The Williamsport Home

December 18, 2020

Dear Residents, Families, and Caregivers,

As a continued effort to keep you informed of any COVID-19 activity, please see updated information on our current numbers.

Number of cases	
0	ADMISSIONS: Residents admitted or readmitted who were previously hospitalized and treated for COVID-19
0	CONFIRMED: Residents with new laboratory positive COVID-19
0	SUSPECTED: Residents with new suspected COVID-19
2	COVID-19 DEATHS: Residents with suspected or laboratory positive COVID-19 who died in the facility or another location.

Since our last letter dated December 11, 2020, there is **0** new residents confirmed and **2** new staff confirmed positive for COVID-19.

This has been a very difficult year for all of us due to the COVID-19 pandemic, but specifically for care facilities. That is why I am pleased to share some good news. The U.S. Food and Drug Administration has found a COVID-19 vaccine to be safe and effective. As healthcare workers, we will be among the first to receive the vaccine. This is very encouraging. We are happy the vaccine is safe and effective. We have an obligation to protect our residents and our community and this vaccine will be a lifesaving turning point in the fight against COVID-19.

The Williamsport Home Skilled Nursing Facility is currently scheduled to participate with the CVS Vaccine Partnership Program on January 4, 2021, from 11 a.m. until 5 p.m. Our pharmacy partner will provide onsite vaccination clinics for our staff and residents. The vaccine includes a series of two injections, with the second round currently scheduled for January 25, 2021, from 11 a.m. until 5 p.m. Please check our website's COVID-19 page for updates. The consent form for the vaccine for your loved one is on the following page. Please sign and return to The Williamsport home by 12/28/2020 if you would like your loved one vaccinated for COVID-19. Please send the consent form with Attention Jennifer Cisneros on the envelope.

Our primary goal is to give staff and residents our utmost support. We continue to focus on the basic principles of cleanliness set forth by policies and procedures from the Centers for Disease Control (CDC), Department of Health (DOH), and Regional Response Health Collaboration Program (RRHCP).

In keeping up with COVID-19 challenges, we have enacted the most recent Centers for Medicare & Medicaid Services (CMS) guidelines regarding visitation. These guidelines related to visitations and screenings are based on county positivity rates.

We thank our frontline workers for their exceptional efforts and encourage staff to maintain social distancing, use caution when attending gatherings, wear a mask and practice hand hygiene while at work and home.

Thank you for entrusting us to care for your loved ones. If you have any questions, we are always available for you.

Sincerely,

Jennifer Cisneros, NHA

Jennifer Cisneros, NHA
Nursing Home Administrator

A Tradition of Caring
1900 Ravine Road • Williamsport, PA 17701
570-323-8781 • Fax 570-323-4858
www.TheWilliamsportHome.com

COVID-19 Responsible Party Consent Form

CVS pharmacy

Resident or Patient Information

Last Name | First Name | Date of Birth | Gender

Address | City | State | Zip | SSN* (or driver's license)

Primary Care Provider (PCP) Name | PCP Phone Number | PCP Fax Number

PCP Address | City | State | Zip

SSN and state of residence, or state identification/driver's license is needed to verify patient eligibility. If a SSN and state of residence, or state identification/driver's license is not submitted, the patient will need to attest that you attempted to capture this information before submitting a claim and the patient did not have this information at the time of service, or that you did not have direct contact with the patient and thus did not have an opportunity to attempt to capture this information. Claims submitted without a SSN and state of residence, or state identification/driver's license may take longer to verify for patient eligibility.

CONSENT FOR SERVICES: I have been provided or can request the Vaccine Information Sheet(s) corresponding to the vaccine(s) that the individual listed above will receive. I have read the information provided about the vaccine they are about to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand the individual stated above should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if they experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to the individual named above for whom I am authorized to make this request. State of Georgia only: I verify a pharmacist can ask the individual stated above for their health history and whether they have had a physical exam within the past year. Health care providers did not identify condition(s) that would mean they should not receive vaccine(s).

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize CVS Pharmacy® ("CVS®") to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that CVS® may be required to or may voluntarily disclose health information to the physician responsible for this protocol of specific health information of people vaccinated at CVS (if applicable), a Primary Care Physician (if they have one), insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that CVS will use and disclose this health information as set forth in the CVS Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacy). State of California only: I agree on behalf of the party I am responsible for to have CAIR share my immunization data with Health Care Providers, agencies or schools.

Vaccine Clinics: If receiving a vaccine through a vaccine clinic, I understand that their name, vaccine appointment date and time will be provided to the clinic coordinator.

If you are legally responsible for the resident listed above, please provide the following:

Name of Responsible Party or Power of Attorney | Relationship | Date

Signature of Responsible Party or Power of Attorney Name | Phone Number