

# **Admission Agreement**

FORT HUDSON NURSING CENTER, INC.



## **OUR VISION**

To be the community's first choice provider in comprehensive and integrated services for older adults.

## **OUR MISSION**

To provide compassionate care and services to the community's older adults, which support personal independence, meaningful quality of life and individual dignity.

## ***ADMISSION AGREEMENT***

This Agreement is made and entered into effective as of on \_\_\_\_\_, 20\_\_\_\_, the date of admission, by Fort Hudson Nursing Center, Inc. ("FACILITY")

and \_\_\_\_\_ (Resident/Patient) residing at \_\_\_\_\_

and \_\_\_\_\_ (Responsible Party) residing at \_\_\_\_\_

and \_\_\_\_\_ (Resident's Spouse or Sponsor) residing at:

\_\_\_\_\_.

In consideration of the mutual covenants contained in this Agreement, the Facility admits the Patient/Resident ("the Resident") subject to the following terms and conditions.

### **1. THE RESIDENT'S AGENTS**

A. THE "**RESPONSIBLE PARTY**" is the person chosen by the Resident who agrees to be primarily responsible to assist the Resident to meet 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 agrees to be personally responsible to ensure the continuity of payment from the Resident's funds to which he/she has access or control and agrees to arrange for third-party payment if necessary to meet the Resident's cost of care.

To assure the Resident's payment and insurance obligations under this Agreement if the Resident were to lack capability, 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**" is the person, usually the Resident's spouse, responsible in part or in whole to pay for the Resident's cost of care. 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 if the Resident becomes Medicaid-covered.

C. A "**FINANCIAL AGENT**" is an individual who has access to or control over some or all of the Resident's assets. A Financial Agent who does not sign this Agreement as the Responsible Party or Spouse (herein the "Undersigned" or the "Undersigned Agents") is not primarily responsible to assist the Resident meet the payment and/or insurance obligations under this Agreement.

Because the cooperation of a Financial Agent other than the Undersigned often becomes necessary, the Facility requests other Financial Agents to agree to help meet the Resident's obligations (1) if requested, and (2) to the extent permitted by their access to or control of the Resident's assets and financial information. This agreement is at Addendum I.

The Resident and the Undersigned Agents confirm that they have provided the Facility a complete list of the Resident's current Financial Agents, and all Powers of Attorney, Guardianship Commissions or other documents authorizing an agent to act for the Resident or to have access to or control of any Resident's assets, e.g., access to or joint ownership of bank accounts, stocks, or social security. They agree to inform the Facility of future appointments or revocations.

#### D. THE RESIDENT'S DIRECTION TO ALL AGENTS

The Resident, or the Undersigned legal representatives on behalf of the Resident, hereby directs all of the Resident's Agents, including future appointees and the Undersigned, (1) to meet all payment obligations under this Agreement from the Resident's assets and/or from insurance coverage; (2) to cooperate in obtaining Medicaid coverage if needed; and (3) to manage the Resident's assets responsibly so that the Facility is not in a position where it is denied payment for the cost of care from the Resident's funds and from Medicaid.

The Resident and Undersigned Agents each separately acknowledge that the Facility has relied on the financial and insurance information they submitted for admission. Each warrant that the information contains no known material omissions, and is true in all material respects.

## 2. SERVICES PROVIDED BY THE FACILITY

#### A. SERVICES INCLUDED UNDER THE DAILY BASIC RATE

The services provided for the daily basic rate are listed at Exhibit A.

#### B. SUBACUTE SERVICES

Subacute or other short term services are those aimed at enabling the Residents 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 continued need for and/or continued improvement from them. Where an insurer or health benefit plan ("health plan" or "third party payor") manages the stay and covers only "medically necessary" services, the initial anticipated length of stay is determined by such health plan.

Discontinuance of Subacute Services. Upon discharge, the Resident and the Undersigned agree to cooperate in securing adequate aftercare services, if needed. Upon discontinuance of subacute services, if the Resident is not discharged, he or she agrees to transfer to another room or unit after appropriate notice.

#### C. PHYSICIAN AND ANCILLARY SERVICES

Physician services, including physician extenders such as nurse practitioners or physician assistants, and the following physician-ordered services (collectively "ancillary services") are available through duly licensed, registered, and/or certified practitioners or entities.

- i) Physical Therapy
- ii) Pharmacy Services
- iii} Audiology Services
- iv) Occupational Therapy

- v) Speech Therapy
- vi) Podiatry Services
- vii) Psychiatric or Psychological Treatment
- viii) Optometric Services
- ix) Laboratory Services
- x) X-ray Services
- xi) Oxygen Therapy
- xii) Dental Services
- xiii) Transportation Services

Ancillary Charges. Physician, physician extender and ancillary services are not included in the private pay basic rate. Charges for such services may be billed by the Facility or by the service provider. Current private charges for ancillary services are provided at admission and are available upon request.

Ancillary services are generally covered by Medicaid and Medicare Part A or Part B. Other third party payors who have negotiated a rate with the Facility may cover all or some of these services but may require the use of plan participating physicians and providers.

Participating Providers. To obtain full coverage from "managed" benefit plans, beneficiaries must use plan participating physicians and ancillary service providers. The Resident agrees to use plan participating providers unless the Facility is notified to the contrary, and agrees to pay privately for requested non-covered non-participating providers' services.

D. Facility arranges for prescription medications for all residents through a specific vendor pharmacy. This paragraph addresses prescription medication costs under Medicare Part D.

I. Part D Eligible Residents. A Resident eligible for Medicare Part D coverage agrees to enroll in a Medicare Part D prescription drug plan which has a contract with Facility's vendor pharmacy ("Pharmacy PDP") as follows:

- a. at or prior to the date of admission, if eligible at such time; or
- b. during the month the Resident first becomes eligible for Medicare Part D coverage, if such eligibility occurs after the date of admission.

The Resident and/or the Resident's designated representative agree to fully cooperate in the enrollment process, including, but not limited to, disenrolling from the Medicare Part D prescription drug plan with

which the Resident is enrolled at the time of admission, to the extent such Medicare Part D prescription drug plan is not a Pharmacy PDP, requesting any required disenrollment/enrollment forms from a Medicare Part D prescription drug plan and timely completing and submitting an enrollment form with a Pharmacy PDP. To the extent permitted by applicable law, Facility will provide assistance to the Resident and/or the designated representative in the Medicare Part D enrollment process. The Resident and/or the designated representative will ensure that the Resident maintains continuous coverage under Medicare Part D with a Pharmacy PDP for the duration of the Resident's stay at Facility, including, but not limited to, payment of any required Medicare Part D premium.

II. Private Pay Resident Eligible for Medicare Part D Coverage. The Resident and/or the designated representative is liable and responsible for all required prescription medications costs and payments under the Medicare Part D program, including, but not limited to, co-payments, deductibles and prescription medication costs that standard beneficiaries are required to pay once the initial coverage limit of \$2,250.00 is reached. The Resident and/or designated representative is liable and responsible for the cost of any and all prescription medications not covered by the Resident's Pharmacy PDP, to the extent not otherwise covered under the Medicare Part D program. If a Resident fails to enroll in a Pharmacy PDP or disenrolls or is disenrolled from a Pharmacy PDP, the Resident will be liable and responsible for prescription medication costs to the same extent as a Private Pay Resident without Medicare Part D coverage (See subsection III below). Facility has no financial liability for prescription medication costs incurred on behalf of the Resident and, to the extent Facility incurs financial liability for such costs, the Resident and/or designated representative agree to reimburse and indemnify Facility for all such costs.

III. Private Pay Resident without Medicare Part D Coverage. The Resident and/or the designated representative is fully liable and responsible for all prescription medication costs incurred on behalf of the Resident, including, but not limited to, any required third-party insurance co-payments, deductibles, or co-insurance amounts. Facility has no financial liability for prescription medication costs incurred on behalf of the Resident and, to the extent Facility incurs financial liability for such costs, the Resident and/or designated representative agree to reimburse and indemnify Facility for all such costs.

IV. Medicare Part A Resident. Prescription medication costs are included in Facility's Medicare Part A rate. When Medicare Part A coverage ceases, the Resident and/or designated representative will be responsible for prescription medication costs to the extent required by the Resident's status under subsections II, III, V or VI.

V. Medicaid Only Resident. A Medicaid only Resident is a Resident who is eligible for Medicaid but not eligible for Medicare Part D coverage. Prescription medication costs incurred on behalf of the Resident are included in Facility's Medicaid rate or, to the extent not so included, are paid for by Medicaid.

VI. Medicaid Resident Eligible for Medicare Part D Coverage. Prescription medication costs covered by the Resident's Pharmacy PDP are fully covered under the Medicare Part D program. Facility has no financial liability for prescription medication costs covered by the Resident's Pharmacy PDP. The Resident and/or designated representative are liable and responsible for the costs of prescription medications not covered by the Resident's Pharmacy PDP, to the extent not otherwise paid for by Medicaid.

#### E. OTHER ITEMS/SERVICES

Certain items and services, such as those below, are not covered by the daily rate or by health plans. They may be paid for directly or charged against the Resident's personal account.

- i) Barber/Beauty Parlor
- ii) Room telephone including installation, maintenance and hook-up fees
- iii) Room TV including installation, maintenance and cable fees
- iv) Newspapers, sundries
- v) Specially prepared or catered meals apart from the regular meal service
- vi) Dry cleaning
- vii) Special transportation for personal use

The Undersigned agree to assist the Resident to obtain needed clothing and requested personal items.

Requests for "Extras". When the Resident requests items that are more expensive than or in excess of items provided under the rate or applicable health plan, the Resident will be charged. Except for the items described above, the Facility will provide notice of the extra charge prior to providing the requested items.

### 3. AGREEMENT TO PAY OR TO ARRANGE FOR PAYMENT

By entering this Agreement, the Resident, the Resident's spouse and/or the Undersigned Agents on the Resident's behalf, understand and agree to the following Resident payment obligations. The Resident agrees to pay for, or arrange to have paid for by Medicaid, Medicare or other insurers, all services provided under this Agreement, and agrees to pay any required third party deductibles, coinsurance or monthly income budgeted by the Medicaid program (called the Net Available Monthly Income or "NAMI" amount). The Undersigned Agents accept the duty to ensure continuity of payment. This includes the duty to arrange for timely Medicaid coverage, if Medicaid coverage becomes necessary.

#### A. PRIVATE PAY STATUS

The privately paying Resident agrees to pay the applicable daily basic room rate ("private pay rate") after any Medicare Part A or other plan coverage has been applied or exhausted, unless and until the Resident is determined to be Medicaid eligible for chronic care. The private pay rate is owed while a Medicaid application is pending and if the Medicaid application is denied unless other insurance covers the rate. See "D". below.

Specifically, the Resident agrees to pay, or arrange for payment of, (1) the daily basic rate of the room occupied; (2) physician and ancillary medical services as set forth above; (3) any applicable deductibles or coinsurance, and (4) individual purchases and "extras" described below. The Resident's Currently assigned room rate is \$\_\_\_\_\_. This rate is subject to change as allowed for in this Agreement, and based on the rate in place at the time of transfer to another room under a different rate (semi-private to private or private to semi-private).

This charge will be paid MONTHLY in advance by or on behalf of the Resident. Payment is due by the FIRST of the month following the billing date.

#### B. PREPAID AMOUNTS AND SECURITY DEPOSITS

If the Resident is not qualified for Medicare Part A, Medicaid or HMO coverage, *or upon termination of such coverage*, the Resident agrees to prepay:

1. A security deposit equal to one month of service at the daily basic rate.
2. An amount equal to the daily rate for the initial month, to be applied toward the first month of service.

Prepaid funds held more than 61 days will be kept in an interest-bearing account. If the Facility uses the security deposit to cover delinquent charges, the Resident agrees to replenish the security deposit to the original amount.

Refund of Deposit. Upon discharge, the deposit will be applied to cover amounts owed. The rest will be refunded to the Resident. If the Resident is deceased, refunds will be paid to the person or probate

jurisdiction administering the estate, or by a New York "small estate" affidavit, or as otherwise required by law.

#### C. ADDITIONAL CHARGES AND RATE INCREASES

No additional charges beyond the daily rate will be assessed except: (1) upon express written orders of the treating physician for specific services and supplies not included in the daily rate; or (2) where a health emergency requires the furnishing of special services or supplies.

The Facility agrees not to increase the daily basic rate except: (1) due to the increased cost of operations and after 30 days' prior written notice to the Resident, the Designated Representative and/or the Undersigned; or (2) upon express written authority of the Resident, the Designated Representative, or the Undersigned.

#### D. DUTY TO PAY PRIVATE RATE UNTIL MEDICAID COVERED

Except where Medicare or other insurance covers the daily rate, the Resident agrees to pay the private pay rate unless and until Medicaid coverage is obtained. The private rate applies while a Medicaid application is pending and/or if Medicaid coverage is denied. Medicaid can only cover up to three months' care prior to the month the Medicaid application is filed. If Medicaid ultimately covers a retroactive period paid for privately, the Facility will refund or credit any excess over the amount owed by the Resident.

If the Resident's liquid assets are exhausted or unavailable prior to Medicaid coverage, the Resident agrees to pay his/her monthly income as partial payment of the daily basic rate until the Medicaid eligibility is established.

#### E. THIRD PARTY COVERAGE

The Facility accepts as payment in full rates which it has negotiated with a Resident's health plan and, as applicable, the Medicaid or Medicare rate plus any deductibles, coinsurance or the Medicaid budgeted income payments.

If the Facility has no agreement with the Resident's indemnity (non-HMO) health insurance 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 are assigned to the Facility.

Assignment of Benefits. The Resident, or the Undersigned Agents on the Resident's behalf, assigns the benefits due to the Resident to the Facility and requests the Facility to claim payment from Medicare or other insurance for covered services or supplies provided by the Facility. The Resident authorizes release of information necessary for the Facility to claim and receive such payments on the Resident's behalf. A separate assignment of benefits will be signed and attached to this Agreement at Addendum II.

Managed Care and Benefit Denials. Residents/patients with coverage for all or part of the Facility's charges by a "managed" health plan understand that although the Facility relies on the plan's verification of eligibility, payment for covered services is not guaranteed. Continued coverage may be subject to specific additional pre-authorization requirements, to modification by the plan, and to the plan's determination that recommended services continue to be or are "medically necessary" as well as covered.

The Facility is not responsible for benefit denials or cut-offs by insurers. The Facility will, however, use its best efforts (1) to present information to support the medical necessity of recommended treatment; and (2) to notify the Patient and/or Responsible Party as soon as it is informed that coverage will cease or decrease.

Termination of Coverage. If the Resident remains in the Facility after coverage terminates or after the insurer deems that otherwise-covered services are no longer "medically necessary," the Resident agrees to pay the applicable private rate and charges for requested non-covered services until Medicaid covers such services.

Cooperation Securing Insurance Benefits. Medicare and Medicaid reimbursement is contingent on having sought payment from all other liable third parties. The Undersigned verify that they have disclosed all sources of third party coverage, and have (i) provided proof of eligibility for coverage or (ii) provided the information and authorization necessary to verify third party coverage.

The Resident, the Responsible Party, and Sponsor further agree:

- i) To keep any insurance coverage premiums current and to notify the Facility if required premiums have not been or cannot be made;
- ii) To notify the Facility of any denial of benefits or termination of coverage;
- iii) To assist with appeals of denials of payment; and
- iv) Upon request, to provide the Facility updated insurance information, including copies of the summary of benefits or policy riders or amendments.

Authorization to Submit Claims For Payment. The Resident or the Undersigned Agents authorize the Facility: (1) to submit claims and receive payment of health plan benefits for services rendered under this Agreement; and (2) to release confidential information required by the insurer for reimbursement to the Facility.

Deductibles and Co-insurance. The Resident agrees to pay any deductibles and/or coinsurance required by Medicare or other health plans, including any budgeted income amounts required under Medicaid.

#### F. DUTY TO ARRANGE FOR TIMELY MEDICAID APPLICATION

The Resident and the Undersigned agree to monitor the Resident's resources and assure uninterrupted payment to the Facility by making timely and complete application to Medicaid (and/or other payors), if necessary, and to notify the Facility (i) when the Resident's resources are expected to reach the Medicaid resource level, and (ii) when the Medicaid application will be and is filed.

Release of Medicaid Information to the Facility. To facilitate the Medicaid application and annual recertification, the Facility requests access to the Resident's Department of Social Services ("DSS") Medicaid application and recertification file. This authorization is at Addendum III.

Authorization to Act on Resident's Behalf. The Facility requests the authority to file and participate in an appeal of a Medicaid denial if it deems appropriate and if the Resident or Undersigned are unable or unavailable to appeal. Authorization for Facility participation in an appeal is at Addendum IV. The Undersigned agree to cooperate in any such appeal and to provide timely financial and other required documentation.

Medicaid Applications/Recertification. The Resident and the Designated Representative and Agent agree to fully cooperate with the County Department of Social Services in the Medicaid application/recertification process. The Resident and the Designated Representative and Agent agree to provide complete information and documentation to the appropriate County Department of Social Services as necessary to complete the Medicaid application or Medicaid recertification or as otherwise requested by the County Department of Social Services, including, but not limited to the disclosure of a description of any interest that the Resident or the Resident's spouse has in an annuity. All such information, documentation and disclosures are to be provided within the time frames requested by the County Department of Social Services.

In the event the Medicaid application or Medicaid recertification is denied due to a transfer of assets within the applicable Medicaid "look-back" period or due to an equity interest in the Resident's home that exceeds the current equity interest limitation, the Resident and the Designated Representative and Agent agree to take one or more of the following actions, as appropriate, to qualify for or to continue eligibility for Medicaid:

- i. undertake, to the Resident's and/or the Designated Representative's best efforts, all reasonable actions necessary to have the transferred assets returned to the Resident or to obtain the fair market value for the assets transferred;
- ii. designate the state in any annuity purchased by or on behalf of the Resident or the Resident's spouse as the remainder beneficiary in either the first or second position, as appropriate, under applicable Medicaid laws and regulations and restructure any such annuity as necessary, including, but not limited to, the removal or elimination of any deferral or balloon payments, the provision for payments in equal amounts during the term of the annuity, ensuring that the annuity is actuarially sound, ensuring the annuity is irrevocable and non-assignable; or
- iii. with respect to home equity interest in excess of the Medicaid limit, sell the home at fair market value or secure a reverse mortgage or home equity loan to reduce the equity interest in the home to below the Medicaid limit.

In addition, the Resident and the Designated Representative agree to forego the purchase of a promissory note, loan, mortgage or life estate, unless such purchase will not adversely affect the Resident's eligibility or continued eligibility for Medicaid.

If due to a transfer of assets or due to an equity interest in the Resident's home in excess of the Medicaid limit, the Resident's Medicaid application or Medicaid recertification is denied, the Resident and/or the Designated Representative or Agent hereby agree to timely request and prosecute a hardship waiver application with the appropriate County Department of Social Services. Alternatively, the Resident and the Designated Representative and Agent agree to consent to the Facility requesting and prosecuting a hardship waiver application and will agree to sign an appropriate authorization when and if the need arises.

#### G. MONTHLY INCOME PAYMENTS UNDER MEDICAID

The Resident understands that, upon Medicaid eligibility, DSS will require most monthly income (the "Net Available Monthly Income" or "NAMI") to be paid to the Facility as part of the Medicaid rate. If DSS sets a NAMI, the Resident agrees (1) to pay the NAMI by the *tenth (10)* of each month, or to require the monthly income to be sent directly to the Facility (Addendum V); and (2) if the Resident disputes the NAMI amount, to place the disputed portion in an escrow account, and pay the undisputed portion to the Facility by the *tenth of* each month. The Parties agree that funds held in escrow will be released according to the determination of the entity adjudicating the NAMI dispute.

#### 4. THE PERSONAL AND INDEPENDENT OBLIGATIONS OF THE RESPONSIBLE PARTY AND SPONSOR

In consideration of the fact that the Undersigned Agents cannot otherwise provide adequate nursing care to the Resident and wish to facilitate his/her admission to the Facility, and to the extent of their access to or control over the 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 as described below. Unless the Undersigned Agents are legally obligated to pay for the Resident's care, as a Spouse may be, they are not required to use their personal funds to pay for such care. The Undersigned nevertheless *personally* agree to pay damages resulting from a breach of the following *personal and independent* promises to the Facility.

#### A. TIMELY PAYMENT FROM RESIDENT'S FUNDS

Private Rate, Deductibles and Coinsurance. If necessary to meet the Resident's payment obligations to the Facility, the Undersigned *personally agree* to pay any deductibles, coinsurance or copays and the daily basic rate and pharmacy charge from the Resident's funds to which he/she has access or control (where Medicare Part A or other negotiated rate coverage is not available) until Medicaid covers such charges.

Monthly Income As Partial Payment of Private Rate. To the extent of the Undersigned Agents' access to or control over the Resident's income, if the Resident's resources are depleted or unavailable while a Medicaid application is pending, the Undersigned Agents *personally agree* to pay the Resident's monthly income as partial payment for the private pay rate owed, unless DSS has budgeted such income to the Resident's spouse.

Payment of Medicaid NAMIs. If Medicaid eligibility is established, the Undersigned Agents either (i) *personally agree* to pay the Resident's monthly NAMI or (ii) agree to arrange to have such income deposited directly with the Facility pursuant to Addendum V. If the NAMI amount is disputed, the Undersigned *personally agree* to place the disputed amount in escrow and pay the undisputed amount pursuant to Section 3 above.

#### B. TRANSFERS OF ASSETS

The Undersigned Agents *personally* agree to use his/her access to the Resident's funds to ensure 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 Medicaid. If the Undersigned Agents receive a transfer of assets from the Resident which causes such nonpayment, the Undersigned Agents agree to use such assets or an amount equal to such assets to assure continuity of payment until Medicaid covers such costs.

#### C. MEDICAID OBLIGATIONS

The Undersigned Agents *personally agree* to cooperate in obtaining timely and continued Medicaid coverage, either with the Facility staff's assistance or independently, as follows:

- i) By timely filing the Resident's Medicaid application to ensure uninterrupted payments to the Facility and by notifying the Facility of the filing date;
- ii) By providing the requested application information and documentation to Medicaid within the specified time frame or by requesting an extension in writing prior to the deadline and notifying DSS that the time frame cannot be met and why; and
- iii) By providing annual Medicaid recertification information timely to DSS upon request.

#### 5. LATE PAYMENTS AND NONPAYMENT

##### A. LATE CHARGES, COLLECTION COSTS, ATTORNEY FEES

A 16% per annum fee or the maximum amount allowed by law, whichever is less, will be assessed on accounts owed by the Resident which are overdue more than 30 days. If non-payment is caused by a breach of this Agreement, the Resident agrees to pay reasonable collection costs and attorney's fees incurred by the Facility.

#### B. DISCHARGE FOR NONPAYMENT

The Resident may be discharged for nonpayment in breach of this Agreement, including nonpayment of the Medicaid NAMI income. See Section 6 below.

#### C. DAMAGES DUE FROM THE RESPONSIBLE PARTY, FINANCIAL AGENTS OR SPONSOR

The Undersigned Agents agree to use their personal resources if necessary to pay damages to the Facility resulting from a breach of their *personal and independent obligations* to the Facility promised at Section 4 above. Such damages include collection costs and attorney fees.

Damages resulting from a breach of a Financial Agent Agreement (Addendum I) will also be due hereunder if the Financial Agent (1) refuses to pay amounts due from the Resident's funds upon request when delivery of such funds is feasible and necessary to meet the Resident's obligations; and/or (2) transfers Resident assets which prevents the Facility from receiving payment for services.

### 6. RETENTION AND DISCHARGE

#### A. NOTICE TO FACILITY OF NON-EMERGENCY DISCHARGE

If the Resident wishes to leave the Facility for reasons within his/her control, the Resident and/or Undersigned agree to give the Facility advance written notice. Privately paying Residents agree to pay one day's basic rate beyond the discharge date if such notice is not given.

#### B. INVOLUNTARY DISCHARGE

Discharge for Nonpayment. 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 to have Facility services paid for by Medicare, Medicaid or other third party coverage. Nonpayment for a Medicaid covered Resident occurs if the budgeted monthly NAMI is not paid and the amount is not in dispute, or funds are actually available or would be available and the Resident, or the Undersigned with access to or control over the NAMI, refuses to pay the NAMI.

Other Bases for Involuntary Discharge. Upon appropriate prior notice, the Facility also may transfer or discharge the Resident involuntarily:

i) when the interdisciplinary care team, in consultation with the Resident or the Resident's Designated Representative determines that the transfer or discharge is necessary for the Resident's welfare and the Resident's needs cannot be met after reasonable attempts at accommodation in the facility;

ii) because the Resident's health has improved and he/she no longer needs nursing facility services;

iii) if the health or safety of individuals in the facility would otherwise be endangered, the risk to others is more than theoretical and all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem; or

- iv) the Facility closes.

## 7. CONSENTS

### A. ROUTINE SERVICES

Subject to the Resident's right to refuse specific medical treatment, the Resident (or the Undersigned Agents for the Resident) consents to receive routine nursing facility services, routine medical assessments, dental examinations and comprehensive assessments required by Medicare.

### B. PHYSICIAN VISITS

A physician and/or a physician extender, if applicable, is authorized to visit the Resident at least once every 30 days for the first 90 days and at least once every 60 days thereafter, and as often as necessary to address the Resident's medical condition. If the Resident's attending, alternate or staff physician is not available as required or as medically necessary, the Facility may arrange for a different physician to visit the Resident.

### C. IDENTIFIABLE HEALTH INFORMATION

Subject to specific federal or state law limitations, the Facility may use and disclose the Resident's personally identifiable health, insurance and financial information for treatment, payment and health care operations, or as permitted or required by law.

### D. RESIDENT PHOTOGRAPH

The Resident's facial photograph may be taken to use as identification. These photographs will be kept confidential.

### E. ROOM TRANSFERS

Upon request, the Resident who occupies a private room and who does not pay the private room rate agrees to move to a semiprivate room unless a private room is medically necessary. The Resident occupying a Subacute/rehabilitation bed agrees to be transferred to a non-specialized unit or bed after Subacute care terminates.

## 8. TEMPORARY ABSENCES AND BED RESERVATIONS

The Resident and Responsible Party acknowledge receipt of Facility's bed hold policy, the terms and conditions of which are incorporated herein. Under those circumstances where the bed hold is not paid for by Medicaid (i.e. private pay resident, Medicare Part A resident or Medicaid bed hold payment not available) and the Resident and/or Responsible Party request, either orally or in writing, that the Facility hold the Resident's bed during a period of hospitalization or therapeutic leave, the Resident and/or Responsible Party agree to pay Facility its Private Pay Rate for each day of the bed hold period.

Beds may be reserved privately during temporary absences if the Resident's payments are not overdue upon written agreement to pay the private rate. Medicaid and some health plans pay for bed reservations under some circumstances. Please review the Resident's health plan and the bed reservation policies at Exhibit B.

## 9. PERSONAL PROPERTY

Facility procedures provide reasonable security for Resident personal property. Locked storage in each room is available upon request. Because of the number of people at the Facility and the diminishing capacity of many residents to safeguard their own property, the Facility can only insure against the loss of valuable items (such as jewelry or money) if they are deposited with the management or placed in locked storage when not in use. Resident property left more than 30 days after discharge will be disposed of in accordance with the Facility's policy.

#### 10. RESIDENT PERSONAL ACCOUNTS

The Facility offers to provide personal accounts with quarterly statements for incidental expenses. Amounts over \$50 or as required by law are deposited in an interest bearing bank account.

Refunds for the balance in the personal account, less amounts owed to the Facility, will be made to the Resident after discharge. Following a Resident's death, refunds will be made to the person or probate jurisdiction administering the Resident's estate or by use of a New York "small estate" affidavit unless the funds are otherwise properly claimed by DSS to recoup Medicaid payments.

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

#### 11. FACILITY RULES

The Resident and the Undersigned agree to abide by the Facility's rules and regulations, and to respect the dignity, personal rights and property of residents, visitors, and staff.

#### 12. GENERAL PROVISIONS ABOUT THE AGREEMENT

**WHO IS COVERED.** In addition to the parties signing this Agreement, the Agreement shall be binding on the heirs, executors, administrators, distributors, successors, and assigns of said parties.

**DURATION.** This Agreement remains in effect if the Resident is readmitted to the Facility after a hospitalization or temporary absence.

**MODIFICATIONS.** This Agreement may not be amended or modified except in writing signed by the Facility and the Resident and/or the Undersigned Agents except for: (1) increases in charges according to this Agreement and (2) modifications required by changes in the law, which are deemed to become part of this Agreement.

**WAIVER OF RIGHTS.** The failure of any party to enforce any term of this Agreement or the waiver by any party of a breach of this Agreement will not prevent the subsequent enforcement of such term, and no party will be deemed to have waived subsequent enforcement of this Agreement.

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

**ENTIRE AGREEMENT.** This Agreement with its Exhibits and all executed Addenda are incorporated herein and contain the entire agreement between the parties.

**GOVERNING LAW AND JURISDICTION.** This Agreement is governed by New York State law. Any action arising out of or related to a dispute under this Agreement shall be brought in the State or District court located in Washington 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 *Eastern* District of New York.

WE THE RESIDENT AND UNDERSIGNED HAVE READ, BEEN ADVISED OF, UNDERSTAND AND AGREE TO BE LEGALLY BOUND BY THE TERMS AND CONDITIONS OF THIS AGREEMENT. WE ALSO CERTIFY TO RECEIVING THE FOLLOWING.

The Statement of Residents' Rights

Physician's Name, Address And Telephone Number

New York State Department Of Health "Hot Line" Telephone Number

New York State Office Of The Aging Ombudsman Program Telephone

The Facility Policy On Advanced Directives

The Facility Rules And Regulations

Information About Medicaid and Medicare Eligibility

The Notice of Privacy Practices

ACCEPTED ON \_\_\_\_\_ (DATE)

\_\_\_\_\_

SIGNATURE (OR MARK OF) OF RESIDENT

\_\_\_\_\_

SIGNATURE OF SPONSOR, e.g. SPOUSE

\_\_\_\_\_  
SIGNATURE (OR MARK) OF  
RESPONSIBLE PARTY

\_\_\_\_\_  
SIGNATURE FOR FACILITY

## **EXHIBIT A**

### **BASIC SERVICES INCLUDED UNDER THE DAILY RATE**

1. Lodging;
2. Board, including therapeutic or modified diets as prescribed by a physician; Kosher food will be provided upon request of the patient who, as a matter of religious belief, wishes to follow Jewish dietary laws;
3. Twenty-four hour per day nursing care;
4. Fresh bed linens;
5. Hospital gowns or pajamas as required by the clinical condition of the Resident, unless the Resident, next of kin and/or sponsor elects to furnish them, and regular non-dry cleaning laundry services for these and other launderable personal clothing items;
6. General household medicine cabinet supplies, including, but not limited to, non-prescription medications, material for routine skin care, oral hygiene, care of hair, and so forth, except for specific items that are medically indicated and needed for exceptional use for a specific resident;
7. Assistance and/or supervision when required with activities of daily living, including, but not limited to, toileting, bathing, feeding and ambulation assistance;
8. Services of members of the Facility staff performing their daily assigned patient care duties;
9. The use of customarily stocked equipment, including, but not limited to, crutches, walkers, wheelchairs, or other supportive equipment, and training in their use when necessary, unless such item is prescribed by a physician for the regular and sole use by a specific resident;
10. The use of all equipment, medical supplies and modalities, notwithstanding the quantity usually used in the everyday care of the Resident including, but not limited to catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads, and so forth;
11. An activities program, including, but not limited to, a planned schedule for recreational, motivational, social and other activities, together with the necessary materials and supplies to make the Resident's life more meaningful;
12. Social services as needed.

## **EXHIBIT B**

### **BED RESERVATIONS FOR TEMPORARY ABSENCES**

#### **PRIVATELY PAYING AND MEDICARE PART A COVERED RESIDENTS.**

Upon agreement to pay the private daily rate, private paying residents including those covered by Medicare Part A or another private health plan (or their sponsors and agents) may hold a resident's bed available if the Resident is expected to return to the Facility *and* providing the Resident's accounts are not in arrears. During the Resident's absence, the daily rate under this Agreement is owed unless the Facility is notified to cancel the bed hold.

#### **BED RESERVATIONS FOR MEDICAID-COVERED RESIDENTS.**

(1) Bed Reservation for Hospitalization:

Medicaid will reimburse the facility for bed reservations for Hospitalization for a cumulative total of 14 days per 12 month period for all hospitalizations occurring within the given 12 month period provided the following requirements are met:

- (i) The resident has been a resident of the facility for at least 30 days from the date of admission; and
- (ii) The nursing facility must have no more than 5% bed vacancy at the time of transfer to the hospital.

If the resident is hospitalized without a bed hold or if the bed hold days per 12 month period are exhausted during a period of hospitalization, and the resident meets the 30-day residence requirement, the resident will be permitted to return to the facility to the first available semi-private room, unless the resident has been discharged from the facility during the period of hospitalization by formal discharge notice. If the resident does not meet the 30-day residency requirement, the resident will be given priority admission status to the next available semi-private room, so long as all other admission criteria are met. A Medicaid resident or his/her family may pay the facility privately at its Medicaid rate to reserve the resident's bed when the resident is hospitalized without a bed hold or the bed hold days per 12 month period are exhausted during a period of hospitalization. The facility will contact you to determine if you wish to pay privately to reserve the resident's room under such circumstances.

(2) Bed Reservation for Therapeutic Leave:

Medicaid will reimburse the facility for bed reservations for therapeutic leaves of absence for a cumulative total of 10 days per 12 month period for all therapeutic leaves occurring within the given 12 month period, provided the following requirements are met:

- (i) The resident has been a resident of the facility for at least 30 days from the date of admission; and
- (ii) The nursing facility must have no more than 5% bed vacancy at the time of the therapeutic leave.

If the resident is on therapeutic leave without a bed hold or if the bed hold days per 12 month period are exhausted during a period of therapeutic leave and the resident meets the 30-day residence requirement, the resident will be permitted to return to the facility to the first available semi-private room, unless the resident has been discharged from the facility during the period of therapeutic leave by formal discharge notice. If the resident does not meet the 30-day residency requirement the resident will be given priority admission status to the next available semi-private room, so long as all other admission criteria are met. A Medicaid resident or his/her family may pay the facility privately at its Medicaid rate to reserve the resident's bed when the resident is on therapeutic leave without a bed hold or the bed hold days per 12 month period are exhausted during a period of therapeutic leave. The facility will contact you to determine if you wish to pay privately to reserve the resident's room under such circumstances.

## **ADDENDUM I**

### **FINANCIAL AGENT'S PERSONAL AGREEMENT**

AGREEMENT between **Fort Hudson Nursing Center, Inc.** (Facility”), at 319 Broadway, Fort Edward, New York

And \_\_\_\_\_ ("Agent"), residing at \_\_\_\_\_, for the benefit of \_\_\_\_\_

and concerning the admission of \_\_\_\_\_ ("Resident") pursuant to the attached Admission Agreement between the Facility and the Resident and/or the Sponsor and/or the Responsible Party (the "Admission Agreement").

WHEREAS, the Agent understands that he/she 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 its terms; and

WHEREAS, the Agent wishes to assist the Resident and to facilitate the Resident's admission to 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:

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

A. Without incurring the obligation to pay for the cost of the Resident's care from the Agent's own 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 to meet his/her obligations under the attached Admission Agreement if such assistance is necessary to enable the Resident to comply with the terms of such Agreement.

B. More specifically, the Agent personally agrees that, to the extent of his/her authority, the Agent will use his/her access to the Resident's assets to ensure 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.

C. 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 (the "NAMI" amount) which the Medicaid agency may direct the Resident to pay towards the cost of his/her care.

D. 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

E. The Agent agrees to pay damages to the Facility caused by a breach of his/her personal obligations set forth in this Agreement.

**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.

Date \_\_\_\_\_

Name of Financial Agent \_\_\_\_\_

Type(s) of Agency: \_\_\_\_\_ (e.g. Power of Attorney, Joint Tenant on Real or Personal Property, Guardian, Conservator, Representative Payee on Pension or Social Security).

By: \_\_\_\_\_ (signature)

Fort Hudson Nursing Center, Inc. \_\_\_\_\_  
[Name and Title]

A copy of the instrument(s) conferring such authority are attached hereto.

**ADDENDUM  
II**

**FORT HUDSON NURSING CENTER**

Date: \_\_\_\_\_ Resident Name: \_\_\_\_\_ Admission Date: \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Name \_\_\_\_\_

Group Number \_\_\_\_\_

(Copy of Insurance Card Attached)

To Whom It May Concern:

The above referenced individual resides in our facility. In order to properly bill for this resident's room and board, we request that you provide us with details of the coverage provided to this resident regarding skilled nursing room and board and related ancillary services. Please send the information to:

Fort Hudson Nursing Center  
Attn: Business Office  
319 Broadway  
Fort Edward  
NY 12828

The proper authorization for release of this information is evidenced below. Please feel free to contact us at 518-747-2811 with any questions.

Thank you in advance for your prompt attention to this matter.

Sincerely,

Business Office Representative

**AUTHORIZATION FOR RELEASE OF INSURANCE COVERAGE INFORMATION:**

I authorize Fort Hudson Nursing Center to request any insurance coverage information in relation to the above referenced resident.

Signature \_\_\_\_\_ Relationship to Resident \_\_\_\_\_ Date \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:**

I assign all benefits which I or the insured may have or be entitled to, to Fort Hudson Nursing Center, toward payment of my care. I understand that I will remain responsible for any unpaid charges whether or not covered by this assignment.

Signature \_\_\_\_\_ Relationship to Resident \_\_\_\_\_ Date \_\_\_\_\_

ADDENDUM III  
**AUTHORIZATION FOR RELEASE OF MEDICAID  
INFORMATION TO FACILITY**

I, \_\_\_\_\_, hereby authorize the \_\_\_\_\_ (Local  
Department of Social Services) to release information about \_\_\_\_\_ (Resident)  
Medicaid case to:  
The Administrator of **Fort Hudson Nursing Center, Inc.** (the "Facility") located at:  
319 Broadway  
Fort Edward, NY 12828.  
Tel: (518) 747-2811

This Medicaid file information to be released is that which enables the Facility to assist the Resident obtain Medicaid eligibility and coverage. 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, the business office staff and social – admissions staff will use released information to facilitate Medicaid coverage.

This authorization will expire after Medicaid determines that the Resident is eligible for coverage of the Facility's nursing facility services, or after the payment obligations for all services provided under this Agreement have been satisfied, whichever is sooner.

I retain the right to revoke this authorization at any time with written notice. I understand that the disclosure made pursuant to this authorization might be redisclosed to others and that a revocation does not apply to information already disclosed.

Date \_\_\_\_\_

Resident Signature \_\_\_\_\_

Date \_\_\_\_\_

Responsible Party or Spouse \_\_\_\_\_

Circle Authority: Power of Attorney/Next-of-Kin/  
Guardian/Designated Representative  
Other

## ADDENDUM

### IV

#### **AUTHORIZATION TO REPRESENT RESIDENT IN THE MEDICAID PROCESS**

I authorize the Administrator of **Fort Hudson Nursing Center, Inc.** (Facility) or his/her designee to act on behalf of \_\_\_\_\_ (Resident) in his/her Medicaid application, an appeal of denial of benefits, and 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 or his/her representatives are unwilling or unable 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 the Resident, Responsible Party 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 necessary financial information, to the extent they are able.

The Facility is authorized to disclose to the appropriate Medicaid agency or adjudicatory tribunal protected health and financial information necessary to take any such actions. The Medicaid agency is authorized to disclose any and all information in its files to the Facility upon the Facility's request pursuant to the attached authorization [use signed Addendum III].

Date \_\_\_\_\_  
Resident Signature \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Responsible Party/Spouse/Financial Agent

**Circle Appropriate Agency:** Power of Attorney, Resident's Agent, Designated Representative, Next-of-Kin, Guardian, Other

## ADDENDUM V

### **AGREEMENT TO ARRANGE DIRECT PAYMENT OF MONTHLY INCOME TO THE FACILITY**

The Resident, and/or the Undersigned on the Resident's behalf, agrees to arrange for direct payment of the Resident's monthly income to the Facility. This monthly income (less any applicable 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 **Fort Hudson Nursing Center, Inc.** [Facility] to apply the amount owed to the Facility with any remainder deposited in the Resident's personal account.

Resident\_\_\_\_\_ Date\_\_\_\_\_

Sponsor (Spouse)\_\_\_\_\_ Date\_\_\_\_\_

Responsible Party\_\_\_\_\_ Date\_\_\_\_\_

*(Use in the Alternative only if No Direct Payment of Income Is Arranged)*

## **ADDENDUM V-A**

### **AGREEMENT TO CHANGE THE RESIDENT'S ADDRESS**

Because the Resident's monthly income is not sent directly to the Facility, to facilitate payment obligations under the Facility Admission Agreement, the Resident and the Undersigned Agents agree to notify payors of monthly income of the Resident's address change and to direct them to send the Resident's monthly income to the Resident at the Facility.

Resident \_\_\_\_\_ Date \_\_\_\_\_

Sponsor (Spouse) \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party \_\_\_\_\_ Date \_\_\_\_\_