Rio Concho Terrace 403 Rio Concho Drive San Angelo, TX 76903 (325) 658-2662

Terrace Security Deposit Agreement

By signing the Terrace Security Deposit Agreement, I agree to and acknowledge the following policy regarding Terrace security deposits. Security deposits at the Terrace are equal to the amount of first month's rent. I understand a security deposit must be paid to reserve or secure an apartment and must be paid prior to moving into the apartment, this includes internal transfers. I understand my security deposit will stay on file for the entire period I occupy the unit. I acknowledge once I have moved out the security deposit will be primarily used for the turnover maintenance of the unit and may also be used to pay on any balance I have at the Terrace. I understand that receiving any deposit refund is not guaranteed and is dependent on the maintenance repairs to the unit and balance I owe. Maintenance repairs to unit are at the discretion of the Community Manager. I agree to forfeit 50% (half) of the security deposit, if I have decided for any reason not to move into the Rio Concho Terrace. Any modifications to this policy must have written approval from the Terrace Community Manager.

_____

Sign

_____

Printed Name

_____

Date

RESIDENT FACT SHEET/EMERGENCY DATA

DATE_____

NAME _____ DOB _____

ADDRESS_____ PHONE _____

EMAIL: _____

DOCTOR _____ PHONE _____

ADDRESS _____

HOSPITAL _____ PHONE _____

MEDICARE _____ SSN _____

OTHER INSURANCE _____

EMERGENCY CONTACT(S)

NAME _____ RELATIONSHIP_____

CELL _____ HOME _____ WORK _____

ADDRESS _____

NAME _____ RELATIONSHIP_____

CELL _____ HOME _____ WORK _____

ADDRESS _____

NAME _____ RELATIONSHIP_____

CELL _____ HOME _____ WORK _____

ADDRESS _____

IMPORTANT MEDICAL INFORMATION

KNOWN DRUG ALLERGIES _____

HEALTH CONDITIONS _____

_____

DNR - YES _____ NO _____ OUT OF HOSPITAL _____ IN HOSPITAL _____

CLERGY/RELIGIOUS PREFERENCE: _____

FUNERAL HOME _____ *PHONE*_____

RIO CONCHO TERRACE
403 Rio Concho Drive
San Angelo, Texas 76903
OFFICE: 325-658-2662
FAX: 325-653-0286

MEDICAL HISTORY AND EXAMINATION
(to be completed by personal physician)

Name: _____ Telephone: (___) _____
Address: _____
City: _____ State: _____ Zip Code: _____
DOB: _____ Marital Status: _____ Sex: _____

PREVIOUS OPERATIONS AND ACCIDENTS:
(Please include dates)

_____
_____

PHYSICAL LIMITATIONS:

_____
_____

PREVIOUS OR PRESENT ILLNESSES:	Yes	No	Date of Illness
Epilepsy	___	___	_____
Heart Trouble	___	___	_____
Chronic Brain Syndrome	___	___	_____
Pneumonia	___	___	_____
Arthritis or Rheumatism	___	___	_____
Polio or Meningitis	___	___	_____
Anemia	___	___	_____
Tuberculosis	___	___	_____
Diabetes	___	___	_____
High or Low Blood Pressure	___	___	_____
Chronic Lung Condition	___	___	_____
Kidney Disease	___	___	_____
Ulcer	___	___	_____
Cancer	___	___	_____

OTHER DISEASES: (Please specify) _____
_____
_____

LIST ALL MEDICATIONS PRESENTLY BEING PRESCRIBED FOR APPLICANT:

_____
_____
_____

DRUG SENSITIVITIES: _____
_____

LIST ALL ALLERGIES: _____
_____

SPECIAL DIET: _____ TYPE: _____
APPETITE: Good _____ Poor _____
AMBULATION: By Self _____ With Assistance _____

WALKING DEVICES:

Cane _____
Walker _____
Wheelchair _____
Able to walk to the dining room? _____
Could applicant ambulate without use of walking aid in an emergency? ____

EYESIGHT:

Sight with glasses _____
Failing vision _____
Inflammation _____
Cataracts _____
Glaucoma _____

CONTINENCE:

Incontinent:

Urine only _____
Feces only _____
Urine and Feces _____

Height _____
Weight _____
Temperature _____
Blood Pressure _____
Pulse _____
General Appearance _____

_____

MEDICAL CONDITION:

		(Other behavioral problems)
Alert	_____	_____
Slightly Confused	_____	_____
Very confused	_____	_____
Wanders	_____	_____

Upon completion of this medical evaluation as personal physician of the applicant: **Please circle appropriate response…**

1. The applicant is independent and needs no assistance with activities of daily living, medication assistance or administration.
2. The applicant is fairly independent and could reside in your facility with the following assistance from home health or a private sitter: Bathing, dressing, medication management, other---please list below

_____

Other Comments: _____

_____

Date: _____

_____
Physician Signature

_____
Physicians Name

_____
Address

_____
City State Zip Code

_____
Telephone

Financial Contact Information

Name:

Address:

City, State Zip:

Email:

Billing should be sent to:

HOUSEKEEPING:

MAY_____ / MAY NOT_____

clean my room if I am not present.

My housekeeping day is _____.

TERRACE PERSONNEL:

MAY_____ / MAY NOT_____

give out my phone number to those who inquire.

RIO CONCHO TERRACE

TENANT DESIGNATION OF REPRESENTATIVE UPON DEATH PURSUANT TO TEXAS PROPERTY CODE 92.014

In the event of my death, I _____ resident at Rio Concho Terrace, hereby designate _____ (name of designee), as the person to act on my behalf pursuant to Texas Property Code 92.014 in the event that I am the sole occupant of the premises on the date of my death.

My designee's mailing address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Email address: _____

In the event of my death, I hereby authorize Rio Concho Terrace to allow the above-named designee to access my rental unit, remove my personal property, and receive any funds due me from Rio Concho Terrace. The designated person's authority to act will terminate if Rio Concho Terrace receives contrary orders from a court of law naming a personal representative of my estate. My designee shall have thirty (30) days from receipt of notice from Rio Concho Terrace to remove my personal property after which Rio Concho Terrace may dispose of the property as they choose. I understand that this designation will remain in effect until it terminates, is revoked by me or is replaced with a new designation. I also understand that I may change or revoke this designation in writing at any time prior to my death.

_____ _____

Resident Signature Date

EQUAL HOUSING OPPORTUNITY

Texas Property Code § 92.014. Personal Property and Security Deposit of Deceased Tenant

(a) Upon written request of a landlord, the landlord's tenant shall: (1) provide the landlord with the name, address, and telephone number of a person to contact in the event of the tenant's death; and (2) sign a statement authorizing the landlord in the event of the tenant's death to:

(A) grant to the person designated under Subdivision (1) access to the premises at a reasonable time and in the presence of the landlord or the landlord's agent; (B) allow the person designated under Subdivision (1) to remove any of the tenant's property found at the leased premises; and (C) refund the tenant's security deposit, less lawful deductions, to the person designated under Subdivision (1).

(b) A tenant may, without request from the landlord, provide the landlord with the information in Subsection (a).

(c) Except as provided in Subsection (d), in the event of the death of a tenant who is the sole occupant of a rental dwelling: (1) the landlord may remove and store all property found in the tenant's leased premises; (2) the landlord shall turn over possession of the property to the person who was designated by the tenant under Subsection (a) or (b) or to any other person lawfully entitled to the property if the request is made prior to the property being discarded under Subdivision (5); (3) the landlord shall refund the tenant's security deposit, less lawful deductions, including the cost of removing and storing the property, to the person designated under Subsection (a) or (b) or to any other person lawfully entitled to the refund; (4) the landlord may require any person who removes the property from the tenant's leased premises to sign an inventory of the property being removed; and (5) the landlord may discard the property removed by the landlord from the tenant's leased premises if: (A) the landlord has mailed a written request by certified mail, return receipt requested, to the person designated under Subsection (a) or (b), requesting that the property be removed; (B) the person failed to remove the property by the 30th day after the postmark date of the notice; and (C) the landlord, prior to the date of discarding the property, has not been contacted by anyone claiming the property.

(d) In a written lease or other agreement, a landlord and a tenant may agree to a procedure different than the procedure in this section for removing, storing, or disposing of property in the leased premises of a deceased tenant.

(e) If a tenant, after being furnished with a copy of this subchapter, knowingly violates Subsection (a), the landlord shall have no responsibility after the tenant's death for removal, storage, disappearance, damage, or disposition of property in the tenant's leased premises.

(f) If a landlord, after being furnished with a copy of this subchapter, knowingly violates Subsection (c), the landlord shall be liable to the estate of the deceased tenant for actual damages.

_____ _____

Resident Signature Date

Figure: 25 TAC §157.25 (h)(2)

OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

STOP DO NOT RESUSCITATE

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Print Form

Person's full legal name _____ Date of birth _____ ☐ Male ☐ Female

A. Declaration of the adult person: I am competent and at least 18 years of age. **I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Person's signature _____ Date _____ Printed name _____

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person: I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature _____ Date _____ Printed name _____ Lic # _____

E. Declaration on behalf of the minor person: I am the minor's: ☐ parent; ☐ legal guardian; OR ☐ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____

Printed name _____

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature _____ Date _____ Printed name _____

Witness 2 signature _____ Date _____ Printed name _____

Notary in the State of Texas and County of _____. The above noted person personally appeared before me and signed the above noted declaration on this date _____.

Signature & seal: _____ Notary's printed name _____ *Notary Seal*

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Physician's signature _____ Date _____

Printed name _____ License # _____

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

Signature of second physician _____ Date _____ Printed name _____ Lic# _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature _____ Guardian/Agent/Proxy/Relative signature _____

Attending physician's signature _____ Second physician's signature _____

Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____

This document or a copy thereof must accompany the person during his/her medical transport.

INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER

PURPOSE: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provision of other emergency care, including comfort care.

APPLICABILITY: This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments.

IMPLEMENTATION: A competent adult person, at least 18 years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows:

Section A - If an adult person is competent and at least 18 years of age, he/she will sign and date the Order in Section A.

Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B.

Section C - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C.

Section D - If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D.

Section E - If the person is a **minor** (less than 18 years of age), **who has been diagnosed by a physician as suffering from a terminal or irreversible condition**, then the minor's parents, legal guardian, or managing conservator may execute the OOH-DNR Order by signing and dating it in Section E.

Section F - If an adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, proxy, or available qualified relative to act on his/her behalf, then the attending physician may execute the OOH-DNR Order by signing and dating it in Section F with concurrence of a second physician (signing it in Section F) who is not involved in the treatment of the person or who is a representative of the ethics or medical committee of the health care facility in which the person is a patient.

In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.

REVOCATION: An OOH-DNR Order may be revoked at ANY time by the person, person's authorized representative, or physician who executed the order. Revocation can be by verbal communication to responding health care professionals, destruction of the OOH-DNR Order, or removal of all OOH-DNR identification devices from the person.

AUTOMATIC REVOCATION: An OOH-DNR Order is automatically revoked for a person known to be pregnant or in the case of unnatural or suspicious circumstances.

DEFINITIONS

Attending Physician: A physician, selected by or assigned to a person, with primary responsibility for the person's treatment and care and is licensed by the Texas Medical Board, or is properly credentialed and holds a commission in the uniformed services of the United States and is serving on active duty in this state. [HSC §166.002(12)].

Health Care Professional: Means physicians, nurses, physician assistants and emergency medical services personnel, and, unless the context requires otherwise, includes hospital emergency department personnel. [HSC §166.081(5)]

Qualified Relative: A person meeting requirements of HSC §166.088. It states that an adult relative may execute an OOH-DNR Order on behalf of an adult person who has not executed or issued an OOH-DNR Order and is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, and the relative is available from one of the categories in the following priority: 1) person's spouse; 2) person's reasonably available adult children; 3) the person's parents; or, 4) the person's nearest living relative. Such qualified relative may execute an OOH-DNR Order on such described person's behalf.

Qualified Witnesses: Both witnesses must be competent adults, who have witnessed the competent adult person making his/her signature in section A, or person's authorized representatives making his/her signature in either Sections B, C, or E on the OOH-DNR Order, or if applicable, have witnessed the competent adult person making an OOH-DNR by nonwritten communication to the attending physician, who signs in Section D. Optionally, a competent adult person, guardian, agent, proxy, or qualified relative may sign the OOH-DNR Order in the presence of a notary instead of two qualified witnesses. Witness or notary signatures are not required when two physicians execute the order by signing Section F. One of the witnesses must meet the qualifications in HSC §166.003(2), which requires that at least one of the witnesses not: (1) be designated by the person to make a treatment decision; (2) be related to the person by blood or marriage; (3) be entitled to any part of the person's estate after the person's death either under a will or by law; (4) have a claim at the time of the issuance of the OOH-DNR against any part of the person's estate after the person's death; or, (5) be the attending physician; (6) be an employee of the attending physician or (7) an employee of a health care facility in which the person is a patient if the employee is providing direct patient care to the patient or is an officer, director, partner, or business office employee of the health care facility or any parent organization of the health care facility.

Report problems with this form to the Texas Department of State Health Services (DSHS) or order OOH-DNR Order/forms or identification devices at (512) 834-6700.

Declarant's, Witness', Notary's, or Physician's electronic or digital signature must meet criteria outlined in HSC §166.011

RIO CONCHO, INCORPORATED

TERRCE POLICY AND/OR PROCEDURE

TITLE: **CARPORT POLICY**

EFFECTIVE DATE: SEPTEMBER 1, 2022

STATEMENT OF PURPOSE:

To establish a policy for the rental and use of the carports at Rio Concho Terrace.

TEXT:

The primary purpose of the carport is to provide covered parking for resident vehicles for residents of Rio Concho Terrace.

Terrace residents shall have first priority for the rental of Terrace carport spaces. If no Terrace resident is currently wanting or waiting for a carport space, then one Terrace carport may be rented by a Terrace family member with the understanding that should a Terrace resident request a carport space the non-resident will vacate the space to allow it to be used by a Terrace resident. If there is no Terrace resident or Terrace family member wanting or waiting for a Terrace carport, then the Terrace carport may be rented by a Manor or Patio Home resident temporarily with the understanding that should a Terrace resident or Terrace family member request a carport space the non-Terrace resident will vacate the space to allow it to be used by a Terrace resident.

No other items other than a vehicle are to be stored in the parking space.

All vehicles must be properly maintained, and all vehicles must have current proper registration.

RIO CONCHO TERRACE
CARPORT PARKING

RESIDENT: _____

ADDRESS: _____

PHONE: _____

CARPORT SPACE: _____

DESCRIPTION: _____

TAG#: _____

FEE: ____ $15.00/Monthly, Terrace does not pro-rate carport fees.

DUE: By the 5th of each month

CANCELLATION: 30 day written notice by Rio Concho or by Resident

REQUIREMENTS: Carport space will be kept neat and clean by Resident
All vehicles must be properly maintained
All vehicles must have current proper registration

PRIORITY: 1. Terrace Residents
2. Terrace Family Member
3. Non-Terrace Rio Concho Residents

_____ _____
Resident Date

_____ _____
Rio Concho Terrace Date

RIO CONCHO TERRACE

ELECTRONIC FUNDS TRANSFER FORM

Resident Name: _____

Amount: _____

Start Date: _____

Resident Signature _____

Unit Number _____

Manager's Signature: _____

Date Manager Submitted: _____

For Administration Office Use Only			
Date Submitted to Admin:	_____	*Notes:*	_____
Date Entered in Computer:	_____		_____
Entered into Computer By:	_____		_____