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ADMISSION AGREEMENT

Agreement entered on_____(date), by_____(Facility)
and _____(Resident/Patient) and _____ (Responsible Party) and/or(Sponsor).

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.

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 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 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 lacks the 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

The "Sponsor" is the person, such as the Resident's spouse who is 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. FINANCIAL AGENTS

A "Financial Agent" is an individual who has access to some or all of the Resident's assets. A Financial agent who does not sign this Agreement as the "Responsible Party" or "Sponsor" is not primarily responsible to assist the Resident in meeting his/her payment and/or insurance obligations under this Agreement.

Because the Resident's payment obligations sometimes require the cooperation of a Financial Agent, the Facility requests Financial Agents to agree to help meet the Resident's obligations under this Agreement to the extent permitted by their access to the Resident's assets and financial information.

The Resident and the Undersigned confirm that they have informed the Facility of the Resident's current financial agents, and have provided it 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. They agree to inform the Facility of newly appointed or revoked financial agent appointments.

2. SERVICES PROVIDED BY THE FACILITY

A. BASIC SERVICES INCLUDED UNDER THE DAILY RATE

The services covered by the daily basic rate are set forth at Addendum I.

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B. CHARGES FOR PHYSICIAN AND ANCILLARY SERVICES

Charges for physician visits and physician-ordered ancillary services are not included in the private pay daily basic rate. Charges may be billed by the Facility or by the service provider. Medicaid, Medicare or other third party payors who have negotiated a rate with the Facility may cover all or some of these services. Physician and ancillary services are normally covered by the Medicaid rate.

The following physician-ordered services are available and will be provided by practitioners who meet the applicable licensing, registration and certification requirements. Currently, except for those services marked by an asterisk (*), the services listed below are covered by Medicaid. Other physician ordered services may become available in the future.

- Physical Therapy
- Laboratory Services
- Occupational Therapy
- Special Nurse or Companion on Order of Physician*
- Podiatry Services*
- Dental Services*

7. Transportation Services*
8. Optometric Services
9. Audiology Services
10. X-ray Services
11. Speech Therapy
12. Oxygen Therapy
13. Psychiatric or Psychological Treatment

*Currently not covered by Medicaid or only covered by Medicaid partially or under certain circumstances.

Current charges for the above-listed services are available in the business office. These charges may increase due to increased costs.

C. ITEMS/SERVICES NOT INCLUDED IN THE BASIC RATE

Certain items and services, such as those listed below, are not covered under the daily basic rate or by Medicaid, Medicare or insurance plans. They are available at the Facility and must be paid for or charged against the Resident's account when the cost is incurred.

- Barber/Beauty Parlor
- Private room telephone including installation, maintenance and fees
- Private room TV including installation, maintenance and cable fees
- Newspapers, sundries
- Shoes and clothing
- Dry cleaning
- Special transportation for personal use

The Undersigned agree to assist the Resident to the best of their ability to obtain necessary personal items and clothing which are not provided under the daily rate. Individual purchases can be deducted from the Resident's incidental account by vouchers.

D. ITEMS OR SERVICES EXCEEDING MEDICAID, MEDICARE OR VETERANS ADMINISTRATION BENEFITS

If the Resident qualifies for Medicaid, Medicare, or Veterans Administration ("VA") coverage, the Facility will accept the Medicaid, Medicare or VA rate plus any deductibles, coinsurance and/or NAMI payments as payment in full for care and services covered by such programs. However, when the Resident requests items or services that are more expensive than or in excess of those covered by Medicare, Medicaid or the VA, the Resident will be charged the difference between the customary private charge and the value of the items/services covered by Medicare, Medicaid or the VA. The Facility agrees to notify the Resident of the extra charge prior to providing the requested items.

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E. RESIDENT PERSONAL ACCOUNTS

Petty cash maybe deposited in the Resident's personal account to cover incidental expenses. The Facility is required to deposit amounts over $50 in an interest bearing bank account. Quarterly statements will be provided and account records are available upon request.

Refunds for the balance in the personal account, less any funds owed to the Facility, will be made to the Resident, or to the Undersigned on the Resident's behalf, after discharge. In the event of the Resident's death, refunds will be made within thirty (30) days to the person or probate jurisdiction administering the Resident's estate. If the Department of Social Services claims funds from a deceased resident's personal account as partial refund of Medicaid funds owed, the Facility is authorized by law to deliver such funds.

The Resident, and/or the Undersigned on the Resident's behalf, consents to the Facility's withdrawal of undisputed amounts owed to the Facility from the personal account prior to returning the balance to the person administering the Resident's estate or to the Department of Social Services. If an account in the Resident's name is deposited with a bank, the Resident and/or the Undersigned and/or the Financial Agent may execute an Assignment of Deposit Balances on the form attached at Addendum III to assign the Facility any remaining amounts owed for services.

3. THE RESIDENT'S PAYMENT AGREEMENT

A. OBLIGATION TO PAY OR TO ARRANGE FOR PAYMENT

The Resident and/or the Undersigned on behalf of the Resident agree to pay for, or arrange to have paid by Medicaid, Medicare or other insurers, all services provided under this Agreement, and to pay third party deductibles, coinsurance or monthly income to the Facility as required. The Resident and/or the Undersigned on behalf of the Resident personally agree to pay the applicable daily room rate ("private pay rate"), pharmacy charges and other non-covered charges to the Facility from the Resident's funds 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. The Resident and/or the Undersigned on behalf of the Resident agree to pay the private rate while a Medicaid application is pending and if the Medicaid application is denied. The Resident and/or the Undersigned on behalf of the Resident accept the duty to ensure continuity of payment, which includes the duty to arrange for timely Medicaid coverage, if and when Medicaid coverage becomes necessary.

Specifically, the Resident and/or the Undersigned on behalf of the Resident agree to pay, or arrange for payment of, the initial daily basic rate of $ per day; physician and ancillary medical services (as in Section 2-B); any applicable deductibles or coinsurance; and for individual purchases and services as set forth in Section 2-C.

If the Resident qualifies for Medicaid, Medicare, Veterans Administration (VA) coverage or for coverage by a benefit plan with which the Facility has negotiated a daily rate, the Facility will accept such payor's daily rate for services and supplies covered by such third-party payors.

B. THE RESIDENT'S DIRECTION TO HIS/HER AGENTS

The Resident hereby directs the Responsible Party, the Sponsor, and all other Financial Agents including future appointees: (1) to ensure that all payment obligations under this Agreement are met from the Resident's assets; (2) to cooperate in obtaining Medicaid coverage, if necessary; and (3) to refrain from using the Resident's assets in such a way that the Facility is placed in a position where it cannot receive payment from either the Resident's funds or Medicaid.

C. PREPAID AMOUNTS AND SECURITY DEPOSIT

If the Resident is not qualified for Medicare Part A, Medicaid, VA, or HMO coverage or if such coverage terminates, the Resident and/or the Undersigned on behalf of the Resident agree to prepay a ninety (90) day deposit. The daily basic rate for the current month and two (2) months security will be applied from this prepayment. The

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balance will be held as security deposit for payment of financial obligations of the Resident under this Agreement. Prepaid funds held more that sixty-one (61) days will be kept in an interest-bearing account. The Facility is legally entitled to deduct from the security deposit a fee of 1% per year as an administrative cost.

Refund of Deposit. We will refund the appropriate pro-rated portion of advance payment made by you or on your behalf in accordance with applicable state law. Refunds may be reduced by outstanding amounts due from private insurance until that time a determination of payment for that balance is received.

If the privately paying Resident leaves the Facility for reasons within the Resident's control during the prepayment period without giving 7 days prior notice, the Facility will retain an additional amount not to exceed one (1) day's daily basic rate.

D. ADDITIONAL CHARGES AND INCREASES IN THE DAILY RATE

The Facility will assess no additional charges beyond the daily rate 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 daily basic rate is subject to increases due to increased costs of maintenance and/or operation. The Facility agrees not to increase the daily basic rate except:

- due to the increased costs of maintenance and/or operation, following thirty (30) days prior written notice to the resident, the Designated Representatives (if different from the Undersigned), and/or the Undersigned; or

- upon express written approval and authority of the Resident, the Designated Representative, or the Undersigned.

E. INSURANCE DISCLOSURE

The Resident and/or the Undersigned on behalf of the Resident agree to inform the Facility of all potential third-party payors. Medicaid reimbursement is contingent on the Facility having sought payment from any and all other liable third parties first.

The Resident and/or the Undersigned on behalf of the Resident agree to provide information pertaining to all potential third-party payors and agree either: (i) to provide proof that arrangements for coverage have been made; or (ii) to provide the Facility with the information and authorization for the Facility to seek third-party coverage.

F. DEDUCTIBLES AND CO-INSURANCE

The Resident and/or the Undersigned on behalf of the Resident understand and agree that the payment obligations under this Agreement include payment of any and all deductibles and/or coinsurance required by Medicare or other insurers and agree to meet these obligations.

G. MEDICAID COVERAGE OBLIGATIONS

1. Duty to Pay Private Rate Until Medicaid Covered

Except where Medicare or other insurance covers the daily rate, the Resident and/or the Undersigned on behalf of the Resident agree to pay the private pay rate unless and until Medicaid coverage is obtained. Currently, upon Medicaid eligibility, Medicaid will cover no more than three (3) months prior to the month in which the Medicaid application was filed. Prior to being determined Medicaid eligible, and/or if Medicaid eligibility is denied, the Resident

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and/or the Undersigned on behalf of the Resident agree to pay the private pay rate. If the Medicaid eligibility is established and covers any retroactive period for which the private pay rate was paid, the Facility agrees to refund or credit any amount in excess of a NAMI amount owed during the covered period.

The Resident and/or the Undersigned on behalf of the Resident agree to refrain from using the Resident's assets in such a way as to render the Resident ineligible for Medicaid benefits unless payment of the daily basic rate is made. If the Resident's liquid assets are exhausted or unavailable prior to Medicaid coverage, the Resident and/or the Undersigned on behalf of the Resident agree to pay the Resident's monthly income to the Facility as partial payment of the daily basic rate.

2. Duty to Arrange for Timely Medicaid Application

The Resident and/or the Undersigned on behalf of the Resident agree to monitor the Resident's resources and to notify the Facility as to the anticipated time when the Resident will have spent down his/her resources to the Medicaid resource level. The Resident and/or the Undersigned on behalf of the Resident agree to timely file a complete Medicaid Application to ensure uninterrupted payments to the Facility. The Resident and/or the Undersigned on behalf of the Resident agree to notify the Facility as to when the Medicaid application is filed and to provide complete information and documentation to the appropriate Department of Social Services within all time frames required.

3. Monthly Income Payments Under Medicaid

The Medicaid eligible Resident and/or the Undersigned on behalf of the Resident understand that the Department of Social Services will require the Resident's income (or some portion thereof) (the "Net Available Monthly Income" or "NAMI") to be paid to the Facility as part of the Medicaid rate. The Resident and/or the Undersigned on behalf of the Resident agree:

- to pay the NAMI to the Facility by the 10th of each month or to arrange for the income payor to send the monthly income directly to the Facility (Addendum IV); and

- that if the NAMI amount is disputed, agrees to place the disputed portion in an escrow account, and to pay the undisputed portion to the Facility by the 10th of each month. The Parties agree that funds held in escrow will be released according to the determination of the agency or court reviewing the NAMI.

4. Release of Medicaid Information to the Facility

To facilitate the Medicaid application and annual recertification, the Facility requests authorization to have access to the Resident's Medicaid application and recertification file. Agreement to such authorization, either to take effect now or only if this Agreement cannot be met without such authorization,. Such authorization will permit the Facility to receive copies of all correspondence regarding the Medicaid application, to assist with the application process, and communicate with the Medicaid Office.

If the Resident, the Undersigned, and/or the Resident's family requests the Facility's assistance with filing the Medicaid application or with an appeal of a Medicaid denial, the Resident, the Undersigned or a family member may authorize the Facility to act on his/her behalf in the Medicaid process pursuant to Addendum VI. The Facility's ability to assist in the Medicaid process, however, will depend on receiving timely financial and other required documentation regarding the Resident's income and resources from the Resident, the Undersigned, the Financial Agent or the Resident's family.

5. Semi-Private Room

If the Resident occupies a private room and ceases to pay the private room rate, or if and when the Resident becomes Medicaid eligible, he/she agrees to move to a semi private room unless a private room is medically necessary.

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4. THE RESPONSIBLE PARTY'S AND SPONSOR'S PERSONAL AND INDEPENDENT OBLIGATIONS TO THE FACILITY

A. TO MEET PAYMENT OBLIGATIONS

In consideration of the fact that the Undersigned cannot otherwise provide adequate nursing care to the Resident and wish to facilitate the Resident's admission to the Facility, the Undersigned personally and independently guarantee continuity of payment to the Facility for the cost of the Resident's care. Unless the Undersigned are otherwise obligated by law to pay for the Resident's care, as the Resident's spouse may be, they are not required to use their personal resources to pay for such care. However, if necessary to meet the payment obligations to the Facility and without incurring the obligation to pay from the Undersigned's own funds, the Undersigned personally guarantee payment of the daily basic rate, pharmacy charges and related non-covered charges to the Facility from the Resident's funds (where Medicare Part A or other coverage is not available) unless and until Medicaid covers such charges. The Undersigned agree personally to pay damages for a breach of this personal agreement to the Facility as set forth in Section 6-C below.

B. MEDICAID OBLIGATIONS

Because the Resident's payment obligations under this Agreement include the duty to arrange for timely and continued Medicaid coverage if and when such coverage becomes necessary to meet the terms of this Agreement, the Undersigned also agree to be personally and independently responsible for the following:

1. TO MAKE TIMELY MEDICAID APPLICATION

The Undersigned personally agree to cooperate in obtaining timely Medicaid coverage:

- by notifying the Facility as to the anticipated time when the Resident will have spent down his/her resources to the Medicaid resource level;
- by timely filing the Resident's Medicaid application to ensure uninterrupted payments to the Facility and notifying the Facility of the filing date;
- by providing complete information and documentation to the appropriate Department of Social Services within the time frames required for such submissions;
- by refraining from using the Resident's assets in such a way as to render the Resident ineligible for Medicaid benefits unless payment at the private-pay daily rate is made.

2. TO PAY MONTHLY INCOME

If the Resident's Medicaid application is pending and the Resident's assets are depleted or not currently available, the Undersigned personally guarantee payment of the Resident's monthly income as partial payment for the private pay rate owed.

Once Medicaid eligibility is established, the Undersigned either: (i) personally guarantee payment of the Resident's monthly income (NAMI) as directed by the Department of Social Services; or (b) agree to arrange to have such income deposited directly with the Facility as agreed at Addendum IV. If the NAMI amount is disputed, the Undersigned agree to place the disputed amount in escrow and deliver the undisputed amount pursuant to Section G-3 above.

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3. TO ENSURE ANNUAL MEDICAID RECERTIFICATION

If and when the Resident becomes Medicaid eligible, the Undersigned personally agree to ensure the Resident's timely Medicaid recertification each year by timely providing the required information and documentation regarding the Resident's assets and income to the appropriate Department of Social Services.

5. TRUTHFULNESS OF INFORMATION PROVIDED

The Resident and the Undersigned each separately acknowledge the Facility's reliance on the financial and insurance information submitted to the Facility, and warrant that it is true, correct, complete and accurate in all material respects and contains no known material omissions.

6. LATE PAYMENTS AND NONPAYMENTS

A. LATE CHARGES, COLLECTION COSTS AND ATTORNEY FEES

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

B. DISCHARGE FOR NON-PAYMENT

After appropriate notice and discharge planning, the Resident may be discharged for nonpayment of sums due from Resident and/or the Undersigned under this Agreement, including, but not limited to, nonpayment of NAMI by a Medicaid covered Resident. See also Section 7 below.

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

The Undersigned agree to use their personal resources if necessary to pay damages to the Facility for breach of their personal obligations set forth in this Agreement. If the Undersigned breach their personal obligations to the Facility and fail to pay the private rate, the NAMI, or the deductibles and coinsurance from the Resident's funds to which they have access, and/or if the Resident's Medicaid eligibility is delayed or denied due to the Undersigned's failure to submit or failure to cooperate in submitting a timely or complete Medicaid application or recertification as set forth above, the Undersigned personally and independently agree to pay damages caused by such failure and/or breach, including reasonable attorney fees.

Damages will also be due from the Resident or Responsible party who refuse or otherwise fail to pay the NAMI or private rate when delivery of such funds is necessary to meet the Resident's obligations, and/or whose use or transfer of Resident assets prevents the Facility from receiving either Medicaid or private payment or otherwise causes Medicaid eligibility to be denied or delayed.

7. 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 7 days advance notice in writing. For privately paying Residents, the Resident agrees to pay the daily basic rate for one (1) day beyond the discharge date if such notice is not given.

B. INVOLUNTARY DISCHAGE

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1. Discharge for Nonpayment

The Facility may discharge a Resident for nonpayment upon appropriate prior notice. Nonpayment occurs upon a failure to pay privately for the Resident's stay or to have it paid for under Medicare, Medicaid or other third party coverage. Nonpayment for a Medicaid-covered Resident occurs if the Net Available Monthly Income (NAMI) is not paid.

2. Other Bases for Involuntary Discharge

The Facility also may transfer or discharge a Resident involuntarily: (1) 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; (2) because the Resident's health has improved and he/she no longer needs nursing facility services; (3) if the Resident becomes a danger to self or others and all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem; or (4) if the Facility closes.

3. Notice of Discharge

The Facility will give the Resident, the Undersigned and/or the Designated Representative thirty (30) days notice prior to involuntary discharge of the Resident unless: (i) the health or safety of others in the Facility is jeopardized; or (ii) the Resident's urgent medical needs necessitate a prior transfer or discharge; or (iii) the Resident has not resided in the Facility for thirty (30) days. In such cases, appropriate notice will be given as soon as practicable.

8. BED RESERVATION POLICY

Bed reservation policies are set forth at Addendum II.

9. PERSONAL PROPERTY

The Facility has policies and procedures to provide reasonable security for the Resident's personal property, and locked storage space in the Resident's room is available upon request.

The Resident and Undersigned agree to arrange for disposition of the Resident's property upon discharge. The Facility may dispose of property left more than thirty (30) days after discharge.

10. CONSENTS

By signing this Agreement, the Resident or the Responsible Party on the Resident's behalf; provides the Facility with the following consents or authorizations.

A. PHYSICIAN VISITS

- A physician is authorized to visit the Resident at least once every thirty (30) days for the first ninety (90) days and at least once every sixty (60) days thereafter, and as often as necessary to address the Resident's medical care needs; and
- The Facility may arrange for another physician if the Resident's personal, alternate or staff physician is unable to see the Resident as required or medically necessary.

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B. IDENTIFIABLE HEALTH INFORMATION

The Facility may use and disclose the Resident's personally identifiable health information for treatment, payment and health care operations, or as required by law.

C. RESIDENT PHOTOGRAPH

The Facility may take the Resident's facial photograph to use as identification.

D. MANAGED CARE PARTICIPATING PROVIDERS

The Facility may use participating physicians, ancillary service providers and suppliers if required by the Resident's insurer to obtain full benefit coverage, unless the Resident specifically requests a nonparticipating provider. Use of non-participating providers may require private payment.

E. ASSIGNMENT OF BENEFITS

The Resident or the Undersigned on the Resident's behalf request the Facility to claim payment for authorized Medicare or other insurance-covered services received during the Resident's stay at the Facility, and authorize release of information necessary for the Facility and/or such physicians or other providers to claim and receive such payments on the Resident's behalf. (A separate assignment of benefits may also be required by the plan or program.)

F. SECURITY CAMERAS

In order to ensure the safety of our residents and staff, security cameras may be installed in public areas of the facility. Security cameras are not used in areas where there is an expectation of privacy, such as restrooms or resident rooms. By signing this Agreement, you consent to the use of such security cameras within the facility.

11. FACILITY RULES

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

12. GENERAL PROVISIONS RELATING TO THIS AGREEMENT

A. WHO IS COVERED BY THE AGREEMENT

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

B. MODIFICATIONS TO BE IN WRITING

This Agreement may not be amended or modified except in writing signed by the Facility and the Resident and/or the Undersigned, except for: (1) increases in charges as set forth in this Agreement; and (2) modifications required by changes in the law. Modification to this Agreement necessitated by changes in statutory or regulatory law (state or federal) or their interpretations are deemed to become part of this Agreement.

C. WAIVER OF RIGHTS UNDER THIS AGREEMENT

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The Failure of any party to enforce any term of this Agreement or the waiver by any party of any breach of this Agreement will not prevent the subsequent enforcement of such term, and no party will be deemed to have waived the right to subsequent enforcement of this Agreement.

D. SEVERABILITY OF CERTAIN PROVISIONS

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

E. ENTIRE AGREEMENT

This Agreement with all Addenda, hereby incorporated herein, contains the entire agreement between the parties.

F. GOVERNING LAW AND SUBMISSION TO JURISDICTION

This Agreement shall be governed by the laws of the State of New York. Any action arising out of or related to this Agreement shall be brought in, and the parties agree to jurisdiction of, the State court located in Nassau County, New York. If the matter is brought in Federal court, the parties agree to the venue of the Eastern District (Suffolk Nassau) 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.
In addition, I/we have received 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 Numbers

The Facility Policy on Advanced Directives

The Facility Rules and Regulations

Information About Medicaid and Medicare Eligibility

A Statement Regarding the Use of The Minimum Data Set and The Privacy Act of 1974 Organ Donor

Gift of Life Program Information

The current Schedule of Charges for Physician-Ordered Ancillary Services is available at the business office upon request.

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ACCEPTED ON (DATE):_____

_____ _____

SIGNATURE (OR MARK) OF RESIDENT

SIGNATURE OF SPONSOR, e.g. SPOUSE

_____ _____

SIGNATURE (OR MARK) OF RESPONSIBLE PARTY

SIGNATURE FOR FACILITY

THIS FACILITY 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.

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RESIDENT FINANCIAL BENEFIT INFORMATION

Resident Name: _____

Responsible Party: _____ Relationship:_____

Statement Mailing Address: _____

_____

_____

Phone Number: _____ Email address: _____

1) Has Resident had another Skilled Care Facility stay in the last 60 days?

Yes_____ No_____

Facility Name and Address: _____

_____

2) Is Resident a US Citizen? Yes_____ No_____

Birth Certificate_____ Proof of Citizenship_____

3) Does Resident own a home? Yes_____ No_____
4) Does Resident have a trust? Yes_____ No_____

Revocable_____ Irrevocable_____ Unknown_____

5) Has Resident sold, gifted or transferred any funds, property or assets in the last 60 months?
Yes_____ No_____

If yes, please list transfer date and assets transferred: _____

_____

_____

Signature of Responsible Party_____ Date_____

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MEDICARE SECONDARY PAYER SCREENING (MSP)

Residents Name: _____ HIC Number: _____

Admission Date: _____ Provider Number: _____

PART I

1. Are you receiving Black Lung (BL) Benefits?
   ☐Yes. Date benefits began (CCYY/MM/DD): _____ **BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL**
   ☐No
2. Are the services to be paid by a government program such as a research grant?
   ☐Yes. Government Program will pay primary benefits for these services
   ☐No
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   ☐Yes. **DVA IS PRIMARY FOR THESE SERVICES**
   ☐No
4. Was the illness/injury due to a work related accident/condition?
   ☐No. **GO TO PART II**
   ☐Yes. Date of injury/illness: (CCYY/MM/DD)_____
   Name and address of WC plan: _____
   Policy or identification number:_____
   Name and address of employer:_____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS. GO TO PART III.

PART II

1. Was the illness/injury due to a non-work related accident?
   ☐Yes. Date of accident (CCYY/MM/DD):_____
   ☐No. **GO TO PART III**
2. What type of accident caused the illness/injury?
   ☐Automobile ☐Non-automobile
   Name and address of no-fault or liability insurer:_____
   _____
   Insurance claim number: _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

☐Other:

_____

3. Was another party responsible for this accident?
   ☐No. **GO TO PART III**
   ☐Yes. Name and address of any liability insurer:_____
   _____
   Insurance claim number: _____

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

PART III

1. Are you entitled to Medicare based on:
   ☐Age. **Go to Part IV**
   ☐Disability. **Go to Part V**
   ☐ESRD. **Go to Part VI**

PART IV – AGE

1. Are you currently employed?
   ☐Yes. Name and address of your employer:_____
   _____
   ☐No. Date of retirement:

(CCYY/MM/DD)_____

2. Is your spouse currently employed?
   ☐Yes. Name and address of spouse's employer:_____
   _____
   ☐No. Date of retirement:

(CCYY/MM/DD)_____

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?
   ☐Yes
   ☐No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

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4. Does the employer that sponsors your GHP employ 20 or more employees?
☐Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION**
Name and address of GHP:_____
_____
Policy identification number:_____
Group identification number:_____
Name of policyholder:_____
Relationship to patient:_____
☐No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

PART V – DISABILITY

1. Are you currently employed?
☐Yes. Name and address of your employer:_____
_____
☐No. Date of retirement:
(CCYY/MM/DD)_____
2. Is a family member currently employed?
☐Yes. Name and address of your employer:_____
_____
☐No.

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own or a family member's current employment?
☐Yes.
☐No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**
4. Does the employer that sponsors your GHP employ 100 or more employees?
☐Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION:**
Name and address of GHP: _____
_____
Policy identification number: _____
Group identification number:_____
Name of policyholder: _____
Relationship to patient: _____
Membership Number: _____
☐No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

PART VI – ESRD

1. Do you have group health plan (GHP) coverage?
☐Yes. Name and address of GHP:_____
_____
Policy identification number: _____
Group identification number:_____
Name of policyholder: _____
Relationship to patient: _____
Name and address of employer, if any, from which you receive GHP coverage:_____
_____
☐No. **STOP. MEDICARE IS PRIMARY.**
2. Have you received a kidney transplant?
☐Yes. Date of transplant: (CCYY/MM/DD)_____
☐No.
3. Have you received maintenance dialysis treatments?
☐Yes. Date dialysis began: (CCYY/MM/DD) _____
If you participated in a self-dialysis training program, provide date training started: (CCYY/MM/DD) _____
☐No.
4. Are you within the 30-month coordination period?
☐Yes.
☐No. **STOP. MEDICARE IS PRIMARY.**
5. Are you entitled to Medicare on the basis of either ESRD and age ***or*** ESRD and disability?
☐Yes.
☐No. **STOP. GHP IS PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
6. *Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?*
☐Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
☐No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**
7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement?)
☐Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
☐No. **MEDICARE CONTINUES TO PAY PRIMARY.**

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ASSIGNMENT OF BENEFITS

To Whom It May Concern:

I, _____give permission to Insurance Company:_____

Policy Number: _____ to make payment(s) directly to

_____ for claims they submit to you.

Resident/Responsible Party Signature_____

Date_____

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Department of Health and Human Services Form Approved OMB
Centers for Medicare & Medicaid Services No. 0938-0950

Appointment of Representative

Name of Party	Medicare or National Provider Identifier Number

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier): I appoint this individual, _____ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the "Act") and related provisions of title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an

_____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

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CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of the Department of Health and Human Services (DHHS) (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council (MAC) review, or a proceeding before an ALJ or the MAC as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR § 405.910(f).

The form , "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for MAC review.

Approval of a representative's fee is not required if (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205, and 207 of Title XVIII of the United States Code makes it a criminal offense for certain officers, employees, and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

WHERE TO SEND THIS FORM

Send this form to the same location where you are sending (or have already sent) your appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision.

If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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ANCILLARY SERVICES AUTHORIZATION FORM

Resident Name:_____
Social Security #:_____

PHYSICIAN
I have selected the following physician: _____ Tel_____Fax: _____

DENTAL YES_____ NO_____

OPTOMETRY YES_____ NO_____

PODIATRY YES_____ NO_____

PSYCHIATRY YES_____ NO_____

AUDIOLOGY YES_____ NO_____

I would like to receive the services selected above and understand that I am responsible for payment of all services not covered by insurance.

By signing this form, Resident acknowledges understanding of the ramifications if he/she should choose not to receive dental, vision, audiology, psychiatry or podiatry services.

Consent to Treatment. I consent to assessment and treatment by the ancillary provider's approved clinicians to discuss the nature of my medical problem, the proposed treatment, the benefits and risks associated with treatment, the probability of successful outcomes and alternatives if any.

Confidentiality. I understand that information about me will be kept confidential and records and information about me shall not be released without my consent. I give the ancillary provider, and all health professionals affiliated with, permission to share records with and discuss my medical condition with any of my other caregivers.

Insurance Authorization. I authorize the release of any medical or other information, regarding my treatment to any third party payor for the purpose of securing payments for services rendered to me by the ancillary provider and all health professionals affiliated with the approved ancillary provider. I hereby assign and set over to the ancillary provider any benefits for the cost of treatment that I may be entitled. I authorize the third party to make payment directly to the approved ancillary provider.

_____ _____
Resident/Responsible Party Date

_____ _____
Witness (include Title) Date

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AUTHORIZATION FOR SERVICES

Resident Name: _____

Please indicate whether you authorize the following services to be provided for the above-named Resident. As there are potential charges for these services, we are required to obtain permission prior to authorizing the services.

- Beauty Shop Yes____ No____ ☐ N/A
- Pharmacy Yes____ No____ ☐ N/A
- Lab Yes ____ No____ ☐ N/A
- Radiology Yes____ No____ ☐ N/A
- Other: Yes____ No____ ☐ N/A
- Outings Yes____ No____

  Facility Name: _____ periodically sponsors outings for our Residents. To do so, we need authorization from the Resident/Responsible Party, the attending physician, and the nurse in charge. The trips are supervised by the **Facility Name:** _____

- Photographs Yes ____ No ____
  Facility Name: _____ uses photographs for Resident identification, infection control, surveillance, other medical purposes and recreational functions. We request permission to photograph Resident. From time to time, **Facility name:** _____ may request a photograph of Resident to be used in collateral materials or in the news media. In either of the last two cases **Facility Name:** _____ will secure permission with a separate agreement.

- Laundry
  Facility Name: _____ requests that all clothing and personal items be marked with the resident's last name and first initial. If you would like the facility to mark and label personal items, please contact the Housekeeping Department.
  - I would like the facility to do the resident's laundry Yes ____ No ____
  - I will be responsible to have the resident's laundry done Yes ____ No____

- Permission to Lock Residents Closet/Dresser Drawer Yes ____ No ____
  I, **Resident Name:** _____ would like the dresser and/or closet to be locked to safeguard my personal belongings. I understand that I may have access to this/these area any time desired by requesting a key from the nursing staff on the floor.

- Authorization to Release Information Yes____ No ____
  I hereby authorize **Facility Name:** _____ to release medical information and necessary data pertinent to the filing of insurance claims in the interest of the Resident and/or **Facility Name:** _____ I hereby authorize the release of information medical or otherwise, to any person or government agency without prior approval of the Resident, legal guardian, or health care surrogate, if any.

- Authorization to Receive Opened Mail Yes____ No____
  I hereby authorize **Facility Name:** _____ to open mail received by the Resident if assistance is required. Furthermore, I would like this mail to be read to the Resident upon receipt. Please note that Resident has the right to send and receive mail unopened. Marking the space labeled "YES" above authorizes the **Facility Name:** _____ open all mail for Resident. Resident has the right to revoke this authorization at any time upon written notice to **Facility Name** _____

- Authorization to Obtain Annual Labs Yes _____ No_____
  I hereby authorize **Facility Name:** _____ obtain annual labs. Labs will not be obtained without a doctor's order.

_____ _____
Signature of Resident or Legal Guardian Date

_____ _____
Signature of Witness Date

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NOTICE DESIGNATION FORM

Resident: _____

I hereby designate the person named below to receive notices regarding Medicare coverage decisions:

Name: Relationship:

Address:

Telephone:

This designation remains in effect until I give the administrator written notice of any change.

_____ _____

Signature of Resident (if the resident is managing his or her affairs) Date

_____ _____

Signature and Title of Party Acting for Resident (Conservator of Estate or Power of Attorney if resident is not managing his/her affairs. Date

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NOTICE REGARDING MEDICARE & MEDICAID ASSISTANCE

Medicare Part A benefits may be available to cover room, board, and basic nursing services if you meet the Medicare coverage requirements.

If you meet these requirements Medicare part A will pay the full cost of room, board, and basic nursing services for up to 20 days and as part of the cost for up to 80 additional days.

In order to be eligible for Medicare Part A benefits, you must be enrolled in the Medicare program, enter the nursing home after a stay at least three consecutive midnights in a hospital, within 30 days of that stay, and be treated in the nursing home for the condition for which you were treated in the hospital. Also you must require limited types of nursing services that are specifically defined by Medicare as skilled nursing services.

You do not need to make a special application for Medicare benefits. If you are not eligible for Medicare benefits, you will receive a separate notice stating that you are not eligible and setting forth your rights. If you have paid for care and services that are later found to be covered by Medicare, you will receive a prompt refund when we receive a final notice of coverage from the Medicare intermediary. For further information, please contact the Social Work Office.

Should you be denied Medicare benefits by the nursing home or the Medicare intermediary, you have the right to demand a bill for benefits be submitted to the Medicare intermediary on your behalf.

I have received Notice regarding Medicare and Medicaid assistance.

Witness	Signature of Resident (if the resident is managing his or her affairs)	Date
Witness	Signature and Title of Party Acting for Resident (Conservator of Estate or Power of Attorney, if resident is not managing his or her affairs)	Date
Witness	Signature of Responsible Party	Date

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Authorization for Release of Protected Health Information for Marketing Purposes

I,_____authorize_____ (referred to herein as "Center") to use or disclose my name, voice, image and likeness for marketing purposes to the public. This may include, but not be limited to, testimonials and/or social media posts. Related marketing materials may include photographs and/or videos of you. By signing this Authorization, I understand that:

- This authorization is completely voluntary. I have the right to refuse to sign this authorization.
- The Center will not condition treatment or payment based upon whether or not I sign this Authorization.
- I may revoke this authorization at any time, to the extent the Center has not already relied upon the Authorization, by informing the Center's Administrator in writing.
- This authorization will expire among the sooner of the following:
    a. My written revocation to the extent the Center has not already relied upon the Authorization; OR
    b. When the defined media are no longer used for the purposes specified above.
- The protected health information that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient(s) and may no longer be protected by the HIPAA Privacy Rule.
- I understand that this authorization does not permit the sale of my protected health information, and that the Center will not receive financial remuneration from a third party based upon this authorization.
- I may receive a copy of this Authorization at any time at my request.
- My questions about this form have been answered to my satisfaction.

I understand that separate authorization/consent will be obtained if/when the disclosure of my protected health information is needed for non-marketing purposes.

_____ _____

RESIDENT SIGNATURE DATE

If not the resident, please state your relationship to the resident, the source of your legal authority to act on behalf of the resident and attach a copy of any documents on which you rely.

_____ _____ _____

NAME AND RELATIONSHIP SIGNATURE DATE

_____

SOURCE OF LEGAL AUTHORITY

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THE FOLLOWING IS TO BE COMPLETED ONLY IF AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES IS WITHDRAWN:

I, the resident or authorized representative listed below, previously authorized the Center to use or disclose my name, voice, image, and likeness for marketing purposes to the public. At this time, I, the resident or authorized representative listed below, am withdrawing such authorization effective immediately upon my signature below if I notified the Center's Administrator in writing before signing here.

_____ _____

Signature of resident or authorized representative* Signature Date

_____

Printed Name of resident or authorized representative*

***If not the resident, please state your relationship to the resident, the source of your legal authority to act on behalf of the resident and attach a copy of any documents on which you rely.**

FOR CENTER'S USE ONLY:

I, Center Administrator, hereby acknowledge that the resident, or authorized agent, has withdrawn authorization to use or disclose my name, voice, image, and likeness for marketing purposes to the public. As a result, I will assist as necessary with any related action(s) to stop the future use or disclosure and will stop all prior use(s) or disclosure(s) to the extent possible at this time.

_____

Signature of Center Administrator

_____ _____

Printed Name of Center Administrator Signature Date

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RESIDENT AND FACILITY ARBITRATION AGREEMENT - READ CAREFULLY

EXECUTION OF THIS AGREEMENT BY THE RESIDENT IS NOT A CONDITION OF ADMISSION TO, OR A REQUIREMENT TO CONTINUE RECEIVING CARE AT, THE FACILITY. IN OTHER WORDS, THE RESIDENT HAS THE RIGHT NOT TO SIGN THIS AGREEMENT AND STILL BE ADMITTED TO, OR CONTINUE RECEIVING CARE AT, THE FACILITY. *Initials* ☐

It is understood and agreed by_____ (the "Facility") and _____ (the "Resident," or "Resident's Authorized Representative," hereinafter collectively the "Resident") that any legal dispute, controversy, demand, or claim (hereinafter collectively referred to as "claim" or "claims") that arises out of or relates to the Resident Admission Agreement or any service or health care provided by the Facility to the Resident shall be resolved exclusively by binding arbitration and not by a lawsuit or resort to judicial process except to the extent applicable law provides for judicial review of arbitration proceedings or judicial enforcement of arbitration awards. Such arbitration shall be conducted at a place that is convenient to both the Resident and the Facility (hereinafter collectively referred to as the "Parties").

Arbitration under this agreement shall be conducted in accordance with the rules of the American Health Lawyers Association which are hereby incorporated into this agreement and, as may be amended from time to time. In the event such rules preclude the arbitration of disputes covered by this type of agreement, the parties mutually agree to adopt alternative rules permitting such arbitration. Such arbitration shall be conducted by a single neutral arbitrator agreed upon by the Parties. In the absence of such agreement, the arbitrator shall be an attorney selected pursuant to Section 5 of the Federal Arbitration Act, 9 U.S.C. § 5. The arbitration shall proceed under the rules of procedure and evidence for civil cases of the State in which the Facility is located, but such rules shall only apply to the extent deemed necessary by the arbitrator. The Parties shall bear their own attorney's fees except in cases where the arbitrator awards such fees under an applicable provision of state or federal law that expressly authorizes such an award. The Facility shall pay the arbitrator's fees.

This agreement to arbitrate includes, but is not limited to: any claim for payment, nonpayment or refund for services rendered to the Resident by the Facility; violations of any right granted to the

Resident by statute, common law, or by the Resident Admission Agreement; breach of contract, fraud, deceptive trade practices, misrepresentation, negligence, gross negligence, malpractice, wrongful death, and any other claim, whether sounding in tort, contract, or otherwise. The Parties agree that any such action or claim must be brought within the statute of limitations established in the applicable state or federal law pertaining to the underlying claim. However, this agreement to arbitrate shall not limit the right of the Resident or anyone else to communicate with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman.

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The Parties agree that damages awarded, if any, in an arbitration conducted pursuant to this agreement shall be determined in accordance with the provisions of the state or federal law applicable to a comparable civil action filed in the State in which the Facility is located, including any prerequisites to, credit against, or limitations on, such damages. The Parties also agree to arbitrate each claim on an individual basis, and will not seek representative, consolidated, or class treatment of any claim.

The Parties intend that this agreement shall inure to the benefit of and bind: the Parties; their successors and assigns; the owners, agents, employees, and independent contractors of the Facility and any affiliated entities; all persons whose claim is derived through or on behalf of the Resident, including that of any parent, spouse, child, guardian, executor, administrator, legal representative, or heir of the Resident; and any person whose claim is predicated on conduct involving the Resident or the aforementioned individuals.

All claims based in whole or in part on the same incident, transaction, or related course of care or services provided by the Facility to the Resident shall be arbitrated in one proceeding. A claim shall be waived and forever barred if it arose prior to the date upon which notice of arbitration is given to the Facility or received by the Resident and is not presented in the arbitration proceeding.

The arbitrator shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability, or formation of this agreement, including, but not limited to, any claim that all or any part of this agreement is void or voidable. If any provision of this agreement is determined to be invalid or unenforceable, in whole or in part, the remaining provisions remain in full force and effect.

Execution of this agreement by the resident is not a condition of admission to, or a requirement to continue receiving care at, the Facility. In other words, the resident has the right not to sign this agreement and still be admitted to, or continue receiving care at, the Facility.

The Resident also understands that: (1) he/she has the right to seek legal counsel concerning this agreement and (2) this agreement may be rescinded by written notice to the Facility from the Resident within 30 days of the Resident's signature below. If not rescinded within 30 days, this agreement shall remain in effect for all care and services subsequently rendered at the Facility, even if such care and services are rendered following the Resident's discharge and readmission to the Facility.

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THE PARTIES UNDERSTAND AND AGREE THAT BY ENTERING INTO THIS ARBITRATION AGREEMENT, THEY ARE GIVING UP AND WAIVING THEIR CONSTITUTIONAL RIGHT TO HAVE CLAIMS DECIDED IN A COURT OF LAW BEFORE A JUDGE AND JURY.

Initials ☐

By signing below, the Resident acknowledges that: (1) this agreement has been explained to the Resident by a representative of the Facility in a form and manner that the Resident understands, including in a language the Resident understands; and (2) the Resident understands this agreement. [§]

This agreement shall be governed by and enforced under the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

Resident/Representative Signature Date	Facility's Authorized Agent Signature Date
Resident/Representative Printed Name	Facility's Authorized Agent Printed Name

☐ Resident has declined to sign agreement.

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INFORMED CONSENT

1. RPM Care Coordination, PC, NY Medical Factor, P.C., and RPM Care Coordination, P.A. (collectively, **PURPOSE OF THIS FORM**: This consent for provides information about telehealth services provided by outlined in this Consent.

2. **BACKGROUND ON OUR SERVICES**: If your care provider determines you may benefit from telehealth services, we may ask questions about your health, conduct examinations, and make recommendations as needed. Care may be provided by Group staff including the medical doctor, nurse, or other staff person. Care may include, but is not limited to, obtaining a medical history, performing a physical examination, recommending clinical observation, and providing treatment as needed. Treatment may include an order for telehealth services such as remote patient monitoring ("RPM") and/or remote therapeutic monitoring ("RTM") as well as providing such services (collectively, "Telehealth Services").

   If Telehealth Services are ordered, Group will remotely review your respiratory rate during your stay to look for any subtle or significant abnormalities. We will look for clinical indications which may be of concern to Group during your inpatient stay and work with your on-site clinical team to provide personalized treatments. This data can be used by the caregivers clinical team in your facility to make changes to your plan of care, or coordinate additional services as needed.

3. **BENEFITS AND RISKS OF OUR SERVICES**: The services provided by Group may help detect early sings of changes in your respiratory health. Early detection may help improve the overall quality of care provided to you.

4. **NOT FOR EMERGENCIES**: The Telehealth Services are NOT emergency services and your data WILL NOT BE MONITORED 24/7. If you think you are experiencing a medical emergency, RING YOUR CALL BELL. Group's Telehealth Services are for retrospective monitoring only and therefore is not designed as an emergency response unit. In the case of an emergency, contact 911 immediately.

5. **NO DUTY OF CARE**: Please note that Group does not take responsibility for your health or ongoing care.

6. **THE CIRCADIA C100 SYSTEM**: Telehealth Services may include use of The Circadia C100 System (the "System") which Group will place within a detectable range of your bed and use to monitor your respiratory rate through radar technology. The System is indicated for both contactless spot checking and continuous measurement of respiratory rate data. The System is must be used under the care of clinicians and medically qualified personnel. The System does not provide alarms for timely response in life-threatening situations.

7. **TELEHEALTH AUTHORIZATION AND CONSENT**: Group relies on telemedicine to provide services to you. By signing below, you accept a greater responsibility to read and understand information about the limitations of telemedicine, the risks of seeking health care information this way, and the risks and benefits of a proposed treatment plan. Specifically, you agree to the following risks:

QUESTIONS: If you have any questions, please call or email us at (800) 985-5596, support@circadia.health.

CONSENT:

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- I understand that while Telehealth Services may provide convenient and timely access to healthcare, there are potential risks associated with telehealth, including technology failures, delays before a provider reviews any information provided through telehealth, and limitations in assessments.
- As with any Internet-based communication, I understand there are risks of security breaches. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.
- I am aware that I have the option to seek in-person healthcare services from a healthcare provider.
- I understand that I may not have an in-person consultation and physical exam with a doctor that might identify a medical condition that needs further investigation or immediate treatment.
- I hereby acknowledge that I am aware of all potential risks associated with the services provided by Group, including, but not limited to, the Telehealth Services, use of the System, and telehealth. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment by Group.
- I understand and agree that the health information I provide at the time of Telehealth Services may be the only source of health information used by the medical professionals during the course of my examination and treatment at the time of the provision of Telehealth Services, and that such professionals may not have access to my full medical record or information.
- I hereby acknowledge that my data will be electronically transmitted from the RPM Equipment to Group's Platform in a safe and secure manner and release and hold harmless Group for any loss of data or information due to technical failures associated with the Telehealth and RPM Services.
- I hereby acknowledge that I will not intentionally tamper with and RPM device used in connection with the services.
- I consent to treatment by Group, and my consent is voluntary. I understand I have the right to withdraw this consent at any time.
- My signature below verifies that I have read all of the information contained in this Consent Form and that I have asked questions about anything I have not understood up to this point.

I HEREBY CERTIFY THAT I READ, UNDERSTAND, AND AGREE TO THE ABOVE INFORMED CONSENT FORM AND THE FOLLOWING ATTACHED DOCUMENTS

□ Services Agreement

□ Notice of Privacy Practices

_____ _____

Patient Name Medical Record Number (or D.O.B.)

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient or patient's representative Relationship to patient

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FOR OFFICE USE ONLY:

If the patient agreed to the terms and conditions but a signature was not obtained, please explain why:

- ☐ Patient not able to hold pen/sign.
- ☐ Representative/patient contacted by phone
- ☐ Other reason: _____

_____

Signature of Facility/Group Representative

_____

Print Name

SERVICES AGREEMENT

This Services Agreement (the "Agreement") is between RPM Care Coordination, PC, NY Medical Factor, P.C., and RPM Care Coordination, P.A. (collectively, "Group") which may do business as "Circadia Health" and me, the Client identified below ("I," "me" or "Client") as of the date identified below. This Agreement sets forth the contractual rights and obligations of the parties with respect to the services (the "Services") provided by Group.

1. **CLIENT RESPONSIBILITIES**: I acknowledge and understand that I am voluntarily becoming a Client of Group and that this agreement will govern my relationship for all Services provided by Group for my care. I understand and agree that my insurance may be billed for the Services and that I may be responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by my insurance carrier.

2. **TERMINATION**: This Agreement shall become effective on the first date of Services and shall continue in full force and effect unless and until terminated by Group or me. This Agreement may be terminated by me at any time and for any reason, or for no reason, by sending an email to support@circadia.health or calling (800) 985-5596.

3. **CONTACTING US**:
   a. Telephone: Group may not immediately be available by telephone. Group returns messages as promptly as Group can, but may be delayed outside of regular business hours, on weekends, and holidays.
   b. Email: I may email Group at support@circadia.health regarding administrative matters. I may call the Group at (800) 985-5596 or email Group at support@circadia.health regarding any questions, concerns, or complaints. Although privacy and security regulations limit the modalities of communication, I hereby authorize Group to communicate with me by email message and SMS text, or any other method to which I have consented by providing contact information in my registration and request for Services from Group. I acknowledge that Group is communicating in this manner irrespective of HIPAA or state legal requirements solely at my direction. I may revoke that permission in writing, at any time, in which event Group will stop any further use or disclosure of my medical information by email, except to the extent Group has already acted in reliance on my permission. I understand that Group is unable to take back any disclosure Group has already made with my permission and that Group is required to retain records of the communications prior to any revocation of authorization.

4. **NOTICE TO CONSUMERS**: I acknowledge that I understand that physicians in California are licensed and regulated by the Medical Board of California. More information is available from the Medical Board at (800) 633-2322 and www.mbc.ca.gov.

5. **DISPUTE RESOLUTION**: Any dispute, claim or controversy arising out of or relating to this Agreement or the

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breach, termination, enforcement, interpretation, or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by arbitration in Los Angeles, California, before one arbitrator. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures pursuant to JAMS' Streamlined Arbitration Rules and Procedures. Judgment on the Award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction. The prevailing party in any Arbitration hereunder shall be awarded reasonable attorneys' fees, expert and non-expert witness costs and any other expenses incurred directly or indirectly with said Arbitration, including without limitation the fees and expenses of the arbitrator(s).

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NOTICE OF PRIVACY PRACTICES

The purpose of this notice is to inform you about the privacy practices of RPM Care Coordination, PC, NY Medical Factor, P.C., and RPM Care Coordination, P.A.. (collectively, "Group") which may do business as "Circadia Health."

Group is dedicated to maintaining the privacy of your protected health information ("PHI"). PHI is information about you that may be used to identify you (such as your name, social security number or address), and that relates to (a) your past, present or future physical or mental health or condition, (b) the provision of healthcare to you, or (c) your past, present, or future payment for the provision of healthcare. In conducting its business, Group may receive and create records containing your PHI. Group is required by law to maintain the privacy of your PHI and to provide you with notice of its legal duties and privacy practices with respect to your PHI.

Group must abide by the terms of this Notice while it is in effect. This Notice is in effect from the date noted above until Group replaces it. Group reserves the right to change the terms of this Notice at any time, as long as the changes are in compliance with applicable law. If Group changes the terms of this Notice, the new terms will apply to all PHI that it maintains, including PHI that was created or received before such changes were made. If Group changes this Notice, it will post the new Notice on its Platform and will make the new Notice available upon request.

1. **USES AND DISCLOSURES OF PHI**. Group may use and disclose your PHI in the following ways:
   - **Treatment, Payment and Healthcare Operations**. Group is permitted to use and disclose your PHI for purposes of (a) treatment, (b) payment and (c) healthcare operations. For example: **Treatment**. Group may disclose your PHI to a physician in connection with your treatment. **Payment**. Group may use and disclose your PHI to your health insurer or health plan in connection with the processing and payment of claims and other charges. **Healthcare Operations**. Group may use and disclose your PHI in connection with its healthcare operations, such as providing customer services and conducting quality review assessments. Group may engage third parties to provide various services for Group. If any such third party must have access to your PHI in order to perform its services, Group will require that third party to enter an agreement that binds the third party to the use and disclosure restrictions outlined in this Notice.
   - **Authorization**. Group is permitted to use and disclose your PHI upon your written authorization, to the extent such use, or disclosure is consistent with your authorization. You may revoke any such authorization at any time.
   - **As Required by Law**. Group may use and disclose your PHI to the extent required by law.
   - **Public Health Activities**. Group may disclose your PHI to public health authorities or other governmental authorities for purposes including preventing and controlling disease, reporting child abuse or neglect, reporting domestic violence, and reporting to the Food and Drug Administration regarding the quality, safety and effectiveness of a regulated product or activity. Group may, in certain circumstances disclose PHI to persons who have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
   - **Workers' Compensation**. Group may disclose your PHI as authorized by, and to the extent necessary to comply with, workers' compensation programs and other similar programs relating to work-related illnesses or injuries.
   - **Health Oversight Activities**. Group may disclose your PHI to a health oversight agency for authorized activities such as audits, investigations, inspections, licensing, and disciplinary actions relating to the healthcare system or government benefit programs.
   - **Judicial and Administrative Proceedings**. Group may disclose your PHI, in certain circumstances, as permitted by applicable law, in response to an order from a court or administrative agency, or in response to a subpoena or discovery request.
   - **Law Enforcement**. Group may, under certain circumstances, disclose your PHI to a law enforcement official, such as for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
   - **Decedents**. Group may, under certain circumstances, disclose PHI to coroners, medical examiners, and funeral directors for purposes such as identification and determining the cause of death.
   - **Organ Procurement**. Group may, under certain circumstances, use or disclose PHI for the purposes of organ donation and transplantation.
   - **Research**. Group may, under certain circumstances, use or disclose PHI as necessary for research purposes.
   - **Threat to Health or Safety**. Group may, under certain circumstances, use or disclose PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

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- **Specialized Government Functions**. Group may, in certain situations, use and disclose PHI of persons who are, or were, in the Armed Forces for purposes such as ensuring proper execution of a military mission or determining entitlement to benefits. Group may also disclose PHI to federal officials for intelligence and national security purposes.

2. **YOUR RIGHTS REGARDING YOUR PHI**. You have the following rights regarding your PHI:
   - **Confidential Communication**. You have the right to receive confidential communications of your PHI. You may request that Group communicate with you through alternate means or at an alternate location, and Group will accommodate your reasonable requests. You must submit your request in writing.
   - **Restrictions**. You have the right to request restrictions on certain uses and disclosures of PHI for treatment, payment, or healthcare operations. You also have the right to request that Group limits its disclosures of PHI to only certain individuals involved in your care or the payment of your care. You must submit your request in writing to Group. Group is not required to comply with your request. However, if Group agrees to comply with your request, it will be bound by such agreement, except when otherwise required by law or in the event of an emergency.
   - **Inspection and Copies**. You have the right to inspect and copy your PHI. You must submit your request in writing to Group. Group may impose a fee for the costs of copying, mailing, labor, and supplies associated with your request. Group may deny your request to inspect and/or copy your PHI in certain limited circumstances. If that occurs, Group will inform you of the reason for the denial, and you may request a review of the denial.
   - **Amendment**. You have a right to request that Group amend your PHI if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is maintained by Group. You must submit your request in writing to Group and provide a reason to support the requested amendment. Group may, under certain circumstances, deny your request by sending you a written notice of denial. If Group denies your request, you will be permitted to submit a statement of disagreement for inclusion in your records.
   - **Accounting of Disclosures**. You have a right to receive an accounting of all disclosures Group has made of your PHI. However, that right does not include disclosures made for treatment, payment or healthcare operations, disclosures made to you about your treatment, disclosures made pursuant to an authorization, and certain other disclosures. You must submit your request in writing to Group and you must specify the time period involved (which must be for a period of time less than six years from the date of the disclosure). Your first accounting will be free of charge. However, Group may charge you for the costs involved in fulfilling any additional request made within a period of 12 months. Group will inform you of such costs in advance, so that you may withdraw or modify your request to save costs.
   - **Breach Notification**. You have the right to be notified in the event that Group (or a Group Business Associate) discovers a breach of unsecured PHI.
   - **Paper Copy**. You have the right to obtain a paper copy of this Notice from Group at any time upon request. To obtain a paper copy of this notice, please contact Group by calling (800) 985-5596.
   - **Complaint**. You may complain to Group and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. To file a complaint with Group, you must submit a statement in writing to Group at support@circadia.health. Group will not retaliate against you for filing a complaint.
   - **Further Information**. If you would like more information about your privacy rights, please contact Group by calling (800) 985-5596 and ask to speak to the Privacy and Security Officer. To the extent you are required to send a written request to Group to exercise any right described in this Notice, you must submit your request to support@circadia.health.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND RESIDENT RIGHTS

Resident: _____ SS Num.: _____
Admit Date: _____

I acknowledge that I have received, read, had the opportunity to ask questions of, and received answers to a copy of both the Notice of Privacy Practices and Resident Rights.

_____ _____
Signature of Resident (if the resident is managing his or her affairs) Date

_____ _____
Signature and Title of Party Acting for Resident Date

_____ _____
Witness Date

(To Be Completed if Unable to Obtain Written Acknowledgement)

On _____ I attempted to obtain an acknowledgement of receipt of the Notice of Privacy Practices and Resident Rights form the above named Resident, but was unable to because:

Check the Applicable Box

☐ Resident (or Personal Representative) declined to sign this Written Acknowledgement

☐ Resident (or Personal Representative) did not understand the request to sign this Written Acknowledgement

☐ Other (specify): _____

_____

_____

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FACILITY DIRECTORY, NOTIFICATIONS, ACTIVITIES

Resident Name: _____
Social Security Number: _____

1. FACILITY DIRECTORY

The Facility may use or disclose limited information for the purpose of maintaining a directory and religious affiliation. The information is kept in order to give relatives, friends, and members of clergy who ask for you by name limited information such as your name and location. Your religious affiliation will be given only to members of the clergy. If you object, we will not be able to tell family and other persons who ask for you by name, where you are in the Facility.

Agree/Object/Restrict

Indicate below where you agree, object to, or wish to restrict certain information. Check one:

I want my name and location in the Directory and my religion given to clergy members.
I do not want the Facility to disclose any of my personal information as described.
I want only the following information disclosed:
Name My location in the Facility My religious affiliation

2. NOTIFICATION

We may disclose to a family member, personal friend or others involved in your care, information that relates to that person's involvement with your care or with payment for your care or to notify, or assist in notifying them of your location or general condition.

Please indicate how you wish the Facility to handle disclosures for notification and to those involved in your care by checking one of the boxes below. If you do not object or request a restriction, we will make disclosures as described above. (Check One):

_____I want _____I do not want: To have my health information disclosed for notification purposes to persons involved in my care or payment for my care as it relates to them and for notification purposes. Except to the following: _____
(List specifically anyone who should not be notified)

3. ACTIVITIES / NEWSLETTERS

Information about you may be used or disclosed during the course of various Facility activities, such as facility newsletters, posting your birth date or other social events. You may agree or object to having your information posted in the Facility or printed in a newsletter. (Check One):

_____I agree _____I do not agree: To have my information for activities used or disclosed in Facility activities or newsletters. I understand that I may be asked to sign a separate Authorization if I allow my picture to be used in a newsletter.

_____
Signature of Resident or Personal Representative Relationship Date

_____
Witness

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BED HOLD NOTIFICATION

Updated bed-hold regulation have been adopted as of May 29, 2019, in accordance with the 2017/2018 Executive budget. Chapter 57 of the Laws of 2017 amended Public Health Law (PHL) & 2808(25) places limits on the availability of Medicaid payments to nursing facilities to reserve a bed for Medicaid recipient 21 years of age or older who is temporarily absent from the facility. These changes conform to NYS code 415.3 and CMS code 483.15(d).

Where the facility has a vacancy rate of no more than 5% and a Medicaid-covered Resident has resided in the Facility for at least (30) days, the Facility will reserve a bed, as described below.

If a Medicaid-sponsored Resident takes a therapeutic leave of absence (personal leave, not for hospitalization) in accordance with that Resident's care plan, Medicaid will pay to hold the bed for up to ten (10)days in any (12) month period.

If a Medicaid-sponsored **Hospice Resident** takes leave of absence overnight for hospitalization, per NYS regulation, the facility is required to hold the bed for up to fourteen (14) days in any twelve (12) month period. This benefit is not available to non-Hospice Residents.

A resident and/or their designated representatives may choose to pay privately to hold a Resident's bed at the prevailing daily basic rate for as long as they wish, if it is expected that the Resident will return to the Facility from the hospital or from a leave of absence and if the Resident's payment obligation are not in arrears. During the Resident's absence, the prevailing daily basic rate is owed unless the Facility is notified to cancel the bed hold.

All Medicare or Medicaid nursing home eligible residents on leave due to hospitalization, and requiring skilled nursing facility services, will be given priority readmission to the next available bed in a semi-private room or multi-bedded room. If the facility determines that a resident who has transferred with an expectation of returning to the facility, cannot return, the appropriate discharge procedures will be followed.

If given to Resident/Responsible Party:

Date: _____ Resident_____

Responsible Party_____

If sent with Resident to the hospital on_____ by_____
Date Name of Sender

If Sent to Responsible Party on_____ by_____
Date Name of Sender

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Resident Name: _____
Admission Date: _____

Dear Resident/Family/Designated Representative,

Welcome to _____, to answer any questions or concerns you may have regarding your financial obligation, below you will find an explanation of Medicare benefits. If you have any questions, please feel free to contact a member of our Admissions, Business, or Administrative staff.

Medicare has a potential of up to but not exceeding 100 days only.

Days 1-20: Medicare covers all Skilled Nursing Services at 100%—no financial obligation to you.

Days 21-100: Medicare covers partially and has a copay of **$**_____per day due to the facility. This may change based on secondary insurance coverage. Your secondary insurance (if applicable) is included below.

Secondary Insurance (if applicable): _____

Residents Financial Responsibility: _____

Medicare coverage begins upon any post-acute level of care, not necessarily upon admission to _____. Any prior stay at a skilled Nursing Facility within the past 60 days will count towards your days used.

Example: If you had a stay at another Skilled Nursing Facility lasting 22 days then went to the hospital and discharged to _____, your Medicare days would start at day 23 and co-pay would begin at that time.

If you require more than 100 days of care, you are responsible for all charges beginning on the 101st day. If at any time before the 100th day your stay does not qualify for Medicare coverage, you will be responsible for all charges.

By signing below, you acknowledge the above information has been explained to you.

_____

Resident/Designated Responsible Party Signature Date

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Skilled Nursing Facility:

Phone Number: _____ Patient's Name: _____

MEDICARE TECHNICAL DENIAL

Upon this admission you are unable to access your Medicare benefit at this time because you have not met the technical requirements as indicated below.

Beginning On: _____, you may have to pay out of pocket for the care received if you do not have other insurances that may cover these costs.

Care:	**Reason Medicare May Not Pay:**	**Estimated Cost:**
Inpatient Skilled Nursing Facility Stay	[ ] No 3 day inpatient qualifying hospital stay [ ] No 60 day custodial (unskilled) care period [ ] Exhausted Medicare Benefit [ ] You do not require daily skilled services [ ] No Medicare Part A benefit [ ] You have elected Hospice or Managed Care benefit	**Up to** **per day**

We estimate that these services will cost you $_____ per day/item or service

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Resident Smoking Policy

All residents admitted to the center will be informed prior to admission that there are NO smoking privileges at the center, this includes the use of any smoking device or e-signature device. The failure to comply with the above policy may result in initiation of discharge from the center.

I acknowledge and agree to abide by the Smoking Policy.

Signature:_____

Date:_____

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TELEHEALTH/TELEMEDICINE CONSENT FORM

By signing this form, I acknowledge that I understand and agree to the following:
Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists and/or subspecialists, nurse practitioners, registered nurses, medical assistants, and other healthcare providers who are part of my clinical care team. In addition to me and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate in the telehealth/telemedicine service(s), and I agree to share my personal information with such family members, caregivers, orother legal representatives or guardians. Related information may be used for diagnosis, therapy, follow-up and/or education.

Telehealth/Telemedicine requires transmission, via Internet or tele-communication device, of health information, which may include, but may not be limited to:

- Progress reports, assessments, or other intervention-related documents,
- Bio-physiological data transmitted electronically,
- Videos, pictures, text messages, audio, and any digital form of data.

The laws that protect the privacy and confidentiality of health care information also apply to telehealth/telemedicine. Information obtained during telehealth/telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing, and healthcare operations. By agreeing to use telehealth/telemedicine services, I am consenting to Bridge Health PLLC and/or its successors and/or its assigns1 (referred to hereinafter as Bridge Health PLLC) using, obtaining, receiving and/or otherwise sharing my protected health information for the aforementioned purposes, which may specifically include sharing my protected health information with my primary physician and other specialists involved in my care and treatment as well as any skilled nursing facility, home care and/or hospital where I received care and/or treatment.

I acknowledge that it is my responsibility to present for the telehealth/telemedicine session in a timely manner and be ready to participate. If the assistance of another person is needed to facilitate my participation, I will have such a person available with me so that the session may start promptly as scheduled. I will notify Bridge Health PLLC at least 48 hours in advance if I need assistance and am unable to coordinate such assistance myself. I also agree to give Bridge Health PLLC at least 24- hour notice in writing if I will not be able to attend my session as scheduled and acknowledge that I may be charged a reasonable fee if I fail to provide such notice. Bridge Health PLLC services are billed directly to your insurance, and any copay will be the same as going to your doctor's office for an in-person visit. If deemed appropriate by Bridge Health PLLC's provider, I consent to receive Advanced Primary Care Management (APCM) services from Bridge Health PLLC, which includes comprehensive care coordination, proactive monitoring of my chronic conditions, and 24/7 access to my care team. I understand that only one provider can furnish APCM services per calendar month, I have the right to stop these services at any time, and cost sharing may apply so I may incur out-of-pocket costs for APCM services.

As with any Internet-based communication and/or transmission, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Despite taking such precautions, a security breach risk remains, and I hereby acknowledge and accept that risk and choose to proceed with these services anyway.

Telehealth/telemedicine sessions may not always be possible. Disruptions of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, audio interference) that prevent effective interaction between consulting clinician(s), participant, patient, or care team. A session may need to be rescheduled if any such issues occur and/or other remedies may be necessary and will be determined as needed.

By signing below, I hereby consent to the use of telehealth/telemedicine in the provision of my care and acknowledge that I understand and agree to all terms and conditions stated herein. I certify that I am the legal representative of the patient or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the information stated herein. I have had all my questions answered. I understand that I do not have to sign this form if I do not understand part of all the information and/or agree, and that I may withdraw my consent at any time by notifying, in writing, Bridge Health PLLC or one of its staff members. I understand that once signed, this informed consent form will become a part of my medical record.

Patient Signature: _____ Date: _____

Patient Name Printed: _____ Best Contact Number: _____

Patient Legal Representative (if applicable):_____ Relationship to Patient: _____

Patient Legal Representative Contact Information: _____

1 Whenever Bridge Health PLLC is mentioned herein it refers to Bridge Health PLLC and/or its successors and/or its assigns.

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Post Acute Specialists
Informed Consent Form

Post Acute Specialists, LLC, and its affiliates, **CA Post Acute Specialists, P.C., IN Post Acute Specialists, PC, Post Acute Specialists of Massachusetts, PLLC, MI Post Acute Specialists, PC, Post Acute Specialists New Jersey, P.C., Texas Post Acute Specialists, P.A., and Post Acute Specialists of Vermont, PLC** (collectively, "**Post Acute Specialists**") are committed to providing the highest quality healthcare services to patients. This **Informed Consent Form** informs the patient ("**Patient,**" "**you,**" or "**your**") of the scope of healthcare services Post Acute Specialists will provide as well as the methods, risks, and limitations of using a telehealth platform.

Patient Acknowledgments:

I further acknowledge and understand the following:

1. By signing this Informed Consent Form, I am authorizing Post Acute Specialists to provide the Services to me.
2. I may elect to seek in-person care as an alternative to receiving telehealth services from Post Acute Specialists.
3. I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time without affecting my right to future care or treatment.
4. In choosing to participate in a telehealth visit, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) and/or imaging may be conducted at another location such as a testing facility, at the direction of my Provider.
5. Persons may be present during the telehealth visit other than my Provider who will be participating in, observing, or listening to my consultation with my Provider (*e.g.*, in order to operate the telehealth technologies). If another person is present during the telehealth visit, I will be informed of the individual's presence and his/her role.
6. I have the right to request a copy of my medical records. I can request to obtain or send a copy of my medical records to my primary care or other designated health care provider by contacting

   medicalrecords@thirdeyehealth.net . A copy will be provided to me at reasonable cost of preparation, shipping and delivery
7. I have been given the opportunity to ask questions and such questions have been answered to my satisfaction.

For additional information on telehealth services and the rules and regulations as it applies to virtual care, please **visit t.ly/TEH**

Patient Informed Consent

□ **ACCEPT**. By checking this Box, I acknowledge that I have carefully read, understand, and agree to the terms of this "**TELEHEALTH INFORMED CONSENT**" and consent to receive the Services.

PATIENT'S NAME:
_____

PATIENT'S SIGNATURE:
_____

DATE:
_____

NAME OF MINOR PATIENT'S PARENT OR LEGAL GUARDIAN:

_____

MINOR PATIENT'S PARENT OR LEGAL GUARDIAN'S SIGNATURE:

_____

DATE:
_____

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Post Acute Specialists
Assignment of Benefits

ASSIGNMENT OF BENEFITS

I hereby assign to **Post Acute Specialists, LLC**, and its affiliates, **CA Post Acute Specialists, P.C., IN Post Acute Specialists, PC, Post Acute Specialists of Massachusetts, PLLC, MI Post Acute Specialists, PC, Texas Post Acute Specialists, P.A., and Post Acute Specialists of Vermont, PLC** (collectively, "**Post Acute Specialists**") all my right, title, and interest in any and all health insurance or other health care benefits payable to me or on my behalf by any insurance payer, including Medicare, private insurance and any other health plan for medical treatment rendered by Post Acute Specialists. The assignment will remain in effect until revoked by me in writing. I authorize the release of pertinent information necessary to process my medical claim. I also authorize direct payment to Post Acute Specialists of all insurance benefits payable to me for such medical treatment. In the event an insurance payer pays me directly, I agree to immediately pay such amounts to Post Acute Specialists.

I understand that my insurance payer may pay less than the actual bill for services. I acknowledge that I am still responsible for paying Post Acute Specialists for any and all amounts not paid by my insurance payer, including non-covered charges and all copayments, coinsurance, and deductibles. I understand that if my insurance requires a referral, I am responsible for obtaining one prior to my appointment. In the event any collection action is necessary to collect amounts I owe to Post Acute Specialists, I agree to pay all expenses associated with such action, including but not limited to collection agency fees and attorneys' fees.

I certify that I have read and understand the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or am otherwise duly authorized by the patient to sign the above and accept its terms on his/her behalf.

Patient Name: _____ Dated: _____

Signed: _____

If not signed by the patient, please indicate relationship:_____

Witness:_____ Dated:_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Facility and affiliated providers, who follow these Privacy Practices as an Organized Health Care Arrangement (OHCA), respect the privacy and confidentiality of your protected health information. This Notice of Privacy Practices ("Notice") describes how we may use and disclose your personal health information whether created or received by us and how you can access this information.

OUR RESPONSIBILITIES TO YOU

We understand that information about you and your health are private and personal. By law we are required to:

- Maintain the privacy of your protected health information;
- Provide you with this Notice of our legal duties and privacy practices related to your protected health information;
- Notify you if there is a breach or unlawful access, use or disclosure of your protected health information; and
- Abide by the terms of this Notice that is currently in effect.

In this Notice, we use the term “protected health information” to describe individually identifiable health information, including demographic data that relates to:

- Your past, present or future physical or mental health or condition,
- The provision of health care to you, or
- The past, present of future payment for the provision of health care to you,

and that actually or reasonably could identify you. This information includes many identifiers, including, for example, your name address, birth date, social security number, health plan beneficiary number, electronic mail address or account numbers.

We will refer to your protected health information as “health information” throughout this Notice.

WHO WILL FOLLOW THIS NOTICE

This Notice applies to this Facility, including its health care professionals, employees, medical staff, trainees, students and volunteers; other direct treatment providers who provide medical services on site

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who for the sole purpose of this Notice comprise of an Organized Health Care Arrangement (OHCA) which includes all members of the medical staff, contracted physicians, rehabilitation service providers, nurse practitioners and physician assistants providing services to you at this Facility; and business associates. The Facility, members of the OHCA and business associates may share health information with each other as necessary to coordinate your care and treatment and for other purposes described in this Notice including payment and health care operations. The members of the OHCA and business associates are not considered to be acting jointly for any purpose other than for the sharing of health information for the purposes described in this Notice.

HOW WE MAY USE AND DISCLOSURE YOUR HEALTH INFORMATION WITH OTHERS

For Treatment. We may use or disclose your health information to provide you with treatment and services and to coordinate your continuing care and treatment with other health care providers. Your health information may be used by doctors, therapists, nurses and other staff members, as well as by laboratory and radiological technicians, or other individuals involved in your care, both within and outside the Facility. For example, we may disclose certain health information about you, including underlying chronic medical conditions, to a pharmacist who needs that information to fill a prescription ordered by your doctor and ensure that there are no harmful effects to your body associated with giving you that medication.

For Payment. We may use or disclose your personal health information as necessary so that we can bill and receive payment for the treatment and services that we provide to you. For example, in order to receive payment for services we provide, we must submit a bill that identifies you, your diagnosis and the treatment we provided to your insurance company or authorized third party. Additionally, if there is a proposed treatment or service, we may submit this information to your insurance company or third party to confirm your coverage and/or to request approval for this treatment or service.

For Health Care Operations. We may use or disclose your health information as necessary for our internal operations or for the operations of the OHCA, such as for administration and management activities, evaluating our employees, reviewing the practices of the OHCA and other providers, and to monitor the quality of care being provided. For example, we may use your health information to evaluate the care provided to you and use the information to further improve the quality of care, for education and training purposes, and/or for planning for services. We may also disclose your health information to other health care providers or entities that have, or have had in the past, a relationship with you for certain limited healthcare operations in compliance with the privacy laws. **If you are a patient of an Accountable Care Organization (ACO) or any other value-based entity, we may share your information with providers within the ACO/entity to evaluate outcomes and ensure quality care.**

Facility Directory. Unless you object, we may use and disclose certain limited information about you in our Directory while you are a resident. This information may include your name, location in the Facility, your general condition and religious affiliation. Our Directory does not include specific medical

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information about you. We may release Directory information that excludes your religious affiliation to people who ask for you by name. We may provide the Directory information, including your religious affiliation, to a member of the clergy, even if the clergy does not ask for you by name.

Persons Involved in Your Care or Payment for Your Care. Unless you object, we may disclose health information about you to a family member, close friend or other persons you identify, including clergy, who are involved in your care. These disclosures are limited to information relevant to the person's involvement in your care or in arranging payment for your care.

Treatment Alternatives and Health-Related Benefits and Services. We may use or disclose your health information to inform you about alternative treatments, providers, therapies or settings and health-related benefits and services that may be of interest to you.

SPECIAL CIRCUMSTANCES WHERE WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

As Required By Law. We may disclose your health information when required to do so by federal, state or local law.

Public Health Activities. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. These activities may also include disclosures to the Food and Drug Administration [FDA] about the quality, safety or effectiveness of an FDA regulated product.

Reporting Victims of Abuse, Neglect or Domestic Violence. If we believe that you have been a victim of abuse, neglect or domestic violence, your personal health information may be used or disclosed to notify a government authority.

Health Oversight Activities. We may disclose your personal health information to a health oversight agency for activities authorized by law. A health oversight agency is a state or federal agency or authority authorized by law to oversee the health care system or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health care information is relevant.

Judicial and Administrative Proceedings. We may disclose your health information in response to a court or administrative order, in response to a subpoena, discovery request, or other lawful process.

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Law Enforcement. We may disclose your health information for certain law enforcement purposes, including, for example, to report certain types of wounds or other physical injuries; to comply with a court order or court ordered warrant, or a subpoena or summons, a grand jury subpoena, or properly authorized administrative request; to identify or locate a suspect or missing person; to report crime in emergencies or suspicious deaths; to answer certain requests for information concerning crimes; or to report criminal activity at the Facility.

Coroners, Medical Examiners, Funeral Directors. We may release your health information to a coroner or medical examiner as necessary to identify a deceased person or to determine the cause of death. We may also release your health information as necessary to a funeral director in order to carry out his/her duties.

Organ, Eye or Tissue Donations. We may use or disclose your health information to organizations that obtain organs or handle organ, eye or tissue transplantation for the purpose of facilitating such donations.

To Avert a Serious Threat to Health or Safety. We may use or disclosure your health information as necessary to prevent a serious threat to your health or safety, or the health or safety of the public or another person.

Military and Veterans. If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities to assure proper execution of a military mission; or as necessary to determine eligibility for entitlement to military benefits. We may also use and disclose health information about foreign military personnel as required by the appropriate foreign military authority.

National Security and Intelligence Activities. We may release your health information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other authorized national security activities.

Protective Services for the President and Others. We may disclose health information to authorized federal officials to provide protection to the President of the United States, other authorized persons or foreign heads of states, or to conduct certain special investigations.

Inmates/Law Enforcement Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the institution or official for certain purposes including your own health and safety as well as that of others.

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Workers' Compensation. We may use or disclose your health information to comply with laws relating to the provision of benefits for work-related injuries or illness without regard to fault.

Disaster Relief. Unless you object, we may disclose health information about you to an organization authorized to assist in a disaster relief effort.

Business Associates. Some of our services are provided by outside people and entities. We may disclose your health information to business associates so they can perform the work we've asked them to do. Our business associates are required by contract to appropriately safeguard your information.

Death. In the event of your death, we may release your health information in order to notify or assist in locating a family member, other person responsible for your care or individual who has been identified by you, to inform such person of your death.

Incidental Disclosures. We view your health information seriously and take reasonable steps to safeguard the privacy of your health information; however, certain disclosures of your information may occur during or as a result of an otherwise permissible use or disclosure of your information. For example, an incidental disclosure may occur if another person approaches a staff member while you are speaking with this staff person about your health information. These "incidental disclosures" are permissible.

WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

Uses and Disclosures Not Covered in this Notice. Other uses and disclosures of your health information that are not covered by this Notice, or by applicable federal, state or local laws, will only be made with your written permission or "Authorization." The Authorization must specify the health information that is to be used or disclosed and the purpose of the use or disclosure. The Authorization must also specify the individual authorized to request the information, the name of the person or entity to whom the health information is being disclosed; and an expiration date or event. Although you may authorize disclosure of your medical information, you may revoke this authorization in writing at any time. If you revoke your Authorization, we will no longer use or disclose your health information for the purposes specified in that Authorization. However, we are unable to take back any disclosures requiring your Authorization that were already made with your permission.

YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

You and/or your legal representative have the following rights regarding your health information:

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Right to Request Restrictions. You have the right to request in writing that we restrict or limit the way we use or disclose your personal health information for treatment, payment or health care operations. However, we are not required to agree to restrictions regarding the **use** of your health information. We are required to agree to restrictions regarding **disclosures** unless you are being transferred to another facility, the information is needed for emergency treatment or the disclosure is required by law. If not required by law, we must also agree to limit disclosures made for the purpose of carrying out payment or health care operations where the health information pertains solely to a health care item or service for which you pay for in full prior to receiving. Should you desire to restrict the use and/or disclosure of your health information, speak with any staff member who will provide you with the appropriate "Request for Restrictions" form.

Right to Request Confidential Communications. You have the right to request in writing that we communicate with you concerning your health information in a certain way or at a certain location. For example, you can request that we forward or send mail to you at a specific address. To request that your health information is shared in the confidential manner of your preference, please specify your preference in writing and provide this writing to any staff member at the Facility. We will accommodate your reasonable requests.

Right to Access and Copy Health Information. You have the right to inspect and, upon written request, obtain a copy of your health information that may be used to make decisions about your care. This information includes medical and billing records, but does not include psychotherapy notes, information pertaining to an authorized legal or administrative proceeding, or certain research activities. We may charge a reasonable fee not to exceed applicable state law for copying. You may request a copy of your record by making a request to the medical records department of your Facility. Under certain circumstances, a request for your health information may be denied. However, if denied, you will be provided with information pertaining to the manner in which this decision may be appealed.

Right to Request Amendment. You have the right to request that we amend any health information maintained by us for as long as the information is kept by the Facility. Your request must be made in writing on a form provided by the Facility and must state the reason for the requested amendment. We are required to respond to your request in a timely manner. We may deny your request if the information was not created by us; is not part of the health information maintained by us; is not part of the information that you would be permitted to inspect and copy; or is already accurate and complete. If we deny your request, we will give you a written denial notice, including the reasons for the denial and your next steps should you disagree with the denial, including your right to submit a written statement disagreeing with the denial, which will be included in your medical record.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of disclosures of your health information. An accounting is a list of individuals or entities who have received your health information in the six years prior to your request. The listing will not include disclosures made: to you or

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your personal representative; for treatment, payment or health care operations; incident to a permitted use; pursuant to an Authorization; to those who request your information through the Facility directory; to your family members, relatives or friends who are involved in your care; for national security or intelligence purposes; to correctional institutions or law enforcement officials; or as part of a "limited data set" for research purposes.

All requests for an accounting must be in writing and must state the time period in which you would like the accounting, which may not exceed six years prior to the date of the request. The first accounting provided within a 12-month period will be free; for additional requests, we may charge you our costs for completing the accounting.

Right to Notice in the Event of a Breach. You have the right to know if the Facility, members of the OHCA or its business associates acquired, accessed, used or disclosed your health information in a manner that is not legally permitted and compromises its security or privacy. Should this occur, we will notify you as soon as is reasonably possible, but not more than 60 days following our discovery of the breach.

Right to Receive a Paper Copy of this Notice. You may receive a paper copy of this Notice at any time upon request, even if your original request was for this information to be in electronic form. To obtain a copy, please contact any staff member, Administrator or the Office of Corporate Compliance at (888) 345-0079.

DISCLOSURE OF PSYCHIATRIC AND HIV-RELATED INFORMATION

For disclosures concerning certain health information such as HIV-related information or records regarding psychiatric care that have been sent to us by another provider, special restrictions may apply. Other than for purposes of treatment or payment for treatment, we will disclose HIV and psychiatric records only with an authorization or as otherwise required by law.

CHANGES TO THIS NOTICE

We reserve the right to change our Notice of Privacy Practices and to make the new provisions effective for all personal health information we maintain, including health information we already have and health information we create or receive in the future. Should we make material changes, we will make the revised Notice available to you upon request. This Notice was last updated on **September 2020.**

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint directly or in writing by contacting the Administrator or Social Services, or with the Office of Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Room 509 F, HHH Building, Washington D.C. 20201.

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To file a complaint in person, please contact: Social Services, the Administrator the Corporate Compliance Officer at (888) 345-0079. We will not retaliate against you in any way for filing a complaint.

FOR FURTHER INFORMATION

If you have any questions about this Notice or if you would like to exercise any of the rights in this Notice or would like further information regarding your privacy rights, please contact the Social Services Department or the Administrator at your FACILITY.

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Grievance/Concern Policy

The facility will support the resident/responsible party to voice grievances/concerns regarding treatment, care, management of funds, lost articles and or any violation of residents' rights. Upon receipt of the grievance/concern the facility will take the appropriate measures to seek a resolution to the concern. The Administrator will appoint a Grievance Officer. The Grievance Officer will be responsible to ensure that all grievances are responded to in a timely manner. Grievances will be maintained in the facility for 3 years.

Procedure for filing a grievance/concern:

The resident/responsible party can bring forward their concerns verbally and or by the written grievance process. Grievance/Concerns forms are available on the nursing units and in the front lobby where applicable. Facility staff is encouraged to attempt to resolve the verbal grievance/concern at the time it is brought forward whenever possible. In the case that a concern cannot be resolved promptly the staff member will complete the grievance form or give it to the person with the concern to complete. Once the form is completed it will be forwarded to the Social Service Department. During the absence of the social worker the forms will be forwarded to the Administrator. The Grievance/Concern book will be kept in the Administrator's office.

Process for Resolution:

- The social worker will review the grievance/concern and forward a copy to the appropriate department head. The social worker will keep the original and document the receipt of the grievance/concern form on the grievance log.
- The department head is responsible for investigating the concern and developing a plan to resolve it. Once a resolution has been determined the department head will document the action taken on the grievance/concern form, sign it and return it to the social worker. The social worker will attach the response to the original grievance/concern.
- The social worker will contact the department head if the completed form has not been returned within 72 hours and notify the Administrator that the resolution is still pending.
- Upon receipt of the completed form, the social worker will follow up with the person who filed the grievance/concern and discuss the resolution and have the complainant sign and or verbally acknowledge that they are in agreement that the issue has been resolved.
- The Administrator is responsible for reviewing grievances/concerns weekly to ensure that they have been investigated and resolved to the resident's/responsible party satisfaction.
- The social worker and or designee will review grievances/concerns for any trends and report findings at the Quarterly Assurance Performance Improvement Committee meeting.

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Resident's Bill of Rights

Exercising Your Rights

- You have the right to be fully informed, orally and in writing, in a form and manner you understand, of your rights and the facility's rules governing your conduct and responsibilities, and of changes in your rights and in the facility's rules. This Bill of Rights tells you about your rights as a nursing home resident.

- You have the right to a safe, clean, comfortable and homelike environment included but not limited to receiving treatment and supports for safe daily living.

- You also have the right to be fully informed about your rights by advocacy programs funded by the federal or state governments.

- You have the right to exercise your rights as a resident and as a citizen. The facility must protect and promote your rights and support, encourage and assist you in exercising them.

- You have the right to designate another person (including same-sex spouse), in accordance with state law, to represent you in exercising your rights. The facility must treat the decisions of such a designated person as your decisions to the extent required by law.

- You have the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.

- You have the right to be treated equally with other residents in receiving care and services, and regarding transfer and discharge, regardless of the source of payment for your care.

- You have the right to exercise your rights without fear of discrimination, interference, coercion or reprisal.

- If you are not capable of exercising your rights, a representative designated in accordance with state law may exercise your rights on your behalf.

- Your rights cannot be reduced, rescinded or abrogated by contract.

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Dignity and Self-Determination

- You have the right to be treated with consideration, respect and full recognition of your dignity and individuality.

- You have the right to receive quality care and services with reasonable accommodation of your individual needs and preferences, except when your health or safety or the health or safety of others would be endangered by such accommodation.

- You have the right to choose activities, schedules (including sleeping/waking times) and health care providers and services consistent with your interests and your assessment and plan of care.

- You have the right to interact with members of the community and participate in community activities both inside and outside the facility.

- You have the right to make choices about aspects of your life that are significant to you.

- You have the right to keep and use your personal possessions, as space permits, unless doing so would infringe on the rights, health or safety of other residents.

- You have the right to notice before your roommate is changed.

- If you are married, you have the right to privacy for visits with your spouse.
- If you are married and your spouse is a resident of this facility, you have the right to share a room with your spouse, subject to his or her consent and when such a room is available.

- You have the right to share a room with the roommate of your choice when both residents live in the facility and both residents consent.

Privacy

- You have the right to privacy in accommodations, in receiving personal and medical care and treatment, in visits and in meetings with family and resident groups. However, the facility is not required to provide you with a private room.

- You have the right to privacy in written, spoken, telephonic and electronic communications, including email and video communications and in internet research.

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- You have the right to associate and communicate privately with persons of your choice, including other residents.

- You have the right to privacy with consenting adults of your choice.

Communicating with Others

- You have the right to communicate with persons both inside and outside of the facility.

- You have the right to reasonable access to the Internet to the extent offered by the facility or at your own expense.

- You have the right to send and promptly receive unopened mail.
- You have the right to send and receive letters, packages and other materials via a means other than the postal service if needed.
- You have the right to have stationery, stamps and writing implements made available by the facility for you to purchase.
- You have the right to reasonable access to a telephone that you can use without being overheard. You also have a right to the use of TTY or TDD services if needed.
- You have the right to receive information from agencies that act as resident advocates and to have the opportunity to contact such agencies.

Visits

- You have the right to receive visitors of your choosing, including but not limited to a spouse (including a same-sex spouse), another family member, or a friend, at the time of your choosing so long as the visitation does not impose on the rights of another resident.

    - You have the right to refuse to receive any visitor you do not want to see.

    - You have the right to be visited by your family or representative.

    - You have the right to be visited by your licensed attending physician or an advanced practice registered nurse (“APRN”), the nursing home Ombudsman, and representatives of federal and state agencies concerned with resident care.

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  - You have the right to be visited immediately by any other person of your choice, including persons who provide health, social, or legal services to nursing home residents, subject to reasonable clinical and safety restrictions.

- The facility does not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability.

- All visitors will enjoy full and equal visitation privileges consistent with resident preferences.

Group Activities

- You have the right to participate in social, religious and community activities that do not interfere with the rights of other residents.

- You have the right to organize and participate in resident and family groups in a private space in the facility if one exists. The facility must take reasonable steps with the approval of the group to make residents and family members aware of the upcoming meetings in a timely manner.

- Your family has the right to meet with the families of other residents in the facility.

- Staff members, visitors or other guests may attend resident or family group meetings only at the group's invitation.

Grievances

- You have the right to voice grievances without discrimination or reprisal.

- You have the right to have prompt efforts made by the facility to resolve any grievances you may have, including those about the behavior of other residents, staff or other concerns regarding your stay.

- You have the right to file a complaint with the State Department of Health ("DOH"), the Department of Social Services or the Long Term Care Ombudsmen regarding abuse, neglect or misappropriation of residents' property, non-compliance with advance directive requirements and requests for information regarding returning to the community. You also have a right to file a complaint with DOH for any suspected violation of a state or federal nursing facility regulation. A list of the names, addresses and telephone numbers of these and other agencies you may wish to contact can be made available.

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Care and Treatment

- You have the right to choose your personal licensed attending physician or APRN. The facility may require you to use another physician if your physician or APRN does not comply with applicable statutes or regulations. The facility will inform the resident if the physician chosen by the resident is unable or unwilling to meet requirements and the facility will seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences. If the resident subsequently selects another attending physician that meets the requirements, the facility must honor that choice.
- You have the right to be informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for your care.
- You and/or your resident representative have the right to be fully informed about your total health status, including your medical condition in a form and manner that you can access and understand including an alternative format or any language you can understand.
- You have the right to participate in the development and implementation of your person-centered plan of care and treatment and to be fully informed in advance about changes in your care and treatment.
- You have the right to participate in establishing the expected goals and outcome of care, the type, frequency and duration of care and any other factors related to the effectiveness of the plan of care.
- You have a right to sign your plan of care after significant changes are made.
- You have the right to see your care plan at any time you like and/or to ask for revisions. The plan of care must include an assessment of the resident's strengths and needs, incorporate personal and cultural preferences and may include the resident's representative when applicable.
- You have the right to receive the services/items in you plan of care.
- You have the right to be informed, in advance, of the care to be furnished and the type of caregiver or professional that will furnish care.
- You have the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

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- You have the right to formulate an advanced directive. The facility will not discriminate against a resident based on whether he or she has executed an advanced directive.

- You have the right to request, refuse or discontinue treatment, including life support systems, in accordance with state law. If the facility is unwilling to honor your wishes regarding advanced directives, it must attempt to transfer you to a facility that will honor your wishes.

- You have the right to administer your own drugs, if your care planning team determines this practice is clinically appropriate.

- Except in an emergency, you have the right to the opinion of two physicians prior to surgery.

- You have the right to participate in or refuse to participate in experimental research.

- You have the right to be free from restraints administered for discipline or convenience and not required to treat your medical symptoms. Physical and chemical restraints may be used only to ensure your physical safety or enable you to function better, and then only on the written order of a physician or APRN that states when and for how long they are to be used, except in an emergency.

- You have the right to have psychopharmacologic drugs administered only on orders of a physician or APRN, as part of a written care plan designed to eliminate or modify the symptoms the drug was prescribed to treat, and only if an independent external consultant reviews whether your drug plan is appropriate at least once a year.

- You have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation, mistreatment and misappropriation of property.

- You have the right not to perform work for the facility. If performing work for the facility is recommended as part of your care plan and suitable work is available, you have the right to choose to perform work for the facility and to choose whether you wish to work as a volunteer or for payment at prevailing rates, if your choice and the kind of work you will be doing are documented in your care plan.

- You have the right to know where to find, and to see, the results of current federal, state and local inspection reports and plans of correction.

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- You have the right to be informed of the name, specialty and way of contacting your physician and other primary care professionals responsible for your care.

- You have the right to participate in establishing goals, outcome of care, the type, amount, frequency and duration of that care, and any other factors related to effectiveness of the plan of care.

- You have the right to be informed of the risks and benefits of your proposed care.

- You have the right to formulate an Advanced Directive.

Personal and Clinical Records

- You have the right to privacy and confidentiality regarding all personal and health information kept by the facility pertaining to you, as provided by federal and state laws governing the facility's use and disclosure of this information. You have received a copy of the facility's Notice of Privacy Practices, as required by law.

- You have the right to approve or refuse the release of these records to anyone outside the facility, except when you are transferred to another health care institution or when the release of your records without your consent is otherwise required or permitted by law.

- You have the right to have access to all facility records pertaining to you upon your request or the request of your legal representative within 24 hours after making such a request. You have the right to have copies of your records provided by the facility in the form and format requested (if such form or format is readily available) within two working days after the records have been provided to you. The facility may impose a cost-based fee for copying as permitted by law.

Transfer and Discharge

- You have the right to be allowed to stay in the facility and may not be discharged from the facility, except as provided by federal and state laws. Federal and state law permit an involuntary transfer or discharge only when your needs and your welfare cannot be met in the facility; or transfer or discharge is appropriate because your health has improved so that you no longer need the services provided by the facility; or the health or safety of individuals in the facility is endangered; or, if you are paying for your care, your account is more than fifteen days in arrears; or if your assets are exhausted and you have failed to file an application for Medicaid assistance or to respond to Medicaid's requests for information in a timely manner; or you are no longer eligible for nursing home care as determined by the PASARR program or level-of-care review; or if the facility ceases to operate.

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- Except in an emergency, you must be given at least thirty days', and no more than sixty days', notice of a transfer or discharge from the facility unless the transfer or discharge is made because the health or safety of individuals in the facility is endangered; your health has improved sufficiently to allow for a more immediate transfer or discharge; immediate transfer or discharge is necessary due to an urgent medical need; or you have resided in the facility for less than thirty days. In such cases, you must be given as much notice as practicable.

- You have the right to appeal an involuntary transfer or discharge from the facility to the State Department of Health.

- You may be involuntarily transferred from one room to another within the facility if necessary due to repairs or renovations; irreconcilable incompatibility between you and a roommate; the need to admit a person of the opposite sex; allowing another resident access to special medical equipment you no longer need; or if you no longer need programs or services offered in a specialized area of the facility. If you reside in a private room and become eligible for Medicaid assistance, you may be moved to a semi-private room (two or more beds). You must receive 15 days' written notice of an involuntary room change, expect that room changes due to non-emergency repairs or renovations or becoming eligible for Medicaid assistance require 30 days' notice. In an emergency where there is a danger of physical harm to you or other residents, you may be moved immediately, without advance notice.

- You may not be involuntarily transferred or discharged from the facility if the transfer or discharge is medically contraindicated. You also may not be involuntarily transferred from one room to another within the facility if the transfer is medically contraindicated.

Payment for Services

- You have the right to be fully informed of the services available in the facility and, if you are paying for the cost of your care, of the per diem rate and charges for nay services not covered by the per diem rate. If your care is paid for by Medicare or Medicaid, you have the right to be informed of the services that are not covered by Medicare or Medicaid and the charges for such services.

- You cannot be required to waive any rights you may have in order to receive Medicare or Medicaid, or to give assurances that you are not eligible for or will not apply for Medicare or Medicaid, as a condition of admission to or continued residence in the facility.

- You cannot be required to have a third party guarantee payment for your care as a condition of admission or expedited admission to, or continued residence in, the facility.

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- You cannot be required to pay or give the facility any gift, money, donation or other consideration as a condition of admission to or continued residence in the facility.

- You have the right to be informed of how to apply for and use Medicare and Medicaid and how to receive refunds for previous payments covered by these programs.

- You have the right to receive a copy of any Medicare or Medicaid application completed by the facility on your behalf or to designate that a family member or other representative receive a copy of any such application.

Personal Funds

- You have the right to manage your personal financial affairs and cannot be required to deposit your personal funds with the facility.
- You have the right to have the facility manage your personal funds, if you authorize this in writing. You have the right to a quarterly accounting of your funds. A separate statement about how the facility manages residents' funds is provided.

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MINIMUM DATA SET (MDS) SYSTEM OF RECORDS

revised 04/28/2007(Issued: 9-6-12, Implementation/Effective Date: 6-17-13)

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974 (5 USC 552a). THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY. Authority for maintenance of the system is given under Sections 1102(a),1819(b)(3)(A), 1819(f), 1919(b)(3)(A), 1919(f) and 1864 of the Social Security Act.

The system contains information on all residents of long-term care (LTC) facilities that are Medicare and/or Medicaid certified, including private pay individuals and not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer data containing other party liability insurance information necessary for appropriate Medicare claim payment.

Medicare and Medicaid participating LTC facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information is also used by the Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. 42 CFR §483.20, requires LTC facilities to establish a database, the Minimum Data Set (MDS), of resident assessment information. The MDS data are required to be electronically transmitted to the CMS National Repository.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS LTC System of Records.

2. PRINCIPAL PURPOSES OF THE SYSTEM FOR WHICH INFORMATION IS INTENDED TO BE USED. The primary purpose of the system is to aid in the administration of the survey and certification, and payment of Medicare/Medicaid LTC

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services which include skilled nursing facilities (SNFs), nursing facilities (NFs) and noncritical access hospitals with a swing bed agreement.

Information in this system is also used to study and improve the effectiveness and quality of care given in these facilities. This system will only collect the minimum amount of personal data necessary to achieve the purposes of the MDS, reimbursement, policy and research functions.

3. ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM. The information collected will be entered into the LTC MDS System of Records, System No. 09-70-0528. This system will only disclose the minimum amount of personal data necessary to accomplish the purposes of the disclosure. Information from this system may be disclosed to the following entities under specific circumstances (routine uses), which include:

(1) To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS;

(2) To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent for purposes of contributing to the accuracy of CMS' proper payment of Medicare benefits and to enable such agencies to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds and for the purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State, and determine Medicare and/or Medicaid eligibility;

(3) To assist Quality Improvement Organizations (QIOs) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Title XI or Title XVIII of the Social Security Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans;

(4) To assist insurers and other entities or organizations that process individual insurance claims or oversees administration of health care services for coordination of benefits with the Medicare program and for evaluating and monitoring Medicare claims

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information of beneficiaries including proper reimbursement for services provided;

(5) To support an individual or organization to facilitate research, evaluation, or epidemiological projects related to effectiveness, quality of care, prevention of disease or disability, the restoration or maintenance of health, or payment related projects;

(6) To support litigation involving the agency, this information may be disclosed to The Department of Justice, courts or adjudicatory bodies;

(7) To support a national accrediting organization whose accredited facilities meet certain Medicare requirements for inpatient hospital (including swing beds) services;

(8) To assist a CMS contractor (including but not limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program to combat fraud, waste and abuse in certain health benefit programs; and

(9) To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste and abuse in a health benefits program funded in whole or in part by Federal funds.

4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION. The information contained in the LTC MDS System of Records is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, e.g. thorough medical history, inappropriate and potentially harmful care may result. Moreover, payment for services by Medicare, Medicaid and third parties, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

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National Health Care Associates Inc.

20 East Sunrise Highway
Valley Stream, NY 11581
516.705.4800.

Pursuant to NY PHL § 2803 (13), _____ hereby provides you with the websites to look up complaints, citations, inspections, enforcement actions, and penalties taken against the Center. This includes the web address for the New York State Nursing Home Profiles website that is maintained by the Department and the Nursing Home Compare website maintained by the Centers for Medicare and Medicaid Services.

Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare:

https://www.medicare.gov/care-compare/#search

NYS Health Profiles to find and compare New York healthcare providers:

https://profiles.health.ny.gov/nursing_home/

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NOTICE OF APPLICANTS FOR ADMISSION

NON-DISCRIMINATION NOTICE

This facility is prohibited by Public Act No. 80-364, effective October 1, 1980, from discriminating against indigent applicants for admission on the basis of source of payment. Indigent applicants who believe they have been discriminated against on the basis of source of payment may make a complaint to the Regional Ombudsman (name, address and telephone number listed below) who will conduct an investigation to the complaint and report his/her findings to the department of Income Maintenance.

NYS LTC OMBUDSMAN PROGRAM

2 EMPIRE STATE PLAZA

ALBANY, NY 12223

(855) 582-6769

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C.), section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C.), and the Age Discrimination Act of 1975, as Amended by _____ does not discriminate on the basis of race, color, creed, age or religion in admissions or access to or treatment of employment in its programs or activities. _____ Administrator has been designated to coordinate our efforts to comply with the U.S. Department of Health and Human Services regulations in implementing these federal laws. For further information about the regulations and our grievance procedures for resolution of disability discrimination complaints please contact:

_____ does not discriminate and does not permit discrimination, including but not limited to, bullying, abuse, harassment, or differential treatment on the basis of actual or perceived sexual orientation, gender identity or expression, or HIV status, or based on association with another individual on account of that individual's actual or perceived sexual orientation, gender identity or expression, or HIV status. You may file a complaint with the office of the New York State Long-Term Care Ombudsman Program at 1-855-582-6769 if you believe that you have experienced this kind of discrimination.

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DIRECTOR OF ADMISSIONS AND MARKETING DOCUMENTATION CHECKLIST

Resident Name _____ Admission Date_____

Primary Payor _____

*****TO BE COMPLETED WITHIN 48 HOURS OF ADMISSION AND ALL DOCUMENTS UPLOADED INTO PCC*****

PREADMISSION DOCUMENTATION:

☐ Discharge Summary

☐ Pre-Admission Screening

☐ Common Working File (CWF)

☐ IVF (uploaded in evals)

☐ Medicare denial letter (if appropriate)

STATE SPECIFIC DOCUMENTATION:

☐State Authorization to Release Information

☐ Bed Hold Notification

ADMISSION DOCUMENTATION:

☐ Signed Admission Agreement

☐ Resident Financial Benefit Information

☐ Medicare Secondary Payor Form (MSP)

☐ Assignment of Benefits

☐ Appointment of Representative

☐ Ancillary Services Authorization Form

☐ Authorization and Charges for Service

☐ Medicare A Notice of Designation Form

☐ Notice Regarding Medicare and Medicaid Assistance

☐ Authorization for Release of Protected Health Information for Marketing Purposes

☐ Resident and Facility Arbitration Agreement

☐ Remote Patient Monitoring

☐ Facility Directory, Notification, and Activities

☐ Acknowledgement of Receipt of Notice of Privacy Practices and Residents Rights

DAM Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

BOM Signature: _____ Date: _____