Catholic Health
Home & Community Based Care

☐ **FBM** ☐ **MNF** ☐ **SCL** ☐ **TMR**

CHS Senior Services
ADMISSION AGREEMENT

Agreement entered on _____ by _____
Date Facility Name

And _____ and _____
Resident Resident Representative

The facility agrees to admit _____ for services under the following terms and conditions. The PARTIES to this Agreement are the FACILITY and you the RESIDENT/PATIENT and/or the RESIDENT REPRESENTATIVE.

NON-DISCRIMINATION STATEMENT

THIS FACILITY DOES NOT DISCRIMINATE IN ADMISSION OR RETENTION OR CARE OF ITS RESIDENTS BECAUSE OF RACE, CREED, COLOR, NATIONAL ORIGIN, SEX, DISABILITY, BLINDNESS, AGE, SOURCE OF PAYMENT, MARITAL STATUS OR SEXUAL PREFERENCE.

I. SERVICES PROVIDED BY FACILITY

Check if applicable:

☐ **SUBACUTE PROGRAM SERVICES/SHORT TERM STAY**

We have admitted you for the provision of subacute/short term stay services, which are necessary for you to reach specific performance goals and to enable your continued recovery or care at home or at a different level of care. Our continued provision of such services is determined by your continued need for and/or continued improvement from them. Where an insurer or health benefit plan ("health plan" or "third-party payer") manages the covered stay and covers only "medically necessary" services, the initial anticipated length of stay is determined by such health plan.

A. BASIC SERVICES ARE COVERED BY THE DAILY RATE

The services listed below are covered by the daily rate. They are provided as needed and/or according to physician orders:

1. Lodging.
2. Board, including therapeutic or modified diets as prescribed by a physician.
3. Twenty-four (24) hours per day nursing care.
4. Fresh bed linens.
5. Hospital gowns or pajamas as required by the clinical condition of the Resident, unless the Resident or Resident Representative elects to furnish them and regular

non-dry cleaning laundry services for these and other launderable personal clothing items.

6. General household medicine cabinet supplies, including but not limited to, non-prescription medications, material for routine skin care, oral hygiene, care of hair, and so forth, except for specific items that are medically indicated and needed for exceptional use for specific resident.
7. Assistance and/or supervision when required with activities of daily living, including but not limited to, toileting, bathing, feeding and ambulation assistance.
8. Services by members of the facility staff performing their daily assigned resident care duties.
9. The use of customarily stocked equipment, including but not limited to, crutches, walkers, wheelchairs, or other supportive equipment, and training in their use when necessary, unless such item is prescribed by a physician for regular and sole use by a specific resident.
10. The use of all equipment, and medical supplies and modalities, notwithstanding the quantity usually used in the everyday care of the Resident including, but not limited to, catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads, etc.
11. An activities program, included but not limited to, a planned schedule for recreational, motivational, social and other activities together with the necessary materials and supplies to make the Resident's life more meaningful.
12. Social work services as needed.
13. Complimentary television and phone on subacute unit.
14. Arrangements for other services as required for the health, safety, proper care and treatment of residents.

B. PHYSICIAN AND ADDITIONAL SERVICES PROVIDED ON A FEE FOR SERVICE BASIS

Charges for physician visits and physician-ordered ancillary services are not included in the daily basic rate. These additional charges may be billed by the facility or directly by the provider of the service. The Resident or Resident Representative is not obligated to pay for services paid for by Medicaid, Medicare or other third party payers who have negotiated a rate with the facility **except for deductibles and co-payments**.

The Facility will arrange for physician and/or physician extender visits as authorized under this Agreement and as required to provide care to the Residents and for the following ancillary services to be available to the Resident when prescribed by a physician. These services will be administered or supervised by practitioners who meet the applicable New York State licensing, registration and certification requirements. The services listed below may or may not be covered by Medicare, Medicaid, or other insurance upon medical review and upon terms and conditions of insurance contracts. The services listed are not exclusive; other physician-ordered services may also be available.

1. Physical Therapy
2. Audiology Services
3. Occupational Therapy
4. Speech therapy
5. Podiatry Services
6. Psychiatric or Psychological Treatment
7. Optometric Services
8. Laboratory Services
9. X-ray Services

10. Special Nurse or Companion on Order of Physician
11. Dental Services provided by the facility dentist. The resident has the right to select a dentist of their own choosing for their dental needs. Resident will be financially responsible for use of an outside dentist.
12. Transportation Services
13. Pharmacy Services
14. Medical Supplies in excess of those allowed by insurance
15. Wound Vac machines and supplies
16. Durable Medical Equipment

C. ITEMS/SERVICES NOT COVERED IN THE DAILY RATE OR BY INSURANCE

Certain items and services, such as those that are not medically necessary or items for personal, individual use, may not covered under the daily basic rate nor are they paid for by Medicaid or Medicare insurance carriers. Such items are made available but must be paid for or charged against the Resident's account when the cost is incurred. An example of such items includes:

1. Barber/Beauty Parlor
2. Newspaper
3. Shoes and clothing
4. Dry cleaning
5. Transportation
6. Ambulance transportation as needed unless medically necessary
7. Additional medication
8. Personal telephone or cellular phone. (A phone is available on each unit for resident use.)

This list is not inclusive of all items. Please contact your Social Worker for further information regarding specific items.

The Resident sponsor and Resident Representative agree to assist the Resident to the best of their ability in obtaining necessary personal items, clothing and effects, which are not provided under the daily basic rate.

II. THE RESIDENT'S OR RESIDENT REPRESENTATIVE'S AGREEMENT TO PAY FOR, OR ARRANGE TO HAVE PAID FOR, SERVICES PROVIDED BY THE FACILITY

A. THE RESIDENT'S (OR RESIDENT REPRESENTATIVE'S) OBLIGATIONS

The Resident or Resident Representative agrees to pay for, or arrange to have paid for by Medicaid, Medicare or other insurers, all services provided by the Facility under this Agreement. The Resident or Resident Representative personally agrees to pay the daily basic rate plus tax as determined by New York State ("private pay rate"), and charges for ancillary services as described below to the Facility from the resident's funds, after any eligible Medicare Part A coverage has been applied or exhausted, until the month in which the Resident's Medicaid eligibility covers such charges. The Resident or Resident Representative understands and agrees that he/she will pay the private pay rate plus NYS tax while a Medicaid application is pending. If the Medicaid application is denied, the resident or Resident Representative **using the resident's funds** understands and agrees to pay the full private pay rate for the period not covered by Medicaid. The duty to ensure continuity of payment includes the duty to arrange for timely Medicaid coverage, if Medicaid coverage becomes necessary.

More specifically the Resident or Resident Representative agrees to pay for or arrange for the timely payment of the daily basic rate as below: (Note- not all CH facilities offer these accommodations)

$ Deluxe Private Room Daily Rate, plus applicable NYS tax
$ Private Room Daily Rate, plus applicable NYS tax
$ Semi- Private Room Daily Rate, plus applicable NYS tax

If Resident's room is changed during the course of their stay the rate will be changed to reflect the applicable accommodations. Notice of any increase in room rate will be provided at least sixty (60) days in advance of such increase.

If the Resident qualifies for Medicaid or Medicare coverage or coverage by an insurance carrier with which the Facility has negotiated a daily rate, the Facility will accept their daily rate in lieu of the daily basic rate of the services and supplies covered by such third-party payers. Long term care insurance is *not* accepted as payment in full. Resident is responsible to pay the difference between their long term care insurance and the daily charges. Charges for additional physician-ordered services are payable directly to the provider of the services.

The Undersigned Agent(s) personally agrees to use their access to the Resident's funds to ensure continuity of payment under this agreement, and agree not to use the Resident's funds in a manner which places the facility in a position where it cannot receive payment from either the Resident's fund or from Medicaid. If the Undersigned Agent(s) receives a transfer of assets from the Resident which causes such non-payment, the Resident's Representative agrees to use such assets or an amount equal to such assets to assure continuity of payment until Medicaid covers such costs.

B. THIRD PARTY COVERAGE

The Facility understands that you may be eligible for insurance coverage of all or a portion of the Facility's charges pursuant to the terms of a third-party payer's health benefit plan or program ("third party payer" or "plan"). Although the Facility has relied on insurance verification of eligibility and coverage, verification of coverage does not guarantee all coverage. Some plans review and deny coverage after the services are provided and continued coverage may be subject to specific additional pre-authorization requirements, to modifications by the plan, and by its determination that recommended services are "medically necessary" as well as covered.

The Facility is not responsible for benefit denials, limitations, or terminations by third party payers. The Facility will, however, make best efforts to (1) present information to support the medical necessity of treatment recommended by your care team; and (2) notify you and/or your Resident Representative as soon as it is informed by the third party payer that coverage will cease or decrease. Financial liability for all non-covered care becomes the responsibility of the resident.

C. THE RESIDENT'S OR RESIDENT REPRESENTATIVE'S OBLIGATION TO ENSURE CONTINUITY OF PAYMENT

In consideration of the services to be rendered to the resident on this date and all future dates, the Undersigned personally guarantees to pay the account of the facilities of the CHS in accordance with the rates and terms established for the services rendered **from the Resident's funds**. The Undersigned also agrees that if the account remains delinquent and thereby requires the services of a collection agency and/or lawful authorities for collection, the Undersigned shall pay reasonable attorney's fees and collection expenses. The Resident or Resident Representative personally agrees to pay the basic semi-private or private rate plus tax (and ancillary charges) to the

Facility **from the Resident's funds** after other coverage has been applied or exhausted until the month in which the Resident's Medicaid application is approved and if the Medicaid application is denied.

The duty to ensure continuity of payment includes the duty to arrange for timely Medicaid coverage if Medicaid coverage becomes necessary, including payment of client share, if any.

If the Resident qualifies for Medicaid or Medicare coverage, the Facility will accept their daily rate, plus the client share as determined by Medicaid, in lieu of the daily basic rate of the services and supplies covered by Medicaid or Medicare. Charges for additional physician-ordered services are payable directly to the provider of services.

If the resident or their Representative has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility, the facility may begin discharge procedures. Nonpayment applies if the resident/representative does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

Involuntary Discharge. This Agreement does not guarantee a particular length of stay. The Facility reserves the right to transfer or discharge you involuntarily after appropriate notice because:

(1) your health has improved and you no longer need the Facility's services;
(2) your needs can no longer be met in the Facility;
(3) the safety or health of individuals in the Facility is endangered by you; or
(4) you have failed to pay for or arranged for payment of services provided under this Agreement.

Discharge for Nonpayment. The Facility's right to discharge for nonpayment includes a loss of payment to the Facility because of your failure to cooperate in arranging for third party payment.

1. THE RESIDENT' DIRECTION TO HIS/HER AGENTS

The Resident directs the Resident Representative, the Sponsor, and all other Financial Agents, including future appointees to ensure that all payment obligations under this Agreement are met from the Resident's assets; and to cooperate in the obtaining Medicaid coverage, if necessary, to meet the Resident's obligations under this Agreement; and, to manage the Resident's assets responsibly so that the Facility is not placed in a position where it cannot receive payment from either Resident's funds or Medicaid, or the third-party payors.

2. PREPAID AMOUNTS AND SECURITY DEPOSIT

In the event the Resident is not qualified for Medicaid upon admission, the Resident agrees to prepay an amount for basic services which shall equal one (1) month's payment at the daily basic rate. The Security Deposit can be waived if it is not determined that the entire length of stay is covered by an alternate insurer. The remainder of the current month's rate and the first month's rate will be applied from this prepayment.

The Security Deposit shall be applied toward any unreimbursed amounts owed to the Facility for Care of the Resident. The Determination as to when the Security Deposit

will be applied to amounts shall be at the sole discretion of the Representatives of the Facility, as required to reimburse the Facility for amounts due for care of the resident.

The Resident is required to make additional payments to fund the Security Deposit at any time it is either depleted, or below the one (1) month private pay basic rate amount.

Refund of Deposit: Upon the Resident's discharge, the pre-paid amount will be applied to pay for any outstanding bills owed to the facility. If the Resident leaves the Facility for reasons beyond the Resident's control, any unused portion of the pre-payment will be refunding promptly to the Resident, the Undersigned, or to the person or probate jurisdiction administering the Resident's estate.

If the privately-paying Resident leaves the Facility for reasons within the Resident's control during the prepayment period without giving fifteen (15) days' prior written notice, the Facility will retain an additional amount not to exceed one (1) day's daily basic rate.

3. PAYMENT OBLIGATIONS UNDER MEDICAID AND OTHER THIRD-PARTY PAYORS

a) Obligation to Assure Third Party Payment

The Facility cannot bill Medicaid for services until the resident's private insurance benefits and Medicare benefits have been exhausted.

The resident agrees prior to admission to provide information pertaining to all potential third-party payors and agrees either (I) to provide proof that a claim for coverage has been made, or (II) to provide the Facility with necessary information and authorization for the Facility to submit the claim.

b) Deductibles and Co-Insurance

Medicare or other insurers may require a deductible and/or co-insurance payment to the Facility. The Resident agrees to meet these obligations and understands that the payment obligations under this Agreement include such payments.

c) Duty to Arrange for and Provide Information in a Timely Medicaid Application

The Resident/Sponsor/Resident Representative/Financial Agent agrees to monitor resources to assure uninterrupted payment to the Facility by making timely and completed application to Medicaid and Medicaid recertification (and/or other payors), as necessary.

The Resident/Sponsor/Resident Representative/Financial Agent agrees to notify the Facility to:

a) the anticipated time when the Resident will have spend his/her resources to the Medicaid resource level; and

b) when the Medicaid application will be and is filed.

The Resident/Sponsor/Resident Representative/Financial Agent recognizes that the Resident can still be qualified for Medicaid if the Resident still owns a house. The Resident/Sponsor/Resident Representative/Financial Agent agree to apply for Medicaid before the Resident's liquid resources have been expended, and to allow the applicable Department of Social Services to lien

the real property held in the Resident's name to allow for Medicaid qualification.

d) Monthly Income Payments Under Medicaid

The Resident/Sponsor/Resident Representative/Financial Agent understands that if he/she receives monthly income (i.e., retirement benefits, Social Security, Railroad Retirement, interest income, etc), and also qualifies for Medicaid, the Department of Social Services will require most of such income (the "Net Available Monthly Income" or "Client Share/NAMI") to be paid to the Facility as part of the Medicaid rate. Under the formula for the client share/NAMI, the Resident will only be allowed to retain $50.00 per month for deposit in the Resident's personal account and that the balance is required to be paid over the Facility as a payment towards the cost of care of the Resident.

In the event, the Resident/Sponsor/Resident Representative/Financial Agent guarantees that:

a. such income will be delivered to the Facility on or before the 10th of each month; or that it will be sent directly to the Facility from the income payor pursuant to an Agreement in the Addendum;

b. During the period when a Resident's Medicaid application is pending approval by the Department of Social Services, all income of the resident shall be paid over to the Facility minus $50.00 per month, and said payment shall be applied to the cost of care of the Resident/Patient;

c. That if any of the client share/NAMI amount is disputed, the disputed portion of the client share/NAMI will be paid directly to a responsible escrow agent, or the Court on or before the tenth (10th) of each month and that the portion of the client share/NAMI which is not in dispute will be paid to the Facility by such date. The Parties agree that the funds held in escrow will be released according to the determination made by the reviewing body or by the Court, or by mutual consent of the Resident/Sponsor/ Resident Representative/Financial Agent and Facility.

d. Failure to remit these funds may result in involuntary discharge for non-payment. Nonpayment for a Medicaid covered Resident occurs if the budgeted monthly NAMI is not paid and the amount is not in dispute, or funds are actually available or would be available and the Resident or the Undersigned Agent with access or control over the NAMI fail or refuses to pay, arrange for payment of, the NAMI to the facility. All such failure or refusal to pay or arrange for payment of the NAMI to the facility are breaches of the Agreement.

e) Duty to Pay Private Rate Until Medicaid Coverage is Obtained

The Resident/Sponsor/Resident Representative/Financial Agent agrees to pay the private pay rate unless and until Medicaid coverage is obtained. Currently, upon Medicaid eligibility, Medicaid coverage is permitted to extend retroactively only up to three (3) months prior to the month in which the Medicaid application was

filed. If the Medicaid application is delayed or denied, the Resident agrees to pay for the services at the private pay rate. If Medicaid eligibility established and covers any period retroactively for which the private pay rate has been paid, the Facility agrees to refund or credit any amount in excess of the client share/NAMI amount owed during the covered period.

If the Resident's liquid assets are exhausted or unavailable prior to Medicaid coverage, the Resident agrees to immediately pay his/her monthly income to the Facility as partial payment for the daily basic rate. The Facility can, at its discretion, apply the Resident's Security Deposit to the amount due for care and services. Additionally, since Medicaid and most insurances only pay for a semi-private room, if Resident/Patient is in a private room, they may be transferred to the next available appropriate semi-private room, after proper notification, if the resident occupying a private room is no longer paying the private rate.

f) Release of Medicaid Information to the Facility

Upon application to the Facility, the Resident/Sponsor/Resident Representative/Financial Agent are required to provide complete and full disclosure of the Resident's financial resources to the Facility in the Application for Admission. Included with this, the Resident/Sponsor are required to list all gifts or transfers of the Resident's and/or Resident's spouse's assets made within thirty-six (36) months, or sixty (60) months for a Trust created by the resident, or resident's spouse, prior to the date of admission that could be construed by the Department of Social Services to effect a decision on the Resident's Medicaid application at a future date.

To facilitate assistance in the Medicaid application process, the Facility may request authorization to have access to the Resident's Medicaid application and recertification file. Agreement to such authorization, either to take effect currently or to take effect only in the event the terms of this Agreement cannot be met without such authorization. With such authorization, the Facility can receive copies of all correspondence regarding the Medicaid application, can assist the Resident with the application process and can communicate with the Department of Social Services regarding the application or recertification.

If the Resident, the Undersigned, and/or the Resident's family requires the Facility's assistance with filing the Medicaid application or with an appeal of the Medicaid denial, the Resident, the Undersigned, or a family member agrees to authorize the Facility, and the Facility's agents to act on his/her behalf in the Medicaid process by executing a notarized Authorization Agreement and providing it to the facility Social Worker.

The facility will make every effort to assist residents and their representative to gather and submit information required by Medicaid, Medicare and other third party payers. If the resident or representative refuses to cooperate with the facility's efforts and does not provide the required information to the payer claims will be rejected and the resident's bill will not be paid. If the resident and/or representative do not take efforts to pay the bill within 60 days, the facility may issue a discharge notice

D. TRUTHFUL AND COMPLETE INFORMATION PROVIDED ON ADMISSIONS APPLICATION

The Resident and the Undersigned each separately warrant that the financial information they have submitted to the Facility on the Admissions Application and any Agent of the Facility concerning the Resident's finances is true, correct, complete and accurate in all material respects and that there are no material omissions. By signing this Agreement, the Resident and Resident Representative acknowledge that the Facility relies on such information to be truthful, complete and accurate.

E. INTEREST AND COLLECTION COSTS FOR NONPAYMENT

If you do not pay amounts that are due from you or if your breach in this Agreement (or your Resident Representative's or agent's breach) causes a loss to the Facility, you and/or your agent or Resident Representative on your behalf agree(s) to pay collection costs including, but not limited to, reasonable attorney's fees incurred by the Facility in enforcing the terms of this Agreement, plus late fees at the maximum legal rate, on amounts due from you for more than thirty (30) days.

F. AUTHORIZATIONS

The undersigned resident and/or resident representative ("Undersigned") hereby grants permission to the employees of the facilities of the Catholic Health System (CHS) to render routine resident care, and to carry out the orders of the resident's attending physician, consultants, associates, and assistants of the Undersigned's choice. For the purpose of advancing medical knowledge, the Undersigned understands that the facilities of CHS provide a teaching environment to medical, allied health, and religious students and consents to such students participating in the resident's care. You (or the Resident Representative for you) hereby authorize(s) the Facility:

1. To use participating physicians and providers of ancillary services or supplies if required by your plan for full benefit coverage unless you specifically request a non-participating provider with the understanding that there may be added charges for using such providers. For example, while the Medicare law at §1802 of the Act guarantees a beneficiary's free choice of any qualified entity that is willing to furnish services to the beneficiary, **in selecting this Skilled Nursing Facility, the beneficiary has effectively exercised this right of free choice with respect to the entire package of services for which the SNF is responsible under the consolidated billing requirement, including the use of any outside suppliers from which the SNF chooses to obtain such services.**

2. **RELEASE OF INFORMATION:** The Undersigned hereby permits the Catholic Health System's facilities and agencies, the workforce of such entities, and the members of the System's various medical staffs, to disclose the resident's personally identifiable information for purposes related to the resident's treatment, to obtain payment for the resident's treatment, and in the other circumstances listed in the System's Privacy Notice where federal law does not require my further Authorization. I have either received a copy of the System's Privacy Notice or one has been made available to me, which completely describes the circumstances in which the System does not require my further Authorization to disclose the resident's medical information. The Undersigned also grants permission to release medical information to other health care providers involved in the resident's care and to others involved in planning for the care of the resident. The Undersigned likewise grants permission for these parties to release appropriate medical information back to the Catholic Health System.

3. **USE OF INFORMATION WITHIN THE CATHOLIC HEALTH SYSTEM:** I understand the Catholic Health System is composed of numerous facilities and agencies including hospitals, nursing homes, adult care homes, home health care companies and related medical staffs. I further understand that in order for the Catholic Health System to effectively operate and to render appropriate health care, it may be necessary to use and review the resident's medical records and information retained at one or more of the facilities of the Catholic Health System. I therefore authorize the use of the resident's medical information by appropriate personnel and medical staff members within the Catholic Health System for purposes related to the resident's treatment, to obtain payment for the resident's treatment, and for the healthcare operations of the Catholic Health System. Additionally, I understand that the Catholic Health System will include the resident's name, location, general condition and religious affiliation in its Resident Directories, such as a resident census and clergy report. I understand that the Catholic Health System may disclose Directory Information to members of the clergy and (except for religious affiliation) to individuals who ask for the resident by name. I do not object to the use of this limited information about the resident in Resident Directories
4. I have received the "Patient's Bill of Rights"/Health Care Proxy Information Packet.

If your third party payer does not pay to hold a Facility bed during a temporary hospitalization, you may pay to hold the bed at the prevailing daily basic rate if (1) you are expected to return to the Facility to resume treatment, and (2) provided your account is not in arrears due to your breach of this Agreement.

G. OBLIGATION TO ABIDE BY FACILITY RULES AND REGULATIONS

The Resident and the Undersigned agree to abide by the Facility's Rules and Regulations and to respect the personal rights and private property of all Residents and staff. I understand that money, jewelry and other valuables should not be brought into the long term care facility, but if of necessity or choosing they are, they should be catalogued on the Resident Belongings sheet, labeled as appropriate, and money deposited with the Social Worker for safekeeping during working hours or the Nursing Supervisor after normal working hours. I further understand that access to a locked drawer will be provided upon my request and agree that the facility shall not be liable for the loss of or damage to any personal effects kept unsecure in my room during my stay. I acknowledge that the use of audio and video recording devices (web cameras, cameras, phones, etc.) are prohibited in resident care areas, including resident rooms, without written permission from Administration.

H. DISCHARGE AND TRANSFER AGREEMENT FOR SHORT STAY ADMISSIONS, IF APPLICABLE

You and your Resident Representative agree to cooperate in securing adequate aftercare services, if needed, upon your discharge.

Although the discharge plan, if indicated, is agreed upon prior to admission, it is understood that the discharge plan will contain more specifics about aftercare needs, if any, as the discharge date approaches and that with your input the discharge date may be adjusted if the interdisciplinary care team and the managed care case manager conclude that:

(1) you require additional services; or

(2) your condition has been resolved sufficiently to permit earlier discharge to the community or to a different level of care; or
(3) further services are inappropriate or not medically necessary because your condition prevents further benefit from such services; or
(4) because of specific health or behavioral dangers set forth below.

Discharges or transfers earlier than anticipated also could occur upon a Resident/Patient's request after third party coverage terminates.

Involuntary Discharge. This Agreement does not guarantee a particular length of stay. The Facility reserves the right to transfer or discharge you involuntarily after appropriate notice because:

(5) your health has improved and you no longer need the Facility's services;
(6) your needs can no longer be met in the Facility;
(7) the safety or health of individuals in the Facility is endangered by you; or
(8) because you have failed to pay for or arranged for payment of services provided under this Agreement.

Discharge for Nonpayment. The Facility's right to discharge for nonpayment includes a loss of payment to the Facility because of your failure to cooperate in arranging for third party payment.

Short Stay Admission Transfers to Another Unit or Room: If your admission is for a planned short stay, you agree that when the care team and/or the third party payer determines that subacute services are no longer medically necessary or that subacute services can be provided more efficiently and as effectively on a different unit, you may be transferred to such room, unit or Facility *after appropriate notice and accommodation.* Additionally, since Medicaid and most insurances only pay for a semi-private room, Resident/Patient may be transferred to the next available appropriate semi-private room, after proper notification, if the resident occupying a private room is no longer paying the private rate.

I. ABOUT THIS AGREEMENT

Who is Covered. In addition to the parties to this Agreement, the Agreement is binding on the heirs, executors, administrators, distributors, successors, and assigns of said parties.

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

Modifications. This Agreement may not be amended or modified except in writing signed by you and/or your Resident Representative and the Facility, except that modifications necessitated by law become a part hereof.

Waiver of Rights. The failure of a party to enforce any term of this Agreement or the waiver of a breach of this Agreement does not waive the right to its full subsequent enforcement.

Entire Agreement. This Agreement with all Addenda contains the entire Agreement between the parties with respect to your admission and receipt of Facility services and is intended to integrate all prior and contemporaneous agreements between the parties.

Governing Law and Jurisdiction. New York law governs this Agreement. The Parties agree to the jurisdiction of the New York court in the county in which the Facility is located for any action arising out of or related to this Agreement.

WE THE UNDERSIGNED HAVE READ, BEEN ADVISED OF, UNDERSTAND AND AGREE TO BE LEGALLY BOUND BY THE TERMS AND CONDITITIONS SET FOR HEREIN.

ACCEPTED:

DATE	SIGNATURE OR MARK OF RESIDENT
DATE	SIGNATURE OF RESIDENT REPRESENTATIVE/AGENT
DATE	SIGNATURE OF SPONSOR, e.g. SPOUSE
DATE	SIGNATURE FOR FACILITY

* If Spouse is also the Resident Representative, sign both capacities.

Catholic Health
Home & Community Based Care

ADDENDUM I

ASSIGNMENT OF BENEFITS

You and the Resident Representative acknowledge the Facility's reliance on the availability of third party coverage and the coverage information provided to it prior to admission. The Undersigned hereby certifies that all insurance information reported to the facilities of CHS for this episode of care include all available sources of coverage, and assigns to the facilities of the CHS, sufficient monies from said insurance to pay for the resident's care and treatment. The Undersigned further understands that regardless of assignment of these benefits, the Undersigned is personally responsible for the total charges for services rendered, and further agrees that all amounts are due and payable upon demand. The Undersigned further agrees that the facilities of CHS retain the right to transfer monies from any credit balance account in the Undersigned's name to any other accounts which may be due and payable by the Undersigned. You and/or the Resident Representative on your behalf further agree(s):

(1) To keep insurance coverage premiums current and to notify the Facility if any required premiums have not been or cannot be made;
(2) To notify the Facility of any notice of benefit, denial, or limitations, or coverage termination;
(3) To provide the Facility with updated insurance information, with copies of the applicable summary of benefits or riders from such plan(s), and, upon Facility request, copies of further third party payer information which is available upon your request to the third party payer;
(4) To authorize the Facility to submit claims for coverage to all sources of coverage (primary and secondary) and to provide the Facility with timely and complete information necessary to file valid benefit claims; and
(5) To authorize the Facility to release confidential Resident/Patient information required by the third party payer for claiming reimbursement.

I authorize the release of any medical or other information necessary to process my claim. For residents entitled to Medicare or Medicaid benefits: if applicable, the Undersigned hereby certifies that the information provided in applying for payment under Title XVIII of the Social Security Act is correct. The Undersigned authorizes any holder of medical or other information about the resident to release to the Social Security Administration and Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers, any information needed for this or a related Medicare claim. The Undersigned requests that payment of authorized benefits are made on the resident's behalf. The Undersigned assigns the benefits payable for physician services to the physician or organization furnishing the services or authorizes such physician or organization to submit a claim to Medicare for payment for the facility checked below:

☐ Father Baker Manor
6400 Powers Road
Orchard Park NY 14127

☐ Mercy Nursing Facility
55 Melroy Avenue
Lackawanna, NY 1421

☐ The McAuley Residence
1503 Military Road
Kenmore, NY 14217

☐ St. Catherine Labouré
2157 Main Street
Buffalo, NY 14214

Name of resident:_____

Signature of authorized Resident Representative: _____

Date: _____

Catholic Health
Home & Community Based Care

ADDENDUM II

☐ **FBM** ☐ **MNF** ☐ **SCL** ☐ **TMR**

BED HOLD RESERVATIONS

BED HOLD FOR PRIVATE PAYING RESIDENTS, INCLUDING THOSE RECEIVING MEDICARE/HMO BENEFITS

Private paying residents and those non-Medicaid residents covered by Medicare and/or their sponsors and agents may 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 obligations under this Agreement are not in arrears. The Facility requires prior written authorization for such bed reservation. During the Resident's absence from the Facility, the daily basic rate remains payable under this Agreement until the reservation is canceled by the Resident or the Resident's agent.

Subject to the above conditions, the Resident or the Undersigned and/or a Resident Representative may authorize, in advance, a three (3) day bed reservation in the event of hospitalization, to be billed at the private pay rate, with the understanding that during such three-day period, the reservation may be continued for as long as needed, or may be canceled. Such authorization is attached to this Agreement, but is not part of this Agreement.

BED HOLD FOR MEDICAID-COVERED RESIDENTS

The Medicaid Program will only pay for a bed reservation under the following conditions:

There is no coverage for bed holds for Medicaid-sponsored residents who are hospitalized unless they are under the age of twenty-one (21) or enrolled in Hospice. If a non-covered resident is hospitalized, he/she will be officially discharged from the Facility and his/her bed may be made available to someone else. The Resident will be considered for re-admission for the next available appropriate bed.

Those Medicaid residents not covered by a paid bed hold who wish to reserve their specific room may 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 obligations under this Agreement are not in arrears.

If the Medicaid-sponsored Resident leaves the Facility overnight for other than hospitalization (a therapeutic leave of absence), the Resident's bed will be reserved if the Resident has been in the Facility at least thirty (30) days prior to the leave. The Resident's bed may be reserved for up to ten (10) days in any twelve (12) month period while the Resident is on a therapeutic or personal leave from the Facility.

ADDENDUM III
Long-Term Care Falls Disclaimer

Falls are a major factor threatening the independence of older individuals. Health problems such as arthritis, heart disease, muscle weakness, poor balance or vision, foot problems, Parkinson's disease, dementia and even certain medications can increase the risk of falling among the elderly population.

According to the Centers for Disease Control and Prevention (2013), each year, one in every three adults age 65 and older falls. In 2010, 2.3 million nonfatal fall injuries among older adults were treated in emergency departments and more than 662,000 of these patients were hospitalized. Without doubt, falls among older adults is a serious issue in skilled nursing facilities. Fall prevention is an important component of keeping elderly residents safe and promoting their quality of life, however all falls cannot be prevented.

Please be aware that Federal and State regulations oblige our facility and residents to accept some risks of a fall in exchange for the benefits of maintaining one's dignity, self-determination and independence. Specifically, federal regulations require that residents remain free from any physical restraints or chemical restraints. Physical restraints are defined as any manual method or physical/mechanical device, material or equipment attached or adjacent to a resident's body that cannot be removed easily (by the resident) and which restricts freedom of movement or normal access to one's body. Physical restraints include leg/arm restraints, hand mitts, soft ties, vests, lap trays and using side rails in bed to prevent a resident from voluntarily getting up. Chemical restraints are any drugs that restrict an individual's movement or freedom. Examples of chemical restraints include the improper administration of sedatives or anti-anxiety medication that impact an individual's behavior, mood, thinking and sensation. Furthermore, chemical restraints cannot be administered to a resident – even when ordered by a physician – unless consent is given by the resident or their representative.

Skilled nursing facilities cannot impose restraints on residents for the purpose of discipline or convenience. The use of restraints are only acceptable under very limited circumstances when ordered by a licensed healthcare professional to treat medical symptoms or to prevent a resident from harming themselves or others. Our facility is committed to limiting the use of any restraints – even when medically indicated – because we understand that even acceptable uses of restraints come with serious medical risks to residents

Our professional staff may make recommendations based on their evaluation of your needs. These important measures are for your safety and will be reviewed by you. In order to assist us to provide a safe environment, please help us by following the plan of care designed to protect your safety and prevent falls. For example, if your care plan requires you to request assistance before getting up, it is very important that you do not attempt to get out of bed, a chair or off the toilet without the help of a staff member. The most effective way to reduce the risk of falls is through the collaborative efforts of the resident, family and the facility.

By signing this form, you are acknowledging that you have been educated on falls and fall risks, and that you understand and agree with the plan of care that has been specifically tailored for you.

_____ _____
Patient, Responsible Party, Sponsor Date

_____ _____
Witness Date

Catholic Health
Home & Community Based Care

ADDENDUM IV
SKIN INTEGRITY INFORMED CARE MEMORANDUM

Resident:_____ Admission Date: _____

The skin is the largest organ of the human body. Like all bodily organs, the skin changes as we age. As people age, their skin becomes thinner and less elastic. This contributes to the skin becoming more easily torn, bruised and damaged. Skin ulcers may occur that are clinically unavoidable, meaning they cannot be prevented. Skin ulcers occur for many reasons, including but not limited to blockage of circulation due to underlying circulatory disease, diabetes, diminished function of a vein. Even when caregivers provide care to minimize skin breakdown, skin ulcers may develop because of a resident's physical decline and underlying disease.

While Catholic Health is committed to providing comprehensive skin and wound management to promote the resident's highest level of functioning and well-being, some risks including skin ulcers and breakdown may be unavoidable. We believe it is important for our residents and their representatives to understand some of the reasons skin breakdown occurs. We also welcome input and involvement of the family on this issue.

Some of the specific reasons that skin tears, bruising, and ulcers occur in the elderly include:

- Age
- Pre-existing conditions such as diabetes, obesity, fractures, swelling, infections, cancer, and kidney or circulatory diseases
- Decreased mobility; immobility; confinement to bed or wheelchair
- Decreased food and fluid intake due to age, underlying disease, decreased appetite
- Use of prosthetic devices
- Confusion or combative behaviors
- Pain
- Refusing to allow staff to turn or reposition them or refusing care

Interventions:

Catholic Health provides various interventions to decrease the chance of skin breakdown. However, even with the best of care, skin breakdown may be clinically unavoidable.

The Role of Families/Responsible Parties:

One of the most important considerations is having the resident's representative(s) remain active in the care of their loved one. Participating in resident care conferences, making suggestions to staff, and pointing out any situation that is of concern can accomplish this. Staff members are always available to listen to suggestions, complaints, concerns, and even compliments.

SKIN INTEGRITY INFORMED CARE MEMORANDUM

Thank you for taking the time to understand the unique skin risks your loved one will experience due to his/her physical and mental condition. Signing below is simply an acknowledgement that these risks and corresponding interventions were discussed with the family member(s) noted.

Resident's Representative:

Resident Representative Printed Name	Resident Representative Signature	Date

Facility's Representative:

Facility Representative Printed Name	Facility Representative Signature	Date