COVID VACCINE CONSENT FORM INSTRUCTIONS AND SIGN UP INFORMATION

Luthercare Independent Living residents we are happy to announce that we have partnered with Phoebe Pharmacy to be able to offer an IL vaccine clinic by the end of the month pending the reception of the vaccine as scheduled through the federal government.

*As of now, we don't know if it will be the Moderna or Pfizer vaccine offered.

*** If you have questions related to your medical history and if you should receive the vaccine we recommend that you consult with your primary care physician for guidance.**

If you wish to receive the vaccine at Luther Acres we need you to complete the following steps by Monday February 15th:

1. Pick up 2 page consent form from either the Towne Home Reception Desk or Muhlenberg Reception Desk.
2. Return completed consent form and have the front and back copy of your insurance cards made and attached to your consent form. Copies can be made at the reception desk. ***Please include both your Medicare card and Prescription card.***
3. Once 2 page consent form is complete with copy of your insurance card and prescription card, please turn in your information to Regina or Jenn at the reception desk and they will add your name to the vaccine waiting list.
4. You will be notified of an appointment date and time once the clinic date is confirmed.
5. On day of vaccine, please arrive on time and wear appropriate attire with easy access to your upper arm.
6. Lastly, please be aware that once vaccinated, you will need to remain in an observation area for 15 minutes to ensure no severe allergic reactions occur.

COVID-19 VACCINE CONSENT FORM

Name: _____ **Birth date:** __/__/____ Sex: ☐ Male ☐ Female

SSN: ___-___-____ **Phone:** _____ **Do you have insurance?** ☐ No ☐ Yes

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity:** ☐Hispanic ☐Non-Hispanic

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

The following questions will help determine if there is any reason you should not receive a COVID immunization injection.

Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Has the person to be vaccinated ever received a COVID-19 vaccine?	☐ No	☐Yes
If yes, date:_____ Type/Brand of COVID vaccine:_____		
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex?	☐ No	☐Yes
List all allergies: _____		
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	☐ No	☐Yes
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	☐ No	☐Yes
Has the person to be vaccinated received any other vaccines in the past 14 days?	☐ No	☐Yes
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	☐ No	☐ Yes

I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Print Name, if different from patient: _____ Relationship:_____

Patient/POA Signature: _____ Date: _____

FOR CLINIC USE ONLY

Clinic site: _____ ***EUA Fact Sheet Provided:*** *Yes* *No*

Date vaccine administered: ___/___/____ ***Date booster required:*** ___/___/____

Vaccine manufacturer: _____ ***Lot number:*** _____

Site of IM injection: *RDT or LDT or* _____ ***Dose:*** *0.3ml 0.5ml*

Signature and title of vaccine administrator: _____

PHOEBE PHARMACY

COVID-19 VACCINE CONSENT FORM

Patient Information

Name: _____ Birth date: ___/___/____

INSURANCE INFORMATION

Medicare Part B Information

Medicare # _____

Address on file with Medicare _____
(if different from Primary Address)

Pharmacy Insurance Information

Prescription Insurance: _____

Cardholder's Name: _____

Group No: _____

Policy No: _____

Relationship to cardholder: _____

Other Insurance: _____

Cardholder's Name: _____

Group No: _____

Policy No: _____

Relationship to cardholder: _____

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims.

I authorize my insurance benefits be paid directly to Phoebe Services Pharmacy.

Print Name, if different from patient: _____ Relationship:_____

Patient/POA Signature: _____ Date: _____

LUTHER ACRES COVID VACCINE FREQUENTLY ASKED QUESTIONS

When will the vaccine clinic be held for independent living residents?

We will confirm the date of the vaccine clinic once the pharmacy confirms receipt of the vaccine.

What time will my appointment be?

Once the date of the vaccine clinic is determined, Luthercare staff will schedule appointment times. If you sign up by the deadline February 15th, 2021, you will be notified of your appointment date and time.

Will I be able to change my appointment time?

Unfortunately no, we will be coordinating appointments for all IL residents and therefore it's important to make your appointment.

Where will the vaccine clinic be held at Luther Acres?

The vaccine clinic will be held in the Towne Center Community Room and the shuttle will be running for the duration of the clinic to provide transportation from Muhlenberg and the cottages.

Is the vaccine safe and should I receive the vaccine given my medical history?

Luther Acres advises you to consult with your primary care physician to review your medical history and safety of the vaccine.

What if I received the first dose of the vaccine off campus at another clinic, can I receive my second dose at Luther Acres?

Unfortunately no, you must receive the second dose at the same clinic where you received the first dose.

What if I have a vaccine appointment already scheduled somewhere else?

Luther Acres would encourage you keep all current appointments until the clinic date is confirmed. Once confirmed it will be up to you on which location you prefer.

Can my family or friends receive the vaccine at Luther Acres?

At this time, the vaccine is being offered to residents only.

Do I need to still wear a mask and follow social distancing guidelines after I receive my second dose of the vaccine?

Yes, the Centers for Disease Control have advised that those vaccinated should continue to follow the current guidelines to continue to prevent the spread of COVID-19.

Can I have friends and family visit me on campus once I am vaccinated?

All residents must continue to follow the current visitor guidelines set by Luther Care. Luther Care will continue to review these restrictions and will make changes as necessary keeping the safety of all residents and staff the priority.

Example:

COVID-19 VACCINE CONSENT FORM

Name: John Smith **Birth date:** 10/4/1951 **Sex:** ☒ Male ☐ Female

SSN: 123-45-6891 **Phone:** 717-626-1212 **Do you have insurance?** ☐ No ☒ Yes

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☒White ☐Other **Ethnicity:** ☐Hispanic ☒Non-Hispanic

Address: 250 St Luke Drive Apt.1234 **City:** Lititz **State:** PA **Zip:** 17543

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Has the person to be vaccinated ever received a COVID-19 vaccine?	☒ No	☐ Yes
If yes, date: _____ Type/Brand of COVID vaccine: _____		
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex?	☐ No	☒ Yes
List all allergies: eggs		
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	☒ No	☐ Yes
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	☒ No	☐ Yes
Has the person to be vaccinated received any other vaccines in the past 14 days?	☒ No	☐ Yes
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	☒ No	☐ Yes

I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Print Name, if different from patient: _____ Relationship: _____

Patient/POA Signature: John Smith Date: 2/1/21

FOR CLINIC USE ONLY

Clinic site: _____ ***EUA Fact Sheet Provided:*** *Yes No*

Date vaccine administered: ___/___/___ ***Date booster required:*** ___/___/___

Vaccine manufacturer: _____ ***Lot number:*** _____

Site of IM injection: *RDT or LDT or* _____ ***Dose:*** *0.3ml 0.5ml*

Signature and title of vaccine administrator: _____

PHOEBE PHARMACY

Example:

COVID-19 VACCINE CONSENT FORM

Patient Information

Name: John Smith Birth date: 10/4/1951

INSURANCE INFORMATION

Medicare Part B Information

Medicare # 1EG4-TE5-MK72

Address on file with Medicare 250 St. Luke Drive Apt 1234 Lititz PA 17543
(if different from Primary Address)

Pharmacy Insurance Information

Prescription Insurance: Silver Script

Cardholder's Name: John Smith

Group No: RXCVSD

Policy No: 9151014609

Relationship to cardholder: Self

Other Insurance: Aetna Medicare Advantage

Cardholder's Name: John Smith

Group No: ABC123

Policy No: 101991234

Relationship to cardholder: Self

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims.

I authorize my insurance benefits be paid directly to Phoebe Services Pharmacy.

Print Name, if different from patient: _____ Relationship: _____

Patient/POA Signature: John Smith Date: 2/1/21

PHOEBE PHARMACY

Examples:

Medicare Card

MEDICARE HEALTH INSURANCE

Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a	Coverage starts/Cobertura empieza
HOSPITAL (PART A)	03-01-2016
MEDICAL (PART B)	03-01-2016

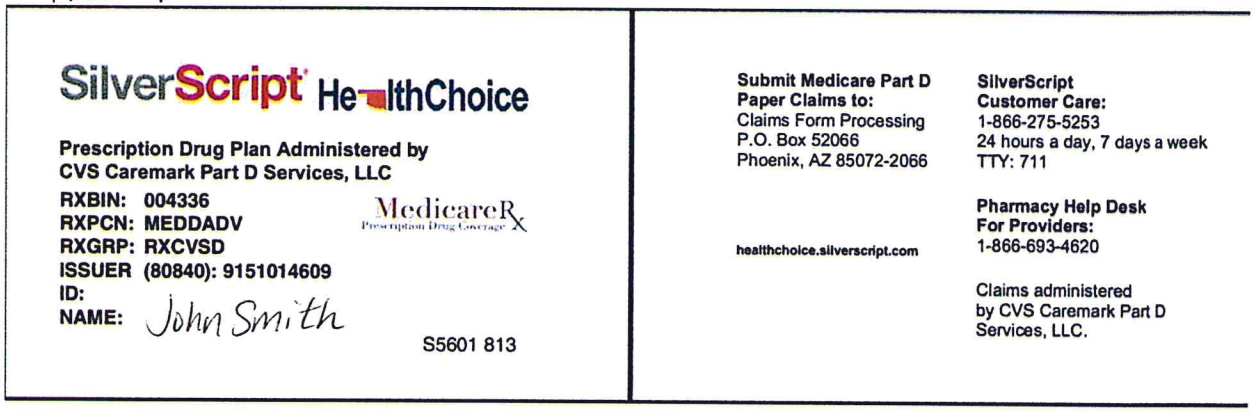
If you have a medical emergency, dial 911 or go to the nearest emergency room.

Your current co-pay, provider and benefit details can be found online/mobile app:
www.wellcare.com/medicare

Customer Service: 1-833-444-9088 TTY: 711
Provider Service: 1-855-538-0454
Nurse Advice Line: 1-877-555-1234

Submit Claims To:
WellCare Health Plans PO Box 31372 Tampa, FL 33631-3372

Prescription Card



SilverScript HealthChoice

Prescription Drug Plan Administered by
CVS Caremark Part D Services, LLC

RXBIN: 004336
RXPCN: MEDDADV
RXGRP: RXCVSD
ISSUER (80840): 9151014609
ID:
NAME: John Smith

MedicareRx Prescription Drug Coverage

S5601 813

Submit Medicare Part D Paper Claims to:
Claims Form Processing
P.O. Box 52066
Phoenix, AZ 85072-2066

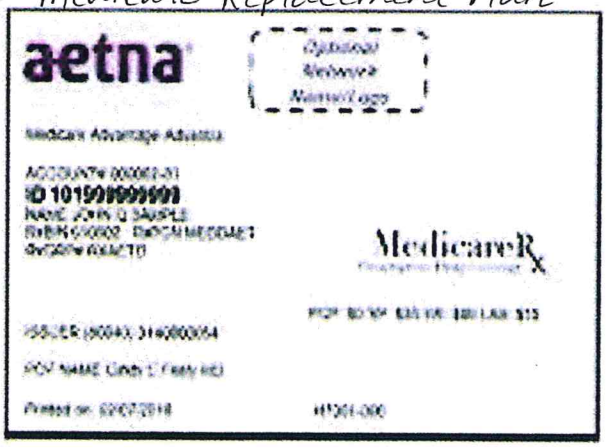
healthchoice.silverscript.com

SilverScript Customer Care:
1-866-275-5253
24 hours a day, 7 days a week
TTY: 711

Pharmacy Help Desk For Providers:
1-866-693-4620

Claims administered by CVS Caremark Part D Services, LLC.

Medicare Replacement Plan



aetna

Optional Network Name/Logo

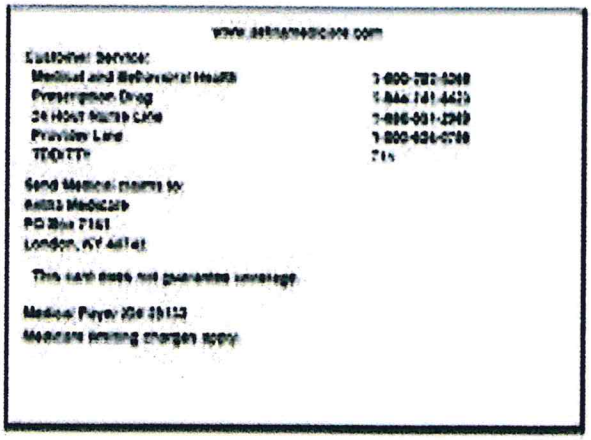
Medicare Advantage Advantra

ID 101[illegible]

MedicareRx

ISSUER (80840) 3140000054

Printed on 02/07/2018



www.aetnamedicare.com

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Medical and Behavioral Health
Prescription Drug
24 Hour Nurse Line
Provider Line
TTY/TTY

Send Medical claims to:
Aetna Medicare
PO Box 7161
London, KY 40741

This card does not guarantee coverage.

Medical Payer ID# 60153

Medicare pending changes apply