PATIENT INFORMATION

Patient Name:

Patient ID #:

SSN#:

Date of Birth:

Home Address:

City: State: Zip:

Date of Birth:

Home Phone: _____ Cell Phone: _____

Marital Status: Sex:

Is patient currently hospitalized? If so, hospital & date of hospitalization

_____

Physician:

Has the patient been admitted to another Nursing Home or hospital within the past year? ____No ____Yes

Where? _____Admission Date: _____ Discharge Date: _____

D/C Plan _____ ST _____ LT _____ Hospice Care _____

AGENT INFORMATION

Name:

Relationship:

Address:

City:

State:

Zip:

Home Phone:

Work Phone:

Cell Phone:

Is there a **Power of Attorney**? _____No ____Yes If yes, please attach a copy.

Is there a **Legal Guardian**? _____No ____Yes If yes, attach copy of Court authorization.

If so:

Name:_____

Relationship: _____

Address: _____ City: _____

State:_____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone:_____

2nd Contact Person:

Name:_____

Relationship: _____

Address: _____ City: _____

State: _____ Zip: _____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

HEALTH INSURANCE INFORMATION

Social Security #:

Medicare #:

Supplemental Insurance:

Group#:

Agreement#: _____

Other Insurance:

Group #:

Agreement #: _____

Medicaid:

Please attach copies of all insurance cards.

Patient Name

Monthly Invoices should be sent to:

Name: _____

Relationship: _____

Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Estimated Length of Stay

_____ Short-term (90 days or less)

_____ Long-term (91 days or longer)

Short Term Stay Expected Source of Payment:

_____ Medicare

_____ Medicaid (Date of Application)

_____ Private Pay

Long Term Stay Expected Source of Payment:

_____ Medicare
_____ Medicare
_____ Medicaid (Date of Application)
_____ Private Pay
_____ Other _____
_____ HMO Insurance
_____ Respite

PATIENT'S COMMUNITY HEALTH CARE PROVIDERS

Attending Physician

Provider:
Specialty:
Address:

Telephone: Cellphone:
Telephone: Office:

Hospital
Provider:
Address:

Telephone:

Funeral Home
Provider:
Address:
Telephone:

Irrevocable Burial Trust Fund Account
Bank: _____
Address:_____
Patient Name: _____

Pharmacy
Provider: «${resident.pharmacy}»
Address:_____
Telephone: _____

Dentist
Provider:_____
Address:_____
Telephone: _____

Podiatrist
Provider:_____
Address:_____
Telephone: _____

Religious Affiliation

Name: _____

Address: _____

Telephone: _____

Religion:

Facility Representative: _____ Date: _____

Crown Heights Center
FOR NURSING AND REHABILITATION
An Allure Facility

Patient Name:

ADMISSION AGREEMENT

This agreement serves as a contract between the parties as identified below. If this agreement conflicts with any present or future law, the law is controlling.

The parties to this agreement are **Crown Heights Center** (hereinafter known as facility) and patient (hereinafter known as patient) or patient's responsible party (hereinafter known as the agent).

It is agreed that the agent is under no obligation to use his/her own funds as payment to this facility; the only legal obligation is to guarantee that he/she will use the patient's own funds to pay for the patient's care at this facility. The patient's agent, however, is hereby contractually bound by the terms of this Agreement and may become liable for failure to perform duties under this Agreement. The agent agrees to pay the Facility, when due, from patient's income or resources, for items/services provided to the patient.

It is further agreed that should the agent receive a transfer of assets from the patient and that transfer results in the patient's ineligibility for Medicaid, the Agent will use the assets received, to pay for the patient's care. If the Agent refuses to turn over the assets to pay for the patient's care and the Nursing Home incurs costs in recovering the assets, the Agent will be liable for all costs of recovering, including but not limited to, reasonable attorney fees, expert witness fees and all other fees.

The parties hereby agree to the following financial terms and arrangements provided for the medical, nursing and personal care of.

I. Medicare/Medicaid Certification

The facility is certified to participate in the Medicare program.
The facility is certified to participate in the Medicaid Program.
Private insurance may/may not cover your stay at the facility or selected services provided.

II. Financial Arrangements

A. Private Patients

A patient is considered private pay when no State or Federal program is paying for the patient's room and board. Such a patient may have private insurance or another party which pays all or some of the charges. All private pay patients are required, as a condition of admission, **to pay 60 days room and board in advance**. The patient and/or their agent, hereby agrees to notify the facility three months prior to the patient's funds being exhausted so that an application for Medicaid Benefits can be made.

B. Private Insurance

Some patients may have private insurance that will pay for some of their care at the facility. It is agreed that the facility will bill the patient directly for the services delivered and the patient or agent will, in turn, be responsible for obtaining payment from their insurance company. The facility will assist the patient and/or agent in applying for and obtaining their insurance reimbursement.

In the alternate, the facility may agree to bill the private insurance company directly. If the facility chooses to perform such a service, the parties agree that the patient remains solely responsible to pay the facility should the insurance company fail to pay for any reason. The patient retains the sole responsibility to appeal any denial of payment and the facility agrees to assist in such appeal.

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Patient Name:

C. **Medicare**

The patient understands that Medicare coverage is established by Federal Regulations and not by the facility. Medicare coverage is not guaranteed and is limited in that only a specified level of care is covered for a specific number of days. If the patient is placed on the transitional admission unit, this will be a temporary room assignment.

If the patient ceases to meet the Medicare criteria, benefits will be discontinued, even if all the allotted days in the current benefit period have not been exhausted.

If services delivered are covered by Medicare, then the patient is not required to make any payment (except the deductible, copayment and for non-covered services) until they are notified, in writing, by the facility that Medicare coverage has been terminated.
The facility will bill Medicare directly during the patient's period of eligibility.

D. **Medicaid**

Payment amounts by patients who are entitled to Medicaid are determined by the State of NY. The Medicaid Program will reimburse the Facility for certain skilled services such as nursing services ordered by a physician. Reimbursable routine services include: dietary services; activities programs; room and bed maintenance services; and customary personal hygiene items and services as required to meet the needs of Patients/Patients, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services (other than Beauty Shop fees), and bathing.

The parties hereto recognize that it is illegal for a Medicaid certified facility to charge, solicit, accept or receive additional monies beyond what the Medicaid program determines is due, as a condition for admitting, expediting the admission of, or retaining a patient under Medicaid. The parties recognize that a Medicaid certified facility may charge for items, equipment or services not reimbursable under the Medicaid program, if the provision of such item, equipment or service and the charge therefore is disclosed and agreed to in advance, pursuant to law. Medicaid recipients who are uncertain whether an item or service is not reimbursable under the Medicaid program should contact the Board of Social Services.

By execution of this Agreement, the Facility, its agents, representatives, successors and assigns shall be authorized to have access to the patient's Medicaid file, and, if the facility so elects, to act on behalf of the patient in connection with any and all matters involving Medicaid, including, but not limited to, representation of the patient at Administrative Fair Hearings and Article 78 judicial appeals. The facility will appeal a Medicaid determination only if it deems an appeal has merit and is necessary and prudent. **The patient or agent agrees to pay to the facility the patient's monthly income, minus personal allowance or other allowances as set by law, from the date of admission until the Medical Assistance approval is received**.

If the Medicaid Application is approved, patient or agent agrees to pay the facility, monthly, that amount which the Medical Assistance Program determines is the Patient Liability Amount.

If the patient is denied Medicaid eligibility or such eligibility is terminated, the parties agree that the patient or his/her agent is solely responsible to appeal that decision or become a private pay individual. See Section II(a) above. The

parties further agree that, if such coverage is denied or terminated, patient/patient's agent shall pay, from patient's assets, any and all unpaid charges.

Patient Name:

E. **Release of Medical Information**

The patient and/or agent authorizes the facility to release medical information and necessary data, that is pertinent to the care and treatment of the patient, and / or for the filing of Medicaid, Medicare, or insurance claims in the interest of the patient and/or the facility. The facility will comply with HIPAA privacy regulations.

Method of payment upon admission:
Medicare _____Medicaid _____Medicaid Pending _____Private Insurance _____ Private Pay _____

To protect the patient's rights of privacy and confidentiality, it is the policy of the facility not to release any of the patient's medical records to any third party (except as identified above), including the patient's agent, unless the request comes from patient, the patient's power of attorney or Court appointed legal representative.

F. **Change of Insurance**

Patient and/or Agent hereby agree to notify the facility immediately upon change of insurance company or payor status.

III. **Consent To Treatment**

Patient hereby 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 patient has the right to select his/her own attending medical physician. If, however, the patient does not select an attending physician, or is unable to select an attending physician, an attending physician may be designated by the facility.

Consent to TX. The physician must be licensed to practice and credentialed as per state law. If the physician chosen by the resident refuses to or does not meet requirements, the facility must discuss an alternative physician with the resident and honor the resident's preferences, if any, among options. The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his/her care.

The patient has been informed that all physicians rendering care to patient are independent contractors and not employees of facility. Patient shall be personally responsible for payment of all physician charges, unless such charges are covered by a third party payor.

Admissions to Composite distinct part. This facility has composite distinct parts geared to care for the special needs, medical or psychosocial needs of the patients on that unit. Patients of this facility may be moved on or off these units based on assessment of the current needs of the patients or facility.

IV. **Charges**

The facility provides various levels of care. Medicare or other private insurance may not cover the full costs of care at this facility. If coverage is not available, then the patient is expected to pay the following private charges:

The following charges for services and/or items will be billed according to the current fee schedule of the facility as applicable:

Current fee as of May 1, 2018 are as follows:
Private Room Rate $425.00 per day

Daily room charge; rehabilitation services; other therapeutic services, including, but not limited to, transportation and laboratory; personal services, such as hairdressing.

Patient/Family members are responsible to supply personal items, clothing and spending money, above the patient's personal allowance amount, as desired by the patient.

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The patient or agent will be responsible for hospital charges if hospitalization of the patient is necessary, unless such charges are paid by a third party payor.

Room and board charges for the current month are billed at the beginning of the month and are due by the fifth of the month. The patient and/or agent agree to pay monthly, and in consideration of this arrangement, the facility agrees to render services to the patient.

Patient Name:

Past due accounts may be subject to a finance charge of one (1%) percent per month. The patient and/or agent will be responsible to pay all charges, expenses and reasonable attorney's fees, whether or not formal legal action is brought.

Patient/Agent hereby acknowledges receipt of the Facility Fee Schedule. _____ initials

V. **Transfer and Discharge of a Patient**

A patient may be transferred or discharged from the facility if:

1. It is necessary for the patient's welfare and the patient's needs cannot be met in the facility;
2. The patient's health has improved sufficiently that the facility's services are no longer required;
3. The health and safety of individuals at the facility are endangered; and
4. The patient has failed, after reasonable notice, to pay for or, if applicable, have Medicare, Medicaid, or other third parties pay for the charges while at the facility.

In the event of any of the above, except in the case of emergency, 30 days written notice will be given to the patient and/or agent. This notice will set forth the reasons for such a transfer or discharge, the effective date and the location to which the patient will be transferred or discharged. Appeal rights will also be described in such notice. In the event of an emergency, the facility will give the patient and/or agent as much notice as is possible under the circumstances.

VI. **Qualified Residents For Bed Reservation For Temporary Absences:**

Private Pay and Medicare Part A Covered Residents:
Upon agreement to pay the private daily rate, private paying residents including those covered by Medicare part A or another private health plan (or their sponsors and agents) may hold a resident's bed available if the resident is expected to return to our facility and providing the resident's accounts are not in arrears. During the resident's absence, the daily rate under the admission agreement is owed unless the facility is notified to cancel the bed-hold.

Medicaid and MLTC/Managed Medicaid Covered Residents:
If a Medicaid-sponsored resident takes leave of absence overnight, for any reason other than hospitalization, Medicaid will pay to hold the bed for up to ten (10) days in any twelve (12) month period. However, they will only do so if our facility's vacancy rate is no more that 5% on the day of the resident's departure and the resident has resided in the facility for at least thirty (30) days. MLTC/Managed Medicaid's may require authorization prior to the resident taking a leave of absence. Failure to wait for approval may cause the plan to deny all future payments and the resident or resident's representative will become liable. The NAMI/income amount continues to be due and during the bed-hold.

If a Medicaid-sponsored resident is temporarily hospitalized or takes a leave of absence overnight due to hospitalization, Medicaid will not pay to hold the bed, unless the resident is receiving Hospice services. In this case Medicaid will pay to hold the bed for up to 14 days in a 12-month period.

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The resident and/or resident's representative have the option to pay to reserve the bed at the prevailing private pay rate. If the bed is not reserved privately, our facility will immediately release the bed.

All Medicare or Medicaid eligible residents on leave due to hospitalization, requiring skilled nursing facility services, will be given priority readmission for the next available semi-private or a bed in a multi-bedded room.

VII. **Patient's Property**

The patient is allowed and encouraged to surround himself/herself with their own property. The only limitation shall be space. The facility reserves the right to refuse certain property if it inhibits the work flow or creates an unsafe environment.

The facility will take reasonable precautions to prevent theft or loss of the patient's property, but the facility will in **NO** instance be responsible for lost or damaged patient property, including eyeglasses, clothing, prostheses, money or valuables. In Instances related to lost or damaged dentures, a dental referral will be made within three days and repair/replacement will be the responsibility of the facility, if not covered by the patients' insurance/Medicaid plan. The patient and/or agent hereby agree to this provision.

Upon the patient's death or discharge, the facility agrees to hold the patient's personal property for a period of 30 days, at which time, if not picked up by agent will be donated or discarded.

Patient Name:

VIII. **Patient Personal Funds**

Patient has the right to manage his/her own personal funds. If the patient wants assistance with management of personal funds, the facility shall assist if requested to do so.

Patient funds, in excess of $50 being managed by the facility, will be placed in an interest-bearing account insured by the Federal Deposit Insurance Corporation (hereinafter known as Patient Trust Fund Account) that is separate from facility accounts.

Facility shall provide patient with an accounting at least quarterly, or more frequently if requested by patient. The facility will notify residents when their account balance reaches $200 less than the SSI resource limit.

If a patient expires, facility may be required by NY State law to forward any remaining funds to the Estate, if facility is not so required than the facility shall refund the patient's account balance within thirty (30) days, and provide a full accounting of these funds to the estate. If patient does want facility to assist with the management of his/her personal funds, the patient will complete and sign the Patient Trust Fund Authorization Form.

IX. **Advance Medical Directives**

The patient and/or agent acknowledge receipt of written materials regarding the patient's right to self-determination. Written materials will be provided to the patient and/or family upon admission.

The patient has a MOLST? _____ Yes _____ No

The patient has a Living Will? _____ Yes _____ No

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The patient has a Durable Power of Attorney? _____ Yes _____ No

Name of POA_____ Relationship_____

(A copy of the document must be provided or patient's directive cannot be followed.)

X. **Modifications of the Agreement**

The facility may modify or amend the terms of this agreement unilaterally to assure compliance with subsequent changes in federal and state laws or regulations. Also, the facility may adjust charges as needed, providing at least thirty (60) days notice, in writing, to the patient/agent.

XI. **Non-Discrimination Clause**

The facility agrees to comply with the provisions of the Federal Civil Rights Act of 1964 and all requirements imposed stating that no person shall, on the grounds of race, color, national origin, ancestry, age, disability, or religious beliefs be excluded from participation in, be denied benefits of or otherwise be subject to discrimination in the provision of any care or services. This non-discrimination policy of the facility applies to patients, physicians, independent contractors and all employees.

XII. **Grievance Procedure**

Should any patient or agent feel a need to voice grievances, recommend changes in policies or services or report discrimination, the facility recommends bringing the problem to the attention of the grievance official, who is designated by the facility Administrator. Should the patient or agent feel that further attention is required into the problem; the following agencies may be contacted regarding the grievance:

NY Department of Health and Senior Services, Complaint Hotline 800-206-8125
New York State Office of Long Term Care Ombudsman 800-342-9871

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XIII. **Jurisdiction, Venue, Waiver of Jury Trial**.

This Agreement shall be governed by, construed and enforced in accordance with the laws of the State of New York. For purposes of this Agreement, including but not limited to questions concerning its interpretation, performance, breach or enforceability, the parties hereto submit to the exclusive jurisdiction of the courts of the State of New York and the parties further designate Nassau County as the exclusive venue for any proceeding or action brought in the courts of the State of New York. EACH OF THE PARTIES HERETO HEREBY IRREVOCABLY WAIVES ANY AND ALL RIGHT TO TRIAL BY JURY IN ANY LEGAL PROCEEDING ARISING OUT OF OR RELATED TO THIS AGREEMENT OR THE MATTERS CONTEMPLATED HEREBY

XIV. **Payment Agreement**

Patient and/or agent agree to be responsible and to pay the facility from the patient's income or resources, when due, all sums due and owing to the facility for the above-named patient in accordance with all the terms and conditions fully set forth above.

In Witness thereof, the Parties have signed and sealed this Agreement as of the **date:** _____

_____ _____
Patient/Agent Date

_____ _____
Facility Representative Date

Crown Heights Center
FOR NURSING AND REHABILITATION
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Patient Name : «${resident.first_name}» «${resident.last_name}»

Notice of Privacy Practices

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

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law. We are required by HIPAA to provide you with this notice. This notice describes our privacy practices and legal duties with respect to your protected health information so that you will understand your rights, our legal duties, and how we may use or disclose medical information about you.

1. Uses and Disclosures of Your Health Information

The following categories describe the ways we use and disclose health information. Not every use or disclosure will be listed; however, all of the ways we are permitted to use and disclose information will fall into one of the categories.

a. For Treatment: We may use or disclose your health information in order to provide you with the services and treatment you require or request. We may disclose medical information about you to doctors, nurses, therapists and others who are involved in taking care of you in order to coordinate your care. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

b. For Payment: We may use or disclose your health information so that the services you receive may be billed to you, an insurance company or a third party. For example, we may confirm your eligibility for Medicare or Medicaid and provide insurers, workers compensation insurers and others with information to obtain payment for supplies and services.

c. For Healthcare Operations: We may use or disclose your health information for our health care operations. For example, the medical, nursing or quality improvement teams may use medical information about you to assess the care provided and outcomes achieved in an effort to continually improve the quality and effectiveness of the services we provide. We may use medical information to review and evaluate staff performance.

2. Other Permitted Uses and Disclosures of Health Information

According to Federal Privacy Regulations, we may make the following uses and disclosures of your health information without obtaining written authorization from you.

a. Persons Involved in Your Healthcare or Payment for your Care: We can disclose your health information to your legally appointed personal representative just as we can disclose to you. If you do not object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts so that your family may be notified as to your location and condition and to coordinate uses and disclosures to family or other individuals involved in your health care.

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Patient Name: «${resident.first_name}» «${resident.last_name}»

b. Business Associates: We may disclose your health information to our "business associates" who provide contracted services, for example laboratory, billing, or consulting. If we disclose health information to a business associate, we will do so only if the business associate has agreed in a written agreement, to safeguard your health information.

c. Regular Practices: The following are examples of disclosures that may occur on a routine basis, during the conduct of regular activities of the home. Please review them carefully and discuss any concerns you may have with the Administrator.

Many disclosures serve primarily to inform and recognize our patients. We may post your name on a sign to welcome you, post or announce your birthday or other special date. We may include your name in a newsletter. We may include your name in articles that are published about our home in the local newspaper. We may post memorials or obituaries or announce memorial services that are being held in patients' honor. We may display a photo of you on a bulletin board but we will not give photographs of you for publication to anyone outside our location unless we have your permission.

Some disclosures serve to expedite the delivery of services, assist and support patients or to facilitate communication.
We may display your name on a seating chart in the dining room, or on the spine of your chart. We may display your name and/or photo on a nameplate near your door. We may post your name on a board listing diagnostic tests, services or appointments. We will make every effort to locate such a posting away from public viewing and will limit the amount of information posted.

d. Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation.

e. Reporting Victims of Abuse or Neglect: We may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable Federal and state laws.

f. To Avert a Serious Threat to Health or Safety: When necessary to prevent a serious threat to your health or safety, or the health or safety of the public, or another person, we may use or disclose your health information to someone able to help lessen or prevent the threatened harm.

g. Public Health Activities: We may disclose your health information for Public Health and Safety activities and purposes including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether an individual has a work-related illness or injury in order to comply with Federal or state law.

h. Health Oversight Activities: We may disclose your health information for Health Oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or other activities necessary for appropriate oversight of government benefit programs.

i. As Required by Law: We may disclose your health information when required by law to do so, but only to authorized persons and only to the extent necessary to meet the requirements of those laws. This includes laws relating to worker's compensation and similar programs.

j. Judicial and Administrative Proceedings: We may disclose your health information in response to a court or administrative order. We may also disclose information in response to a subpoena, discovery request or other lawful process that meets the requirements of Federal Privacy Regulations.

k. Law Enforcement: We may disclose your health information for certain law enforcement purposes. For example, we may disclose information to report emergencies, to report a crime, to report suspicious death, to identify or locate a suspect or missing person or to answer certain requests for information related to a crime.

l. Coroners, Funeral Directors and Others: We may release your health information, upon your death, to a coroner, medical examiner or funeral director and, if you are an organ donor, to an organization involved in the donation of organs and tissue.

m. National Security: We may disclose health information to authorized federal officials as required for lawful national security activities.

n. Military and Veterans: Your health information may be used or disclosed in order to comply with laws related to military service or veterans' affairs.

o. Benefits and Services: We may use or disclose health information to tell you about options, treatments and services. For example, we may use information about you to provide appointment reminders.

3. **Authorization**

Your written Authorization is required for uses and disclosures not described in the categories listed above. The Authorization will describe the particular health information to be used or disclosed, the name of the person or entity receiving the information, the purpose of the use or disclosure and a date or event when the Authorization will expire. You may revoke an Authorization previously given by you at any time, but you must do so in writing. If you revoke your Authorization, we will no longer use or disclose your health information for the purposes specified except where we have already taken actions in reliance on your Authorization.

4. **Your Rights With Respect to Your Personal Health Information**

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

a. Right to Request Restrictions on Use or Disclosure: You have the right to request a restriction on certain uses and disclosures of your personal health information about yourself. For example, you may ask us not to disclose information about surgery you may have had to a certain family member. While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergencies. You may request a restriction by submitting a specific request in writing to the Facility Administrator. Request must be in writing and must state the specific restriction requested and to whom you want the restriction to apply.

b. Right to Receive Confidential Communications: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable

requests. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Administrator.

c. Right of Access to Personal Health Information: With some limited exceptions, you have the right to look at or get copies of your health information. You must submit your request in writing to the Administrator. We may charge a fee for copying, mailing or other services associated with your request. We may deny your request to inspect or receive copies only in certain limited circumstances. If you are denied access to health information, in some cases, you will have a right to request a review of the denial.

d. Right to Request Amendment: If you feel that the health information we have about you is incorrect or incomplete, you may request that we amend the information. You have this right for as long as the information is kept by the nursing home. Your request must be in writing and must state the reason you believe the information is incorrect. We also may deny your request for amendment in certain other circumstances. If we deny your request for an amendment, we will give you a written notice, explaining the reasons for the denial. You have the right to submit a written statement disagreeing with the denial and that statement will be filed in your record.

e. Right to Receive an Accounting of Disclosures of Your Personal Health Information: Beginning on November 1, 2006 and going forward, we will keep an accounting of persons or organizations we give your health information for reasons other than treatment, payment or healthcare operations. It excludes disclosures we may have made to you, to others with your authorization, for a facility directory, to family members or friends involved in your care, or for notification purposes. You may get a copy of the list for six (6) years back from the date of your request (however, the list was not kept before November 1, 2006). You must submit your request in writing to the Administrator.

f. Paper Copy: You have the right to obtain a paper copy of this notice from us upon request.

5. Changes to This Notice

We respect the confidentiality of your personal health information. We must follow the privacy practices described in this notice. The effective date of this notice is November 1, 2006 and it will remain in effect unless and until we publish and issue a new notice. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices

6. Questions and Complaints

If you have any questions or concerns about the handling of your health information, or would like additional information about this Notice, you may contact the Administrator. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. We will not retaliate in any way if you file a complaint.

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COMPLIANCE INFORMATION RESOURCES

In adhering to directives effective October 1 2021, geared towards increasing awareness to the availability of compliance information maintained by NYSDOH (New York State Department of Health) with regards to residential health care facilities, this facility includes the below information as a resource for patients and families.

New York State Nursing Home Profiles

Website: profiles.health.ny.gov/nursing_home/index

Maintained by: NYSDOH

Nursing Home Compare

Website: Medicare.gov/care-compare/

Maintained by: US Department of Health and Human Services (HHS)

Information pertaining to but not limited to complaints, citations, inspections, enforcement actions and penalties taken against this facility and others like it is deemed public information. Accessing this information can be performed by visiting the Nursing Home Compare website; medicare.gov/care-compare/ . Simply search by entering the location, provider type and/or name of the facility to access the respective facility's profile.

Notice of Privacy Practices
Acknowledgement of Receipt of Notice

I have been given a copy of the Notice of Privacy Practices that describes how my health information may be used and disclosed and how I can get access to my health information. I understand the Notice may be changed at any time as permitted by applicable law. I may obtain a current copy of the Notice by contacting the business office.

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

Signature of Patient/Agent: _____
Date: _____
If signed by Legal Representative, relationship to Patient: _____

Patient Name:

MEDICARE SECONDARY PAYER (MSP) FORM

Do you have Medicare? _____ Yes _____ No

1. Do you receive Veteran's benefits? Yes _____ **- STOP** No _____ **- Go to question 2**
2. Are you receiving benefits under the Black Lung program? Yes _____ **- STOP** No _____ **- Go to question 3** A.) If yes, date benefits began _____

   B.) If yes, are services you will be receiving related to a non-black lung condition? Yes _____ No _____
3. Was this injury/illness due to a work related accident? Yes _____ **- STOP** No _____ **- Go to question 4** If yes, date of injury/illness _____
4. Was this injury/illness related to a motor vehicle accident? Yes _____ **- STOP** No _____ **- Go to question 5** If yes, date of accident _____
5. Was this injury/illness related to another type of accident? Yes _____ **- STOP** No _____ **- Go to question 6**

   If yes, date of injury/illness _____

   If any yes to 3, 4, or 5, is there a liability suit or litigation pending? Yes _____ No _____

   If yes, please provide: Attorney's Name: _____

   Address: _____

   _____

   Phone: _____
6. Are you entitled to Medicare based on: _____ (Age 65 & over) **Go to question 7**

   _____ Disability – **Go to question 7**

   _____ End Stage Renal Disease
7. Are you currently employed? Yes _____ No _____ Date of retirement _____A.) Do you have an employee group health plan (EGHP) as primary coverage?

   Yes _____ **- STOP** No _____ **go to question 8**
8. Is your spouse currently employed? Yes _____ **- STOP** No _____ Date of retirement_____

   A.) Do you have an employee group health plan (EGHP) as primary coverage? Yes _____ No _____

   Does the employer that sponsors your GHP employ 20 or more employees? Yes _____ No _____

If you answered "YES" to any of the above questions, please complete the following information:

Insurance Company: _____

Address:_____

Policy/Cert #: _____

Group Name # _____

If you answered "NO" to all of the above questions, then Medicare is primary.

ASSIGNMENT OF INSURANCE BENEFITS

I assign the Skilled Nursing Facility and Physician benefits payable to me to the facility and/or to Physician groups, and any contracted vendors. I authorize and request that payment be made directly to the facility and/or to Physician Groups and any contracted vendors. I understand that I am financially responsible to the Skilled Nursing Facility, Physician Groups, and/or any other contracted vendors for charges not covered by this authorization. This assignment or a photocopy hereof is acceptable.

_____ _____

Facility Representative Date

_____ _____ _____

Patient/Agent Date Relationship to Patient

MEDICARE BILLING PAYMENT SERVICES BY SKILLED NURSING FACILITY, PHYSICIAN BENEFITS, PHYSICIAN GROUPS AND CONTRACTED VENDORS.

I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for Physician services to the Physician or organization to submit a claim to Medicare for payment to me. Received Medicare beneficiary information statement.

_____ _____

Facility Representative Date

_____ _____ _____

Patient/Agent Date Relationship to Patient

MEDICAL ASSISTANCE PROVIDER/PHYSICIAN GROUPS/CONTRACTED VENDORS

I understand that payment for services or items will be from Federal/ State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

This authorization or photocopy hereof, will authorize the facility staff and Physician Groups to furnish all information, they may have, regarding my condition to any party who may be responsible for payment to the Skilled Nursing Facility, Physician Groups, and other contracted vendors, including the history obtain, x-ray and physical findings, diagnosis and prognosis. I have read and agree with the above statement.

_____ _____

Facility Representative Date

_____ _____ _____

Patient/ Agent Date Relationship to Patient

Patient Name:

AUTHORIZATION FORM FOR PERSONAL SERVICES

REQUEST TO OPEN PERSONAL MAIL

I request that the Administration (or designee) of this facility assist me in the opening of and/or reading of my personal and/or financial mail as I have indicated below. Financial mail includes such items as checks, medical bills or statements, and Medicare and Medicaid correspondence.

I understand that I may revoke this request at any time by giving notice to the Administrator or designee.

_____ Opening of Personal Mail Requested _____Opening of Personal Mail Not Requested

_____ Opening of Financial Mail Requested _____ Opening of Financial Mail Not Requested

PERSONAL LAUNDRY

_____ I request the Facility to provide routine laundry services for personal laundry.
_____ My family will provide routine laundry services.

BEAUTY/BARBER

Routine shampoos are provided by Facility staff. For the convenience of our patients, the facility made arrangements with a private, independent contractor to provide other barber and beauty services at the Facility. The cost of these other services are the responsibility of the Patient. A "fee schedule" will reflect charges, based upon plan chosen.

_____ The Patient desires the following services from the contracted barber/beautician.

_____ The Patient does not desire barber/beautician services.

PHOTO RELEASE

I _____hereby, authorize and consent to my picture being taken and being displayed in the Medication / Treatment Kardexes, for the purposes of identification.

ELECTRICAL

It is the policy of this facility that all personal electrical items such as clock radios, televisions, lamps, etc. be directed to the Maintenance Department for inspection before they are placed in the Patient' room. We appreciate your cooperation with this policy.

I / my Agent, have signed below and initialed above the services that I desire. I realize that these services will be billed to my Agent or my Patient Fund Account, when these services are rendered.

_____ _____
Patient/Agent Signature Date

_____ _____
Facility Representative Date

Patient Name:

THERAPEUTIC RECREATION APPROVAL FORM

(1) MEDIA APPROVAL

I hereby irrevocably grant to **The facility** and its affiliates, permission to record the above named patient's likeness and/or voice for use in commercial activities by electronic or printed media for identification
purposes and to further the program and patient service goals or patients and the facility.
I hereby release same from any and all claims.

_____ _____

Patient/Agent **Date**

(2) FACILITY TRIP AUTHORIZATION

I hereby grant permission for The Facility to take above named patient on trips into the community for recreation purposes. These would be facility sanctioned trips coordinated through the Therapeutic Recreation Department, permission given by the attending physician, and under the authority of the facility Administrator. All suitable considerations will be made to insure a pleasant and safe trip. Van services that provide hydraulic lifts will be used, and the patient's agent will be notified a week in advance of any plans to take a patient on an activity trip.

_____ _____

Patient/Agent **Date**

Patient Name:

SUGGESTED CLOTHING LIST FOR PATIENTS

The suggested clothing list represents what a Patient may require. It is not a mandatory required list of items needed upon admission. The clothing should be "washable material only".

FEMALE	**MALE**
1 Bathrobe	1 Bathrobe
2 Pairs Washable Slippers	2 Pairs Washable Slippers
4 House Dresses, with snaps or zippers	4 Pairs of Pajamas (Cotton & Flannel)
4 Nightgowns	8 Under shorts (Boxer or Jockey)
2 Cardigan Sweaters	8 Pairs of Socks (Same Colors)
8 Pairs Knee Socks (same color) OR Cotton Stockings	4 Pairs slacks (washable & comfortable)
1 Pair comfortable Walking Shoes	2 Sweaters
8 Pairs of Panties	4-8 Comfortable Shirts
3 Slips (all cotton, no lace)	2 Belts
1 Warm coat (if patient expects to go out)	1 Pair comfortable shoes
8 Outfits (dresses or blouses with skirts or slacks) 3 Bras	1 Overcoat
	1 Dress outfit

NOTE

We hope that this list is of help to you when deciding what to bring for or with the patient. We remind you that all items brought into the facility should be clearly marked with a permanent marker to ensure that items are properly returned to the right person.

PERSONAL HYGIENE ITEMS

We will provide the personal hygiene necessities, however, if you family member has preferences for particular brands or special items (electric razor, cologne, aftershave, etc.) you may provide them at your expense.

OTHER ITEMS

To make the patient feel comfortable in his/her new setting, some personal belongings may be brought in to the facility to make it feel more "like home". The items can include:

comfortable clothes	radio/television*
blankets and pillows	small plants
pictures and photographs	

* All electrical equipment will need to be checked out by maintenance department.

Patient Name:

ASSET SUMMARY FOR PRIVATE RESIDENTS

(1) Total Monthly Income (include any monthly income received on a regular basis from SS, Pension, Rentals, Stocks, Bonds, etc.) $_____

(2) Total of any Assets (this should include estimated property values, Bank Accounts, CD's, etc.) $_____

(3) Combined Patient Assets to be used for Spend Down purposes. $_____

(4) Estimated Monthly Private Charge (include Room & Board, Pharmacy, Coinsurance, etc.) $_____

(5) To estimate the projected date of spend down and/or conversion to Medicaid, divide #(4) into #(3) to get the number of months this resident can pay Privately. _____

(6) Take the number of days/months and count from the day of Admission forward to arrive at the effective date of Medicaid. _____

SAMPLE

Total assets are $35,000.00 (1)+(2)=(3)

The monthly charge will be $7,000.00 (4)

This resident can be Private for five months (5) ($7,000.00 divided into $35,000.00 = 5 months).

The resident was admitted 1/1/99, five months from this date would make the effective date 6/1/99.

THIS FORM IS TO BE USED TO REPORT CHANGES

(Such as address, direct deposit or death) for your residents

Date: _____

PLEASE BE ADVISED OF RECENT CHANGE

Resident Name:

Social Security #:

Part A: (to be completed by facility)

He/she became a resident on:

He/she is expected to stay over 90 days? ___Yes ___No

If No, what is the expected date of release? _____

Does the individual currently have a representative payee for his/her Social Security / SSI benefits?

___Yes ___No

If Yes, and you wish to be the new representative payee, return Form SSA-11 to our office.

Please note: We must have Form SSA-11. DO NOT SEND THIS FORM.

The individual named above died on _____.

Name of Facility Representative. (Please print): _____.

Part B. (BOTH questions, need to be completed by resident when there is no representative payee needed)

I want my mail sent to the above named facility. ___Yes ___No

I want my Social Security/and or SSI checks directly deposited into the bank account the above named facility has set up for me. ___Yes ___No

Routing #_____ C or S (circle one) Acct #_____

Signature of Claimant: _____

Cannot be signed by social worker or family member