Shaker Place

REHABILITATION & NURSING CENTER

ADMISSION AGREEMENT

ADMISSION AGREEMENT

Shaker Place Rehabilitation and Nursing Center does not discriminate in admission or retention or care of its Residents because of race, creed, color, national origin, sex, disability, age, source of payment, marital status, or sexual preference.

This agreement is entered into on _____, 20____ by Shaker Place and _____
(Name of Resident)
currently residing at:

_____
Street Address

_____
Apartment Number

_____ _____

City _____ State _____ Zip _____

and/or_____ _____
(Name of Responsible Party) (Relationship)

currently residing at:

_____ _____
Street Address **Telephone Number**

_____ _____
Apartment Number **Cell Phone Number**

_____ _____
Email Address **Alternative Phone Number**

City _____ State _____ Zip _____

and/or _____
(Name of Resident's Spouse or Sponsor)
currently residing at:

_____

The persons signing this Agreement as the “Responsible Party” and/or “Sponsor” are also referred to as the “Undersigned”. Reference to the Undersigned in the plural also includes the singular. Shaker Place Rehabilitation and Nursing Center is referred to as the “Facility”.

THIS IS A LEGALLY BINDING CONTRACT THAT CREATES OBLIGATIONS FOR THE RESIDENT, THE RESPONSIBLE PARTY, THE SPONSER AND THE FACILITY. EACH PARTY SIGNING THIS AGREEMENT ACKNOWLEDGES THAT THEY HAVE READ IT, FULLY UNDERSTAND IT AND AGREE TO ITS TERMS.

IN CONSIDERATION OF THE MUTUAL COVENANTS HEREIN CONTAINED, THE PARTIES HERETO HEREBY AGREE AS FOLLOWS:

1. **THE RESIDENT’S AGENTS**

A. THE RESPONSIBLE PARTY

The “Responsible Party” is the person chosen by the Resident who is primarily responsible to assist the Resident in meeting his/her obligations under this Agreement. Unless the Responsible Party is also the Resident’s spouse, the Responsible Party is not obligated to pay for the cost of the Resident’s care from his/her own funds.

By signing this Agreement, however, the Responsible Party personally guarantees continuity of payment from the Resident’s funds and agrees to arrange third-party payment if necessary to meet the Resident’s cost of care and obligations under this Agreement.

To guarantee the Resident’s payment and insurance obligations under this Agreement, if the Resident cannot manage these responsibilities, the Responsible Party must have sufficient access to the Resident’s funds and financial information. This access, usually granted through a Durable Power of Attorney, may be limited solely to meeting the payment and insurance obligations under this Agreement and may be limited to take effect in the future only if necessary to fulfill the Resident’s obligations under this Agreement.

B. THE SPONSOR

The “Sponsor” is the person, such as the Resident’s spouse, who is responsible in part or in whole for the financial support of the Resident. A spouse may also serve as the Resident’s Responsible Party. The spouse’s personal financial duty may be limited by the amount of his/her assets as

determined by the County Department of Social Services if the Resident becomes Medicaid covered.

C. FINANCIAL AGENTS

A "Financial Agent" is an individual who has access to all of the Resident's assets via a General Durable Power of Attorney or appointment as the Resident's Article 81 or Surrogate's Court Procedure Act 17A Guardian. The Resident and the Undersigned confirm that they have informed the Facility of the Resident's current financial agents and have provided (or agree to provide) the Facility with copies of all Powers of Attorney, Guardianship Commissions or other documentation authorizing an agent to act for or on behalf of the Resident or to have access to or control of the Resident's assets within ten (10) days of their execution of this agreement. The Resident and the Undersigned agree to inform the Facility of any and all future appointments or revocation of appointments of financial agents

2. Services provided by the Facility

A. Routine services included in the daily rate and provided under this agreement and include the following:
   1. Lodging
   2. Board, including therapeutic or modified diets as prescribed by a physician
   3. Twenty-four hour per day nursing care
   4. Fresh bed linen provided at least two times per week
   5. If necessary, hospital gowns as determined by the Resident's condition
   6. General toiletries including supplies for oral hygiene, hair care, bathing, and personal hygiene
   7. Assistance or supervision when required for activities of daily living, including toileting, bathing, feeding, and ambulation assistance.
   8. Daily routine care
   9. The use of equipment that the Facility customarily stocks including wheelchairs, walkers, assistive devices, and equipment used to re-train or rehabilitate the Resident
   10. The use of medical supplies and modalities including catheters, hypodermic syringes, irrigations kits, dressings, pads, incontinence supplies, etc. (When applicable, the Facility may bill for these services through Medicare Part B or other third-party payors.)
   11. A program of diversional activities including therapeutic recreation
   12. Social services as needed

B. Subacute or other short term rehabilitative or skilled nursing services are designed to assist and enable a Resident to reach a specific performance goal so that continued recovery can take place at home or at a lower level

of care. The duration of such services is determined by the Resident's continuing need for said services. When an insurer, health benefit plan, or other third-party payor manages the Resident stay, only "medically necessary" services may be covered and the length of stay may be determined by the health plan or third party payor. The length of stay may be determined in the Resident's discharge plan and the Resident may receive a notice of discharge accordingly.

C. Ancillary services such as physician visits, visits from physician extenders and/or nurse practitioners, and some other ancillary services are not included in the basic daily rate. Other examples of ancillary services might include, but are not limited to, laboratory services, X-ray services, podiatry services, etc. Charges for such services may be covered under Medicaid or by Medicare Parts A or B, or they may be billed by the service provider. Certain ancillary services may be subject to annual payment caps. Additionally, some services, such as Medicare Part B, may be subject to co-payment(s). The Resident is responsible to pay for those services beyond the capped or covered amounts.

3. Payment for Services

A. By entering into this agreement, the Undersigned understand and agree to the Resident's payment obligations. The Resident agrees to pay for, or arrange to have paid for by Medicaid, Medicare, or other third-party insurers or payors, all services provided hereunder and agrees to pay any required third-party deductibles, co-insurance, or monthly income budgeted by the Medicaid program (called the "NAMI" amount). The Undersigned accepts the duty to ensure continuity of payment. This includes, but is not necessarily limited to, the duty to arrange for timely Medicaid coverage if Medicaid coverage becomes necessary.

B. The private pay Resident agrees to pay the applicable daily basic room rate and pharmacy charges after any Medicare Part A or other third-party plan coverage has been applied or exhausted unless and until the Resident is determined to be Medicaid eligible for chronic care with placement in a skilled nursing facility. The New York State Department of Health also administers a Health Facility Cash Assessment Program (HFCAP) fee to private payers. The 6.8% fee is an additional charge to the room rate.

C. Specifically, the Resident agrees to pay, or arrange for payment of, (1) the daily basic room rate of $_____ per day for a ☐ private room, or $_____ per day for ☐ a semi-private room, or $_____ for semi private room sharing a bathroom ☐ (2) physician and ancillary services as set forth in paragraph 1 (c) above; (3) any applicable deductible or co-

insurance payments; (4) individual purchases or “extras” as described below in paragraph 2 (d) or any non-covered services. Payment for all services is due and payable in full no later than ten (10) days after the date of billing.

D. Certain items are identified as “personal items” or as non-covered services. These items are not covered by the daily rate and may be paid directly or charged against the Resident’s personal account. Examples of such items include, but are not limited to:
    i. Barber or beautician services
    ii. Private room telephone including installation, maintenance, and other fees
    iii. Newspaper subscriptions
    iv. Dry cleaning
    v. Special transportation for personal use
    vi. Specially prepared, catered, or alternate meals apart from the Facility’s regular meal service or menu offerings
    vii. Personal clothing
    viii. Personal items of brand name choice
    ix. If a Resident requests an item different from that routinely provided by the Facility and that item is more expensive than the item routinely provided by the Facility, the Resident will incur a charge for the item equal to the difference in cost of the item(s) in question.

E. From time to time it may become necessary for the Facility to increase rates due to increased cost of operations. In such situations, Resident agrees to pay such increases and Facility agrees to notify Resident no less than thirty (30) days prior to such increases.

F. Except in those cases wherein Medicare Part A and/or private insurers or other third-party payors provide reimbursement to the Facility that covers the daily rate, the Resident is responsible to pay the private room rate unless and until Medicaid coverage is obtained. The private rate shall continue to apply while a Medicaid application is pending and/or if Medicaid coverage is denied. The Resident understands that Medicaid retroactive approval will only cover up to three (3) months of care prior to the month the Medicaid application is filed. If Medicaid approves retroactive payment for a period in which the Resident has provided payment, the Facility shall provide a refund of any and all excess funds in this regard. If the Resident’s liquid assets are exhausted or unavailable prior to Medicaid coverage, the Resident agrees to pay the Resident’s monthly income to the Facility as partial payment of the daily rate until Medicaid eligibility is established.

4. **Assignment of Benefits**

A. The Resident and/or the undersigned agents each acknowledge the Facility has relied upon the financial and insurance information submitted to the Facility at the time of or prior to admission. Each warrants that the information contains no material omissions and is true in all material respects.

B. The Resident and/or the Undersigned assign(s) benefits due to the Resident to the Facility and requests the Facility to claim payment from Medicare or other insurance payors for covered services or supplies received during the Resident's stay at the Facility. The Resident authorizes the release of information necessary for the Facility to claim and receive such payment on the Resident's behalf. If the Resident has an insurance plan that requires a separate assignment, such an assignment shall be signed and attached to this agreement as an addendum. (See Addendum I.)

C. The Facility agrees to accept as payment in full daily rates it has negotiated with a third-party payor or insurer or health plan and, as applicable, the Medicaid, Medicare, or Veteran's Administration rate plus any deductibles, co-insurance, or the Medicaid budgeted income payments. If the Facility has no agreement with the Resident's insurance provider or plan to accept a negotiated rate, the Resident agrees to pay any portion of or all of the applicable private rate and ancillary charges which the plan does not cover. All health plan benefits shall be assigned to the Facility.

D. The Facility is authorized to provide care with and maintains agreements with certain managed care organizations to provide skilled nursing care. It is the responsibility of the Resident and/or the Undersigned to notify the Facility prior to enrolling in and/or changing enrollment with a managed care organization. In the event the Resident and/or the Undersigned fail to notify the Facility prior to enrollment or change of enrollment, the Resident and/or the Undersigned will be personally responsible for any resulting unpaid or uncovered services. It is understood that the Facility may not provide care to a Resident who participates in a managed care organization that does not hold an agreement with the Facility. Resident realizes that all or part of a managed care organization's payment for covered services is not guaranteed. Coverage may be subject to prior authorization requirements and the managed care organization may also determine "medically necessary" services. While the Facility will make its best efforts to present information to the managed care organization that will support the medical necessity of coverage, the Facility is not responsible for benefit or claim denials made by a managed care

organization or other insurer and the Facility makes no representations regarding coverage decisions. The Facility will notify the Resident as it is informed of coverage decisions by the insurer. The Resident is responsible to pay any co-payments or other costs assigned to the Resident under the terms of the Resident's health care plan. The Resident is also responsible for payment to the Facility for any service or supply the insurer declines to cover. Further, the Facility reserves the right to terminate its contractual relationship with any third-party payor at any time. If the Resident chooses to remain in the Facility after coverage stops for any reason, the Resident understands and agrees to be responsible for the payment of the Facility's private rate and all applicable charges.

E. The Resident or the Undersigned authorize the Facility to: (1) submit claims to and receive payment of any and all third-party payors, and (2) release confidential information required by the third-party payor for reimbursement to the Facility as the provider of service.

5. **Medicare Part D Prescription Benefits**

A. If the Resident is an eligible beneficiary under the Medicare Part D insurance program, the Resident shall provide Facility with written notification and verification of the Resident's chosen Part D provider. If the Resident elects to change Part D providers, the Resident is responsible to notify the Facility of all changes prior to the effective date of the change.

B. The Resident is responsible to pay for the charges for all prescription drugs and other drugs, medications, and treatments, while the Resident resides in the Facility, except to the extent that the drug, medications, or treatments are covered in whole or in part by an applicable governmental reimbursement program. The Resident shall also be responsible for payment for any pharmaceutical provided to the Resident for which payment has been denied.

C. If a Resident becomes eligible for Medicaid at any time during the Resident's stay at the Facility and the Resident also qualifies for benefits under Medicare, then the Resident shall be required to enroll in a Medicare Part D program to insure coverage of the Resident's pharmaceutical needs. The Resident shall provide the Facility with written acknowledgement of enrollment. The Resident understands that if the Resident and/or the Undersigned fails to select a Medicare Part D program then the federal Center for Medicare and Medicaid Services will assign a Part D program to the Resident.

D. The Resident is responsible for and shall pay any and all cost-sharing amounts applicable under the Resident's Part D program. The Facility

accepts no responsibility to pay for any fees, cost-sharing amounts, deductibles, and/or co-insurance payments related to the Resident's Part D coverage. If the Resident qualifies as a "subsidy eligible individual" under the Part D program, then the Resident is solely responsible for making application for such benefits.

E. The Resident's Medicare Part D prescription benefit program does not apply if or while the Resident's stay at the Facility is covered under the Medicare Part A program.

6. **Duty to Arrange for Timely Medicaid Application**

A. The Resident and/or the Undersigned agree to monitor the Resident's resources and assure uninterrupted payment to the Facility by making timely and complete application to Medicaid (or any other applicable payor), if necessary, and to notify the Facility (1) a minimum of sixty (60) days prior to the anticipated exhaustion of the Resident's resources which would enable Medicaid application, and (2) when the Medicaid application will be and is filed.

B. In order to facilitate the Medicaid application and approval process as well as annual recertification, the Resident and/or the Undersigned hereby grants the Facility access to the Resident's Department of Social Services (DSS) Medicaid application and recertification file. (See Addendum II.)

C. If the Resident and/or the Undersigned are unavailable, the Resident hereby grants to the Facility the authority to file a Medicaid application and participate in all appeals of the Medicaid application process. The Resident and/or the Undersigned agree to fully participate and cooperate with any such application and/or appeal. It is expressly understood that should the Resident and/or the Undersigned fail to fully cooperate with the Facility in the processing of the Medicaid application and same results in an unpaid balance due and owing to the Facility, the Resident and/or the Undersigned will be personally and independently responsible for any and all damages incurred as a result of their nonfeasance.

D. The Resident and/or the Undersigned grants authority to the Facility to apply for a hardship waiver with the Medicaid program in the event the Resident is deemed ineligible for Medicaid due to a transfer of assets for less than fair market value within the time period prescribed by law. The Resident and/or the Undersigned agree to fully participate and cooperate with any such application or appeal. (See Addendum III.)

7. **Transfers By Resident/Spouse**

The Resident and/or the Undersigned understand that the Resident's ability to qualify for Medicaid coverage could be impaired by certain transfers or gifts of assets by the Resident or his or her spouse within the five (5) years preceding the Resident's requested date for Medicaid benefits (commonly referred to as the Medicaid program "5 year look back"). They further understand that the purchase by the Resident or his or her spouse of an annuity contract, life estate interest in a home, loan, promissory note or mortgage will be considered a transfer under certain circumstances for Medicaid eligibility purposes. The Resident and the Undersigned warrant and represent the following:

A. Except as set forth below, they do not have any knowledge of transfers or gifts by the Resident or his or her spouse within the last five (5) years (i) of assets for less than their fair value or (ii) to a trust of which the Resident or his or her spouse is a grantor or beneficiary.

B. Except as set forth below, they do not have any knowledge of the purchase by the Resident or his or her spouse of an annuity contract, life estate interest in a home, loan, promissory note or mortgage within the last five (5) years.

8. **TRUTHFULNESS OF INFORMATION PROVIDED**

The Resident and the Undersigned each jointly and separately guarantee the truthfulness of all information they each provide to the Facility (including information relating to the financial resources of the Resident and his or her spouse and transfers by the Resident and his or her spouse). By signing this Agreement, the Resident and the Undersigned acknowledge that the Facility relies on such information, and they agree to pay on demand all damages directly or indirectly resulting from their misrepresentation of information provided to the Facility, including reasonable attorney's fees.

9. **Payment Under the Medicaid Program**

A. The Resident and/or the Undersigned understand that the Medicaid program will require the Resident's net available monthly income (NAMI) to be paid to the Facility as part of the Medicaid reimbursement rate. The Resident agrees to (1) pay to Facility the NAMI amount no later than the tenth (10^{th}) day of each month, or (2) arrange for the NAMI amount to be sent monthly directly to the Facility.

B. In consideration of the fact that the Resident and/or the Undersigned agents cannot otherwise provide adequate nursing or other care to the Resident and wish to facilitate admission to the Facility, and to the extent of their excess control over Resident's assets, the Undersigned personally and independently agree to assure continuity of payment for services by

delivering payments from such assets and/or by arranging for benefit coverage. Unless the undersigned are legally obligated to pay for the Resident's care (as a spouse may be), the Undersigned are not required to use their personal funds to pay for such care. Nevertheless, the Undersigned personally agree to pay damages resulting from a breach of the following specific personal and independent promised to the Facility:

i. If necessary to meet the Resident's payment obligations to the Facility, the Undersigned personally agree to pay any deductibles, co-insurance amounts, or co-payments, and the daily basic rate and pharmacy charges from the Resident's funds to which the Undersigned has access or control unless and until Medicaid (or another third party payor) covers such charges.
ii. To the extent of the Undersigned's access or control of the Resident's income or funds, if the Resident's resources are depleted or unavailable, or unless the Medicaid program has budgeted such income to the Resident's spouse, the Undersigned personally agrees to pay the Resident's monthly income as partial payment for the private pay rate owed while the Medicaid application is pending.
iii. If Medicaid eligibility is established, the Undersigned personally agrees to (1) pay the Resident's monthly NAMI amount to the Facility, or (2) arrange to have such income deposited directly with the Facility. (See Addendum IV.)
iv. The Undersigned personally agree to use his or her access to the Resident's funds to insure continuity of payment under this agreement and agree not to use the Resident's funds in a manner which places the Facility in a position where it cannot receive payment from either the Resident's funds or from the Medicaid program. If the Undersigned receives a transfer of assets from the Resident which causes such nonpayment, then the undersigned agrees to use such assets or an amount equal to such assets to ensure continuity of payment until Medicaid coverage commences. (See Addendum V.)
v. The Undersigned and/or the Resident personally agree to fully cooperate in obtaining timely and continued Medicaid coverage by performing as follows:
    1. By timely filing the Resident's Medicaid application to ensure uninterrupted payments to the Facility and by notifying the Facility of the filing date;
    2. By providing requested information and documentation during the Medicaid application process within the specified time frame

3. By providing annual Medicaid recertification documentation in a timely fashion to the Facility and the applicable County Department od Social Services.

C. Late Payment and Nonpayment. The Facility maintains the following policies regarding payment and the Resident and/or the Undersigned hereby agree to said policies and conditions:
    i. An eighteen percent (18%) per annum fee, or the maximum amount allowed by law whichever is less, shall be assessed on all accounts owed by the Resident. If payment is not received, this assessment will be applied immediately following due date. If nonpayment is caused by a breach of this agreement, the Resident and/or the undersigned agrees to pay reasonable collection costs and legal fees incurred by the Facility.
    ii. The Resident may be discharged from the Facility for nonpayment in breach of this agreement, including nonpayment of Medicaid NAMI income. The Resident may be discharged for nonpayment upon appropriate prior notice with appeal rights. Nonpayment includes a failure to pay privately after reasonable notice or a failure to have Facility services paid for by Medicare, Medicaid, or other third-party payor. Nonpayment for Medicaid services occurs if the budgeted NAMI payment amount is not paid or there is a refusal to pay. The Resident and/or the Undersigned agree to use personal resources if necessary to pay damages to the Facility resulting from a breach of their personal and independent obligations to the Facility. Such damages shall include collection costs and legal fees.

10. **Involuntary Discharge**
    A. The Resident may be discharged or transferred involuntarily for failure to remit their assets and/or income or failure to secure a third-party payment source.
    B. Upon appropriate notice, the Resident may also be transferred or discharged involuntarily if:
        i. The discharge or transfer is necessary for the Resident's welfare and the Facility cannot meet the Resident's needs.
        ii. The Resident's health has improved sufficiently so that the Resident no longer needs the care and/or services of the Facility.
        iii. The Resident's clinical or behavioral status (or condition) endangers the safety of individuals in the facility.
        iv. The Resident's clinical or behavioral status (or condition) otherwise endangers the health of individuals in the facility.
        v. The Resident has failed, after reasonable and appropriate notice to pay, or have paid under Medicare or Medicaid, for his or her stay at the Facility.

vi. The facility ceases to operate.

11. **Consents**

A. Subject to the Resident's right to refuse a specific medical treatment, the Resident and/or the Undersigned herein consents to treatment provided by the Facility and to receive all applicable care and services provided by Facility. These services include, but are not limited to, medical and nursing services, therapeutic services, social services, dental examinations, comprehensive assessments, consultations, and treatments and services as ordered by the physician. The Resident and/or the Undersigned understands and agrees that a failure to provide "consent to treat" will result in the Facility's refusal to admit the Resident.

_____ (Resident or Responsible Party or Sponsor initial here.)

B. The Resident and/or the Undersigned hereby authorizes a physician or physician extender to visit the Resident once every thirty (30) days for the first ninety (90) days and every sixty (60) days thereafter, and/or as often as is necessary as determined by the physician and the Resident's medical condition. In the absence of the availability of the Resident's attending physician, the Facility reserves the right to arrange for another physician to visit the Resident.

C. Subject to federal or state law or regulatory limitations, including HIPAA regulations, the Facility may use and disclose the Resident's personally identifiable health information, insurance information, and financial information for the purposes of treatment, payment, or health care operations, or as permitted by law.

D. The Resident's facial photograph will be taken to use as identification. Additionally, photographs of specific conditions or injuries may be taken to supplement the Resident's medical record.

E. The Resident consents _____ yes _____ no (Resident or Responsible Party or Sponsor initial here.) to allow the Facility to photograph the Resident for the purposes of the Facility's activity or socialization programs and consents to the publication of said photograph(s) in newsletters, the newspaper, brochures, for use on television, and for other marketing purposes as may be determined by the Facility.

F. The Resident consents _____ yes _____ no (Resident or Responsible Party or Sponsor initial here.) to allow the Resident's name to be listed in a master Facility Directory that may be used to notify visitors,

clergy, or volunteers of the Resident's presence and location within the Facility.

12. **Accommodations**
    A. Unless otherwise specified, usual and customary accommodations are defined as a semi-private, two-person room.

    B. A Resident who resides in a private room agrees to (1) pay for the room at the private room rate, or (2) move from the room upon the notification by the Facility. Payment for a private room may be waived if the Facility places the Resident in the room for medically related conditions that require a private room.

    C. Beds may be reserved during temporary absences if the current payment due is not overdue and the Resident agrees to pay the private rate to reserve the bed. Medicaid and some other payors may pay for bed reservations under some circumstances. (*See Bed hold exhibit attached hereto.)

13. **Personal Funds and Personal Property (Including Facility Disclaimer)**
    A. The Facility encourages Residents to maintain personal property including some furnishings and appropriate clothing as space permits, unless to do so would infringe on the rights of health and safety of that Resident or other Residents. The Facility provides for reasonable security for Resident personal property. The facility will provide the Resident with an individually locked space, upon request. Residents are encouraged to keep valuables and personal possessions in locked drawers. Personal property remaining at the Facility more than thirty (30) days after discharge shall be disposed of at the discretion of the Facility.

    B. The Facility offers to provide personal accounts with quarterly statements for incidental expenses. As required by law, accounts that exceed fifty dollars ($50.00) shall be deposited in an interest- bearing account. Bank hours are Monday through Friday 10:00am – 11:00am and 1:30PM – 2:30PM, after hours accommodations can be made with the business office.

    C. Refunds for balances remaining in a Resident's personal account, less amounts owed to the Facility, shall be made to the Resident within thirty (30) days after discharge. Should a Resident expire, refunds will be made to the appropriate person or jurisdiction as recognized by probate law unless the funds are encumbered by DSS to recoup Medicaid payment.

D. The Resident and/or the Undersigned consent to the Facility's withdrawal of amounts owed to the Facility from the personal account prior to the return of the balance.

14. **General Rules and Provisions**

A. The Resident and the Undersigned agree to abide by the Facility's rules and regulations and to respect the dignity, personal rights, privacy, and property of others within the Facility.

B. In addition to the parties signing this Agreement, the Agreement shall be binding upon the heirs, executors, administrators, distributors, successors, and assigns of said parties.

C. This Agreement shall remain in effect upon readmission to the Facility after temporary absences such as hospitalizations or leaves of absence. This provision shall not apply in instances wherein the Resident has been discharged from the Facility "against medical advice" (AMA). Resident discharged AMA may be deemed ineligible for readmission. Should, however, a Resident discharged AMA be allowed to re-enter the Facility, a new Agreement shall be required.

D. This Agreement may not be modified or amended except in writing by the Facility and the Resident and/or the undersigned except for (1) increases or changes in charges in accordance with the Agreement, and (2) modifications that may become necessary as are required by changes in the law or regulation which are deemed to be a part of an Admission Agreement.

E. The failure of any party to enforce any term of this Agreement or the waiver by any party of a breach of this Agreement shall not prevent the subsequent enforcement of such term and no party shall be deemed to have waived subsequent enforcement of this Agreement.

F. If any provision in this Agreement is determined to be illegal or unenforceable, the provision will be deemed amended to render it legal and enforceable and to give effect to the intent of the provision. If any such provision cannot be amended, it shall be deemed deleted without affecting or impairing any other part of this Agreement.

G. This Agreement with any of its accompanying exhibits and all executed addenda are incorporated herein and contain the entire Agreement between the parties.

H. This Agreement is governed by Federal Regulations and the laws of the State of New York. Any action arising out of or related to a dispute under this Agreement shall be brought in the State or District Court located in Albany County, New York. The parties agree to such Court's jurisdiction. If the matter is brought in Federal Court, the parties agree to the venue of the Northern District of New York.

15. **PERSONAL RECORDING DEVICES**

Residents, personal representative(s) and/or family members are expressly prohibited from photographing, recording or videoing other Residents, personal representative(s), family members or staff without first receiving written permission from the Administrator, in accordance with state and federal law.

16. **Acknowledgements**

The Resident and/or the Undersigned have read, been advised of, understand, and agree to be legally bound by the terms and conditions of this Agreement. The Resident and/or the undersigned also certify to the receipt of the following:

a. The Statement of Residents' Rights
b. Physician Contact Information (If Assigned by The Facility)
c. New York State Department of Health "Hot Line" Contact Information
d. New York State Office of the Aging Ombudsman Contact Information
e. Information Regarding Advanced Directives/Health Care Proxy
f. The Facility Rules and Regulations/Resident Code of Conduct
g. Information Regarding Medicaid and/or Medicare Eligibility
h. Notice of Privacy Practices
i. HIPAA Authorization Form(s)
j. HIPAA Consent Form
k. A Listing of Key Facility Personnel Contact Information
l. Bed Hold Policy
m. Listing of Providers and Authorization Letters
n. Personal Clothing/Personal Items Information
o. Discharge/Transfer Information
p. Self-Administration of Medications Information
q. Medicare Determination/SNF Determination
r. Grievance Procedure/Concerns & Comments
s. Vaccination Information
t. Listing of Additional Charges
u. Resident/Family Council Information
v. Survey Information
w. Television Service Information
x. Food Distribution Letter

y. A Copy of this Agreement with exhibits A-C and Addenda I-V

SIGNATURES

Your signature below shall indicate that you have carefully reviewed and fully understand the contents of this Agreement and agree to be bound by the terms hereof. This Agreement may be executed in counterparts with all of such counterparts, when taken together; having the same effect as if only a single Agreement has been executed. Facsimile, e-mail or electronic signatures below shall be deemed original and shall have the same force and effect as original signatures. Gurwin Center may choose to maintain solely scanned or electronic versions of this Agreement.

The parties to this Agreement have read, been advised of, understand and agree to be legally bound by the terms and conditions set forth herein.

This Agreement is accepted on this _____ day of _____, 20____.

By:

_____

Signature (or Mark) of the Resident

And/or:

_____

Signature (or Mark) of the Responsible Party

And/or:

_____

Signature (or Mark) of the Resident's Spouse or Sponsor

_____

Signature of Facility Representative

Shaker Place Rehabilitation and Nursing Center

Facility Bed Hold Policy

Shaker Place Rehabilitation and Nursing Center will hold a bed in accordance with the following terms and conditions:

1. Medicaid

Effective May 29, 2019, New York State Medicaid will no longer allow bed hold for hospitalization for emergency or other medical treatment. In the event the resident is transferred to the hospital and is admitted, the resident and/or the resident's representative has the option to pay privately to reserve the bed at the current NYS Medicaid all-inclusive benchmark rate. If the bed is not reserved privately, the facility has the option to release the bed and, in such instances, shall give the resident priority for readmission to the next available bed.

Residents 21 and over on therapeutic leaves of absence will be made at 95% of the Medicaid rate otherwise payable to the facility for services provided and payments cannot exceed 10 days in any 12 month period.

2. Medicare/Private Insurance/Long Term Care Insurance/Private Pay

In the event the resident is transferred to the hospital and is admitted or leaves the facility for therapeutic leave, the resident and/or the resident's representative has the option to pay privately to reserve the bed at the prevailing private rate currently charged for the bed. If the bed is not reserved privately, the facility has the option to release the bed and, in such instances, shall give the resident priority for readmission to the next available bed.

Please note that Medicare and most private insurers do not pay for bed holds. It is important that a resident covered under an insurance plan consult with the insurance company regarding the insurer's bed hold policy. It is also important to understand that a resident who takes any leave from the facility will not automatically be guaranteed that Medicare, or private insurance coverage will continue upon return to the facility. In fact, such coverage may be jeopardized by taking leave during a coverage period. Prior to or at the time of leave or transfer, the resident and/or resident's representative should consult with facility staff regarding continuing stay coverage.

3. Hospice

Residents 21 and over on hospice will be reimbursed at 50% of the Medicaid rate otherwise payable to the facility for services provided. Payments cannot exceed 14 days in any 12 month period.

The facility is not obligated to hold a bed for which there is no bed hold payment arrangement. Shaker Place Rehabilitation and Nursing Center shall notify the resident and/or resident's representative of the first available bed that becomes available.

4. Veterans' Administration

Residents at the facility under the auspices of a contract for payment with the Veteran's Administration should be aware that the Veteran's Administration may pay for a designated number of bed hold days in accordance with the provisions of the contract. If a bed hold paid for by the Veteran's Administration expires, the bed may be reserved by the resident and/or resident's representative for the prevailing private rate. The facility is not obligated to hold a bed for which there is no bed hold payment arrangement. Shaker Place Rehabilitation and Nursing Center shall notify the resident and/or resident's representative of the first available bed that becomes available.

5. Time Parameters

The necessity for a bed hold becomes effective as soon as the resident is absent from the facility for a hospitalization and is admitted.

6. Admission Agreement

Should the resident be required to temporarily leave the facility for a therapeutic leave or hospitalization, the terms and conditions of the resident's original admission agreement shall remain in effect during the course of any bed hold period (or lack thereof) and remain in effect until the resident's readmission to the facility. Admission agreements do not remain in effect once a resident is officially discharged from the facility. Hospital or therapeutic leaves that result in official discharge may require the execution of a new admission agreement.

7. Storage of Personal Items

In the event of a hospital admission without a bed hold, the facility reserves the right to release the bed. Belongings will be packed by Shaker Place Rehabilitation and Nursing Center and stored in a safe location within the facility until such time as the resident is re-admitted to a new room or until the designated representative retrieves the belongings within 30 days of discharge from the facility.

Resident's Name: _____

Room & Bed Number _____

Please indicate your choice by initialing the appropriate space and affixing your signature below:

_____ I request a bed hold during my absence from the Facility and understand and agree to the terms in conditions set forth herein.

_____ I DO NOT request a bed hold during my absence from the Facility and have read and understand the terms and conditions set forth herein.

_____ ____/____/____

Signature of Resident or Resident's Representative Date

_____

Signature of Staff Person Receiving Bed Hold Request

Exhibit B
Shaker Place Rehabilitation and Nursing Center

Consent for the Use or Disclosure of Health Information
(For Treatment, Payment, or Health Care Operations)

Name of Resident: _____

I understand that as part of my health care, the facility and the physician(s) who care for me originate and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payor, including Medicare and Medicaid, can verify that services billed were actually provided
- A tool for the routine health care operations, such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided a Notice of Privacy Practices for the Shaker Place Rehabilitation and Nursing Center that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Facility reserves the right to change its notices and practices and that prior to implementation of such changes the facility will mail a copy of the revised notice to me. **I have been informed that if I refuse to sign this consent for the use and disclosure of my health information that the Facility may refuse to admit or to treat me in any manner.**

I understand that I have the right to:

- Object to the use of my health information for directory purposes
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the Facility is not required to agree to the restrictions requested. If the

Facility does agree to my requested restrictions, I further understand the Facility will be bound to those restrictions.

- Revoke this consent in writing, except to the extent that the Facility has already taken action in reliance thereon. I understand that if I revoke my consent, then the Facility will no longer be able to treat me and I will be discharged from the facility.

Legal Authority for Signature:

☐	I am the Resident named above
☐	I am the Resident's attorney-in-fact and I have attached (or provided to the Facility) to this authorization a valid power of attorney or durable power of attorney for health care (DPAHC) that grants me the power to request the Resident's medical records. If I am exercising my DPAHC, I have also attached (or provided to the Facility) evidence that the Resident's attending physician has determined that the Resident has lost the capacity to make informed health care decisions.
☐	I am the Resident's legal guardian and I have attached (or provided to the Facility) a valid appointment of guardianship by a probate court.
☐	I am the Resident's Health Care Proxy in accordance with New York State law and I have attached (or provided the facility) with a copy of my proxy acceptance.

_____ _____

Signature Date

_____

Print name of signatory

Exhibit C
Shaker Place Rehabilitation and Nursing Center

Authorization for the Release of Health Information
(Non-record, Information Only Request)

I hereby authorize the Shaker Place Rehabilitation and Nursing Center to disclose my individually identifiable health information as described below:

_____	_____	_____
Resident Name	Social Security Number	Date of Birth

Name and address of person(s) or organization(s) requesting the record if different than the Resident:

___☐___	The person identified above is a relative of the Resident
___☐___	The person identified above is a surrogate for the Resident
___☐__	The person identified above is not a relative or representative of the Resident
___☐___	I understand this request grants the person/party designated above access to information about my condition but does not grant access to view my medical record.

Legal Authority for this request (Please initial):

_____	I am the Resident noted above.
_____	I am the Resident's attorney-in-fact and I have attached (or provided to the Facility) to this authorization a valid power of attorney or durable power of attorney for health care (DPAHC) that grants me the power to request the Resident's medical records. If I am exercising my DPAHC, I have also attached (or provided to the Facility) evidence that the Resident's attending physician has determined that the Resident has lost the capacity to make informed health care decisions.
_____	I am the Resident's legal guardian and I have attached (or provided to the Facility) a valid appointment of guardianship by a probate court.

_____	I am the Resident's Health Care Proxy in accordance with New York State law and I have attached (or provided the facility) a copy of my proxy acceptance.
_____	The Resident is deceased and I am the executor/administrator of the Resident's estate and I have attached (or provided to the facility) a valid copy of my appointment papers by a court of law.

Understandings and Agreements of Requestor:

1. This authorization is voluntary.
2. This authorization will expire _____days from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying the facility in writing, however, if I choose to revoke this authorization that decision will have no effect on any actions taken prior to the date of the revocation.
4. I agree to waive all claims against the facility for the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or business associate that has a contract with the facility.
6. I understand that if I request that records be copied and sent to me that the facility will make a good faith effort to send those records to me within a reasonable period of time.

7. I understand that if I wish to have copies of records made, then the facility may assess a fee for copying the records.
8. The facility will notify me of the total amount due for copying and shipping of the requested records and I agree and understand that the facility will only send me (or forward to designated party) the requested information once it has received payment in full for its costs.

_____ _____

Signature of Person Making Request Date

Printed name of person making request

Contact for person making request if different than Resident:

Address:	
Phone:	

Addendum I

Shaker Place Rehabilitation and Nursing Center
Assignment of Benefits

Resident Name: _____

Medicare Number: _____

Medicaid Number: _____

Insurance Company: _____

Insurance ID Number: _____

The Resident and/or the undersigned on the Resident's behalf hereby assigns the benefits due to the Resident to Shaker Place Rehabilitation and Nursing Center. The Resident and/or the undersigned also authorizes the Facility to claim payment from Medicare, Medicaid, or other insurance coverage for services, treatment, or supplies received during the Resident's stay at the Facility. The Resident consents to the release of information by the Facility as is necessary to claim and receive such payment(s) on behalf of the Resident.

Date: _____/_____/_____

_____
Resident Signature

_____
Signature of Resident Representative

_____
Relationship of Representative to Resident

_____
Legal Authorization or Designation of Representative

Addendum II

Shaker Place Rehabilitation and Nursing Center

Authorization for Release of Medicaid Information to Facility

I, _____ (name of Resident), hereby authorize the Albany County Department of Social Services or any other agency that may participate in the Medicaid eligibility process to release information about my Medicaid case (Number: _____) to the Administrator (or the Administrator's designee) of Shaker Place Rehabilitation and Nursing Center located at 100 Heritage Lane, Albany, New York, 12211.

This Medicaid file information to be released is that which enables the Facility to assist the Resident to obtain Medicaid eligibility, coverage, and/or recertification. It includes all correspondence and income, resource, and eligibility information associated with the Medicaid file, including any information pertinent to a past or pending appeal of a denial of benefits. The Facility Administrator (or the Administrator's designee), the Facility's business office staff, the Facility's admission office staff, and/or the Facility's social service staff will use released information to facilitate Medicaid coverage.

The undersigned retains the right to revoke this authorization at any time by providing written notice to the Facility. I understand that the disclosure made pursuant to this authorization may be re-disclosed to others and that a revocation of this authorization does not apply to information provided or disclosed prior to the revocation.

Date: _____/_____/_____

_____
Resident Signature

_____
Signature of Resident Representative

_____
Relationship of Representative to Resident

_____
Legal Authorization or Designation of Representative

Addendum III

Shaker Place Rehabilitation and Nursing Center

Authorization to Represent Resident in the Medicaid Process

The undersigned hereby authorizes the Administrator (or the Administrator's designee) of Shaker Place Rehabilitation and Nursing Center to act on behalf of _____ _____ (name of Resident) in his/her Medicaid application, appeal of denial of benefits, and/or the recertification process.

The Facility is authorized, but not obligated, to file or to assist the Resident with a Medicaid application, a recertification, or an appeal of a denial of Medicaid eligibility on behalf of the Resident if the Resident and/or the Resident's representative(s) are unable or unwilling to take such actions. The Facility will appeal a Medicaid determination on the Resident's behalf only if the Facility deems an appeal necessary and prudent. This authorization for assistance does not relieve or release the Resident or the Resident's representative or other signatories to the admission agreement from their obligations to the Facility. All parties also acknowledge that the Facility must have the cooperation of the undersigned and financial agents in procuring any necessary financial information to the extent such information is available.

The Facility is authorized to disclose to the appropriate Medicaid agency or adjudicatory tribunal any protected health information necessary to take such action. The Medicaid agency is authorized to disclose any and all information in its files to the Facility upon the Facility's request pursuant to this authorization and the attached authorization (Addendum II of this agreement).

Date: _____/_____/_____

_____

Resident Signature

_____

Signature of Resident Representative

_____

Relationship of Representative to Resident

_____

Legal Authorization or Designation of Representative

AUTHORIZATION TO ACT AS REPRESENTATIVE
AND
AUTHORIZATION FOR RELEASE OF FINANCIAL RECORDS

I hereby authorize **Shaker Place Rehabilitation and Nursing Center**, and/or any representative thereof, to represent me in all matters pertaining to my eligibility to receive, and any application for, government benefits, including, but not limited to, Social Security Disability benefits, Supplemental Security Income benefits, and Medical Assistance ("Medicaid") benefits.

In connection therewith, I hereby authorize the release of any and all of my financial records to ST **Shaker Place Rehabilitation and Nursing Center**, and/or any representative thereof, including all bank statements, be they monthly, quarterly or annual statements, brokerage account statements and mutual fund account statements from all banks and other financial institutions wherein I maintain or maintained an account during the past five (5) years.

_____ **Date:** _____/_____/_____

Resident Signature

_____ **Date:** _____/_____/_____

Signature of Resident Representative

Addendum IV

Shaker Place Rehabilitation and Nursing Center

Agreement to Arrange Direct Payment of Monthly Income to the Facility

The Resident and/or the undersigned on behalf of the Resident hereby agrees to arrange for direct payment of the monthly income for_____ (name of Resident) to the Facility. This monthly income (less any applicable and allowable personal allowance deposited in the Resident's personal account) will be applied by the Facility as part of the monthly Medicaid payment, or the full amount will be applied as partial payment of the private pay amounts owed as applicable.

I hereby agree to have direct payment of the Resident's monthly income checks to Shaker Place Rehabilitation and Nursing Center to apply to the amount owed to the Facility with the remainder, if any, to be deposited in the Resident's personal account.

Date: _____/_____/_____

_____
Resident Signature

_____
Signature of Resident Representative

_____
Relationship of Representative to Resident

_____
Legal Authorization or Designation of Representative

Addendum V

Shaker Place Rehabilitation and Nursing Center

Financial Agent's Personal Agreement

This agreement between Shaker Place Rehabilitation and Nursing Center (Facility), located at 100 Heritage Lane, Albany, New York, 12211, and

_____

(name of person acting on the financial behalf of the Resident, hereinafter referred to as "Agent"), currently residing at:

_____

for the benefit of and concerning the admission of

_____

(name of Resident) pursuant to the attached admission agreement between the Facility and the Resident and/or sponsor and/or responsible party:

Whereas the Agent understands that the agent is a financial agent for the Resident because the agent has access to some or all of the Resident's assets, and

Whereas the Agent understands the Resident's obligations to the Facility set forth in the admission agreement and acknowledges the Resident's wishes for the agent's compliance with the agreement's terms and conditions, and

Whereas the Agent wishes to assist the Resident and to Resident facilitate the Resident's admission to and stay at the Facility, and

Whereas the Agent agrees and acknowledges that the Facility will rely on the Agent's agreements contained herein;

Now therefore, in consideration of the foregoing and for other and further valuable consideration, the parties hereby agree as follows:

Agent agrees to provide the following assistance to the Facility in the event such assistance is needed and requested:

1. Without incurring the obligation to pay for the cost of the Resident's care from the Agent's own, personal funds, and in recognition that the Agent is not currently the responsible party for the Resident, the Agent personally agrees to use the Agent's access to the Resident's funds to aid the Resident in meeting the Resident's obligations under the attached admission agreement as such assistance becomes necessary to enable the Resident to comply with the terms and conditions of said agreement.

2. More specifically, the Agent personally agrees that, to the extent of the Agent's authority, the Agent will use the Agent's access to the Resident's assets to insure continued satisfaction of the Resident's payment obligations to the Facility and agrees not to use the Resident's assets in a manner which places the Facility in a position where it cannot receive payment from either the Resident's funds or from Medicaid.
3. If the Resident becomes Medicaid eligible and if the Agent has access to or control over the Resident's income, the Agent personally agrees to assure that the Facility is paid that portion of the monthly Medicaid rate (called the "NAMI" amount) which the Medicaid agency may direct the Resident to pay towards the cost of the Resident's care and services.
4. The Agent personally agrees to assist in meeting the insurance obligations under the admission agreement if necessary and if requested by providing timely financial information and/or documentation of the Resident's assets to which the Agent has access, and
5. The Agent agrees to pay damages to the Facility caused by a breach of the Agent's agreement for the benefit of the Resident as of the date indicated.

In Witness Whereof, intending to be legally bound, the Agent hereby executes this agreement for the benefit of the Resident as of the date indicated.

_____

Name of Financial Agent

_____/_____/_____ _____

Date Signature of Financial Agent

For Shaker Place Rehabilitation and Nursing Center:

_____/_____/_____ _____

Date Signature and Title of Facility Representative

Addendum VI

SPECIAL RULES REGARDING MEDICARE

PAYMENT FOR IN-PATIENT LONG TERM CARE SERVICES IS AN EXPENSIVE AND COMPLICATED PROCESS. THIS SUMMARY PROVIDES OUR RESIDENTS AND THEIR FAMILIES WITH BASIC INFORMATION WHICH SHOULD SIMPLIFY THE PROCESS. NOTHING HEREIN SHOULD BE CONSIDERED TO BE LEGAL ADVICE. WE URGE YOU TO CONSULT WITH AN INSURANCE AGENT, ATTORNEY AND/OR OTHER KNOWLEDGEABLE PROFESSIONAL(S) IN ORDER TO HELP MAXIMIZE AVAILABLE COVERAGE. FURTHER, AS THE INFORMATION PROVIDED BELOW IS BASED UPON STATUTES AND REGULATIONS, IT IS SUBJECT TO CHANGE WITHOUT NOTICE.

MEDICARE PART A PAYMENT

Medicare Part A Hospital Insurance Skilled Nursing Facility coverage is generally available to qualified individuals 65 years of age or older, and individuals under age 65 who have been disabled for at least twenty-four months, who meet the following five requirements: 1) The Resident requires daily skilled nursing or rehabilitation services that can be provided only in a skilled nursing facility; 2) The Resident was hospitalized for at least three consecutive days, not counting the day of discharge, before entering the skilled nursing facility; 3) The Resident was admitted to the facility within 30 days after leaving the hospital; 4) The Resident is admitted to the facility to receive treatment for the same condition(s) for which he or she was treated in the hospital; and 5) A medical professional certifies that the Resident requires skilled nursing care on a "daily basis". A Resident requires skilled nursing or skilled rehabilitation services on a daily basis when services are medically necessary and provided seven (7) days a week. There is an exception if they are only provided by the facility for five (5) days per week, due to staffing levels at the facility. Additionally, there may be a one to two day break if the Resident's needs require suspension of the services.

Where these five criteria are met, Medicare will provide coverage of up to one hundred (100) days of care in a skilled nursing facility (SNF) as follows: the first twenty (20) days of covered services are fully paid for; and the next eighty (80) days (days 21 through 100) of the covered services are paid for by Medicare subject to a daily coinsurance amount for which the Resident is responsible. The Medicare Part A co-insurance amount is currently $170.50 per day (2019).

Additionally, Medicare Residents requesting a leave of absence from the facility should be aware of the Medicare rules regarding leave of absence and transfer within thirty (30) days. Medicare treats a leave of absence where a Resident leaves the facility on a particular day and does not return by twelve (12:00 AM) midnight that day, as an

_____ initial

uncovered day. Additionally, the day in which a Resident begins a leave of absence, and does not return by twelve (12:00 AM) midnight, is treated as a day of discharge.

Medicare also has a thirty (30) day transfer requirement. A Resident must be transferred from a hospital or other SNF within thirty (30) days of discharge in order to be eligible for SNF coverage. As discussed earlier, a Resident may leave the Facility past twelve (12:00 AM) midnight; however, this will be considered a discharge and they may be readmitted to the SNF if they return within the thirty (30) day time limit and meet the skilled care requirements.

If a Resident meets the eligibility requirements for Skilled Nursing Facility benefits under the Medicare Part A Hospital Insurance Program, the Facility will bill Medicare directly for all Part A services provided to the Resident. Medicare will reimburse the Facility a fixed per diem or daily fee based on the Resident's classification within the Medicare RUGS III guidelines. RUGS is an acronym for Resource Based Utilization Groups. These guidelines are a measure of what type of care the Resident requires and what it costs health care providers to provide that care to a Resident. Members of our professional staff will evaluate the Resident's health condition based on a standardized assessment form (called the MDS 2.0) provided by the Health Care Financing Administration (HCFA). Information from the MDS 2.0 form will be used by Medicare to assign the Resident a RUGS III category.

The Resident will be responsible for the daily co-insurance amount determined by Medicare. This amount is subject to increase each calendar year. With limited exceptions, a Resident who requires more than 100 days of SNF care in a benefit period will be responsible for private payment of all charges beginning with the 101st day. A new benefit period may begin when the Resident has either not been in a facility or has not been receiving a covered level of care in a skilled nursing facility for at least 60 days, returns to the hospital for another three-day stay, and then re-enters the SNF. A SNF may not request private payment until the Resident has received an official initial determination from Medicare that "skilled nursing" benefits are no longer available. While a SNF may make a determination of non-coverage, beneficiaries have a right to request an official Medicare determination of coverage (called a "Demand Bill"), which can be appealed.

MEDICARE PART B PAYMENT

Individuals who pay monthly premiums to enroll in Medicare Part B will be charged according to the Facility's or the provider of services' stated charge schedule for services they receive at the Facility. Medicare Part B pays for a wide range of additional services beyond Part A coverage. Part B may cover some of a Resident's care

_____ initial

regardless of whether they are eligible for Part A benefits. Part B covers eighty (80%) percent of the Medicare approved charge for a specific service and the individual is responsible for the additional twenty (20%) percent. In general, Part B covers medical services and supplies.

Part B covers such services as: physician services, durable medical equipment, ambulance services and certain out-patient and clinical laboratory services. Some Part B benefits have limitations. Individuals who are currently enrolled in Part B are entitled to receive payment directly. However, the Facility can bill and receive payment if you fill out a Medicare assignment of benefits form. If you complete an assignment of benefits form, a health care provider cannot charge you above the Medicare approved charge. In order to determine your Part B coverage you should contact the Social Security Administration.

As a result of recent legislation, Medicare-Choice and other alternatives now exist which may increase available Medicare benefits. To receive additional information about Medicare coverage, call the Social Security Administration at 800-772-1213.

_____ initial

Addendum VI

SPECIAL RULES REGARDING MEDICAID

PAYMENT FOR IN-PATIENT LONG TERM CARE SERVICES IS AN EXPENSIVE AND COMPLICATED PROCESS. THIS SUMMARY PROVIDES OUR RESIDENTS AND THEIR FAMILIES WITH BASIC INFORMATION WHICH SHOULD SIMPLIFY THE PROCESS. NOTHING HEREIN SHOULD BE CONSIDERED TO BE LEGAL ADVICE. WE URGE YOU TO CONSULT WITH AN ATTORNEY AND/OR OTHER KNOWLEDGEABLE PROFESSIONAL(S) IN ORDER TO HELP MAXIMIZE AVAILABLE COVERAGE. FURTHER, AS THE INFORMATION PROVIDED BELOW IS BASED UPON STATUTES AND REGULATIONS, IT IS SUBJECT TO CHANGE, SOMETIMES RETROACTIVELY, WITHOUT NOTICE.

Medicaid is a publicly-funded program of assistance that covers nursing home Residents who can demonstrate financial need. To qualify for Medicaid, an individual may have only limited assets. For example, in 2019, the individual resource limit is $15,450 (subject to annual increases); plus any funds held in an “irrevocable burial trust” arrangement or up to $1,500 under a revocable burial account. Generally, most of the Resident’s monthly income must be paid to the Facility, except for a $50 monthly “personal needs allowance” and the monthly cost of retaining a private health insurance policy. This monthly income obligation, called the NAMI (Net Available Monthly Income), is determined by the Medicaid agency. If the Resident has a spouse in the community, the spouse might be entitled to a contribution from the Resident’s monthly income. During 2019, the “community spouse” is entitled to a minimum monthly income of $3,160.50 and resources of $74,820 or one-half the couple’s resources as of the date of institutionalization up to a maximum of $126,420 (these figures are subject to increase each calendar year); increases beyond these amounts are possible, but a Department of Social Services Fair Hearing or Family Court support proceeding may be required. The Resident’s home may be exempt for Medicaid eligibility purposes if the equity value is less than $878,000 (adjusted for inflation) or if the spouse or a disabled or minor child resides there. Upon application, Medicaid looks back at financial transactions made five (5) years from the date upon which the person was institutionalized and applied for Medicaid coverage. A Resident or spouse who makes a transfer within this period may create a period of Medicaid ineligibility. Private-pay Residents should apply for Medicaid approximately three months before their funds are depleted. A Medicaid application must include proof of the Resident’s identity, U.S. citizenship or legal alien status, and past and present financial status. Medicaid recipients are required to recertify eligibility each year in order to retain benefits. Medicaid is a complex program and a knowledgeable professional can advise Residents and their families as to their rights under the Medicaid program. To receive information about Medicaid, individuals can call their local Department of Social Services in the county in which the Resident resides.

_____ initial