Date/Time: _____

Responsible Party/POA Name: _____ Relationship:_____

Address: _____ Phone: _____ Work: _____

If Insurance is Unavailable: **(Check One)**

- ☐ Send Medication and **Charge** cash price for Medication
- ☐ **Do Not Send any Medication** until Insurance is provided

Insurance Information: **(Check all that apply)**

- ☐ Medicaid Number: _____
- ☐ Medicare Number: _____(send copy of card)
- ☐ Medicare Part D Drug Plan Name: _____ (send copy of card)
- ☐ Private Insurance Plan Name: _____ (send copy of card)
- ☐ Self-Pay

_____ _____

Staff Signature Date

PHARMACY Privacy Notice

Federal Government regulations require that we take additional measures to protect your personal health information (PHI). In short, our Privacy Notice states that: We will not disclose your PHI for any reason other than your healthcare without your prior approval; you have the right to inspect and obtain a copy of your PHI; you have the right to restrict the uses and disclosure of your PHI at any time; the only people who have access to your PHI are pharmacy employees, other healthcare providers and your insurance party; we will disclose no more information than necessary in order to protect your privacy and provide you with the best care possible. I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give to pharmacy, any and all such information. A complete copy of the Privacy Notice is available upon request from the pharmacy or may be found in the Pharmacy Procedure Manual at Reception.

- I KNOW that I may request to receive a copy of the Authorization.
- I AGREE that a photographic copy of this Authorization shall be as valid as the original.
- I AGREE this Authorization shall be valid for the duration of my residence at this community.

Acknowledgment/Good Faith Effort to Obtain Acknowledgment (CHECK ONE)

☐ I certify that I am aware of the above-named entity's Privacy Notice and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting my health information.

Date:_____ Resident Signature:_____

☐ I certify that I am the authorized representative of _____(Resident Name) I am aware of the above-named entity's Privacy Notice and have had an opportunity to review this document and ask questions to assist me in understanding the patient's privacy rights. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting health information.

Date:_____ Authorized Representative Signature:_____

*****Federal regulations require your signature acknowledging our privacy practices.*****

PHARMACY Financial Agreement

RelyCare PHARMACY
Your prescription for health.

I Understand and Accept the Following Terms and Conditions:

- I agree that facility personnel are authorized to order purchases and charges on behalf of the below named resident.
- I agree to pay all charges incurred for the below named resident not paid for by the third-party Payees including Medicaid.
- I will pay the entire amount due within 30 days of the statement date shown on the monthly billing statement, either by Automatic Withdrawal from a checking account or Credit Card.
- I agree in order to keep the account active, the account balance must remain current, any delinquency of 30 days or more will incur a 1.5% late charge, pharmacy services will be stopped on any account 30 days delinquent.
- I agree to pay a service fee each month for repackaging medications obtained from another pharmacy such as the VA or mail order pharmacies.
- I agree to pay all costs of collection including court costs and attorney's fees, if necessary, in order to collect any and all delinquent balances.
- I understand that the medications furnished to the below named resident are not packaged in child proof containers.

Assignment of Benefits of Medicare/Medicaid/Medigap/Supplemental/Commercial Insurance and Health Plan Benefits

- I request payment of authorized Medicare, Medicaid, Medigap, Supplemental, Commercial Insurance or any health plan benefits be made on my behalf directly to Provider for any services, equipment, supplies, and/or medications furnished to me by provider.

Pharmacy Payment Options

1) Automatic Bank Withdrawal *(Fill Out Below or Attach a Voided Check in the space below)*

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Name of Bank: _____ Voided Check #:_____

Bank Routing #: _____Bank Account #: _____

2) Automatic Payment Via Credit Card ($5.00 Convenience fee per month)

Cardholder: _____ Credit Card Number: _____-_____-_____-_____

Exp. Date _____ CVV Code _____

By signing below, I agree with all of the above Terms and Conditions.

_____ _____

Printed Applicant Name Printed Responsible Party/Guarantor Name

_____ _____ _____ _____

Applicant Signature Date Responsible Party/Guarantor Signature Date

PHARMACY Packaging & Repackaging Agreement

RelyCare PHARMACY
Your prescription for health

(check one) Medications Provided By:

Medications Start Date: _____

- ☐ Pharmacy stock
  - Pharmacy will provide all medications
  - No repack fee to use up current supply of patient stock if applicable
- If Using up At Home Medication
  - Will Need the medication 24 hours in advance to allow time for repackaging, otherwise pharmacy stock will be utilized.
  - Will repackage one time up to 90 days of Prescriptions or OTC items, allowing at home supplies to be used up at no cost.
  - No OTC items greater than 90 days will be accepted for repackaging
  - Specialty Items (not available at the pharmacy) will be repackaged with a $5.00 monthly fee
- ☐ Patient V.A. and Mail Order Stock
  - VA or Mail order will provide medications and it will be ongoing
  - $5.00 per med/per month repacking fee
  - Will Need the medication 24 hours in advance to allow time for repackaging

V.A. & Mail Order - Please initial each of the following below:

- _____ I will allow pharmacy to order/receive all medications from V.A./Mail order providers.
  (initial)
- _____ I have called the V.A./Mail Order Pharmacy and changed the mailing address to
  (initial)

  RelyCare LTC
  1219 N Cotner Blvd
  Lincoln, NE, 68505

  V.A. Phone #: 1 (855) 560-1722
  Mail Order Phone#: listed on the Prescription Bottle
- _____ I will allow pharmacy to fill new, short-term therapy medications, along with all items not
  (initial) supplied by the V.A./Mail order without verbal authorization up to a maximum amount per order of $_____.
- _____ I am aware of the repackaging fee of $5.00 per medication/per month for OTC
  (initial) repack/V.A./Mail order medications and the facility will order meds on demand.
- _____I know I am responsible for the cost of any medication not supplied by Mail-Order and V.A.
  (initial) (These medications need to be marked on the original medication list)
- Other information/requests I would like pharmacy to know _____

By signing below, I agree to with all of the above Terms and Conditions

_____
Print Applicant Name

_____ _____
Applicant/Responsible Party/POA Signature Date

NHCP
Nebraska House Call Physicians, P.C.
PO Box 22359, Lincoln, NE 68542
Phone: 402-560-5110 Fax: 888-658-4005

Patient Name	Birth Date	Gender	SSN
Patient Address	City, State	Zip Code	Phone Number

Please Initial One:

_____**I choose NHCP for my Primary Care Provider**

_____**I choose to keep my Primary Care Provider but use NHCP for back up care/ancillary services (lab, etc.)**

Authorization to pay benefits to physician: I hereby authorize payment directly to the physician of the surgical and or medical benefits, if any, otherwise payable to me for services rendered. I understand the provider's charge may exceed the private insurance carrier payment, and if greater than such payment, I will be responsible for that amount. We will submit your insurance as a courtesy to you; however, you are ultimately responsible for any services rendered.

Authorization to release information: I hereby authorize the physician to release any information required in the course of my examination or treatment according to the HIPAA privacy act.

Acknowledgment of receipt of notice of privacy practices: I have been given, or offered and declined, a copy of NHCP's notice of privacy practices for Protected Health Information. I understand the physician has the right to change the notice of privacy practices at any time. I may obtain a current copy by requesting it from NHCP. The undersigned does hereby acknowledge receipt of physician's notice of privacy practices for protected health information.

_____ _____

Patient's Signature (or other authorized signor) Date

_____

Printed Name and relationship if other than patient's signature

Facility: The Lexington Assisted Living

Please fax completed document with demographics to 531-301-6455

Revised November 2022

The Lexington

5550 Pioneers Blvd. | Lincoln, NE 68506 | 402.486.4400 | Fax 402.486.4441 | erayburn@thelexington.com | thelexington.com

MEDICAID WAIVER APPLICANTS:

The remaining forms are income- and asset-verification forms we have verified by a third party. **These forms must be completed PRIOR to move-in**. The applicant must sign the Social Security Verification form and it is preferable that the applicant sign all forms.

REQUIRED FOR ALL MEDICAID WAIVER APPLICANTS:

- ☐ Unemployed Affidavit
- ☐ Annual Student Certification
- ☐ Anticipated Household Income
- ☐ Asset Income
- ☐ Social Security Verification (**MUST BE SIGNED BY THE APPLICANT**)
- ☐ Bank Verification (Must include Account Number)
- ☐ Medicaid Waiver Budget Acknowledgement
- ☐ Provide copies of Medicare Insurance Cards, Social Security Card, Medicaid Insurance Cards, and if available, VA Insurance Card and Picture ID
- ☐ Designation of Authorized Representative (This allows The Lexington to contact Medicaid on the Applicant's behalf.)

REQUIRED IF THE APPLICANT OWNS THE ASSET: Write NA if the form doesn't apply.

- ☐ Pension Income Verification (Must include a current copy of the PENSION STATEMENT)
- ☐ Mutual Funds/Stocks/Bonds Verification (Include current copy of the BROKER STATEMENT)
- ☐ Annuity Verification (Include a copy of the ANNUITY showing current value)
- ☐ Life Insurance Verification (Include copy of LIFE INSURANCE POLICY showing current Cash Value)
- ☐ Real Estate Verification (Include copy of the PROPERTY APPRAISAL)
- ☐ Retirement Savings Plan Verification (Include current copy of the RETIREMENT documentation)

1. Complete the name and address for the institution where income or assets are held.
2. Complete the account type and account numbers where applicable. DO NOT include amounts or interest rates – these items will be verified by the third party.
3. Include the name of recipient, social security number and other identifying information as specified.
4. Sign and date the authorization to release information at the bottom on each applicable form.
5. DO NOT sign below the line "Verified By." This is for the third party to sign on.
6. **If you bank with WELLS FARGO**, please sign and date at the bottom of the VERIFICATION OF DEPOSIT HOUSING ASSISTANCE AGENCIES form provided.

If you have any questions, please contact the Executive Director at (402) 486-4400.

UNEMPLOYED AFFIDAVIT

This Affidavit is to be signed by each individual 18 years of age and older when no employment income for them is indicated on the Tenant Income Certification.

Check applicable statement:

☐ I am not presently employed and do not anticipate becoming employed within the next twelve (12) months.

☐ I am not presently employed, and not aware of an employment start date, but anticipate becoming employed within the next twelve (12) months. Based on my past work experience, skills, and income history, I expect to earn $_____/year when I become employed.

☐ I am not presently employed, but am aware of an employment start date of _____ at $_____ per _____ (If amount is hourly, please provide number of hours per week, _____).

Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned further understands that providing false representations herein constitute an act of fraud. False, misleading or incomplete information may result in the termination of a lease agreement.

Print Name: _____

_____ _____

Applicant/Responsible Party/POA Signature Print Applicant/Responsible Party/POA Signature

_____

Date

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ANNUAL STUDENT CERTIFICATION

Effective Date: _____

Move In Date: _____

(MM/DD/YYYY)

This Annual Student Certification is being delivered in connection with the undersigned's application/occupancy in the following apartment:

Head of Household Name: _____ Unit Number: _____

THE LEXINGTON ALF BIN: NE-00-01447

Check A, B, or C, as applicable (note that "student" includes those attending public or private elementary schools, middle or junior high schools, senior high schools, colleges universities, technical, trade, or mechanical schools, but does not include those attending on-the-job training courses):

A. __X__ Household contains at least one occupant who is not a student and has not been/will not be a student for five or more months out of the current and/or upcoming calendar year (months need not be consecutive). If this item is checked, no further information is needed. Sign and date below.

B. _____ Household contains all students, but is qualified because the following occupant(s) _____ is/are PART TIME student(s). Verification of part time student status is required for at least one occupant.

C. _____ Household contains all FULL TIME students for five or more months out of the current and/or upcoming calendar year (months need not be consecutive). If this item is checked, questions 1-5, below must be completed:

1. Are the students married and entitled to file a joint tax return? (attach marriage certificate or tax return) YES NO
2. Is at least one student a single parent with child(ren) and this parent is not a dependent of another individual and the child(ren) is/are not dependent(s) of someone other than a parent? (attach student's most recent tax return or Certification of Dependent Child(ren)) YES NO
3. Is at least one student receiving Temporary Assistance to Needy Families (TANF), formally known as Aid to Families with Dependent Children (AFDC) (provide third party verification) YES NO
4. Does at least one student participate in a program receiving assistance under the Job Training Partnership Act, Workforce Investment Act, or under other similar, federal, state or local laws? (attach verification of participation) YES NO
5. Does the household consist of at least one student who was previously under foster care? (Provide verification of participation) YES NO

Full-time student households that are income eligible and satisfy one or more of the above conditions are considered eligible. If questions 1-5 are marked NO, or verification does not support the exception indicated, the household is considered an ineligible student household.

Under penalty of perjury, I/we certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned further understand(s) that providing false representation herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of a lease agreement.

All household members age 18 or older must sign and date.

_____	_____	_____	_____
Signature	Date	Signature	Date
_____	_____	_____	_____
Signature	Date	Signature	Date

Rev. 12/16

ANTICIPATED HOUSEHOLD INCOME:

PRESENT EMPLOYMENT AND OTHER INCOME RECEIVED BY HOUSEHOLDMEMBERS:

For the following indicate the amount of anticipated income for all household members (for minors, unearned income amounts only), during the 12 months period beginning this date. If you are uncertain which types of income must be included or may be excluded, please ask the management personnel for assistance.

Would you like management personnel to assist you in filling out this/these financial forms? ❑ Yes ❑ No

Print Name: _____

YES	NO	Do you or anyone in your household have:	Annual Amount
_____	_____	Wages or Salaries (include overtime, tips, bonuses, commissions and payment received in cash)	$_____
_____	_____	Child Support, (includes child support you are entitled to but may not be receiving)	$_____
_____	_____	Alimony (includes alimony you are entitled to but may not be receiving)	$_____
_____	_____	Social Security	$_____
_____	_____	Supplemental Security Income (SSI)	$_____
_____	_____	Public Assistance (General Relief, and/or TANF/AFDC)	$_____
_____	_____	Veterans Administration Benefits	$_____
_____	_____	Pension Income	$_____
_____	_____	Unemployment Compensation	$_____
_____	_____	Income from Insurance Policies	$_____
_____	_____	Disability, Death Benefits and/or Life Insurance Dividends	$_____
_____	_____	Worker's Compensation	$_____
_____	_____	Severance Pay	$_____
_____	_____	Net Income from a Business (including rental property, land contracts or other forms of real estate)	$_____
_____	_____	Interest, Dividend & Other Income from Net Family Assets	$_____
_____	_____	Regular Contributions and/or Gifts from Person not residing at unit	$_____
_____	_____	Lottery Winnings or Inheritances (Paid as an annuity)	$_____
_____	_____	All regular pay paid to members of the Armed Forces	$_____
_____	_____	Annuities	$_____
_____	_____	Retirement Savings Plans (IRA/401K/Keogh)	$_____
_____	_____	Required Minimum Distribution	$_____
_____	_____	Education Grants, Scholarships or Other Students Benefits	$_____
_____	_____	Self Employment	$_____
_____	_____	Other _____	$_____
		TOTAL	$_____
_____	_____	Are any of these incomes listed above being deposited onto a pre-paid debit card (ReliaCard, Direct Express, NetSpend, Citi Bank, etc.) If so, please provide documentation so this may be verified.	
_____	_____	Other _____	$_____

ASSET INCOME:

List all assets currently held by all household members and the cash value of each. The cash value is the market value of the asset minus reasonable costs there was, or would be, incurred in selling or converting the asset to cash.

YES	NO	Do you or anyone in your household have:	Cash Value
_____	_____	A Savings Account?	$_____
_____	_____	A Checking Account?	$_____
_____	_____	Certificates of Deposit?	$_____
_____	_____	Money Market Account?	$_____
_____	_____	A Safety Deposit Box?	$_____
_____	_____	Money Held in Trust?	$_____
_____	_____	Any Stocks, Bonds or Securities?	$_____
_____	_____	Any Treasury Bills?	$_____
_____	_____	A Retirement Fund? (Includes IRA's, Keogh accounts)	$_____
_____	_____	Annuities?	$_____
_____	_____	A Pension Fund?	$_____
_____	_____	Have any Personal Property held as an Investment (this includes: paintings, artwork, collectors or show cars, jewelry, coin or stamp collections, antiques etc.)	$_____
_____	_____	Other equity in real estate, rental property, land contracts/contract for deeds or other real estate holding or other capital investments (this includes your personal residence, mobile homes, vacant land, farms, vacation homes, or commercial property)? Market Value Less: (a) Any unpaid balance on loans secured by property, and (b) reasonable costs that would be incurred in selling the asset – penalties, broker fees, etc.	
_____	_____	Received any Lump Sum Receipts? When_____ (Include inheritances, capital gains, lottery winnings, insurance settlements and other claims)	$_____
_____	_____	Other Assets not listed?	$_____
_____	_____	Have you disposed of any assets (e.g. real estate, cash, stock, etc.) in the past two years? If yes, please describe: _____	$_____

_____

For <u>Each</u> source of income and <u>Each</u> source of assets, complete the appropriate verification form (attached) and return ALL of the Forms to The Lexington Assisted Living Center with your application.

SOCIAL SECURITY VERIFICATION

THIS SECTION TO BE COMPLETED BY TENANT AND EXECUTED BY MANAGEMENT
*****MUST INCLUDE A COPY OF THE SOCIAL SECURITY ANNUAL NOTICE FOR THIS YEAR.*****

TO: _____ _____
Name and Address of Social Security Administration — Phone Number

_____ _____
Fax Number

_____

RE: _____ _____
PRINT Applicant/Tenant Name — Social Security Number

_____
Unit # (if assigned)

I hereby authorize release of my Social Security information.

_____ _____
*****Signature of Applicant/Tenant***** — Date

The individual named directly above is an applicant/tenant of a housing program that requires verification of income. The information provided will remain confidential and will be used solely for the purpose of determining eligibility for occupancy. Your prompt response is crucial and greatly appreciated.

_____
Signature of Owner's Representative

Return Form To: The Lexington Assisted Living Center
5550 Pioneers Blvd., Lincoln, NE 68506
PH: 402-486-4400 FAX: 402-486-4441

THIS SECTION TO BE COMPLETED BY PENSION PROVIDER

☐ The gross amount of the monthly Social Security Benefit is (do not substract Medicare deduction) $_____

The above amount became effective: _____/_____
Month Year

☐ The monthly payment of the Supplemental Security Income payment is $_____

The above amount became effective: _____/_____
Month Year

☐ Other information needed: _____

Complete only if you are unable to verify information requested:
☐ Claim Still Pending
☐ No record based on identifying information
☐ Other _____

_____ _____ _____
Social Security Official's Signature — Printed Name — Date

_____
Social Security Administration's Name and Address

_____ _____ _____
Phone # — Fax # — E-Mail

NOTE: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction. Rev. 12/14

BANK VERIFICATION

THIS SECTION TO BE COMPLETED BY TENANT AND EXECUTED BY MANAGEMENT

TO: _____ _____
Name and Address of Financial Institution — **ACCOUNT #**

_____ _____
Phone Number

_____ _____
Fax Number

RE: _____ _____
PRINT Applicant/Tenant Name — Social Security Number

_____ _____
PRINT Applicant/Tenant Name — Social Security Number

_____
Unit # (if assigned)

I hereby authorize release of my asset information.

_____ _____
Signature of Applicant/Tenant — **Date**

_____ _____
Signature of Applicant/Tenant — **Date**

The individuals) named directly above is an applicant/tenant of a housing program that requires verification of income. The information provided will remain confidential and will be used solely for the purpose of determining eligibility for occupancy. Your prompt response is crucial and greatly appreciated.

_____
Signature of Owner's Representative

The Lexington Assisted Living Center
5550 Pioneers Blvd., Lincoln, NE 68506
Return Form To: PH: 402-486-4400 FAX: 402-486-4441

THIS SECTION TO BE COMPLETED BY FINANCIAL INSTITUTION

SAVINGS ACCOUNT:
Acct #: ----------
Current Balance $ _____
Current % Rate _____

SAVINGS ACCOUNT:
Acct #; ----------
Current Balance $_____
Current % Rate _____

CHECKING ACCOUNT:
Acct #: ----------
Average Balance for the Past Six Months: $_____
Current Balance: $_____
Rate of Inerest: _____%

CHECKING ACCOUNT:
Acct #: ----------
Average Balance for the Past Six Months: $_____
Current Balance: $_____
Rate of Interest: _____%

Please list other asset accounts below (Certificates of Deposit, Money Market Accounts, etc.)

Account Number	Balance	Type of Account	Rate of Interest	Cash Value*
_____	$_____	_____	_____%	$_____
_____	$_____	_____	_____%	$_____
_____	$_____	_____	_____%	$_____

*NOTE: CASH VALUE IS THE CURRENT VALUE MINUS ANY PENALITIES FOR EARLY WITHDRAWAL.

_____ _____ _____
Signature — Printed Name & Title — Date

_____
Bank Name and Address

_____
Bank Name and Address

_____ _____ _____
Phone # — Fax # — E-Mail

NOTE: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction

Rev. 12/14

PENSION INCOME VERIFICATION

THIS SECTION TO BE COMPLETED BY TENANT AND EXECUTED BY MANAGEMENT

TO: _____ _____
Name and Address Phone Number

_____ _____
Fax Number

_____

RE: _____ _____
PRINT Applicant/Tenant Name Social Security Number

_____
Unit # (if assigned)

I hereby authorize release of my pension income information.

_____ _____
Signature of Applicant/Tenant **Date**

The individual(s) named directly above is an applicant/tenant of a housing program that requires verification of income. The information provided will remain confidential and will be used solely for the purpose of determining eligibility for occupancy. Your prompt response is crucial and greatly appreciated.

_____
Signature of Owner's Representative

Return Form To:
The Lexington Assisted Living Center
5550 Pioneers Blvd., Lincoln, NE 68506
PH: 402-486-4400 FAX: 402-486-4441

THIS SECTION TO BE COMPLETED BY PENSION PROVIDER

Pereiodic Payments Received: $_____ ☐ Weekly ☐ Monthly ☐ Other _____

Effective Date: _____ Ending Date, known: _____

Additional Remarks: (please indicate any anticipated changes) _____

_____

_____

_____ _____ _____
Signature Printed Name & Title Date

_____

_____
Name and Address

_____ _____ _____
Phone # Fax # E-Mail

NOTE: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

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MUTUAL FUNDS/STOCK/BONDS VERIFICATION

THIS SECTION TO BE COMPLETED BY TENANT AND EXECUTED BY MANAGEMENT

TO: _____ _____
Name and Address of Financial Institution — Phone Number

_____ _____
Fax Number

RE: _____ _____
PRINT Applicant/Tenant Name — Social Security Number

_____
Unit # (if assigned)

I hereby authorize release of my asset information.

_____ _____
Signature of Owner's Representative — **Date**

The individual named directly above is an applicant/tenant of a housing program that requires verification of income. The information provided will remain confidential and will be used solely for the purpose of determining eligibility for occupancy. Your prompt response is crucial and greatly appreciated.

_____
Signature of Owner's Representative

Return Form To: The Lexington Assisted Living Center
5550 Pioneers Blvd., Lincoln, NE 68506
PH: 402-486-4400 FAX: 402-486-4441

THIS SECTION TO BE COMPLETED BY FINANCIAL INSTITUTION

Market Value: $_____ Cash Value*: _____

Number of Units (i.e. shares): Owned: _____ at $_____ per unit

Dividends Paid and/or Interst Rate (the includes reinvested interest/dividends): $_____/_____%
(If varies, please use average dividend paid and/interest rate, or the rate at the close of business yesterday)

Frequency of Interest/Dividend payments: ☐ Monhtly ☐ Quarateriy ☐ Semi-annual ☐ Annually ☐ Other _____
*Cash Value is the current value less the cost to turn the asset into cash.

Additional Remarks: (please indicate any anticipated changes) _____

_____

_____

_____ _____ _____
Signature — Printed Name & Title — Date

_____
Financial Institution Name and Address

_____ _____ _____
Phone # — Fax # — E-Mail

NOTE: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

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ANNUITY VERIFICATION

THIS SECTION TO BE COMPLETED BY TENANT AND EXECUTED BY MANAGEMENT

TO: _____ _____
Name and Address of Financial Institution — Phone Number

_____ _____
Fax Number

RE: _____ _____
PRINTApplicant/Tenant Name — Social Security Number

_____
Unit # (if assigned)

I hereby authorize release of my annuity information.

_____ _____
Signature of Applicant/Tenant — **Date**

The individual named directly above is an applicant/tenant of a housing program that requires verification of income. The information provided will remain confidential and will be used solely for the purpose of determining eligibility for occupancy. Your prompt response is crucial and greatly appreciated.

_____
Signature of Owner's Representative

Return Form To: The Lexington Assisted Living Center
5550 Pioneers Blvd., Lincoln, NE 68506
PH: 402-486-4400 FAX: 402-486-4441

THIS SECTION TO BE COMPLETED BY FINANCIAL INSTITUTION

Type of Annuity held: ☐ Fixed ☐ Variable ☐ Hybrrid ☐ Immedicate ☐ Life ☐ Other _____

Current/Market Value: $_____ Cash Value*: $ _____

Does the applicant/tenant have access to the lump sum amount in the annuity? ☐ Yes ☐ No

Is the applicant/tenant receiving periodic payments? ☐ Yes ☐ No If yes, what amount: $_____ Frequency: _____

Is the annuity earning interest and/or dividends? ☐ Yes ☐ No If yes, what amount: _____ Frequency: _____
(This includes reinvested interest/dividends)

*Cash Value is the current value less the cost to turn the asset into cash.

Additional Remarks: (please indicate any anticipated changes) _____

_____

_____ _____ _____
Signature — Printed Name & Title — Date

_____
Financial Institution Name and Address

_____ _____ _____
Phone # — Fax # — E-mail

NOTE: Section 101 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

Rev. 12/14

LIFE INSURANCE VERIFICATION

THIS SECTION TO BE COMPLETED BY TENANT AND EXECUTED BY MANAGEMENT

TO: _____ _____
Name and Address Phone Number

_____ _____
Fax Number

_____

RE: _____ _____
PRINT Applicant/Tenant Name Social Security Number

_____
I hereby authorize release of my annuity information. Unit # (if assigned)

_____ _____
Signature of Applicant/Tenant **Date**

The individual(s) named directly above is an applicant/tenant of a housing program that requires verification of income. The information provided will remain confidential and will be used solely for the purpose of determining eligibility for occupancy. Your prompt response is crucial and greatly appreciated.

_____
Signature of Owner's Representative

Return Form To:
The Lexington Assisted Living Center
5550 Pioneers Blvd., Lincoln, NE 68506
PH: 402-486-4400 FAX: 402-486-4441

THIS SECTION TO BE COMPLETED BY LIFE INSURANCE PROVIDER

Policy Account#	**Market/Free Value**	**Cash Surrender Vaslue**	**Dividend Paid and/or Interest Rate** (Thie includes reinvestedd interest/dividents) ("N/A" if no interest or divident paid)
_____	$_____	$_____	$_____/_____%
_____	$_____	$_____	$_____/_____%
_____	$_____	$_____	$_____/_____%

Does the applicant/tenant have access to the lump sum amount? ☐ Yes ☐ No

Is the applicant/tenant receiving periodic payments? ☐ Yes ☐ No If yes, what amount $_____ Frequency _____

Additional Remarks: (please indicate any anticipated changes) _____

_____

_____ _____ _____
Signature Printed Name & Title Date

_____
Name and Address

_____ _____ _____
Phone # Fax # E-mail

NOTE: Section 101 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

Rev. 12/14

REAL ESTATE VERIFICATION

THIS SECTION TO BE COMPLETED BY TENANT AND EXECUTED BY MANAGEMENT

TO: _____ _____
Name and Address Phone Number

_____ _____
Fax Number

_____

RE: _____ _____
PRINT Applicant/Tenant Name Social Security Number

_____ _____
PRINT Applicant/Tenant Name Social Security Number

_____
Unit # (if assigned)

I hereby authorize release of my real estate information.

_____ _____
Signature of Applicant/Tenant **Date**

_____ _____
Signature of Applicant/Tenant **Date**

The individual(s) named directly above is an applicant/tenant of a housing program that requires verification of income. The information provided will remain confidential and will be used solely for the purpose of determining eligibility for occupancy. Your prompt response is crucial and greatly appreciated.

_____
Signature of Owner's Representative

Return Form To:

The Lexington Assisted Living Center
5550 Pioneers Blvd., Lincoln, NE 68506
PH: 402-486-4400 FAX: 402-486-4441

THIS SECTION TO BE COMPLETED BY COUNTY ASSESSOR/REAL ESTATE AGENT

Cash Value: $ _____ Market Value: $_____

Average Assessment Ratio: _____%_____

*Cash Value is the current value less the cost to turn the asset into cash.

Please provide documentation of cost incurred in converting this asset to cash.

Additional Remarks: (please indicate any anticipated changes) _____

_____

_____ _____ _____
Signature Printed Name and Title Date

_____
Name and Address

_____ _____ _____
Phone # Fax # E-Mail

NOTE: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

Rev. 12/14

RETIREMENT SAVINGS PLAN VERIFICATION
(401K, IRA, Keogh, etc.)

THIS SECTION TO BE COMPLETED BY TENANT AND EXECUTED BY MANAGEMENT

TO: _____ _____
Name and Address Phone Number

_____ _____
Fax Number

_____

RE: _____ _____
PRINT Applicant/Tenant Name Social Security Number

_____
I hereby authorize release of my annuity information. Unit # (if assigned)

_____ _____
Signature of Applicant/Tenant **Date**

The individual(s) named directly above is an applicant/tenant of a housing program that requires verification of income. The information provided will remain confidential and will be used solely for the purpose of determining eligibility for occupancy. Your prompt response is crucial and greatly appreciated.

_____
Signature of Owner's Representative

Return Form To:
The Lexington Assisted Living Center
5550 Pioneers Blvd., Lincoln, NE 68506
PH: 402-486-4400 FAX: 402-486-4441

THIS SECTION TO BE COMPLETED BY FINANCIAL INSTITUTION

Does the holder have access to the lump sum amount? ☐ Yes ☐ No Type of Account: _____
(*This includes funds available even if withdrawal would result in penalty)*

Cash Value *: $_____ Market Value*: $ _____

Is the applicant/tenant receiving periodic payments? ☐ Yes ☐ No If yes, what amount: $_____ Frequency: _____

Is this savings plan earning interest and/or dividends? ☐ Yes ☐ No If yes, what amount: ____% / $_____ Frequency: _____

(T*his includes reinvested interest/dividends*)

If the applicant/tenant is over 70 ½ Required Minimum Distributions (RMD) must be withdrawn from the account.

Is the applicant/tenant over 70 1/2? ☐ Yes ☐ No If yes, what is the annual RMD amount: $_____
*Cash Value is the current value less the cost to turn the asset into cash.

Additional Remarks: (please indicate any anticipated changes) _____

_____

_____ _____ _____
Signature Printed Name & Title Date

_____
Name and Address

_____ _____ _____
Phone # Fax # E-mail

29565

Verification of Deposit

Housing Assistance Agencies

WELLS FARGO

For faster processing, please complete the form on your computer before printing.

This form is for housing assistance agencies requesting consumer deposit information. Please complete the form including the customer authorization signature and fax to the number noted below. Your completed request will be faxed to the return fax number provided on this form.

TYPE or complete in BLACK INK. Use only CAPITAL LETTERS

Fax Requests To.....1-844-879-0412
Online Instructions.....www.wellsfargo.com/biz/vod
Balance Confirmation Services.....1-540-563-7323

SECTION 1: REQUESTER INFORMATION

The Lexington Assisted Living
Company Name

Candice Herzog
Attention

5550 Pioneers Blvd
Street Address

Lincoln | NE | 68506
City | State | Zip

candice@thelexington.com
Requester Email (optional)

402 - 486 - 4400
Requester Phone Number

402 - 486 - 4441
Return Fax Number

SECTION 2: CUSTOMER INFORMATION

Customer One Full Name (First Middle Last)

Customer Two Full Name (First Middle Last)

Account Number(s) (Required)

- -
Customer One Social Security Number

/ / 20
Month / Day / Year

CUSTOMER AUTHORIZATION

I/We authorize and direct Wells Fargo Bank to release the following information to the above mentioned requestor on my deposit accounts listed above or if only a Social Security Number is provided, all open depository accounts: Account Number, Account Type, Open or Closed, Account Holder(s), Current/Closing Balance, Open/Close Date, Current Interest Rate, Previous Six Average Statement Balances and Previous Six Months Interest Paid. In addition, CDs and IRAs will include: Term, Maturity Date, Interest Payment, Interest Method and Penalty.

X _____ _____ _____ _____
Signature of Account Holder | Date | Signature of Account Holder | Date

MEDICAID WAIVER BUDGET ACKNOWLEDGEMENT

I have been informed that while on the Medicaid Assisted Living Waiver Program the majority of my income (Social Security, pension or other income) will be used to pay my health insurance plans, The Lexington room and board, and a portion of The Lexington services (share of cost), if any. This amount is determined by the Department of Health and Human Services DHHS). I will be allowed to keep $64 to $84 of my income, depending on what DHHS determines. Out of this $64-$84 allowance, I must pay for monthly cable, if I have elected to have it, and any other expenses.

_____ _____

Resident Signature Date

_____ _____

Family Member/POA/Representative Signature Date

MEDICAID WAIVER SUPPLY LIST

As a recipient of Medicaid, you are entitled to receiving personal care items at no cost to you. We'll provide toilet paper, Kleenex and a bar of soap in your apartment when you move in.. If you need a specific brand of an item that Medicaid doesn't provide, you will need or provide those name-brand items. When you need to order more supplies, please follow these instructions.

SUPPLY ORDERING INSTRUCTIONS:

1. Locate the grocery tote supplied to you on the day you moved in.
2. Complete the Supply Request Form provided in your tote..
3. Place the form in the tote and give the tote to a staff member at the Reception Desk.
4. Items will be returned to you in your tote.

These items can be ordered using your Grocery Tote:

- Toilet paper
- Kleenex
- Bar Soap or Body Wash
- Deodorant
- Tooth Brush
- Tooth Paste
- Denture Cup
- Denture Cleaner
- Shampoo

FOR INCONTINENCE PRODUCTS, please see the Reception Desk at the main entrance to order incontinence products at no cost to you.