

Bronx Gardens Rehabilitation and Nursing Center

ADMISSIONS AGREEMENT

This Admission Agreement (“Agreement”) is made effective as of _____ (“Effective Date”) by and between **Bronx Gardens Rehabilitation and Nursing Center** (“Facility”) and _____ (“Resident”) and _____ (Legal Representative).

(Relationship of Legal Representative to Resident): _____

A. Definitions. For purposes this Agreement the following terms are defined and incorporated:

- a. **“Facility”** refers to the above-reference skilled nursing Facility and the location at which the Resident will reside.
- b. **“Resident”** refers collectively to the individual to be admitted to the Facility and, where applicable, the Legal Representative.
- c. **“Legal Representative”** refers to an individual who acknowledges and certifies that he/she has decision-making capacity for and control of or legal access to the resident income and/or assets, or by law, is an agent under Power of Attorney, or a court-appointed guardian or conservator of the Resident and agrees that these funds shall be used for the resident’ welfare including making prompt payment for care and services rendered to the resident in accordance with the terms of this Agreement. The Legal Representative does acknowledge and agree that he or she wants the resident to be admitted to and receive the care and services provided by the facility; that he or she is making certain promises and undertaking certain obligations in this agreement and attachments; and that the Facility is admitting the resident and providing care and services in reliance upon these promises. The Legal Representative is personally liable for any damages incurred by the facility due to the Legal Representative’s failure to fulfill these promised and obligations. The Legal Representative does not, however, personally guarantee or serve as a surety for payment for the care provided to the resident of the facility. The Legal Representative does have a duty to cooperate with all Medicare/Medicaid/other payor source requirements when the resident becomes Medicare/Medicaid/other payor source eligible.
- d. **“Attachment”** refers to additional documents attached, provided to the Resident on or at, or soon after, the time of admission, which are incorporate herein as a legal part of this Agreement.

B. Care and Services.

- a. **Consent.** Resident consents to admission to and treatment by our Facility and health care providers. *See Attachment B, Consent to Admission and Treatment, incorporated by reference herein).*
- b. **Influenza Vaccine and Pneumococcal Vaccine Information Statements.** *Please see Welcome Packet.*
- c. **Attending Physician.** By execution of this Agreement, the Resident agrees to be admitted to the Facility and while residing in the Facility to be under the care and treatment of an attending physician of the Resident’s choosing who is licensed in **New York**. The attending physician selected by the Resident must act in accordance with the applicable state and federal rules and regulations and the Facility’s Rules and policies and procedures, including being credentialed by the Facility. If the Resident has no attending physician, or does not provide information concerning an attending physician, the Facility shall consult with and assist the Resident in selecting an attending physician of the Resident’s choice. If after consultation, the Resident does not select a physician, the Facility will select an attending physician for the Resident. If the Facility selects an attending physician for the Resident, the Facility shall make all reasonable efforts to ensure that the services of the physician are covered by the Resident’s health insurance, if any, and shall provide the Resident with the physician’s name, phone number and specialty. In the event of a life-threatening emergency, the Facility will make reasonable efforts to contact the Resident’s attending physician, and if unable to do so, the Facility may obtain another physician’s services for the Resident. The Facility does not assume responsibility for an attending physician’s acts and/or omissions, or for designees of the attending physicians who provide services to the Resident while in the Facility.

The Resident agrees to arrange and be financially responsible for payment for services provided by the attending physician, the attending physician’s designee or in the event the attending physician or designee is unavailable, a physician who is contacted for emergency treatment of the Resident.

The Resident agrees to urgent medical treatment by a Telehealth Services Provider.

- d. Emergency Treatment. In the event of an emergency and the attending physician is unavailable, the Resident authorizes the Facility to contact a physician for purposes of providing emergency treatment to the resident.
- e. Nursing. The Facility is required to meet applicable state and federal nurse staffing requirements. The Facility does not provide 24-hour, one-to-one nurse to resident care. While residing in the Facility, the resident will receive medically necessary routine nursing services and, as applicable, emergency treatment to the resident.
- f. Ancillary. In accordance with the Resident's plan of care, the Facility will arrange for ancillary services which may include rehabilitation, podiatry, ophthalmology, audiology, dental, laboratory and diagnostic, hospice and pharmacy services. The Resident agrees to the conducting of diagnostic tests for the provision of ancillary services as ordered by the Resident's attending physician, and/or nurse practitioner.
- g. Transfer to Hospital. The Facility will arrange for the Resident's transfer to a hospital or other healthcare facility when any such transfer is ordered by the Resident's physician or a physician whom the Facility chooses. The Facility is not responsible for payment for care and services rendered to the Resident by any hospital or any other healthcare facility.
- h. Pharmacy. While residing at the Facility, the Resident has the right to utilize the services of a pharmacy of the Resident's choice; however, the facility provides and utilizes a preferred vendor. (See Welcome Packet for Vendor Specifics) Resident acknowledges that the Resident's choice of pharmacy is subjected to limitations imposed by the Resident's health insurance provider. The Resident's pharmacy needs to meet the federal and state regulations and adhere to the policies and procedures of the Facility, and there should be no medication or time limitations for delivery of said items by the Resident's pharmacy. The Resident agrees not to bring medications or drugs into the Facility unless those medications or drugs are accurately labeled and delivered to the Facility's Director of Nursing or a nursing supervisor in charge of the nursing station responsible for the Resident's care. The Director of Nursing and Consultant Pharmacist are authorized to destroy any excess or undesired medications in accordance with applicable law.

C. Resident's Rights.

- a. Right to Choose Ancillary Services Provider. Nothing in this Agreement shall be constructed to limit the right of a resident to select a different healthcare or ancillary services provider. The ancillary services provider with which Facility has a contact or is affiliated by common ownership will provide to the Resident any physician ordered ancillary services unless the Resident informs the Facility that the Resident wishes to use a provider of his or her choosing. In such a case, the Facility will work in good faith with the Resident in an effort to arrange for the provision of ancillary services by the Resident's choice of provider(s). Any provider requested by the Resident must comply with applicable state and federal laws and regulations concerning the provision of items and services to the Resident and with the Facility's rules and policies and procedures.
- b. Right to Participate in Treatment Decisions. Consistent with applicable state and federal law, the Resident has the right to (1) consent to or refuse any treatment or procedure; (2) be informed of the potential risks and consequences of and refusal of, or revocation or consent for treatment; (3) be informed of available alternative treatments, and (4) revoke, at any time, previously provided consent for treatment or procedure.
- c. Notice of Change in Resident's Condition. Upon a significant change in the Resident's condition, the Resident and/or Legal Representative will be notified, and the attending physician will be consulted. The Resident and Legal Representative agree to provide the Facility with accurate and up to date contact information for all authorized persons and to update this information as needed.
- d. Advance Directives. The Resident has a right to formulate advance directives consistent with applicable state and federal law. The Facility will not discriminate against or condition the admission or provision of care to the Resident based on whether the Resident has or has not elected to execute advance directives. The Facility shall act in accordance with the Residents advance directives, if the advance directives are legally binding under applicable state law and the Resident provides the Facility with a copy of the executed advance directives. It is the responsibility of the Resident to timely provide the Facility with copies of the Resident's advance directives for reference and incorporation into the Resident's medical record. Social Work will provide support of Advance Directive status post admission to Facility.

Initial one of the 3 columns below. Enter Date (when applicable):

ADVANCE DIRECTIVES *	EFFECTIVE DATE Noted on Paperwork	RECEIVED & PLACED IN RESIDENTS CHART (Initial)	FACILITY REPRESENTATIVE* TOLD BUT NO COPIES HAVE BEEN PROVIDED (Initial)	The Resident States that the Advance Directive has not been Executed (Initial)
Living Will; Declaration or Directive to Physicians				
Power of Attorney (Business and Financial Management)				
Durable Power of Attorney for Healthcare				
Guardian				
Do Not Resuscitate (DNR)				
MOLST/POLST				
Health Care Proxy				
Other (specify)				

*Facility Representative whose initials appear above

*Name of Facility Representative (Print Clearly)

Signature of Facility Representative

Print Title Clearly

Date

Name of Resident (Print Clearly)

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

_____ I have been provided with a blank Physician Order or Medical Order for Life-Sustaining Treatment and information regarding advance directives.

Organ Donation: Facility will provide information on Organ Donation upon request. Please feel free to contact a facility representative at any time.

***Social Work will provide support of Advance Directive status post admission to Facility.**

- e. Transfers and Discharges: The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless; (1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (2) the transfer or discharge is appropriate because the Resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (3) the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (4) the health of individuals in the facility would otherwise be endangered; (5) the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident 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; or (6) the facility ceases to operate. In such cases, the Resident has a right to written notice of the transfer or discharge and the right to appeal. Resident may be transferred or discharged if the Resident voluntarily wishes to be transferred or discharged. In any situation in which the Resident is being transferred or discharged, the Facility will work cooperatively with the Resident/Legal Representative to develop and implement a safe, appropriate, and timely discharge plan.

The Resident is entitled to at least thirty (30) days advance notice of transfer or discharge, except where the health or safety of individuals in the Facility would be endangered; the Resident's health improves sufficiently to allow a more immediate transfer or discharge; an immediate transfer or discharge is required by the Resident's urgent medical needs; or Resident has not resided in the facility for thirty (30) days and, in those situations, notice may be given as soon as practicable before the transfer or discharge.

At the end of any applicable notice period, if the Resident/Legal Representative has failed to make other appropriate arrangements for the Resident's care, the Resident/Legal Representative agrees that the Facility may discharge and deliver the Resident to the care of the Legal Representative.

In the event Resident is admitted for Rehabilitation Services and thereafter no longer requires rehabilitation only services and requires long term care placement due to his/her health condition, an intra-facility room change or transfer to a more appropriate setting may be necessary. Any such room change shall be carried out in accordance with applicable law and the Facility's policies and procedures.

- f. Request for a Bed Hold. Before the Resident may be transferred to a hospital or for a therapeutic leave, the Facility will provide a Request for Bed Hold to the Resident and a family member or Legal Representative. The Request for Bed Hold Form includes any state Medicaid bed hold requirements and information on how Medicare, Veterans' Administration and private pay Resident's may request and obtain a bed hold. Please note that our facility's ability to accept your return to our facility, even with a bed hold, is contingent upon our ability to provide the proper care for you at the time of your intended return. *See Attachment A, Request for Bed Hold, incorporated herein by reference.*
- g. Notice of Privacy Practices. The information contained in the Resident's medical record is confidential and will not be disclosed without the written authorization of the Resident or as required by law. Specific information on how the Resident's medication information may be used and/or disclosed and the Facility's responsibility to safeguard the Resident's private health information is provided in the attached Notice of Privacy Practices. By signing this Agreement, the Resident acknowledges receipt of the attached Notice of Privacy Practices and authorizes and acknowledges that the Facility may take photographs of the Resident for health care purposes and identification of the Resident within the Facility. *See Attachment C, Notice of Privacy Practices, incorporated herein by reference.*
- h. Concerns and Grievances. The Resident has the right to express concerns or grievances to the Administrator or other Facility representative without resulting in discrimination or retaliation. Upon notice of a grievance, the Facility will work to resolve the matter in accordance with the Facility's grievance policy and procedures. The resident also has the right to file a complaint with the applicable state representatives and agencies concerning resident abuse, neglect, misappropriation of the Resident's personal property of funds, and a failure to comply with applicable federal and state laws and regulations governing advance directives. *See Welcome Packet, incorporated herein by reference,* for a list of the applicable state representatives and agencies, and the representatives' and agencies' contact information. In Addition, Facility offers a Compliance Hotline (800-557-1066), which allows for anonymous and confidential reporting of compliance issues without fear of retaliation. Signs with information for contacting the Compliance Hotline are visible throughout our Facility.
- i. Facility Policies and Procedures. By signing this Agreement, the Resident agrees to comply with the Facility's established policies and procedures. The Facility will provide the Resident with a written notice of any change to the Facility's policies and procedures unless circumstances necessitate the immediate implementation of a policy or procedure or the

amendment to or revision of an existing policy or procedure, if applicable. Please contact our Director of Social Services for additional information.

- j. Tobacco Policy. The Facility is committed to providing a healthy and safe environment for our employees, residents and all others. *See reference Attachment D1 or Attachment D2 for Facility specific policy information.*
- k. Personal Belongings. The Facility will make reasonable efforts to safeguard Resident's personal property; however, there are many people who work and visit the Facility each day. For this reason, the Facility strongly discourages the keeping of valuables or cash unsecured in the Facility. Residents are encouraged to deposit valuables, such as jewelry, in a personal locked space or have a family member or trusted friend keep the valuable for safekeeping. Residents are encouraged to deposit any excess cash in the Facility's Resident Trust Account. Please see the Facility's Business Office for more information. The Facility is not responsible for the loss or damage to the Resident's personal belongings, unless required by law or the loss or damage was directly due to Facility's negligence.

I would like a key to my personal locked space

I do not require a key to my personal locked space

- l. Personal Mail. The Resident will designate whether he/she would like assistance with the opening and/or reading of personal and/or financial mail. If the Resident designates that the Resident would like assistance, the Resident understands that the Resident may revoke such a request at any time by notifying the Administrator.

D. Financial Matters.

- a. Resident Identification and Billing Information. It is imperative that upon admission, the Resident provide the Facility the information that is necessary to properly identify the Resident and for billing purposes. This information includes copies of the Resident's Medicare, Medicaid and/or private insurance cards and a form of personal identification. If the Facility is not provided with the necessary information to enable it to bill a third-party payor for its services, the Facility will bill the Resident directly.
- b. Financial Disclosure. Resident certifies that all financial information disclosed to the Facility is a true and complete statement of the Resident's financial position. Resident authorizes Facility to periodically verify this information by all reasonable means and Resident agrees to immediately notify Facility of any material changes of financial disclosures(s).
- c. Responsibility of Payment. Payment for the Resident's care is the ultimate responsibility of the Resident; however, the Legal Representative, or other individual may voluntarily agree to pay from their own personal funds for the cost of the Resident's stay at the Facility.

By signing this Agreement as the Legal Representative, you agree and understand if the Resident is eligible for Medicaid benefits, you are required by law to facilitate payment to the Facility from the Resident's monthly income that the Resident is required to contribute to his/her nursing facility care and services, referenced as the "Patient Pay Amount or NAMI (Net Available Monthly Income) As the Legal Representative, you understand and agree that if you fail to fulfill your responsibilities, you shall be held responsible for those payments. The Resident may have insurance, government benefits and/or a third-party payor source to pay or assist in the payment for the Resident's stay at the Facility and you understand and agree that those monies must be used for the Resident's stay at the Facility. The Resident is responsible for paying the Facility for any charges that are unpaid by other payor sources. In addition, the Legal Representative, if any, must utilize the income and resources of the Resident to pay the Facility for any charges that are unpaid by other payor sources.

If a Legal Representative, who has legal access to or physical control of the Resident's available income or resources, does not fulfill responsibilities required under this Agreement including those involving the Residents income and/or resources or uses such income and/or resources for purposes other than the Resident's stay at the Facility from the Resident's income and/or resources in accordance with this Agreement, the Legal Representative shall be personally responsible for payment due to the Facility. Legal Representative acknowledges that in the event of his/her failure to apply income and assets of Resident to Resident's care at Facility, he or she will be personally liable for the misappropriation or misapplication of Resident's funds or assets. Additionally, the Legal Representative is responsible to the extent that the Facility relies to its detriment on false, misleading, or incomplete information and/or documentation supplied by the Legal Representative regarding matters, including, but not limited to, the Resident's financial resources, citizenship or immigration status, and for third party insurance coverage.

- d. Personal Funds. The Resident has the right to manage his or her personal funds. If the Resident would like assistance with the managing the Resident's funds, the Facility can provide such assistance, or the Resident can designate in writing another person to manage the Resident's personal funds. Any associated costs for assistance provided by the Facility are included in the Resident's basic rate. Upon the Resident's written request, the Facility will manage the Resident funds by

depositing the funds into the Facility's Resident Trust fund account. The resident will be provided with at least quarterly statements that account for any interest earned and transactions made on behalf of the Resident. *See Attachment E1, Resident's Personal Funds, incorporated herein by reference.*

- e. Coverage/Reimbursement Disclaimer. Payment for the Resident's Care is the ultimate responsibility of the Resident and the Facility makes no guarantee that the Resident will be eligible for and covered by Medicare, Medicaid, any third-party payor or other reimbursement source. The Resident releases the Facility, its employees and any agents, from any liability or responsibility for obtaining coverage and/or subsequent payment from any reimbursement or payment source.
- f. Determination of Medicare coverage and benefits will be evaluated prior to or upon admission. Medicare does not pay for everything, even some of the care that your or your healthcare provider think you need. Our Facility will provide you with a Skilled Nursing Facility Beneficiary Notice of Non-coverage (SNFABN). Our decision is not the official Medicare decision. Our Facility will also provide you with Notice of Medicare Non-Coverage with Appeal Rights (CMS NOMNC). Please see Social Services for further information.
- g. Assignment of Benefits. The Resident acknowledges that the Facility will provide care and services for which payment may be made under Medicare, Medicaid, and/or by private insurance. By signing this Agreement, the Resident assigns to the Facility any and all rights to receive third-party payments, for care and services provided by the Facility to the Resident and authorizes the release of any information necessary to process any and all claims for payment on behalf of the Resident. *See Attachment G1, Assignment of Benefits incorporated herein by reference.*
- h. Medicare.
 1. Medicare Status. The Facility participates in the Medicare Program and is authorized to provide care and services to residents who are eligible for Medicare benefits. The Resident is considered a Medicare beneficiary if the Resident is eligible to receive benefits from the Federal Medicare Program and where required has enrolled in the applicable Medicare Program. *See Attachment G, Medicare Secondary Payor MSP Screening, incorporated herein by reference.*
 2. Limited and Expiration of Medicare Coverage. Medicare coverage limits are established by federal guidelines, not by the Facility. For Resident's transferred to the Facility within 30 days of a hospital discharge, a Resident may qualify (subject to applicable eligibility requirements) for a short-term stay. In these cases, Medicare will pay for room and board, therapies, medications prescribed by physicians, and personal laundry. The maximum stay is 100 days. If the Resident does not meet the Medicare coverage criteria, coverage will end regardless of the number of allotted days left in the current benefit period. Medicare pays 100% of the daily charges for the first 20 days. A co-payment of \$170.50 per day for 2022 is charged on day 21 through day 100. If applicable, Medicare supplemental insurance may cover payment of the co-payments. Upon the expiration of Medicare benefits, the Resident may remain in the Facility if arrangements for timely payments are in place. The private pay provisions provided below apply if the Resident elects to stay at the Facility as a private pay Resident.
 3. Daily Rate. *See Welcome Packet, incorporated herein by reference,* for a detailed list of items and services which are covered under Medicare and included in the daily rate. Also included in the list are non-covered items and services for which Medicare beneficiaries who request such items or services will be separately billed.
 4. Coinsurance and Deductibles; Payment Policy. A Medicare beneficiary is at all times responsible for the payment of any Medicare coinsurance and/or deductibles. The Facility's Business Office can provide information as to when payment is due for any coinsurance and/or deductibles. The Facility is responsible for billing Medicare for all but expressly excluded services. The Resident should consult with the Facility's Business Office before obtaining any services outside of the Facility. This consultation is also necessary, so the Facility can effectively supervise and coordinate the Resident's care.
- i. Medicaid.
 1. Medicaid Status Eligibility. The Resident is considered a Medicaid beneficiary if the Resident receives benefits from a state Medicaid Program. Eligibility for Medicaid assistance is determined by applicable state law and is based on the Resident's financial resources. The Facility does participate in the Medicaid program and has a provider agreement with the state. If Resident is admitted to the facility as Private Pay, the Resident/Legal Representative are responsible for contacting the facility's Business Office six (6) months in advance of anticipated application for Medicaid. If Resident is Medicaid eligible at time of admission, the Resident/Legal Representative agree to apply immediately for Medicaid. In addition Resident/Legal Representative must notify the Business Office of the Date the Financial Medicaid application process was initiated. The Resident/Legal Representative agree to timely inform the facility of the status of the eligibility process, denials, approvals, appeals and information requests, if they have filed an application prior to admission.

2. Payment Pending Medicaid Eligibility. If the Resident has applied for Medicaid, the Resident agrees that 1) the Resident is privately responsible for the Facility's charges (subject to applicable state law) pending a determination as to the Resident's eligibility and 2) the private pay provisions provided below apply. Whether or not the Resident is covered by Medicaid, the Resident remains responsible for applicable deductible and coinsurance amounts, as well as non-covered costs. The Resident may pay for such costs from Social Security funds, pension plans and assets, and accounts held with banking institutions.
3. Transition of Resident from Private-Pay Status to Medicaid Eligibility. If the Resident pays for an item or service as a private-pay resident, but the Medicaid program later determines that during the at time the Resident was eligible for Medicaid payment for that item or service, the Facility shall refund the private payment to the Resident within a reasonable time after being notified on the Resident's eligibility for Medicaid payment for that item or service.
4. Shared Cost; Payment Policy: Medicaid residents are at all times responsible for the payment of any monthly share of costs as determined by the Medicaid program. The Facility's Business Office can provide information as to when payment is due for shared costs.
5. Asset Attestation; Responsibility. The Legal Representative who is or will be applying for Medicaid Benefits and, as such, hereby attests, agrees and accepts full responsibility for the accuracy, current status and efforts to be made on behalf of the Resident as follows:
 - (1) Within the previous five (5) years, the Resident has not transferred any assets (i.e. cash, securities, real estate, insurance policies etc., as defined in the applicable Medicaid Regulations) to me or, to my knowledge, to anyone else or to any Trust.
 - (2) To diligently and expeditiously apply for and pursue Medicaid benefits for the Resident (now and annually thereafter), and in any event, no later than thirty (30) days after eligibility has been determined, and to promptly and expeditiously respond to any and all requests and inquiries from any source made in connection with such application, all within the prescribed time frames, and to continue to do so for as long as such Medicaid benefits are available to pay for charges incurred by the Resident at the Facility, whether or not the Resident is deceased.

j. Private Pay.

1. Private Pay Status: The Resident is considered a private pay Resident when there is no government or managed care program paying for the Resident's stay at the Facility and the services provided to the Resident by the Facility are paid from the Resident's personal funds, by private insurance or a third-party payor.
2. Daily Rates. The Facility's private pay daily rate is based on the type of room assigned to and the level of care required by the resident. *See Attachment 1, Welcome Packet, incorporated herein by reference,* and the Facility's Business Office for the private pay daily room fees.
3. Payment Policy. A security deposit in the amount of one month's payment, and the first month's payment, are required on the day of Admission and billed monthly thereafter. This deposit will be held in an interest-bearing account and may be applied to outstanding balances with Resident and /or Legal Representative. If the Resident is private pay and is discharged before the end of the month the Resident's account will be reconciled and any outstanding debts owed to the Facility will be deducted from the remaining balance. Any amount remaining after deducting what is owed to the Facility will be refunded to the Resident within thirty (30) days of the date of the Resident's discharge or as required by applicable state law. Fees not paid when due shall be late-payments and shall be subject to delinquency charges in the amount of 1.5% per month. All overpayments will be refunded in accordance with applicable law. In the event of non-payment or default, the Resident agrees to pay attorney's fees, or any other costs/penalties incurred in collecting payment for Facility care and services provided for the Resident.
4. Notice When Leaving Facility. The Resident may leave the Facility at any time; however, for payment purposes the Resident is required to provide at least forty-eight (48) hours advance notice and the Facility may charge the Resident for one day if this advance notice is not given to the Facility.
5. Daily Rate Adjustments. The Facility may, at some time, need to increase the daily rate or optional services charges. If such an increase is to occur, the Facility will provide private pay residents with not less than forty-five (45) days advance written notice of the rate adjustments, or as required by applicable state law. If a change in the Resident's level of care warrants an increase or decrease in the daily rate to reflect the Resident's new level of care, the Facility may adjust the daily rate without prior notice. Any rate adjustment shall be considered as agreed to by the parties on the date the notice is mailed.

6. Notification of Charge in Assets or Coverage. The Resident, if private pay, is responsible to inform the Facility of any change in the Resident's assets and resources or coverage as soon as reasonably possible so any needed arrangements may be made to ensure timely payment is made to the Facility.
7. Application for Medicaid. The Resident agrees to provide to the Facility, upon request, financial information on available assets and/or resources. When the Resident's available income and resources are within the limits that would qualify the resident for Medicaid under applicable state regulations, the Resident/Legal Representative agree to initiate the Medicaid process. The Resident/Legal Representative agree to timely inform the Facility of the status of the eligibility process, denials, approvals, appeals and information requests, if these have filed an application prior to admission and/or after admission. The Resident/Legal Representative further agree to pursue obtaining Medicaid coverage and to keep the Facility informed as to the status of the application process. If the Resident is denied Medicaid coverage, upon request, the Resident agrees to assign to the Facility the Resident's right to appeal the determination and to assist the Facility, to the degree possible, with pursuing appeal of the denial determination as warranted. The designated Financial Coordinator and/or Legal Representative for the Resident is responsible for all appeals paperwork. Facility will assist if requested.
8. Private Health Insurance. In some cases, the Facility may accept the Resident's private health insurance and whether or not the payment by the Resident's plan represents full payment to the Facility depends upon the coverage and benefits offered by the plan and the Facility's participation agreement with the plan. The Resident remains primarily responsible for the payment of the Facility's charges. Any and all charges that are not covered by the Resident's private health insurance are the responsibility of the Resident. These charges include any coinsurance and/or deductible amounts and charges for any non-covered items or services.
9. Optional/Covered items and Services. Items and services that are covered by a third-party payor, such as Medicare, Medicaid or private insurance, and items and services that are considered optional and, therefore, not covered by a third-party payor may vary based on the payor source. The Facility may not charge the Resident for any items or services for which payment is made under Medicare or Medicaid (except for applicable deductible and coinsurance amounts). The Facility may charge the Resident for requested items and services that are more expensive than, or in excess of, covered services for items or services requested by the Resident that are not covered or paid for by Medicare, Medicaid, or other third-party payor and for which the Facility has provided advance written notice of the amount to be charged. The Facility will provide the Resident with not less than thirty (30) days advance written notice of any change in the charges for items and services that the Resident has requested, which are not covered under Medicare, Medicaid or other third-party payor or as required by applicable state law. *Please see Welcome Packet, incorporated herein by reference*, for a list of covered items and services, based on payor source, which are included in the daily rate and which are not covered by a payor source and for which the Resident will be separately billed. All ancillary charges are the responsibility of the resident. A price list for all ancillary charges is available for review in the Facility's Business Office, and/or the Facility's Business Office is available to answer any questions regarding all financial matters.

E. Additional Provisions.

- a. Independent Contractor Status. Non-Facility employed healthcare and service providers who provide services to Residents of the Facility are independent contractors and not employees of the Facility, and the Facility does not assume responsibility for the acts and/or omissions of these providers or their designees.
- b. Continuation of This Agreement. Temporary transfer of the Resident to another healthcare facility for medical or surgical treatment, or the Resident's authorized temporary absence from the Facility for any other purpose shall not automatically terminate this Agreement. Upon the Resident's return and re-admission, this agreement shall continue in full force and effect.
- c. Nondiscrimination. Neither party shall discriminate against any individual, to include residents, employees and independent contractors, on the basis of race, color, sex, gender, age, religion, national origin, sexual orientation, pregnancy, marital status, military or veteran status, disability or any other basis under this Agreement. At all times, the Facility shall act in accordance with applicable federal, state, and local laws.
- d. Governing law; Amendment. Any disputes concerning this Agreement, or the services provided pursuant to this Agreement shall be governed by the Alternate Dispute Resolution Agreement and laws of New York. The Facility reserves the right to amend this Agreement from time to time as needed to comply with applicable state and federal laws and regulations.
- e. Assignability. This Agreement is fully assignable by Facility at its option in the event that the Facility is sold and/or the license is transferred such that a new licensee operates Facility.

- f. Entire Agreement; Headings and Severability. This Agreement and the attachments to this Agreement constitute the entire Agreement and understanding between the Resident and Facility with respect to matters addressed in this Agreement and no oral representations which are not stated in the Agreement have been relied upon by either party. The headings of this Agreement are inserted for convenience only and are not to be considered in the interpretation of this Agreement. In the event any provision of this Agreement is deemed to be invalid or unenforceable, such a determination shall not affect the validity or enforceability of the remaining provisions of this Agreement.
- g. Termination of Agreement. The Resident and/or Legal Representative may terminate this Agreement by providing at least forty-eight (48) hours written notice to the Facility of intent to terminate Agreement. This Agreement will remain in effect until Resident has vacated the Facility or the date a new Agreement between the parties is executed. If Resident and/ or Legal Representative terminates Agreement by vacating Facility, this does not relieve the Resident and/or Legal Representative from liability of any sums due and owing pursuant to this Agreement.
- h. Effective Date. The effective date of this Agreement is the date of the Resident's initial admission to the Facility. This Agreement will remain in effect during the following any temporary absence by the Resident from the Facility (including but not limited to absence due to hospitalization or home leave).
- i. Good Faith Effort. The execution of this Agreement will constitute an acceptance on the part of the Facility, the Resident/Legal Representative to undertake faithfully all of the obligations of this Agreement and all of its attachments, incorporated by reference.
- j. Grievance Procedure. Should the Resident/Legal Representative feel a need to voice grievances concerning Resident abuse, neglect, misappropriation of the Resident's personal property or funds, and a failure to comply with applicable federal and state laws and regulations governing advance directives, recommend changes in policies or services or report discrimination, the Facility recommends bringing the problem to the attention of the Administrator and/or Facility Designee. See the Director of Social Services and/or *Welcome Packet, incorporated by reference*, for a list of federal and state agencies that may be contacted regarding the grievance.
- k. Medicare and Medicaid Govern. If the Resident is deemed eligible for Medicare benefits or Medicaid assistance, the laws and regulations governing those programs will control this Agreement.
- l. Non-waiver. If any party to this Agreement at any time elects not to require compliance with a particular term of this agreement, this election shall not be construed as a waiver of that party's right to require compliance with that or any other provision at any future time.
- m. Leaves of Absence. The Facility and its owners, directors, officers and employees assume no responsibility for any personal injury, illness, or deterioration in the Resident's condition that may occur when the Resident is temporarily absent from the Facility with or without physician or facility approval. The Resident/Legal Representative release the Facility, its owners, directors, officers and employees from all liability for any personal injury, illness or deterioration in the Resident's condition that may occur while the Resident is temporarily absent from the Facility.
- n. Alternate Dispute Resolution. *Attachment K is an Alternative Dispute Resolution Agreement incorporated by reference herein*, that if voluntarily entered into by the Resident and Facility, provides an alternative means to dispute resolution. Executing the Alternative Dispute Resolution Agreement is not a precondition for either treatment or admission to the Facility.
- o. Disputed Related Costs. In the event of any dispute, including but not limited to litigation arising from, or related to, any aspect of this Agreement or the services provided under this Agreement, the facility shall be entitled to recover from the Resident/Legal Representative all reasonable costs incurred including, but not limited to, court costs, attorney's fees, and all other reasonably related expenses incurred in such dispute.

Admissions Agreement Signature Page

This Agreement and its Attachments, including but not limited to a Consent for Treatment, Alternative Dispute Resolution Agreement and Assignment of Benefits, indicated above, which are incorporated by reference, are legally binding on all parties. It should be read carefully and understood before signing. By signing below, the undersigned consents to be legally bound by this Agreement and acknowledges that, in advance of signing, the undersigned read the Agreement, any questions asked regarding the Agreement were adequately answered, and after the parties signed the Agreement, the undersigned received a complete copy of the executed Agreement.

I also certify that my signature in this Agreement and its Attachments, whether by my name a mark _____, a symbol _____, or my initials, _____ represents my present intention to authenticate this Agreement.

IN WITNESS WHEREOF, the parties hereto have signed their names, marks, symbols or initials to the Agreement and Attachments, on (date)_____.

Name of Resident (Print Clearly)	Signature of Resident
---	------------------------------

(Two witnesses if Resident signs with a mark such as an "X", a symbol or initials)

Witness (1)

Witness (2)

Name of Legal Representative (Print Clearly)

Signature of Legal Representative

Relationship of Resident to Legal Representative:

Phone Number (1): _____

Phone Number (2): _____

Legal Representative's Email Address:

Legal Authority to use the Resident's Income/Resource – Check one:

- Financial Power-of Attorney
- Guardian/Conservator of the Estate
- Individual has Access to Resident's funds; however, does not have a POA or Guardianship / Conservatorship

Acknowledgments

By signing this Agreement with all Attachments, which are incorporated by reference, and by initialing below next to each Attachment, the Resident acknowledges and certifies that the Facility has provided information to the Resident verbally and in writing in a language the Resident understands.

- ____ Attachment A, Request for a Bed Hold;
- ____ Attachment B, Consent to Admission and Treatment;
- ____ Attachment C, Notice of Privacy Practices
- ____ Attachment D1 or D2, Smoking Policy;
- ____ Attachment E1, Management of Resident’s Personal Funds;
- ____ Attachment E2, Resident Fund Management Service;
- ____ Attachment F1, Assignment of Benefits;
- ____ Attachment F2, Social Security and/or SSI Payments;
- ____ Attachment G, Medicare Secondary Payor (MSP) Screening;
- ____ Attachment H, Consent to Photograph/Publish;
- ____ Attachment I, Consent to Student Care and Treatment
- ____ Attachment J, Personal Recording Device Policy;
- ____ Attachment K, Alternative Dispute Resolution Agreement;
- ____ Attachment L, Transportation Services;
- ____ Attachment M, Insurance Coverage / Financial Responsibility
- ____ Attachment 1, Welcome Packet;
- ____ Attachment 2, Influenza Vaccine & Pneumococcal Vaccines
- ____ Attachment 3, Resident Rights – Federal;
- ____ Attachment 4, Resident Rights – New York;
- ____ Attachment 5, State Guide to Nursing Care;
- ____ Attachment 6, Non-Discrimination Requirements

**Attachment A
Bed Hold Policy and Notification**

It is our policy to inform residents/Legal Representatives upon admission and after leaving the facility for hospitalization, observation or therapeutic leave of our Request for Bed Hold Form and Notification.

For Residents 21 years of age and older, Medicaid will NOT pay to hold the bed at this facility while the Resident is in the hospital.

Private Pay Residents may elect to hold the bed for an unlimited number of days. Payment is due within 24 hours of electing the private bed hold at the regular daily rate of \$_____per day.

Third Party Payors do not cover any type of hospital, observation or therapeutic leave. A Resident and/or Legal Representative may elect to pay for the bed hold at the established daily rate of \$_____per day.

Medicare A and Medicare Replacement Policies do not cover any type of hospital, observation or therapeutic leave. A Resident and/or Legal Representative may elect to pay for the bed hold at the established daily rate of \$_____per day.

**Please reference New York Department of Health Letter dated July 2019 for final guidance. 18 NYCCR § 505.9(d)(5)*

My signature below acknowledges that I have been provided with **a copy of the New York Bed Hold Policy:**

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility's Authorized Agent

Signature of Facility's Authorized Agent

Date: _____

Attachment B

Consent to Admission and Treatment

The Resident, _____ voluntarily consents to be admitted to the Facility and understands and agrees to the following:

- A. Attending Physician. By execution of this Agreement, the Resident agrees to be admitted to the Facility and while residing in the Facility to be under the care and treatment of an attending physician of the Resident's choosing who is licensed in the state in which the Facility is located. The attending physician selected by the Resident must act in accordance with applicable state and federal rules and regulations, and the Facility's rules and policies and procedures.
 - a. Independent Contractors – In some circumstances, an Attending physician may not be an employee of the Facility, and the Facility does not assume responsibility for the acts and/or omissions of the attending physician, or designees of the attending physicians, who provide services to residents of the Facility
- B. Physicians' Fees. The Facility is not responsible for paying for the services of the attending physician or the Attending Physician's Designee. The Resident is responsible for obtaining information regarding the Resident's attending physician's fees and for the payment of these fees.
- C. Medical Treatment. The Facility may contact the Resident's attending physician or designee as medically necessary in an effort to meet the Resident's care needs. The Resident consents to admission to the Facility, and, pursuant to the Resident's attending physician's orders, authorizes medically necessary routine nursing and other services and, as applicable, emergency care. The Resident, however, has the legal right to refuse at any time any treatment and to be informed of the consequences of refusing such treatment. The Resident acknowledges that the duty to inform the Resident of the risks associated with any proposed treatment, which is neither routine nor in response to an emergency, is that of the Resident's attending physician or attending physician's designee.
- D. TeleHealth Provider. The Facility may be contracted with a TeleHealth Provider, which involves the use of electronic communications to enable healthcare providers at different locations to share individual patient information for the purpose of improving patient care.
- E. Resident hereby consents to admission to the Facility and consents to the Facility providing routine nursing and other health care services, including, but not limited to, accepted medical procedures, diagnostic tests, administration of medications and x-rays, as directed by the attending physician. The Resident has the right to select his/her own attending medical physician. If, however, the Resident does not select an attending physician, or is unable to select an attending physician, an attending physician may be designated by the Facility.

IN WITNESS WHEREOF, the parties hereto have signed their names, marks, symbols or initials, on the dates indicated below.

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility's Authorized Agent

Signature of Facility's Authorized Agent

Date: _____

Attachment C
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer,

Lalita Dougal at 718-960-3913.

Protected Health Information (“PHI”) is information about you, including demographic, financial, and health information, that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

The Privacy Rule, a Federal law, gives you rights over your PHI and sets rules and limits as to who can look at and/or receive your PHI. The Privacy Rule applies to all forms of individuals’ PHI, whether electronic, written or oral. The Security Rule is a federal law that requires security for PHI in electronic form. This Notice of Privacy Practices describes how we may use or disclose your PHI to carry out treatment, payment or health care operations, as well as other purposes permitted or required by law.

Facility Name (“our Facility/Company”) is required by law to maintain the privacy of your PHI and provide you with this Notice of Privacy Practices, so that you understand our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the current Notice of Privacy Practices.

We reserve the right to change the terms of this Notice of Privacy Practices, at which time, the provisions of the newer Notice of Privacy Practices will be effective for all PHI that we maintain. If this Notice of Privacy Practices is revised at any time, we will provide all individuals with a revised copy, in accordance with the Privacy Rule.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time we provide care to you, a record is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information:

- to plan your care and treatment
- to communicate with other health professionals involved in your care
- to document the care you receive
- to educate health professionals
- to provide information for medical research
- to provide information to public health officials
- to evaluate and improve the care we provide
- to obtain payment for the care we provide
- for administrative purposes

Understanding what is in your record and how your PHI is used helps you to:

- ensure it is accurate
- better understand who may access your PHI
- make more informed decisions when authorizing disclosure to other

USES AND DISCLOSURES OF YOUR PHI THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT

The following are examples of ways that we may use and/or disclose PHI. These examples are not meant to be exhaustive, but instead describe different types of permissible uses and disclosures that may be made by us.

- For Treatment. We may use or disclose PHI about you to provide you with medical treatment. We may disclose PHI about you to doctors, nurses, therapists or other between **Bronx Gardens Rehabilitation and Nursing Center** personnel and/or vendors who are involved in taking care of you at our Facility. We may also use or disclose PHI about you in order to coordinate your care and provide you medication, lab work and x-rays. We may also disclose PHI about you to people

outside our

Facility who may be involved in providing medical care to you. For example, we would disclose your PHI, as necessary, to a home health agency that provides care for you in your home.

- For Payment. We may use and disclose PHI about you so that the treatment and services you receive may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- For Health Care Operations. We may use and disclose PHI about you for our day-to-day health care operations. This is necessary to ensure that you receive quality care. For example, we may use PHI for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine PHI about many residents to help determine what additional services we should offer, what services should be discontinued, and whether certain new treatments are effective. PHI about you may be used for business development and planning, cost management analyses, insurance claims management, risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your PHI include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your PHI may be used and disclosed for the business management and general activities of our Facility including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of our Facility. In limited circumstances, we may disclose your PHI to another health care provider subject to HIPAA for its own health care operations. We may remove information that identifies you so that the PHI may be used to study health care and health care delivery without learning your identity.
- Business Associates. There are some services that we provide through contracts with business associates. Examples include but are not limited to attorneys, accountant's pharmacy consultants and a copy service we use when making copies of your record. When these services are contracted, we may disclose your PHI so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your PHI, federal law requires that business associates appropriately safeguard your information.
- Providers. Many services provided to you, as part of your care at between **Bronx Gardens Rehabilitation and Nursing Center**, are offered by participants in one of our organized healthcare arrangements. These participants may include a variety of providers such as physicians, therapists, portable radiology units, clinical labs, hospice caregivers, pharmacies, psychologists, social workers and suppliers.
- As Required by Law. We will disclose PHI about you when required to do so by federal, state or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.
- Public Health. We may use and disclose PHI about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We may disclose your PHI for public health activities, to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.
- Organ and Tissue Donation. If you are an organ donor, we may disclose PHI to organizations that handle organ procurement to facilitate donation and transplantation.
- Risk of Contracting a Communicable Disease. We may use or disclose PHI about you if you may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, so long as we are authorized by law to notify you as necessary in the conduct of a public health intervention or investigation.
- Military and Veterans. If you are a member of the armed forces, we may disclose PHI (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; and/or (3) to foreign military authorities if you are a member of that foreign military service.
- Research. Under certain circumstances, we may use and disclose PHI about you for research purposes. For example, a research project may involve comparing the health and recovery of all residents who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with residents' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process. We may, however, disclose PHI about you to people preparing to conduct a research project so long as the PHI they review does not leave our Facility.

- Workers' Compensation. We may disclose PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- Reporting Abuse, Neglect or Domestic Violence. We may disclose your PHI to an appropriate government agency if we believe you may have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- Criminal Activity. We may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to health or safety of you, another person or the public. We may also disclosure PHI if it is necessary for law enforcement officials to identify or apprehend an individual.
- Legal Proceedings. If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement. We may disclose PHI when requested by a law enforcement official:
 1. In response to a court order, subpoena, warrant, summons or similar process, or otherwise as required by law;
 2. To identify or locate a suspect, fugitive, material witness, or missing person;
 3. About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
 4. About a death we believe may be the result of criminal conduct;
 5. About criminal conduct at our Facility;
 6. In emergency circumstances to report a crime; the location of the crime or victims; and/or the identity, description or location of the person who committed the crime; and
 7. Where there is a medical emergency (not on our Facility's premises) and it is likely that a crime has occurred.
- Coroners, Medical Examiners and Funeral Directors. We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to funeral directors as necessary to carry out their duties, as authorized by law.
- National Security and Intelligence Activities. We may disclose PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- Food and Drug Administration. We may disclose PHI to a person or company required by the Food and Drug Administration ("FDA") for the purpose of quality, safety or effectiveness of FDA-regulated products or activities including, without limitation, to report adverse events, product defects or problems, or biologic product deviations; to track products; to enable product recalls; to make repairs or replacement; or to conduct post marketing surveillance, as required.

USES AND DISCLOSURES THAT REQUIRE PROVIDING YOU THE OPPORTUNITY TO AGREE OR OBJECT

- Treatment Alternatives. We may use and disclose PHI to tell you about possible treatment options or alternatives that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.
- Health-Related Benefits and Services and Reminders. We may contact you to provide appointment reminders. You may contact our Privacy Officer to request that these communications not be made.
- Fundraising Activities. We may use your demographic information and the dates that you received treatment, as necessary, in order to contact you as part of a fundraising effort. You may contact our Privacy Officer to request that these materials not be sent to you.
- Facility Directory. We may include information about you in between **Bronx Gardens Rehabilitation and Nursing Center** directory while you are a resident. This information may include your name and location in between **Bronx Gardens Rehabilitation and Nursing Center**. The directory information, except for your religion, may be disclosed to people who ask for you by name. Your religion may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This

enables your family, friends and clergy to visit you in between **Bronx Gardens Rehabilitation and Nursing Center** and generally know how you are doing.

- Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose PHI about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose PHI about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

USES AND DISCLOSURES OF PHI BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke your written authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your authorization.

- Uses and Disclosures of Psychotherapy Notes. Psychotherapy notes are notes (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and a summary of the following: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes will not be used or disclosed without a valid, written authorization, except in the following circumstances:
 1. Use by the originator of the psychotherapy notes for treatment;
 2. Use or disclosure by between **Bronx Gardens Rehabilitation and Nursing Center** for its own training programs in which students, trainees, or practitioners in mental health learn, under supervision, to practice or improve their skills in group, joint, family, or individual counseling; or
 3. Use or disclosure by between **Bronx Gardens Rehabilitation and Nursing Center** to defend itself in a legal action or other proceeding brought by the resident; and
 4. A use or disclosure that is required by or permitted by the applicable regulations with respect to the oversight of the originator of the psychotherapy notes.
- Marketing. If we use PHI to make a communication about a product or service, with the purpose of encouraging recipients of the communication to purchase or use the product or service, we must first obtain valid, written authorization. Marketing does not include communications in the form of face to face communications between us and you or a promotional gift of nominal value provided by us. Such authorization will state that the disclosure will result in remuneration to us, if applicable.
- Disclosures that Constitute a Sale of PHI. We must receive your valid, written authorization for any disclosure of your PHI that constitutes a sale. Such authorization will state that the disclosure will result in remuneration to us.
- Other Uses and Disclosures not covered in this Notice of Privacy Practices, which are not otherwise permitted by the Privacy Rule.

YOUR RIGHTS REGARDING YOUR PHI

Although your health record is between **Bronx Gardens Rehabilitation and Nursing Center** property, the information belongs to you. You have the following rights regarding your PHI:

- Right to Inspect and Copy. With some exceptions, you have the right to review and copy your PHI.

You must submit your request in writing to our Privacy Officer. We may charge a fee for the costs of copying, mailing, etc. associated with your request.

You may not be permitted to inspect or copy the following: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; or laboratory results that are subject to law that prohibits access to PHI.

Depending on the circumstances, a decision to deny access to these records may be reviewed. Please contact our Privacy Officer if you have questions about access to your medical records.

- Right to Amend. If you feel that PHI in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for between **Bronx Gardens Rehabilitation and Nursing Center**.

You must submit your request in writing, along with a reason for your request, to our Privacy Officer.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
 2. Is not part of the PHI kept by or for between **Bronx Gardens Rehabilitation and Nursing Center**; or
 3. Is accurate and complete.
 4. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your PHI, other than those made for purposes of treatment, payment, or health care operations.

You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than six (6) years from the date the request is submitted and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you, including information used or disclosed for the purposes of treatment, payment or health care operations. You may also request that your PHI not be disclosed to family members or friends who may be involved in your care.

You must submit your request in writing to our Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

We are not required to agree to your request, unless the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and the PHI pertains solely to a health care item or service for which you, or a person other than the health plan on behalf of the individual, has paid the covered entity in full.

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- Right to Request Confidential and/or Alternate Communications. You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box. We will not request an explanation from you as to the basis for the request.

You must submit your request in writing to our Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time. Additionally, you have the right to receive a copy of this Notice when between **Bronx Gardens Rehabilitation and Nursing Center** seeks additional consent.

To obtain a paper copy of this Notice, please contact our Privacy Officer.

- Right to a Revised Copy of this Notice. You have the right to receive a copy of this Notice upon request when it is revised on or after the effective date of its revision. Additionally, the revised Notice will be posted in a clear and prominent location.
- Right to be Notified Following a Breach of Unsecured PHI. If there is a breach to your PHI, you will be notified within a reasonable amount of time, as required by law.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our Facility and on our website, if any. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to

this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting our Privacy Officer.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Bronx Gardens Rehabilitation and Nursing Center or with the Secretary of the Department of Health and Human Services. To file a complaint with Bronx Gardens Rehabilitation and Nursing Center, contact our Privacy Officer. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint.

You may contact our Privacy Officer, _____ at _____, for further information about the complaint process.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Resident Name: _____

Medical Record No: _____

Facility Name: Bronx Gardens Rehabilitation and Nursing Center

Facility Address: 2175 Quarry Rd Bronx, NY 10457

I have been given a copy of Bronx Gardens Rehabilitation and Nursing Center Notice of Privacy Practices (“Notice”), which describes how my PHI is used and shared. I understand that Bronx Gardens Rehabilitation and Nursing Center has the right to change this Notice at any time. I may obtain a current copy by contacting Bronx Gardens Rehabilitation and Nursing Center’s Privacy Officer, or by visiting their website, if any.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility’s Authorized Agent

Signature of Facility’s Authorized Agent

Date: _____

Rehabilitation and Healthcare Authorization Form

I authorize the use/disclosure of health information about me to the following friend, family member or personal representative:

1. Person(s) or class of persons authorized to use/disclose the information:

a. _____ Relationship to Resident _____

Phone/Email: _____

b. _____ Relationship to Resident _____

Phone/Email: _____

c. _____ Relationship to Resident _____

Phone/Email: _____

d. _____ Relationship to Resident _____

Phone/Email: _____

2. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

3. I understand that I may revoke this authorization in writing at any time by signing the Revocation or Authorization except to the extent that action has been taken in reliance on this authorization. This authorization expires _____ [insert applicable date or event].

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility's Authorized Agent

Signature of Facility's Authorized Agent

Date: _____

**Attachment D1
Tobacco-Free Environment Policy**

1. Policy. Facility prohibits the use of tobacco and tobacco products by employees, contractors, volunteers, Residents, visitors and others entering our healthcare facility premises such as any agencies contracting with the Facility.
2. Rationale. Facility recognizes tobacco and tobacco smoke pose a significant health threat to anyone exposed to them.

Definitions: Tobacco and Tobacco Products

Any tobacco-containing or smoking product, including cigarettes, cigars, pipes, chewing tobacco, smokeless tobacco and e-cigarettes.

3. Facility Premises. Property leased or owned by the Facility including all buildings, sheds and other structures on Facility owned or leased property parking lots, including vehicles parked on Facility owned or leased parking lots or property. There will be no designated smoking areas on Facility premises unless specifically identified for the use of Resident admitted to the facility before the implementation of the Tobacco-Free Environment Policy.

Tobacco-Free Environment Policy Acknowledgement

Facility is committed to providing a healthy and safe environment for our employees, Residents and all others. Facility is a tobacco free facility.

I understand and agree to enter a tobacco free Facility where I will not be allowed to use smoking or any other tobacco products as defined in the Tobacco-Free Facility Policy.

IN WITNESS WHEREOF, the parties hereto have signed their names, marks, symbols or initials, on the dates indicated below.

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility's Authorized Agent

Signature of Facility's Authorized Agent

Date: _____

**Attachment D2
Tobacco-Restrictive Policy Acknowledgement**

Policy. It is the policy of the Facility to discourage any smoking in the facility. However, we are also understanding of the fact that as a skilled nursing and rehabilitation facility, some of our residents may choose to smoke. Therefore, the facility will designate an outside smoking area to accommodate the request of those individuals.

Purpose. The purpose of restricting the smoking in the facility is to reduce the effect of smoking to residents who do not smoke, including possible adverse effects on treatment, to reduce the risk of passive smoke, and to, reduce the risk of fire.

Procedure. Every resident who smokes will be assessed for safety.

- Staff will dispense the resident’s cigarettes, light the cigarette, and stay with the resident until the cigarette is properly extinguished.
- Family members or other responsible people may stay with the resident if they agree to.
- All residents smoke with supervision and will do so only in the designated area.
- All cigarettes, lighters and any other smoking materials will be kept at the nurses’ station
- A current list of smokers will be kept at the nurses’ station.
- Residents who choose to smoke will have it addressed on their individual plan of care.
- Residents who choose to smoke will be taken to the designated smoking area at **Bronx Gardens Rehabilitation and Nursing Center** by the facility staff.
- Residents may smoke outside in the designated smoking area on the back patio. Safety aprons are required if resident fails the smoking assessments.
- All employees, residents, and visitors are prohibited from smoking anywhere in the facility. Smoking is to take place in designated smoking areas.

I have read and agree to the above Tobacco-Restrictive Policy. I understand that failure to abide by these rules can result in the termination of my smoking privileges and/or discharge from the Facility.

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility’s Authorized Agent

Signature of Facility’s Authorized Agent

Date: _____

Attachment E1
Resident's Personal Funds Authorization

Personal Funds – Your Rights

You have the right to select how your personal funds will be handled. You may choose:

- A. To manage your personal funds yourself.
- B. To designate in writing another person to do this for you.
- C. You can give the facility written permission to hold, safeguard, manage and account for your personal funds on deposit. The facility is obligated to do this at **no additional charge. The facility cannot require that you select this alternative.** If you do selection see this, see the Accounting for Personal funds section below:

Personal Funds Management

The Resident has the right to manage his or her personal funds. The Facility does not require Residents to deposit their personal funds with the Facility; however, if the Resident authorizes the Facility to manage the Resident's personal funds, the Facility will manage the funds as follows:

- 1. Amounts over \$50.00 are deposit in an interest-bearing account. Interest earned is credited to the resident's account. This account is separate from the facility's operating accounts.
- 2. Amounts under \$50.00 are kept in a noninterest-bearing account or a petty cash fund.
- 3. The Facility will maintain a separate accounting of the Resident's funds that assures a full and complete and separate accounting, in accordance with generally accepted accounting principles. The Facility's system of managing the Resident's funds precludes any commingling of the Resident's funds with Facility funds or with the funds of any person other than the Resident.
- 4. The Facility will provide the Resident with at least quarterly account statements that provide an accounting of any transactions made on the Resident's behalf.
- 5. If the Resident receives Medicaid benefits, the Facility will notify the Resident when the amount in the Resident's account reaches \$200 less than the social security income ("SSP) resource limit for one person and that if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.
- 6. Upon the death of a resident with personal funds deposited with the Facility, the Facility will convey within thirty (30) days the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the Resident's estate.
- 7. The Facility has purchased a surety bond, or otherwise provided assurance satisfactory to the Secretary of the Department of Health and Human Services, to assure the security of all personal funds of residents deposited with the Facility.
- 8. The Facility does not charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts).

By initialing the applicable box below, the Resident:

- Authorizes the Facility's Administrator (NHA) or designee to endorse and deposit any Social Security checks or other checks made payable to the Resident or any cash received from or on behalf of the Resident into the Facility's resident personal funds account.
- Authorizes the NHA or designee to make disbursements from the money deposited into the resident personal funds account on behalf of the Resident and to pay any outstanding balance and/or Resident authorized charges for items and/or services provided to the Resident during the Resident's stay at the Facility. The spending limit for personal items and/or services per resident withdrawal, if applicable, is _____.
- Prohibits the NHA or designee from making any disbursements from the money deposited into the resident personal funds account on behalf of the Resident.
- Prohibits the Facility's NHA or designee to endorse and deposit any Social Security checks or other checks made payable to the Resident or any cash received from or on behalf of the Resident into the Facility's resident personal funds account.
- Resident declines assistance with the management of Resident's personal funds. IN WITNESS WHEREOF, the parties hereto have signed their names, marks, symbols or initials, on the dates indicated below.

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility's Authorized Agent

Signature of Facility's Authorized Agent

Date: _____

**Attachment E2
Resident Fund Management Service**

AUTHORIZATION AND AGREEMENT TO MANAGE RESIDENT FUNDS

Resident Name: _____ Social Security No. _____

Facility Name: **Bronx Gardens Rehabilitation and Nursing Center**
Resident ID: _____

If different than Facility's address, statement address: _____

CHECK AN ACCOUNT TYPE:

1. RESIDENT FUND ACCOUNT.

- Non-transferring Account (no automatic transfer of deposits to pay for care cost).
- Transferring Account (automatic transfer of payments for care due to the Facility) with
\$ _____ Monthly Allowance Amount.

2. BURIAL ACCOUNT (deposit only account - monies to be used for burial expenses only).

- Revocable (may be closed prior to death).
- Irrevocable (to be closed upon death, if the Resident transfers from Facility or money is transferred to a different burial account).
- Non-interest-bearing burial account (interest will be paid if this item is NOT checked).

3. DIRECT DEPOSIT: Please enroll Resident's indicated recurring benefit payments for direct deposit.

Social Security	Supplemental Security Income	Veterans Administration
Civil Service	Railroad Retirement	Miners Benefit/Blank Lung

Note: Enter the direct deposit information or complete the appropriate direct deposit form (Direct Deposit Enrollment Form or other pension form).

- The Resident, or the individual authorized to act on behalf of the Resident, authorizes the Facility to establish and manage a FDIC insured interest bearing resident fund or burial account with the options as specified above. The following is acknowledged and understood: The Resident's recurring checks may be direct deposited to the resident fund account, the Resident may make deposits to and withdrawals from the resident fund account, and a statement of the account activities will be provided at least quarterly.
- In the event that the Resident, or individual acting on behalf of the Resident, elects to have a resident fund transferring account, the Resident, or individual acting on behalf of the Resident, directs that the amount stipulated to, required or permitted under federal, state or local law from time to time in effect, will be withheld monthly for the Resident's personal use and that the remainder will be transferred to The Facility for the payment of costs for the Resident's care. The Resident, or Individual acting on behalf of the Resident, authorizes the Facility's administrator, or designee, from time to time, to adjust the Resident's personal allowance amount to comply with applicable governing laws.
- In the event of the Resident's death, it is acknowledged that any funds owed or advanced to the Resident by the Facility prior to the Residents death are to be paid to the Facility with any remaining balance in the Resident's resident fund account ID paid to the Resident's estate.
- By signing this form, under penalties of perjury, the Resident, or individual signing on behalf of the Resident, certifies that (1)

the taxpayer identification number provided is correct, and (2) the Resident is not subject to back-up withholding, because (a)

the Resident has not been notified that he/she is subject to back-up withholding as a result of a failure to report all interest or dividends, or (b) the Internal Revenue Service (IRS) has notified the Resident that he/she is no longer subject to back-up withholding. If the IRS has notified the signer that he/she is subject to back-up withholding, cross out the language in (2) above.

THE INDIVIDUAL ACTING ON BEHALF OF THE RESIDENT CERTIFIES TO THE FOLLOWING:

I, the undersigned, certify that I am a Legal Representative authorized to act on behalf of the Resident and on behalf of the Resident agree to the terms stated above. By signing below, the Resident certifies that the Resident has directed the Facility as to the management of the Residents fund as indicated above. If signing on behalf of the Resident, write and date your signature, print your name and indicate the title that represents your affiliation to the Resident (Legal Representative for Finances and/or Healthcare.).

IN WITNESS WHEREOF, the parties hereto have signed their names, marks, symbols or initials, on the dates indicated below:

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility's Authorized Agent

Signature of Facility's Authorized Agent

Date: _____

**Attachment F1
Facility Assignment of Benefits**

The undersigned acknowledges that **Bronx Gardens Rehabilitation and Nursing Center** is providing care and services for which payment may be made under Medicare and/or other insurance programs in which the undersigned is enrolled and through which the undersigned is entitled to benefits. The undersigned agrees to assist and cooperate with the Facility in applying for and obtaining such benefits. The undersigned hereby assigns to the Facility any payments of benefits to which he or she may be entitled under Medicare and any other insurance program for care and services provided by the Facility and authorizes the Facility to bill Medicare and any other applicable insurance program for such payments of benefits and to receive direct payment from Medicare and any other applicable insurance program.

IN WITNESS WHEREOF, the parties hereto have signed their names, marks, symbols or initials, on the dates indicated below.

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility's Authorized Agent

Signature of Facility's Authorized Agent

Date: _____

Attachment F2
Social Security and/or SSI Payments
Selection of Organization Representative Payee

Resident Name: _____ Social Security Number: _____

The beneficiary whose name appears above currently receives Social Security and/or Supplemental Security Income (SSI) payment from the Social Security Administration (SSA). The beneficiary is no longer able to handle his/her own benefits. He/she is currently a resident of a skilled nursing facility where he/she receives a daily medical and/or nursing care and is no longer in a position to handle his/her own financial affairs. I ask that the Social Security Administration designate _____ as the beneficiary's representative payee.

Currently, the beneficiary does not manage his/her own financial affairs and has designated an attorney- in-fact pursuant to a power of attorney (POA) to handle those affairs on his/her behalf.

_____ would be the best representative payee because the beneficiary is currently also a Medicaid recipient pursuant to Title XIX of the Social Security Act. Beneficiary is living in a nursing facility and agrees that all of the beneficiary's deemed available income must be paid to _____ as part of the beneficiary's liability amount.

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility's Authorized Agent

Signature of Facility's Authorized Agent

Date: _____

Attachment G
Medicare Secondary Payer (MSP) Screening

Facility Name: **Bronx Gardens Rehabilitation and Nursing Center**

Resident: _____

Admission Date: _____

Medicare No. _____

Provider No.: _____

Our Facility may be held liable for billed services if a Medicare overpayment occurs and Medicare determines that the Facility furnished erroneous information or failed to disclose facts it knew were relevant to payment. Therefore, the Resident must be asked the applicable questions below. If the Resident responds "yes" to any question, ask the remaining questions in that section.

Illness/Injury Caused by Accident

1. Is a current illness or injury due to any kind of accident?

No If no, proceed to question No. 2 below.

Yes If yes, Medicare may be a secondary Payer source.

Check the appropriate box below and fill in the requested information.

Motor Vehicle Accident:

Name of Resident's automobile insurer: _____

Policy No.: _____

- Obtain copy of insurance card.
- Call to verify coverage.

If auto insurance is the primary Payer source, bill the insurance company.

Motor Vehicle Accident - Third Party Liability:

Name of third-party's liability insurer: _____

Policy No.: _____

The liability insurer may be a primary Payer source.

- Bill Medicare unless the Resident's automobile insurer is the primary Payer source.
- Attach copies of all pertinent documentation to this document.

Work Related Accident or Injury:

Name of Worker's Compensation insurer: _____

Group No.: _____

Resident's Account No.: _____

Worker's Compensation insurer is the primary Payer source.

- Bill the Worker Compensation insurer.

Slip and Fall Accident or Injury:

Where did fall occur? _____

Name of third-party insurer: _____

Policy No.: _____

- Obtain copy of third-party insurer's insurance card if available.
- Call to verify coverage.

If fall occurred at a place other than the Resident's home, determine whether a liability claim or suit will be filed or if any kind of compensation will be received or is due. Bill third-party insurer as primary. If claim denied or received partial payment, bill Medicare.

Other Accident: No Third-Party Compensation:

Give description of accident and location: _____

- Bill Medicare and attach copies of all pertinent documentation.

Coverage through other Government Entity

2. Does the Resident have coverage through the VA, the Department of Labor’s Black Lung Program or some other Federal or State agency program other than Medicaid?

No If No, proceed to Question No. 3 below.

Yes If Yes, enter name of program: _____

Policy / Claim No.: _____

- Obtain copy of insurance card
- Call to verify coverage

The entity with which the Resident has coverage must be billed as primary and Medicare secondary. Medicare may reject the claim unless the entity pays as primary or submits a denial of the services.

Employer Group Coverage for those 65 and older

3. Is the Resident 65 or older and was employed at the time of this service?

No If No, proceed to question No. 4 below

Yes If Yes, enter the Resident’s date of birth (MM/DD/YY): _____

Name of Resident’s Employer: _____

Full-Time

Part-Time

Does the applicable employer employ 20 or more employees?

Yes

No

Does the Resident have an Employer Group Health Plan (“EGHP”) through his/her current employer?

Yes

No

If yes, enter name of EGHP: _____

Policy/Group No.: _____

- Obtain copy of insurance card.
- Call to verify coverage.

If the Resident is age 65 or older, is covered by EGHP through current employment AND the employer has less than 20 employees: Medicare is primary, EGHP is the secondary Payer source.

If the Resident is age 65 or older, is covered by a EGHP through current employment AND the employer has 20 or more employees (or at least one employer is a multi-employer group that employees 20 or more individuals): EGHP is Primary; Medicare is the secondary Payer source.

4. Does the Resident have a spouse who is employed at the time of the applicable date of service?

No If No, proceed to question No. 5 below.

Yes If Yes, enter the Resident’s date of birth (MM/DD/YY): _____

Name of Spouse’s company/employer: _____

Full-Time

Part-Time

Does the employer employ 20 or more employees?

Yes

No

Does the Resident have an EGHP through his/her current employment?

Yes

No

If yes, enter name of EGHIP: _____

Policy/Group No.: _____

- Obtain copy of insurance card.
- Call to verify coverage.

If the Resident is age 65 or older, is covered by an EGHP through spouse’s current employment AND the employer has less than 20 employees: Medicare is primary, EGHP is the secondary Payer source.

If the Resident is age 65 or older, is covered by an EGHP through spouse’s current employment AND the employer has 20 or more employees (Or at least one employer is a multi-employer group that employees 20 or more individuals): EGHP is Primary, Medicare is the secondary Payer source.

Employer Group Coverage for those Entitled to Medicare solely due to End Stage Renal Disease

5. Is the Resident under the age of 65 and entitled to Medicare solely because of End Stage Renal Disease (“ESRD”) and in the first 18 months of Medicare entitlement?

- No If No, proceed to questions No. 5 below.
- Yes If Yes, enter Resident’s date of entitlement as shown on Resident’s Medicare card (MM/DD/YY): _____

Does the Resident have Employer Group Health Plan (“EGHP”) coverage through self, spouse, parent or guardian?

- No Yes

If yes enter name of employer: _____

Name of EGHP: _____

Policy/Group No.: _____

- Obtain coy of insurance card
- Call to verify Coverage

If Resident answer yes to both questions above, the EGHP is primary Payer source and should be billed accordingly. Medicare is the secondary Payer source.

Employer Group Coverage for Those Entitled to Medicare solely because of Disability.

6. Is the Resident under the age of 65 and entitled to Medicare solely because of disability (does not have/has not had ESRD)?

- No If No, proceed to questions No. 7 below.
- Yes If Yes, enter Resident’s date or Birth (MM/DD/YY): _____

Does the Resident have coverage through his/her, a spouse’s, parent’s or guardian’s EGHP?

- No Yes

If yes, enter name of each insured whose policy covers the Resident (e.g., Resident and Resident’s Spouse).

Name of corresponding employer(s).

Policy / Group No.

Name of corresponding EGHP(s).

Policy / Group No.

- Obtain copy of insurance card.
- Call to verify coverage.

If the Resident answered yes to both questions above, the EGHP is/are primary and should be billed accordingly. Medicare is secondary or third Payer source.

7. Is the Resident enrolled in an HMO that has Medicare benefits assigned?

No If no, proceed to question No. 8 below.

Yes If yes, enter name of HMO: _____

Policy/Group No.: _____

If yes, **IMPORTANT**: Obtain authorization by contracting HMO and copy Resident's HMO Card.

HMO is Primary Payer source; Medicare is not to be billed.

8. Has the Resident elected Hospice benefits instead of Medicare Part A and Part B benefits?

No If no, Medicare is the primary Payer source and should be billed accordingly.

Yes If yes, Hospice is primary Payer source and should be billed accordingly, unless diagnosis is not Hospice-related.

- Obtain copy of insurance card.
- Call to verify coverage.

By signing below, the Resident certifies that the information provided above is true, accurate and complete. If signing on behalf of the Resident, write and date your signature, print your name and indicate your affiliation with the Resident.

IN WITNESS WHEREOF, the parties have signed their names, marks, symbols or initials on the dates indicated below:

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility's Authorized Agent

Signature of Facility's Authorized Agent

Date: _____

Attachment H
Consent to Photograph / Publish

Resident Name: _____

I hereby indicate my consent, as expressed by my initials, to permit _____ to:

_____ Use my name in connection with any publication (including but not limited to newspaper, displays, television, radio, books, report, web-sites and brochures) for marketing and/or other facility purpose.

_____ Use photographs and video of me in any publication (including but not limited to newspaper, displays, television, radio, books, reports, web-sites and brochures) for marketing and/or other facility purposes.

_____ Use any quotations and comments made verbally by me and/or concerning me (including but not limited to newspaper, displays, television, radio, books, reports, web-sites and brochures) for marketing and/or other facility purposes.

Name of Resident (Print Clearly)

Signature of Resident

Name of Personal Representative (Print Clearly)

Signature of Personal Representative

Relationship of Personal Representative to Resident:

Date: _____

**Attachment I
Consent for Care and Treatment by Students in Training**

Facility: **Bronx Gardens Rehabilitation and Nursing Center**

Resident/Patient Name: _____ Date: _____

Legal Representative: _____

Legal Representative Address: _____

In order to train future caregivers, the facility has partnered with different educational institutions in order to give Nursing students and Certified Nursing Assistants in Training practical experience. These Nursing students and Certified Nursing Assistants in Training under the supervision of a licensed professional or educator, may assist the residents with activities of daily living.

Nursing Students: _____ I allow care and treatment

Certified Nursing Assistants in Training: _____ I allow care

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility's Authorized Agent

Signature of Facility's Authorized Agent

Date: _____

**Attachment J
Personal Recording Device Policy**

Resident Name: _____

Bronx Gardens Rehabilitation and Nursing Center will protect the privacy of residents and staff from unauthorized use of personal recording devices in resident rooms by requiring residents and family members to obtain permission from **Bronx Gardens Rehabilitation and Nursing Center**, in accordance with federal and state law, prior to use or installation of personal recording devices in resident rooms and by defining the parameters in which personal cell phones with camera or video capability and other personal image recording devices may be used by residents and/or their personal representatives/family members at Riverdale Rehabilitation and Nursing Center.

The use or installation of a Personal Recording Device in group or public areas is not permitted in the Facility

A Personal Recording Device is any device that is not property of **Bronx Gardens Rehabilitation and Nursing Center** and is capable of capturing an image, live action or still, of a resident or staff member. Such devices include, but are not limited to, video cameras, cell phones with cameras, cell phones with videotaping capability and digital cameras.

The following procedure will be followed:

- A. Any resident, personal representative or family member who wishes to install or use a Personal Recording Device in a resident room must request and receive permission from the Administrator of the facility prior to using or installing such Personal Recording Device.
- B. If the Administrator grants the request, the resident, personal representative and/or family member is required to:
 - a. Obtain consent from the resident’s roommate(s) or personal representative(s) for the video recording device to be installed in the resident’s room;
 - b. Place the video recording device in plain view with some form of notice posted outside the resident’s room in order to provide notice to staff.
- C. Residents, personal representative(s) and/or family members are responsible for all costs associated with purchase and installation of the device.
- D. **Bronx Gardens Rehabilitation and Nursing Center** is prohibited from retaliating against those who use a personal recording device after receiving permission from the Administrator.
- E. Residents, personal representative(s) and/or family members are expressly prohibited from photographing, recording or videoing other residents, personal representative(s) or family members without receiving written permission from the Administrator of the facility and in accordance with both, **Bronx Gardens Rehabilitation and Nursing Center’s** policies regarding the photographing, recording or video taking of residents and HIPAA.
- F. Any exceptions to this Policy must be approved by either the Administrator or the Compliance Officer.
- G. Noncompliance with this Policy that results in violations of _____ HIPAA Privacy and Security Policies and Procedures will subject the violator to either removal for visitors and resident family members and/or discharge for resident in accordance with federal and state laws and regulations.

Please see the business office if you require additional information.

I acknowledge that my signature on this Policy signifies I have read, understand and am committed to its principles.

Resident

Personal Representative

Family Member

Name of Resident

Signature of Resident

Name of Personal Representative

Signature of Personal Representative

Relationship of Personal Representative to Resident:

Date: _____

ATTACHMENT K
Alternative Dispute Resolution Agreement Between Resident and Facility

THIS AGREEMENT IS OPTIONAL FOR RESIDENTS AND FACILITY. ADMISSION TO THE FACILITY IS NOT CONDITIONAL UPON A RESIDENT'S WILLINGNESS TO ENTER INTO THIS AGREEMENT.)

A. Alternate Dispute Resolution (ADR) Agreement Provisions.

- a. Voluntary Agreement to Mediate/Arbitrate Disputes. The undersigned parties understand and acknowledge that this is a voluntary agreement to submit any disputes, other than payment disputes, that may arise between them for resolution by mediation, and if mediation is unsuccessful, then by arbitration. The parties further understand and acknowledge that, with the exception of payment disputes, all other disputes are governed by this agreement, and each of the parties is giving up his/her/its right to resort to the courts, except to the extent that courts are empowered by law to enforce the decisions of an arbitrator who has been chosen by the parties to resolve their disputes.
- b. Scope of ADR Agreement. Any and all claims or controversies, with the exception of payment disputes, arising out of or in any way relating to this ADR Agreement ("Agreement") or the Resident's stay at the Facility including disputes regarding interpretation of this Agreement, whether arising out of State or Federal law, whether existing or arising in the future, whether for statutory, compensatory or punitive damages and whether sounding in breach of contract, tort or breach of statutory duties (including, without limitation, any claim based on violation of rights, negligence, medical malpractice, any other departure from the accepted standards of health care or safety or violation of federal and/or state laws or regulations, including, but not limited, to those promulgated by the State Department of Health or the Code of Federal Regulations, irrespective of the basis for the duty or of the legal theories upon which the claim is asserted, shall be submitted to ADR as described in this Agreement. **The parties understand that this Agreement contains provisions for both mediation and binding arbitration. If the parties are unable to reach settlement informally, or through mediation, the dispute shall proceed to binding arbitration. Binding arbitration means that the parties are waiving their right to a trial, including their right to a jury trial, their right to trial by a judge and their right to appeal the decision of the arbitrator(s) except as provided for under applicable state and/or federal laws governing the arbitration.** This Agreement includes claims against the Facility, its employees, its medical director, agents, officers or directors of the parent corporations, affiliates or subsidiaries of the Facility, (hereafter, all referred to as "Facility"), to the extent that the Resident seeks to hold the Facility liable for any act or omission of the Medical Director in his/her capacity as Medical Director, as well as any claims against employees, agents, officers or directors of the parent corporations, affiliates or subsidiaries of the Facility.
- c. No Class Actions. The parties agree to mediate or arbitrate each claim on an individual basis and will not seek consolidated or class treatment of any claim in any mediation or arbitration.
- d. Binding on Successors. It is the intention of the parties to this Agreement that it shall inure to the benefit of and bind the parties, their successors and assigns, including the agents, employees, servants, officers, directors and any parent, affiliate or subsidiary of the Facility, and all persons whose claim is derived through or on behalf of the Resident, including any parent, spouse, child, guardian, executor, administrator, Legal Representative, or heir of the Resident. The term "Resident" includes the resident, his or her Guardian or Attorney in Fact, his or her agents, or any person whose claim is derived through or on behalf of the resident.
- e. Parties. The "Claimant" may be either the Facility or the Resident, depending on who files the Request for ADR (the "Request"). The other party or parties against whom the Request is filed will be the "Respondent(s)"
- f. Administration. Any mediation or arbitration conducted pursuant to this Agreement shall be administered by an independent impartial entity that is regularly engaged in providing mediation and arbitration services. The Request for ADR shall be made in writing and may be submitted to the Facility, by regular mail, certified mail, or overnight delivery. The Facility will coordinate the choice of an ADR Administrator (the "Administrator") that is selected and mutually agreed upon by both parties based upon independence and impartiality and is regularly engaged in providing mediation and arbitration services. Requests for ADR, regardless of the entity chosen to be Administrator, shall be conducted in accordance the Facility's Alternative Dispute Resolution Rules of Procedure ("Rules of Procedure").
- g. Combining Claims/Limitations. Only disputes that would constitute a legally cognizable cause of action in a court of law may be submitted to alternative dispute resolution. All claims based in whole or in part on the same incident(s), transaction(s), or related course of care or services provided by the Facility to the Resident, shall be mediated or arbitrated in one proceeding. A claim shall be waived and forever barred if it arose prior to the Request for ADR and is not presented in the arbitration hearing or if not commenced by Request as above set forth within the time prescribed by applicable state law for the commencement of a civil action concerning the subject matter of that claim,
- h. Mediation — Followed by Arbitration. The parties shall attempt to resolve any dispute arising out of or relating to the Agreement or the Resident's stay at the Facility, with the exception of payment disputes, by mediation. The mediator and arbitrator(s) will be selected as described in applicable Rules of Procedure, the mediation shall convene not later than 120 days after the Request is received by the Administrator. Any claim or controversy that remains unresolved after the conclusion or termination of the mediation shall be settled by binding arbitration in accordance with the Agreement. The

arbitration shall convene not later than sixty (60) days after the conclusion or termination of mediation. Claims where the demand is less than \$50,000 shall not be subject to mediation and shall proceed directly to arbitration, unless one of the parties' requests mediation, in which case all parties shall mediate in good faith. The parties, at their own expense, may be represented by an attorney at the mediation or arbitration.

- i. Discovery. The parties agree to engage in limited discovery of relevant information and documents before and during mediation in accord with applicable Rules of Procedure. Any disputes which the parties cannot resolve regarding the scope and limits of discovery shall be resolved as described in the applicable Rules of Procedure.
 - j. Electronic Storage of ADR Agreement (Scanning and Photocopies). The parties hereto agree and stipulate that the original of this ADR Agreement, including the signature page, may be scanned and stored in a computer database or similar device, and that any printout or other output readable by sight, the reproduction of which is shown to accurately reproduce the original of this document, may be used for any purpose just as if it were the original, including proof of the content of the original writing.
 - k. Place of Arbitration. The seat or place of arbitration shall be at a mutually agreed upon location in the State of New York, Nassau County, unless the parties mutually agree upon an alternate venue.
- B. Decision.
- a. The Arbitrator may grant any remedy or relief that the Arbitrator deems just and equitable and within the scope of the Agreement of the parties and consistent with applicable law, provided that the Arbitrator shall not make an award of double or treble damages or attorney's fees pursuant to applicable state laws unless that award is supported by a reasoned decision which addresses every question of law and fact which a court would be required to address under the terms of that statute, and further provided that the Arbitrator shall not award duplicative damages in respect of a single injury. If the parties settle their dispute during the course of the arbitration, the Arbitrator may set forth the terms of the agreed settlement in an award.
 - b. Exclusive Process — Result Final. The parties agree that, except to the extent that reconsideration is allowed by the Rules of Procedure, an arbitration decision shall be the final and un-appealable resolution of any controversy within the scope of this Agreement, provided that either party shall be entitled to challenge an arbitral decision upon the limited grounds which are set forth in applicable state law, as that statute is presently formulated.
- C. Cost of ADR.
- a. Payment of Fees. Each Party shall equally pay the mediator's fees and other reasonable costs (excluding resident's attorney's fees) associated with the mediation. Each Party shall equally pay the Arbitrator(s)' fees and other reasonable costs associated with the arbitration (excluding resident's attorney's fees) up to a maximum of five (5) days of hearing.
 - b. Relationship to Statutes. The Parties agree that except as otherwise provided herein, this Agreement shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1 et seq., and not by recourse to a court of law.
 - c. ADR is Voluntary. The Resident, or his or her legal guardian, his or her agent, or authorized Power of Attorney understand that other local nursing home's agreements may not contain an alternative dispute resolution provision. The parties agree that the cost-effectiveness, time-efficiency and mutual agreement to accept alternative dispute resolution methods as binding as stated above are good and sufficient consideration for the acceptance and enforcement of this Agreement.
 - d. Attorney Fees and Costs. Except in cases in which the Arbitrator awards a successful claimant reasonable attorney's fees and expenses pursuant to applicable state law, the parties shall bear their own attorney's fees and costs of preparing for and presenting their cases in mediation and arbitration.
- D. Severability Provision.
- a. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, in whole or in part, the remaining provisions, and partially invalid or unenforceable provisions, to the extent valid and enforceable, shall nevertheless be binding and valid and enforceable.

E. Resident's Understanding of Agreement.

- a. **The Resident, the Legal Representative, or the Resident's authorized representative, has read this Agreement in its entirety, and understands the language in which it is written. If this Agreement has been read on behalf of the Resident by an authorized representative or agent of the Resident, the representative or agent has explained to the Resident, to the extent of the Resident's capability to understand such explanation, the nature of this Agreement and its essential terms.** The Resident understands that (A) he/she has the right to seek legal counsel concerning this Agreement, (B) the execution of this Agreement is not a precondition to admission, expedited admission or the furnishing of medical services to the Resident by the Facility, and (C) this ADR Agreement may be revoked by providing notice to the Facility from the Resident within ten (10) days of signature. If not revoked within thirty (30) days, this Agreement shall remain in effect for all care and services rendered at the Facility, even if such care and services are rendered following the Resident's discharge and readmission to the Facility. (D) Nothing in this Agreement shall prevent Resident or any other person from reporting alleged violations of law or any other Resident grievance to the appropriate administrative, regulatory or law enforcement agency.

THIS AGREEMENT GOVERNS IMPORTANT LEGAL RIGHTS. PLEASE READ THE AGREEMENT IN ITS ENTIRETY BEFORE SIGNING.

IN WITNESS WHEREOF, the parties hereto have signed their names, marks, symbols or initials, on the dates indicated below.

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility's Authorized Agent

Signature of Facility's Authorized Agent

Date: _____

Facility representative has presented the ADR to the Resident and / or Legal Representative.

**Attachment L
Transportation Services**

Transportation services are a necessary component of a comprehensive medical care.

MEDICARE

- Medicare does not cover any non-emergency wheelchair or stretcher transportation, such as routine visits to the physician.
- The only transportation services that Medicare (under Medicare Part B) pays for are: situations that are life-threatening emergencies and non-emergency situations that are deemed medically necessary after documentation is reviewed by contracted transportation company.

MEDICAID

- Medicaid **may** pay for transportation services to get you to a medical appointment **if you are eligible**.

PRIVATE INSURANCE

- Pre-authorization required.

Ambulance services can be arranged by Nursing Homes, at the residents and/or their representative’s responsibility. If you are not covered by insurance, transportation services can range from \$90.00 to \$500.00 (roundtrip), depending on the need of the resident and mileage. ***I understand that my signature below acknowledges that I may be billed for transportation services that are not covered by my insurance carrier.***

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility’s Authorized Agent

Signature of Facility’s Authorized Agent

Date: _____

Attachment M
Insurance Coverage / Financial Responsibility

ADMISSION DATE: _____

RESIDENT'S NAME: _____

PRIMARY INSURANCE:

INSURANCE NAME: _____

POLICY#: _____

OF DAYS COVERED ON PLAN: _____ / # OF DAYS AVAILABLE ON ADMISSION: _____

CO-PAYMENT: _____

DEDUCTIBLE: _____

OUT-OF-POCKET MAX: _____

SECONDARY INSURANCE:

INSURANCE NAME: _____

POLICY#: _____

OF DAYS COVERED ON PLAN: _____ / # OF DAYS AVAILABLE ON ADMISSION: _____

CO-PAYMENT: _____

DEDUCTIBLE: _____

OUT-OF-POCKET MAX: _____

TERTIARY INSURANCE:

INSURANCE NAME: _____

POLICY#: _____

OF DAYS COVERED ON PLAN: _____ / # OF DAYS AVAILABLE ON ADMISSION: _____

CO-PAYMENT: _____

DEDUCTIBLE: _____

OUT-OF-POCKET MAX: _____

Name of Resident

Signature of Resident

Name of Legal Representative

Signature of Legal Representative

Name of Facility's Authorized Agent

Signature of Facility's Authorized Agent

Date: _____