PALATINE NURSING HOME
ADMISSION AGREEMENT

THIS ADMISSION AGREEMENT (this "Agreement") is entered into the __ day of ________, 20__ by and between PALATINE NURSING HOME (hereinafter referred to as "Facility), and ____________________________ (hereinafter referred to as "Resident" or "You"/"you"/"your").

TRUTH OF STATEMENTS TO PALATINE NURSING HOME

The Resident warranties that all statements and financial information provided to the Facility prior to and along with the signing of this Agreement are true and accurate. By signing this Agreement the Resident acknowledges that the Facility relies on such information to determine the source of payment and to ensure continuity of payment. The Resident personally agrees to pay all damages directly or indirectly resulting from the Resident's misrepresentation of information provided to the Facility.

RECITALS

Facility is duly licensed under New York State law to provide skilled nursing facility services. The Resident's physician has determined that the Resident requires skilled nursing facility services.

Facility admits and treats all residents who are appropriate for placement in a skilled nursing facility on a non-discriminatory basis in compliance with New York State and Federal laws which prohibit discrimination in admission, retention, and care of residents on the basis of race, creed, color, blindness, marital status, disability, national origin, sex, sexual preference, source of payment, sponsorship, or age.

Resident hereby stipulates that valuable and sufficient consideration exists for Resident's obligations under this Agreement, including but not limited to, the Facility's agreement to admit Resident to the Facility on or about _______________, and any and all services and other things of value provided to Resident since Resident's admission to the Facility. Therefore, Facility and the Resident agree to the following terms and conditions relating to the admission and provision of services to the Resident by Facility:

1. CONDITIONS TO RESIDENT ADMISSION.

1.1 Admission/Physician. You must have a physician order to be admitted to the Facility. You appoint_________________, a licensed New York physician, as your personal physician to oversee your medical care throughout your stay at the Facility. You agree to a physician visit at least once every thirty (30) days for the first ninety (90) days after admission and at least once every sixty (60) days thereafter and more often when medically indicated.

1.2 Additional Examinations. You authorize all of your physicians, other medical personnel, and the Facility's Medical Director to perform all such necessary examinations (including but not limited to, dental examinations) as may be required by law or regulation.

1.3 Financial Statement. You agree to furnish Facility prior to admission, whenever your financial circumstances change, and also upon request a true statement of your financial resources and income available to pay for your care. You agree to notify Facility promptly if you

add or discontinue any medical insurance coverage, and if there are any other changes in your Medicare or private insurance coverage. In addition, you agree to notify Facility when your personal resources have declined to $18,000.00 above the Medicaid eligibility level to allow sufficient time to process your Medicaid application. By signing this Agreement, Resident warranties that the financial information provided to Facility is accurate and complete and will be relied upon by Facility.

1.4 Rights and Responsibilities. Resident shall be entitled to the rights, and must abide by the responsibilities, specified in the Facility's Statement of Resident's Rights, which will be provided to Resident and which is incorporated into this Agreement. By signing this Agreement, you specifically acknowledge that you and your Designated Representative and the other Resident Agents you appoint understand and agree to abide by and accept the responsibilities set forth in the Facility's Statement of Resident's Rights.

1.5 Resident Agents. Resident hereby appoints ____________________ as Resident's Designated Representative. Resident represents (knowing that Facility will rely upon such representation) that ______________________ has been validly appointed as Resident's Health Care Proxy, and ________________ has been validly appointed as Resident's Power of Attorney. These individuals are each a "Resident Agent" and collectively "Resident Agents." You agree to promptly notify Facility of any and all changes in address, phone number or identity of any Agent. You direct all current and future Agents to (1) meet all payment obligations under this Agreement from Resident's assets and/or insurance coverage, including by signing additional authorizations as required, (2) cooperate in applying for and obtaining Medicaid and recertification of Medicaid for Resident, if needed, (3) manage Resident's assets responsibly so that Facility will not be denied payment for the cost of care from Resident's assets and from Medicaid, and (4) sign **Attachment A (Personal Agreement)** to this Agreement. You agree to fulfill the financial obligations set forth in this Section if they cannot be performed by an Agent and you personally agree to ensure that your assets, income, and other resources are not used or transferred in any way to prevent you from qualifying for Medicaid or other insurance benefits. Resident authorizes Facility and its agents, including but not limited to, the Facility's attorneys and debt collectors, to communicate directly with Resident Agents and family members regarding any issues arising under this Agreement and with any third parties for the purposes of collecting any unpaid charges or bills. See also **Attachment B** for designations for Agents.

2. SERVICES, CHARGES, AND PAYMENT FOR SERVICES.

2.1 Basic Services; Additional Services. Facility shall provide the Resident the Basic Services as specified in this Section of this Agreement for the Basic Charge as defined in this Agreement. Resident authorizes the consultant physicians and other medical staff of the Facility to administer routine nursing facility services as may be deemed necessary in the diagnosis and treatment of the Resident.

Basic Services

(a) An attractive room in a clean, healthful, sheltered environment, properly outfitted, that includes a therapeutic or modified diet as prescribed by the Attending Physician. Resident understands that room changes may become necessary as care needs dictate during your stay at the Facility and you agree to cooperate in making such changes. Facility will give Resident notice prior to any room or roommate change, in accordance with all legal obligations.

(b) Twenty-four-hour nursing care and services by other staff members in the daily performance of their assigned duties. Resident understands that Resident will be touched by members of Facility's staff in providing these services and Resident consents to all appropriate touching and physical contact.

(c) Physician Services.

(d) Dental Services.

(e) The use of all equipment, medical supplies and modalities, notwithstanding the quantity usually used in everyday care of the Facility residents, including but not limited to catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads, and so forth. Also, the use of equipment customarily stocked by Facility including, but not limited to, crutches, walkers, wheel chairs, or other supportive equipment, including training in their use when necessary, unless such item is prescribed by Resident's Attending Physician for Resident's regular and sole use. Provided, however, if any equipment is ordered at Resident's request for Resident's sole use, regardless of whether or not it requires a physician order, Resident will be charged a separate fee for any such equipment if not covered by any applicable insurance or third party coverage.

(f) Fresh bed linen, as required, changed at least weekly, including sufficient quantities of necessary bed linen or appropriate substitutes changed as often as required for incontinence.

(g) Hospital gowns or hospital pajamas as required by the clinical condition and needs for privacy and dignity of the Resident, unless the Resident elects to furnish these items.

(h) Laundry services for hospital gowns or pajamas and other launderable personal clothing items used by Resident.

(i) General household medicine cabinet supplies, including but not limited to, non-prescription medications, materials for routine skin care, oral hygiene, care of the hair, and so forth, except when specific items are medically indicated and prescribed for exceptional use by a specific resident.

(j) Assistance and/or supervision, when required, with activities of daily living, including but not limited to, toileting, bathing, feeding, and ambulation.

(k) Activities programming, including but not limited to, a planned schedule of recreational, motivational, social, and other activities, together with the necessary materials and supplies to make the Resident's life more meaningful.

(l) Interdenominational and Roman Catholic Services to meet the religious needs of all residents wishing to attend. Services and times will be posted on each unit's activity schedule board. The Facility will also obtain pastoral counseling for any Resident requesting such services.

(m) Resident and Family Services counseling and support services as needed.

(n) Provide a kosher meal for the Resident upon request as long as it is realized that the Facility does not have a kosher kitchen on the premises.

Additionally, Facility agrees to make available to you on a fee-for-service basis the additional services listed below to the extent that they are ordered by your personal physician or other authorized and qualified practitioner:

Additional Services

Resident shall be responsible for and shall promptly pay all fees, co-payment, co-insurance and deductible amounts due for any and all of these services provided to the Resident:

1. Audiology. Services related to Resident's hearing to be administered by a qualified audiologist.

2. Therapy Services. Physical, occupational and/or speech pathology treatment provided by or under the supervision of a qualified therapist as prescribed by Resident's physician. The federal government may require a cap on the amount of funds Medicare will pay for these services in one year. This amount may be changed from time to time. Resident agrees to pay for any services not covered by Medicare or any other third party payor.

3. Lab and X-Ray. Laboratory and radiology services administered by appropriately licensed personnel.

4. Podiatry. Podiatry services administered by an appropriately qualified specialist that may include special nail care, corn and callous care, and other procedures as ordered by Resident's physician.

5. Medical Specialty Services. Medical specialty services including, but not limited to psychiatry, dermatology, orthopedics, surgery and ophthalmology, provided by a qualified specialist.

6. Prescription Drugs. Prescription drugs are not included in the Facility daily rate/Basic Charge. For residents with Medicare Part D or other third party coverage, the costs of prescription drugs will be billed to such payor on a monthly basis. The cost of the Resident's prescription drugs not covered by any third party plan, including but not limited to Medicare Part D, will be billed monthly to the Resident and Resident shall promptly pay all charges, co-payments, co-insurance and deductible amounts due for the prescription drugs provided to the Resident. Facility utilizes generic medications whenever available.

7. Dental Surgery and Prosthesis. Dental surgery, orthodontia work; dental prosthesis (including repair).

8. Additional Services and Supplies. Additional supplies or services will be provided if prescribed or recommended by the attending physician. Examples of additional services and supplies, include but are not limited to: (a) diagnostic services as ordered by a physician and not routinely provided by Facility; (b) audiology equipment; (c) eye exams and/or eyeglasses; and (d) intravenous therapy.

9. Transportation Expenses. Facility shall make arrangements for Resident transportation as necessary for medical care or services provided outside Facility. The Resident shall pay or provide for the payment of transportation expenses not covered by third-party payors.

10. Personal Items. Resident shall pay directly for items of a personal nature including clothing/shoes, personal items, beautician and barber services, professional dry cleaning, cosmetics, specialty brand toiletries, newspapers, magazines, personal televisions, television stands, authorized personal appliances, personal telephones in rooms (including installation and maintenance charges), companion and/or guest meals, and special transportation costs.

Additionally, any other health care service charges that the Resident may incur shall also be paid by the Resident if they are not covered by insurance or other third-party payor.

2.2 MDS Assessment. Resident agrees to cooperate with the Facility regarding the MDS assessment, as follows: State and Federal law require the Facility to complete an assessment (called the MDS assessment) of every resident, including the Resident, at pre-determined intervals. The MDS assessment may be used by the government to determine the reimbursement amounts to be received by Facility and to ensure that Facility is providing appropriate and quality care to its residents. The MDS assessment, upon completion, is submitted electronically to the New York State Department of Health and to the Centers for Medicare and Medicaid Services. Facility endeavors to ensure every resident that the information collected in the MDS assessment is confidential and is protected from improper disclosure, as required by federal law. Questions regarding the use of the MDS assessment and/or the submission process may be directed to the Resident's social worker or to the Director of Medical Records.

2.3 Charges. Resident agrees to pay the "Basic Charge" as the cost for all Basic Services as set forth in this Agreement and in **Attachment C**. Resident also agrees to pay for all additional services as detailed in Section 2.1 of this Agreement. Resident agrees to remain personally liable for any cost of care determined not covered by any third-party payor, including but not limited to, Medicare, Medicaid, or any third-party health plan or insurance carrier. Facility may change any charge prospectively, including but not limited to, the Basic Charge and charges for additional services, upon giving sixty (60) days' prior notice to Resident or Resident Agents.

2.4 Payment.

(a) Resident at all times agrees to the payment of any applicable assessment levied by New York State from time to time regardless of payor source (the "NYS Assessment").

(b) If you wish to have your Social Security benefit issued directly to the Facility, the Business office will assist you. As applicable and in accordance with the law, Fifty Dollars ($50) from each Social Security check will be placed in your Resident Fund account. If your Social Security check is directly deposited in an account that is shared with or can be accessed by someone else, that person is required to execute **Attachment A** and use your funds to pay for your care.

(c) If the Resident is private pay, then the Resident agrees to pay the applicable per day Private Room or Semi-Private Room rate as detailed in **Attachment C**, as appropriately modified by the Facility and as detailed in Section 2.3 of this Agreement. This

charge will be paid monthly in advance by or on behalf of the Resident. Payment is due by the 10th of the month following the billing date.

(d) If the Resident is a Medicaid recipient, whenever Medicaid is approved, the Resident shall provide Facility with a copy of the Budget Letter(s) issued to the Resident and Resident expressly agrees to pay and hereby directs his/her Resident Agents to pay Facility the amount specified in the Budget Letter(s) as may be amended from time to time. If Resident fails to make any payment required by this Agreement in a timely manner, Facility is authorized to apply for and become Resident's Representative Payee to provide for direct deposit to the Facility of your Social Security benefits and pension(s).

(e) If Resident has Medicare Part A coverage upon or relating back to the Resident's first day of admission to Facility, typically there will be no co-payment or other charges incurred for each covered day of skilled nursing care until the 21st day of Medicare Part A coverage, unless the Resident has previously exhausted his/her skilled nursing care benefits or unless coverage is denied. If you have Medicare coverage in effect on the day of admission, or if you request a Medicare eligibility review, you must arrange to provide advance payment to Facility equal to twenty (20) days advance payment of the Basic Charge, plus the NYS Assessment. Notwithstanding the foregoing, on the 21st or other applicable day after the commencement of Medicare Part A coverage, Resident shall be responsible to pay to Facility the amount of co-payment due under Medicare in advance until the end of the current month and for the subsequent month, and each month thereafter while Resident is eligible for Medicare Part A coverage.

(f) Any portion of a bill not paid in full by the end of the month shall accrue a late charge of one and one third percent (1.3%) per month (late charges are not compounding). Resident agrees this is a reasonable charge to compensate Facility for the lost time value of money. Late charges are due by the tenth day of the month after they are incurred. Payment will be applied first toward any outstanding late charge before applying it toward any other charges, fees, or expenses. A Thirty Five Dollar ($35) fee will be assessed for all returned checks.

(g) If Resident fails to timely make any payment owed under this Agreement, Resident agrees to pay any costs incurred by Facility to collect such payment, including but not limited to, Facility's attorneys' fees and court costs. Palatine Nursing Home will not hesitate to take legal action on delinquent accounts for non-payment.

(h) It is Resident's, not Facility's, obligation to obtain and maintain any third-party payor coverage and/or benefits, including but not limited to, those provided by Medicaid, Medicare, health plans, and long-term care insurance plans. In the event Resident anticipates coverage and/or benefits from such third-party payors to pay any portion of the Basic Charge or other charges, fees, and expenses, Resident agrees to timely pay the Facility for the amount of all charges, fees, and expenses owed without such coverage and/or benefits until Facility receives written notice that such coverage and benefits are approved and will be paid. Therefore, the Resident must continue to pay the private-pay rate while any application for third-party coverage and/or benefits is pending. Additionally, the submission of a claim to Medicare or a request for reconsideration of a claim to Medicare does not relieve the Resident from any payment obligations under this Agreement if the fiscal intermediary determines that the Resident's cost of care is not covered by Medicare.

(i) By signing this Agreement, the Resident acknowledges receipt of information regarding the Medicaid and Medicare programs including that set forth in **Attachment C**.

3. REFUND. Upon discharge from Palatine Nursing Home, any outstanding bills will be paid from any prepaid amount. The balance of the prepayment and of the personal funds account will be refunded within thirty (30) days after termination of the Resident's stay, or in accordance with legal obligations. In the event of the resident's death, such refund may only be delivered to the individual, entity, or probate jurisdiction which is appointed to administer the Resident's estate, to the Department of Social Services upon an authorized claim, or as otherwise authorized or required by law.

4. DISCHARGE OF RESIDENT.

4.1 Discharge by Resident. The Resident is free to leave Facility at any time. The Resident is requested to give seven (7) days prior written notice of intent to leave. If Resident discharges himself/herself from Facility against the advice of the attending physician, Resident shall indemnify and hold harmless Facility and its employees and agents against all claims, actions, proceedings, costs, damages and liabilities, including reasonable attorneys' fees arising out of, connected with or resulting from such discharge.

4.2 Discharge by Facility. Facility may, upon appropriate prior written notice, transfer or discharge the Resident if: the Resident fails to timely pay for care provided and for any other purpose permitted under New York State and federal regulations.

4.3 Discharge Planning. Resident agrees to accept discharge planning upon the advice of his/her personal physician and the Facility's rehabilitation team to be discharged from the Facility upon attainment of the goals set forth in the Resident's care plan. Resident agrees to cooperate and participate with the Facility staff in preparing and effectuating the discharge plan.

5. RESIDENT'S PERSONAL PROPERTY.

5.1 While Palatine Nursing Home has appropriate policies and procedures to provide reasonable security for the Resident's personal property, it can only ensure against the loss of valuable items (such as jewelry or money) if they are deposited with the management for safekeeping or kept in a locked space when not in use. The Resident's items may be held in the safe and will be logged by the Facility. The Facility will not be liable for the loss of any valuable items if the Resident refuses to keep valuables in the safe or locked securely when not in use.

5.2 Utmost care will be taken to assure the safety of the Resident's personal belongings. Any allegation of misappropriation of a resident's property will be thoroughly investigated.

5.3 It is the obligation of the Resident and undersigned to arrange for disposition of the Resident's property upon discharge. Palatine Nursing Home shall not be responsible for any property upon discharge. Palatine Nursing Home shall not be responsible for any property left more than thirty (30) days after discharge. After thirty (30) days, Palatine Nursing Home has the right to dispose of such personal items as it sees fit.

6. MEDICAL CARE; COMMUNICABLE DISEASES.

6.1 It is the philosophy of Palatine Nursing Home to ensure that each resident understands his/her rights to determine their health care treatment and his/her right to execute an advance directive. In emergency situations, advance directives such as **DO NOT RESUSCITATE** orders will be honored to the extent legally and practically possible. In the absence of advance directives to the contrary, the parties recognize that for proper resident care, certain emergency surgical and medical procedures may become necessary and must be applied without previous consultation with the Resident or the Designated Representative. In each case, the Facility will endeavor to obtain the consent of the Resident or legal representative. If such prior consent cannot be obtained, and the treating physician and/or the nursing staff determines that such surgical or special medical treatment is essential to save the Resident's life or to prevent adverse immediate and serious physical consequences, the Resident hereby authorizes the Facility to perform such treatment or to transfer the Resident to a facility where such treatment may be performed without prior consultation and without written permission.

6.2 A resident suffering from a communicable disease will only be admitted or retained if a physician certifies in writing that transmissibility is negligible and poses no danger to other residents, and if Palatine Nursing Home is staffed and equipped to manage such cases without endangering the health of other residents.

7. ENGAGEMENT OF PRIVATE NURSING SERVICES. The Resident agrees he/she will not engage Palatine Nursing Home staff to provide private nursing services. Private Duty Nurses, Certified Nursing Assistants, and sitters must sign and comply with provisions of the Facility.

8. RULES AND REGULATIONS. The Resident agrees to abide by the Palatine Nursing Home rules and regulations and to respect the personal rights and private property of other residents and staff.

9. MISCELLANEOUS PROVISIONS.

9.1 This Agreement, along with the Attachments and other documents referenced in this Agreement, which the Resident hereby acknowledges having received, contain the entire agreement between the parties. This Agreement may not be amended or modified except in a writing signed by the parties. Notwithstanding the foregoing, if there are changes to Federal, State, or Local laws or regulations or regulatory guidance which require modifications to the terms of this Agreement such modifications shall supersede the provisions set forth in this Agreement when required by the laws, regulations, and/or guidance. The Attachments to this Agreement, as may be amended in the future, may be distributed to residents and/or their representatives as stand alone policies of the Facility. This Agreement is governed by the laws of the State of New York. The parties specifically consent that the courts of the State of New York shall have exclusive jurisdiction over any dispute arising from or related to this Agreement and the venue of any such action or proceeding shall be in the County in which the Facility is physically located. This Agreement shall supersede all prior Admission Agreements, if any, between the parties; notwithstanding the foregoing, any rights or claims of either party accruing or arising under such prior Admission Agreements, if any, shall continue to survive as permitted by the provisions of such prior Admission Agreements.

9.2 If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid, illegal, or unenforceable, such provision shall be construed so as to render it enforceable and effective to the maximum extent possible in order to effectuate the intent of this Agreement and the validity, legality, and enforceability of the remaining provisions in this Agreement shall not in any way be affected or impaired thereby.

9.3 This Agreement remains in effect if the Resident is readmitted to the Facility after a hospitalization or other temporary absence of less than thirty (30) days duration. Notwithstanding any other term in this Agreement or the length or purpose of the Resident's stay, this Agreement shall continue in force and effect until a new agreement is signed between the parties.

9.4 Resident acknowledges receipt of the Facility's Bed Hold/Red Reservation Policy (see **Attachment D**).

9.5 By signing this Agreement, Resident hereby acknowledges receipt of the Facility's Privacy Notice (see **Attachment E**) and consents to the uses and disclosures contained in such Notice and elsewhere in this Agreement, including, but not limited to, any uses and disclosures of protected health information for the Resident's care, payment for the care, and the Facility's health care operations, and for such other uses that are permitted or required under Federal or State law without the Resident's consent or authorization.

9.6 Resident also agrees to the execution of the Statement of Intent to Return to Primary Residence, as applicable (see **Attachment F**).

9.7 The Resident's facial photographs, and photographs of specific injuries or conditions, may be taken to use as identification or for other health care operations of the Facility, as necessary. Resident consents to the use of these photographs by the Facility. The Facility will maintain the confidentiality of these photographs, as required by law.

9.8 Only those terms, conditions or provisions of this Agreement intended to survive termination of this Agreement shall so survive.

9.9 **State and federal laws prohibit discrimination in the admission, retention and care of residents who are appropriate for placement in a skilled nursing facility in accordance with all applicable Federal and State legal requirements on the basis of race, creed, color, blindness, age, marital status, physical handicap or disability, national origin, sex, sexual preference or sponsor**.

9.10 **By signing this Agreement, Resident certifies that the information given by Resident in applying for payment under Title XVIII of the Social Security Act is correct. Resident authorizes any holder of medical or other information about Resident to release to the Social Security Administration or its intermediaries or carriers any information needed for a Medicare claim. The Resident requests that payment of authorized benefits be made on the Resident's behalf**.

9.11 **By signing this Agreement, Resident acknowledges that Facility has the right, at its election, to act as the Resident's agent for submitting payment requests to Medicaid or other payors, and assisting with any Medicaid application, and for appealing any and all denials of such requests or applications. Resident acknowledges and agrees that the primary**

obligation to complete Medicaid application(s) and appeals remains with the Resident. As necessary, Resident agrees to provide Facility and Medicaid with any and all records and supporting documents, including bank and financial records, that may be required. Resident hereby authorizes personnel of any banks or other financial institutions maintaining Resident funds or other assets to release information to Facility representatives.

9.12 By signing this Agreement, Resident expressly authorizes personnel of the county and/or state department of social services, other Federal, State or local agencies, Medicare and other third-party payors to communicate with and furnish information to Facility concerning Resident's eligibility for Medicaid, Medicare or other insurance. Resident grants Facility access to the Resident's Department of Social Services Medicaid application and recertification file.

9.13 By signing this Agreement, Resident assigns to Facility any and all rights Resident has to appeal or challenge determinations by Medicare or the Medicare intermediary regarding Resident's placement in a particular "RUG," "PDPM," or successor category or classification, including any reclassification. Resident agrees to assist Facility in any such appeal.

9.14 By signing this Agreement, Resident expressly agrees to assign to Facility all Resident's long-term care insurance benefits and agrees that any such payments received shall be applied to amounts owed to Facility under this Agreement. Resident agrees to execute any required assignment of benefits form(s) or other documentation necessary to effectuate this assignment of benefits. Notwithstanding the foregoing, Resident agrees at all times to comply with the payment terms of this Agreement.

9.15 Facility and Resident agree that the Attachments referenced in this Agreement are incorporated in and are a part of this Agreement. Additionally, Resident acknowledges that he/she has been advised of, understands, and agrees to be legally bound by the following policies (which can be revised from time to time by the Facility):

- Palatine Nursing Home Admission Packet
- Statement of Resident's Rights
- Information/documents regarding Advance Directives

Signatures on next page

IN WITNESS WHEREOF, Facility and Resident have signed this Agreement this ___ day of ______________, 20___.

RESIDENT	**FACILITY**
_________________________ Signature of Resident (or Legal Representative)	By: ___________________________________ Signature of Facility's Representative Title: _____________________

FACILITY CERTIFICATION: This Admission Agreement was signed only after an in-person or telephone interview with _________________, during which the terms of this Agreement were reviewed and I answered any questions concerning Facility policies asked of me.

___________________________ (Name/Signature of Facility's Representative)

ATTACHMENT A

PERSONAL AGREEMENT

This Agreement is effective the __ day of ______________, between Palatine Nursing Home (the "**Facility**") and ______________, residing at ______________________ (hereinafter "**Signator**").

Signator hereby stipulates that valuable and sufficient consideration exists for Signator's obligations under this Agreement, including but not limited to, the Facility's agreement to admit ______________ ("**Resident**") to the Facility and to provide any and all services and other things of value to Resident as specified in the Resident's Admission Agreement with Facility (the "**Admission Agreement**") since Resident's admission to the Facility. Therefore, in consideration of the Facility's agreement to admit **Resident** and to provide the services specified in the Admission Agreement,

NOW, THEREFORE, for other good and valuable consideration, the parties hereby agree as follows:

1. Signator warranties that Signator has authority to represent and/or legal access to the income, funds, and resources of the Resident.

2. Signator agrees that this Agreement is valid and binding upon Signator and incorporates the terms of the Admission Agreement without regard to whether the Admission Agreement is signed or binding upon the Resident. If a court of competent jurisdiction determines that the Admission Agreement is not binding upon Resident, Signator agrees that the Facility is still legally entitled to payment for Resident's stay from Resident's assets, income, Medicare and insurance benefits, and other resources (collectively "**Resources**"), and agrees that the amount owed to the Facility shall be calculated based upon the terms of the Admission Agreement as if it were binding and effective.

3. Signator agrees to promptly and timely assist the Resident in fulfilling his/her financial responsibilities under the Admission Agreement, the terms of which are fully incorporated into this Agreement.

4. Signator warranties that if any information is entered on any financial questionnaire of the Facility, it is true, complete and accurate to the best of Signator's knowledge. Signator agrees to use Signator's legal authority to assist Resident in making all payments due to the Facility in accordance with the terms of the Admission Agreement.

5. Signator agrees that Resident's Resources will be used to timely pay all of Resident's charges, fees and expenses, payments for physician visits and all properly authorized additional charges and rate increases at the Facility.

6. Signator agrees to promptly and timely initiate and complete applications, recertifications, and appeals for Medicaid benefits on behalf of the Resident when he/she becomes eligible. In the event that Facility agrees to assist Resident in applying for, recertifying for, or appealing Medicaid benefits, Signator will cooperate with Facility in that process. In connection with any application or re-certification for Medicaid benefits, Signator agrees to fully cooperate

with the New York State and the local county Department of Social Services or comparable agency ("**DSS**") in securing the Resident's continued eligibility for Medicaid benefits, including but not limited to, personally ensuring the timely submission of any documentation requested by DSS.

7. Signator agrees, as the agent of the Resident, to adhere to his/her obligations to pay any Net Available Monthly Income ("**NAMI**") specified by DSS to the Facility. If Signator should fail to ensure payment of NAMI in accordance with the Admission Agreement, Facility is authorized at its option to apply for and become Representative Payee of the Resident to provide for the direct deposit of Social Security benefits and to become Representative Payee of the Resident with respect to any Resident pension(s).

8. Signator warranties that no transfer of Resident's Resources has taken place or will occur which would prevent Resident from qualifying for Medicaid benefits or result in Resident having insufficient funds to pay Facility's bill.

9. Signator agrees to take all steps necessary to effect the terms of this Agreement, including without limitation signing additional authorizations as requested by Facility or Resident's benefit providers, providing documentation and information as requested by Facility or Resident's benefit providers, and pursuing legal action on behalf of Resident to recover funds fraudulently transferred from Resident.

10. Signator agrees to pay damages to Facility caused by a breach of his/her personal responsibilities under this Agreement including without limitation, attorney's fees and costs.

11. Signator agrees to permit Facility and its agents, including without limitation, Facility's attorneys and debt collectors attempting to enforce the rights of the Facility under the Admission Agreement and/or this Agreement, to communicate directly with third parties in connection with the terms of the Admission Agreement and this Agreement, including without limitation, for purposes of collection of any debt owed to Facility.

12. Signator agrees that although Facility may help in its discretion, Signator and Resident are and remain solely responsible for any application, recertification, and/or appeal for third-party benefits (including without limitation Medicaid, Medicare, and private insurance) on behalf of Resident. Facility is not required to mitigate its damages by assuming responsibility for any application, recertification, and/or appeal of third-party benefits. In consideration of the possibility that Facility will decide to help with an application, recertification, and/or appeal for Medicare or Medicaid benefits for Resident, Signator hereby also agrees to the following:

a. Signator specifically designates Facility as an entity that may act as Resident's agent for the purpose of processing requests for Medicaid and Medicare eligibility and for appealing any denial of such eligibility;

b. Signator agrees to provide Facility with any and all records and supporting documents required to complete a Medicaid application or recertification, including without limitation banking and financial records, and Signator hereby directs all institutions, entities, and individuals to release to Facility all records of Resident accounts;

c. Signator will comply with requests for documentation and information from the Facility, and/or any agency or entity responsible for administering Medicare or Medicaid, such as DSS, in a prompt manner and, in any event, no later than the time frame set forth by such agency; and

d. Signator authorizes any agency responsible for administrating Medicare or Medicaid, and any other third-party payors, to provide information to Facility concerning Resident's eligibility for benefits.

13. Signator agrees that any final determination by any third-party benefit provider/payor concerning eligibility for benefits or the amount of any co-pay, co-insurance, NAMI, or cost sharing amount is binding upon the Resident and Signator unless the same is subject to an appeal or court action against such benefits provider.

14. Signator agrees to authorize the Facility to assign a physician to conduct resident visits in order to meet the Facility's requirements under the Regulations of the Department of Health. All medical and dental services that are provided by this Facility shall be provided by practitioners who are credentialed with us as part of a "closed medical staff."

This Agreement may be signed in one or more counterparts all of which will constitute one and the same instrument.

DATED: ____________________ ____

SIGNATOR
Social Security No: ________________

DATED: ____________________ ____

FACILITY'S REPRESENTATIVE

ATTACHMENT B

DESIGNATION OF RESIDENT AGENTS

WHO WILL EXERCISE YOUR RIGHTS AND RESPONSIBILITIES IF YOU CANNOT:

Resident Agents.

(a) **Designated Representative:** You are requested to designate some person (family member, friend, advisor) as your Designated Representative. By signing this Agreement you designate ________________________ (name), ________________________ (street), ________________________ (city), ______________________ (state and zip) ______________ (phone) as your Designated Representative. The Designated Representative shall receive information from Facility as required by Department of Health regulations. You authorize Facility to contact the Designated Representative whenever it is deemed necessary or appropriate by you or by Facility to seek the assistance of a third party in discussing and/or conducting transactions between the parties.

(b) **Financial Representative** (such as a Power of Attorney or Guardian) ("Agent"): You are required to advise Facility as to the identity of any and all individuals who you have authorized to act in your place as Attorney-In-Fact when you signed the legal document known as the Power of Attorney. You identify the following individual(s) as the person(s) you have designated as your Power of Attorney _________________ (name), ________________________ (street), ___________________ (city), ______________________ (state and zip) _____________ (phone) ____________ (soc. sec. #). (Submit a copy of the Power of Attorney Form.)

Other Financial Representatives/Agents are listed as follows:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

This person(s) may have been given control over your money by you and will be responsible for seeing that charges incurred for your care are promptly paid either through the use of your personal resources or by any applicable third-party payor. You further agree to immediately notify Facility if you revoke such designation and/or identify any other individual(s) to be your Power of Attorney. If your Power of Attorney or any other person has access to or control over your income or assets, he/she/they will be required to sign **Attachment A** to this Agreement. Your Agent may be asked to assist you to fulfill your responsibilities hereunder and to cooperate with Facility in its efforts to see that your needs are met. Your Agent is expected to cooperate with Facility in obtaining timely payment from available funds and to assist you in applying for all payment programs to which you may be entitled.

(c) **Health Care Agent:** By executing a form known as the Health Care Proxy, you may authorize an individual to make health care decisions for you in the event that you are no longer able to make those decisions for yourself. Facility encourages all residents to carefully consider and to execute a Health Care Proxy. If you have already designated someone to be your Health Care Agent, you are required to provide Facility with a copy of your Health Care Proxy form. The Social Worker can assist you in completing a Health Care Proxy form if you have not already designated someone to act as your Health Care Agent.

(d) **Direction to Agent:** You agree to promptly notify Facility of any and all changes in address, phone number or identity of any Agent. You direct all current and future Agents to comply with all obligations as set forth in the Admission Agreement.

If you are declared legally incompetent under State law, all Rights and Responsibilities specified shall devolve upon your judicially designated legal representative.

WHO CAN THE FACILITY COMMUNICATE WITH REGARDING YOUR CARE AND TREATMENT WHILE YOU ARE AT THE FACILITY:

The Facility may disclose to a family member, other relative, a close personal friend, or any other person identified by you your protected health information directly relevant to that person's involvement with your care or the payment for your care. The Facility may also use or disclose your protected health information to notify or assist in notifying (including identifying or locating) such person of your location, general condition or death. However, this can only occur if you agree to a disclosure to such person. If you wish to name such a person and agree to such disclosures, please designate the family member, other relative, close personal friend, or any other person and to whom the Home may make such disclosures (a "Family Member/Friend"):
____
____
____

ATTACHMENT C

MEDICARE AND MEDICAID PAYMENT OF BASIC CHARGES

FOR MEDICARE PART A COVERED RESIDENTS AND ALL NON-MEDICAID RESIDENTS: Resident, who is not covered by Medicare Part A, agrees to pay Facility the sum of $ _____ (private) (semi-private) per day, plus any assessment levied by New York State from time to time, payable monthly in advance for the Basic Services. If Resident is a Medicare beneficiary whose stay is covered under Medicare Part A, the Basic Charge for the Covered Services shall be the Medicare Part A rate for Facility. The Covered Services for such Medicare Part A covered stays shall include the Basic Services, the audiology, rehabilitative therapies, laboratory and x-ray services, and certain transportation charges as detailed in the Agreement. Each Resident's case is reviewed by Facility and the intermediary, in accordance with Medicare regulations, to determine eligibility and length of coverage, if any. If Resident has met all of the Medicare eligibility requirements, Resident will be eligible to receive up to one hundred (100) days of Medicare Part A coverage, per Benefit Period, if medically qualified. The full cost of Covered Services for the first twenty (20) days will be paid to Facility by Medicare through Medicare Part A rate. For the next eighty (80) days, providing the Resident continues to meet the eligibility requirements and remains a Medicare beneficiary, the Resident agrees to pay Facility the amount of co-insurance provided for in the applicable Medicare regulations, as amended. The balance of the cost of Covered Services for the next eighty (80) days will be paid to Facility by Medicare. The Finance Office will, at your request, tell you the current Medicare Part A rate. The current Medicare Part A co-payment amount is $_____ per day. The Part A rate and co-payment amount are set by the federal government and are subject to change from time to time. The Resident is responsible for the annual Medicare Part A, Part B and Part D deductibles and for any and all Medicare Part A, Part B and/or Part D co-insurance. In addition to the Basic Charge, Resident will be charged for services requested that are not paid for by Medicare or other applicable insurance coverage.

FOR MEDICAID ONLY RECIPIENTS WITHOUT MEDICARE PART D: If Resident is a Medicaid only recipient and not eligible for Medicare Part D, the Basic Charge for the Basic Services listed in the Agreement (Basic Services for Medicaid recipients shall also include prescription drugs and rehabilitative services) shall be the Medicaid rate for Facility. The current Medicaid rate is set by New York State. The Finance Office will, at your request, tell you the current Medicaid rate. This rate may be changed from time to time by the State Government without notice to the Resident. Resident, if a Medicaid recipient, has been advised by the Department of Social Services that Resident will be responsible for paying a portion of the charges made by Facility and the Department shall pay the balance (See the County Department of Social Services Budget Letter(s) made a part of this Agreement by your signing this Agreement). Resident understands that the Department of Social Services may from time to time change the portion of the charges Resident must pay. Resident agrees to forward a copy of each and every Budget Letter received from the Department of Social Services to the Finance Office within seven (7) days after receipt of each Budget Letter. In addition to the Basic Charge, Resident will be charged for services requested and for which payment is not made by Medicaid.

FOR MEDICAID RECIPIENTS WITH MEDICARE PART D COVERAGE: If Resident has Medicare Part D coverage and is a Medicaid recipient, the Basic Charge for the Basic Services listed in the Agreement shall be the Medicaid rate for Facility. The cost of prescription drugs will be billed to appropriate and applicable Medicare Part D plan, and the Resident will not be responsible for meeting all applicable cost sharing responsibilities specified by the Medicare Part

D plan, which shall be paid by Medicaid. The Finance Office will, at your request, tell you the current Medicaid rate. This rate may be changed from time to time by the State Government without notice to the Resident. Resident, if a Medicaid recipient, has been advised by the Department of Social Services that Resident will be responsible for paying a portion of the charges made by Facility and the Department shall pay the balance (See the County Department of Social Services Budget Letter(s) made a part of this Agreement by your signing this Agreement). Resident understands that the Department of Social Services may from time to time change the portion of the charges Resident must pay. Resident agrees to forward a copy of each and every Budget Letter received from the Department of Social Services to the Finance Office within seven (7) days after receipt of each Budget Letter. In addition to the Basic Charge, Resident will be charged for services requested and for which payment is not made by Medicaid (for example, the room rate differential between a semi-private and a private room, except where Resident must occupy a private room for therapeutic reasons).

FOR RESIDENTS WITH MEDICAID APPLICATIONS PENDING AND WHO HAVE MEDICARE PART D COVERAGE: If Resident has Medicare Part D coverage and a Medicaid application pending or in process (i.e., the Resident is Medicaid pending) the cost of prescription drugs will be billed to the appropriate and applicable Medicare Part D plan, and the Resident will be responsible for meeting all applicable cost sharing responsibilities specified by the Medicare Part D plan. Once the Resident becomes a Medicaid recipient, the Basic Charge for the Basic Services listed in the Agreement shall be the Medicaid rate for Facility. The cost of prescription drugs will be billed to Medicare Part D plan and the Resident will not be responsible for meeting all applicable cost sharing responsibilities specified by the Medicare Part D plan, which shall be paid by Medicaid. The Finance Office will, at your request, tell you the current Medicaid rate. This rate may be changed from time to time by the State Government without notice to the Resident. Resident, if a Medicaid recipient, has been advised by the Department of Social Services that Resident will be responsible for paying a portion of the charges made by Facility and the Department shall pay the balance (See the County Department of Social Services Budget Letter(s) made a part of this Agreement by your signing this Agreement). Resident understands that the Department of Social Services may from time to time change the portion of the charges Resident must pay. Resident agrees to forward a copy of each and every Budget Letter received from the Department of Social Services to the Finance Office within seven (7) days after receipt of each Budget Letter. In addition to the Basic Charge, Resident will be charged for services requested and for which payment is not made by Medicaid (for example, the room rate differential between a semi-private and a private room, except where Resident must occupy a private room for therapeutic reasons).

ATTACHMENT D

BED HOLD/BED RESERVATION POLICY

A. <u>When a Resident is transferred to an acute care hospital setting, the bed is reserved as follows:</u>

1. For **Non - Medicaid residents** and for **Medicaid residents that are <u>not</u> described in Section (2) below**: Payment for the bed during the period of temporary hospitalization is assured by the Resident and the Resident's accounts are not in arrears. The Resident will owe the Basic Charge (private pay charge) under this Agreement for each day the bed is reserved, and the bed reservation will continue until it is cancelled by the Facility, the Facility is notified to cancel the bed reservation, or it is terminated as permitted or required by law.

2. For **Medicaid residents as described in subparagraphs (a) and (b) below**, the Facility will comply with Medicaid regulations concerning a bed reservation (including all applicable Facility vacancy requirements), as detailed in part below:

(a) Medicaid residents **aged 21 years or older**, will have a Medicaid bed reservation, but only if the Resident has resided within the Facility for at least thirty (30) days since initial admission and the Resident is receiving hospice services within the Facility, and subject to all other applicable conditions and limitations as provided by law. Medicaid payment for temporary hospitalizations are limited by Medicaid to a total of fourteen (14) days in a twelve-month period. The applicable rate of Medicaid reimbursement for a Medicaid bed reservation under this subparagraph is 50% of the Medicaid rate.

(b) Medicaid residents **under the age of 21 years**, will have a Medicaid bed reservation only if the Resident has resided within the Facility for a period of at least thirty (30) days since initial admission and subject to all other applicable conditions and limitations as provided by law. The applicable rate of Medicaid reimbursement for a Medicaid bed reservation under this subparagraph is established by the Department of Health and approved by the Director of the Budget.

B. <u>When a Resident is on therapeutic leave, the bed is reserved as follows:</u>

1. For **Non-Medicaid residents** and **Medicaid residents for which Medicaid is not paying for, or no longer paying for, a bed reservation,** upon and pursuant to the same conditions as a bed reservation under (A)(1) of this policy, above.

2. For Medicaid residents **aged 21 years or older**, a Medicaid bed reservation is available for therapeutic leaves of absence outlined in a recipient's medically acceptable therapeutic or rehabilitative plan of care only if the Resident has resided in the Facility for a period of at least thirty (30) days since initial admission. Medicaid payment for such leaves of absence are limited to ten (10) days in a twelve-month period. The applicable rate of Medicaid reimbursement for a Medicaid bed reservation under this subparagraph is 95% of the Medicaid rate.

3. For Medicaid residents **under the age of 21 years**, a Medicaid bed reservation is available only if the Resident has resided within the Facility for at least thirty (30) days since initial admission and only if the leave of absence is provided for in the Resident's medically acceptable therapeutic or rehabilitative plan of care. The applicable rate of Medicaid reimbursement for a Medicaid bed reservation under this subparagraph is established by the Department of Health and approved by the Director of the Budget.

C. Other Terms

1. Combined Aggregate Limit. For Medicaid residents aged 21 years or older, Medicaid payment for a bed reservation is limited to a combined aggregate of fourteen (14) days in a twelve-month period for all hospitalizations and leaves of absence, combined.

2. Effect of Medicare. Medicaid will not pay for a bed reservation if Medicare is the Resident's primary third-party resource, unless the Resident has resided in the Facility for at least thirty (30) days prior to the hospitalization that triggered Medicare coverage.

3. Termination of Medicaid Bed Reservation. If a resident's Medicaid bed reservation is terminated for any reason, including but not limited to the exhaustion of available Medicaid payment for such bed reservation, the bed reservation will be cancelled unless the bed is reserved pursuant to and upon the conditions in (A)(1) of this policy, above.

D. Written Notice:

1. A resident whose hospitalization or therapeutic leave exceeds the bed-hold period will be readmitted to the nursing facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the nursing facility and is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.

2. A resident who has resided in the nursing facility for thirty (30) days or more and who has been hospitalized or who has been transferred or discharged on therapeutic leave without being given a bed reservation is readmitted to the nursing facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the nursing facility and is eligible for Medicaid nursing facility services.

**This policy is subject to revision in accordance with changes in applicable Federal and/or State laws and regulations, as well as clarifications by the New York State Department of Health.

ATTACHMENT E

HIPAA PRIVACY NOTICE

(See Attached)

PALATINE NURSING HOME

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Palatine Nursing Home ("Facility") is committed to maintaining the privacy of your protected health information ("PHI"), which includes electronic PHI, and which includes information about your medical condition and the care and treatment you receive from the Facility and other health care providers, all in accordance with the provisions of the Health Insurance Portability and Accountability Act and the Health Information Technology for Economic and Clinical Health Act, and their regulations (collectively, the "HIPAA Rules"). This Notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of the Facility, and for other purposes permitted or required by law and the HIPAA Rules. This Notice also details your rights regarding your PHI.

This Facility includes the physicians and other providers who provide health care services to you but are legally independent from the Facility. Although these providers are all independent, as you would expect they cooperate to provide an integrated system of care to you. This type of clinically integrated setting in which you receive health care from more than one health care provider is called an organized health care arrangement ("OHCA") under the HIPAA Privacy Rules. We may share your health information with participants in the OHCA for treatment, payment, and health care operations of the OHCA. Those participating in the OHCA include, but are not limited to, a pharmacy, physicians, podiatrists, dentists, physical therapists, occupational therapists, and speech language pathologists. This Notice is provided as a joint notice made by each of them, and, that each of them will abide by the terms of this Notice.

USE OR DISCLOSURE OF PHI

1. The Facility may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the Facility. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

(a) **Care** – In order to care for you, the Facility will provide your PHI to those health care professionals, whether on the Facility's staff or not, directly involved in your care so that they may understand your medical condition and needs and provide advice or treatment. For example, a physician treating you for a condition such as arthritis may need to know what medications have been prescribed for you by the Facility's physicians.

(b) **Payment** – In order to get paid for some or all of the health care provided by the Facility, the Facility may provide your PHI, directly or through a billing service, to appropriate third party payors. For example, the Facility may need to provide the Medicare program with information about health care services that you receive from the Facility so that the Facility can be properly reimbursed.

(c) **Health Care Operations** – In order for the Facility to operate in accordance with applicable law and in order for the Facility to provide quality and efficient care, it may be necessary for the Facility to compile, use and/or disclose your PHI. For example, the Facility may use your PHI in order to evaluate the performance of the Facility's personnel.

AUTHORIZATION NOT REQUIRED

1. The Facility may use and/or disclose your PHI, without a written Authorization from you, in the following instances:

(a) **De-identified Information** – Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.

(b) **Business Associate** – To a business associate, which is someone who the Facility contracts with to provide a service necessary for your treatment, payment for your treatment and health care operations (e.g., billing service). The Facility will obtain satisfactory written assurance, in accordance with applicable law and the HIPAA Rules, that the business associate will appropriately safeguard your PHI, and that the business associate will ensure its subcontractors, if any, appropriately safeguard your PHI as well.

(c) **To you or a Personal Representative** – To you, or to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) **Public Health Activities** - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability.

(e) **Food and Drug Administration** - If required by the Food and Drug Administration to report adverse events, product defects or problems or biological product deviations, or to track products, or to enable product recalls, repairs or replacements, or to conduct post marketing surveillance.

(f) **Abuse, Neglect or Domestic Violence** - To a government authority if the Facility is required by law to make such disclosure. If the Facility is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm or if the Facility believes that you have been the victim of abuse, neglect or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.

(g) **Health Oversight Activities** - Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.

(h) Judicial and Administrative Proceeding - For example, the Facility may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(i) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Facility; and (6) a medical emergency (not on the Facility's premises) has occurred, and it appears that a crime has occurred.

(j) Coroner or Medical Examiner - The Facility may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.

(k) Organ, Eye or Tissue Donation - If you are an organ donor, the Facility may disclose your PHI to the entity to whom you have agreed to donate your organs.

(l) Research - If the Facility is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI such as approval of the research by an institutional review board and the requirement that protocols must be followed.

(m) Avert a Threat to Health or Safety - The Facility may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(n) Specialized Government Functions - When the appropriate conditions apply, the Facility may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Facility may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.

(o) Inmates - The Facility may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safety of other individuals or inmates.

(p) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Facility may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(q) **Disaster Relief Efforts** – The Facility may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.

(r) **Required by Law** - If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

(s) **Fundraising Communications** - The Facility may contact you and your personal representative for appropriate fundraising communications. "Fundraising communications" include communications to you and your personal representative for the purpose of raising funds for the Facility and the communication is not made for your care or treatment. You and your personal representative will be given the opportunity to opt out or restrict your receipt of such fundraising communications. If you or your personal representative choose to opt out, the Facility will honor the decision and not use such personal information for fundraising purposes.

AUTHORIZATION

As detailed in the HIPAA Rules, certain uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes (as described in the "Marketing" section of this Privacy Notice), and disclosures that constitute a sale of PHI require a written authorization from you, and other uses and disclosures not otherwise permitted as described in this Privacy Notice will only be made with your written authorization, which you may revoke at any time as detailed in the "Your Rights" section of this Privacy Notice.

TREATMENT ALTERNATIVES/BENEFITS

The Facility may, from time to time, contact you about treatment alternatives, or other health benefits or services that may be of interest to you.

MARKETING

The Facility may only use and/or disclose your PHI for marketing activities if we obtain from you a prior written Authorization. "Marketing" activities include communications to you that encourage you to purchase or use a product or service, and the communication is not made for your care or treatment. However, marketing does not include, for example, sending you a newsletter about this Facility. Marketing also includes the receipt by the Facility of remuneration, directly or indirectly, from a third party whose product or service is being marketed. The Facility will inform you if it engages in marketing and will obtain your prior Authorization.

FAMILY MEMBER/FRIEND

The Facility may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Facility may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) of a family member, a personal

representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) The Facility may use or disclose your PHI if you agree, or if the Facility provides you with opportunity to object and you do not object, or if the Facility can reasonably infer from the circumstances, based on the exercise of its judgment, that you do not object to the use or disclosure.

(b) If you are not present, the Facility will, in the exercise of its judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

FACILITY DIRECTORY

The Facility will maintain a Directory of individuals who reside in the Facility. You will be included in that Directory, which will indicate your name and your room number. Your information will also be provided to any person who asks for you by name. However, you have the right to object to the use of your information in the Directory, and you have the right to request that some or all of that information not be used or disclosed as described herein. If, because of your condition or an emergency situation, you cannot exercise your right to object, the Facility will use or disclose your information in the Directory if that is consistent with your prior expressed preference and the Facility determines that such use or disclosure is in your best interest.

ROOM LOCATION

The Facility may post, either on the door of your room or on the wall adjacent to the door, your name. This will be done for your safety and to promote efficient, quality care.

GOVERNMENT REGULATION

The Facility is subject to various rules and regulations of New York and the federal government. As a result of those rules and regulations, periodically representatives from federal or state agencies will audit the operations of the Facility and, in the process of that audit, will review medical records, some of which may contain your PHI. In addition, you, as a recipient of Medicare benefits, may have agreed to allow representatives from the federal or state governments to review your medical records as a result of an audit being conducted of the Facility. Access by a federal or state agency to your PHI for audit purposes does not require your prior authorization.

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Facility's Privacy Officer.

(b) Request restrictions on certain uses and/or disclosures of your PHI as provided by law. However, the Facility is not obligated to agree to every requested restriction, except to the extent required by the HIPAA Rules or by law. To request restrictions, you must submit a written request to the Facility's Privacy Officer. In your written request, you must inform the Facility of what information you want to limit, whether you want to limit the Facility's use or disclosure, or both, and to whom you want the limits to apply. If the Facility agrees to your request, the Facility will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Restrict certain disclosures of PHI about you to a health plan where you pay out of pocket in full for the health care item or service.

(d) Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Facility's Privacy Officer. The Facility will accommodate all reasonable requests.

(e) Inspect and copy your PHI, except psychotherapy notes, all as provided by law. To inspect and copy your PHI, you must submit a request (oral or written) to the Facility's Privacy Officer. In certain situations that are defined by law, the Facility may deny your request, but you will have the right to have the denial reviewed. The Facility can charge you a fee for the cost of copying, mailing, or other supplies associated with your request, all in accordance with law.

(f) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Facility's Privacy Officer. You must provide a reason that supports your request. The Facility may for various reasons deny your request. If you disagree with the Facility's denial, you will have the right to submit a written statement of disagreement.

(g) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Facility's Privacy Officer.

(h) Receive a paper copy of this Privacy Notice from the Facility upon request to the Facility's Privacy Officer.

(i) Be notified following a breach of your Unsecured PHI (as such term is defined by the HIPAA Rules).

(j) Complain to the Facility, or to the United States Department of Health and Human Services, Office for Civil Rights, Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201. To file a complaint with the Facility, you must contact the Facility's Privacy Officer. All complaints must be in writing.

(k) To obtain more information on, or have your questions about your rights answered, you may contact the Facility's Privacy Officer at (518) 673-5212.

FACILITY'S REQUIREMENTS

1. The Facility:

(a) Is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice of the Facility's legal duties and privacy practices with respect to your PHI.

(b) Is required to abide by the terms of this Privacy Notice, which is currently in effect.

(c) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(d) Will not retaliate against you for making a complaint.

(e) Must make a good faith effort to obtain from you an acknowledgement of receipt of this Notice.

(f) Will post this Privacy Notice on the Facility's web site, if the Facility maintains a web site.

(g) Will provide this Privacy Notice to you by e-mail if you so request. However, you also have the right to obtain a paper copy of this Privacy Notice.

EFFECTIVE DATE

This Notice was originally in effect as of April 14, 2003. This Revised Notice is in effect as of November 1, 2019.

ATTACHMENT F

STATEMENT OF INTENT TO RETURN TO PRIMARY RESIDENCE

The undersigned is the Resident referred to in the attached Admission Agreement or is the person representing the Resident. The undersigned has knowledge that the Resident currently owns a primary residence and Resident intends to return to that primary residence when Resident is able to be discharged from the Facility.

Dated:

____
Resident

____
Resident Representative