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ADMISSION AGREEMENT

Agreement entered on ______________________, 202_ between ______________________ (also referred to as the "Facility") and

____
(Resident)

and ____
(Responsible Party)

THE PARTIES TO THIS AGREEMENT AGREE AS FOLLOWS:

1. NON-DISCRIMINATION

THE FACILITY DOES NOT DISCRIMINATE BECAUSE OF RACE, CREED, COLOR, NATIONAL ORIGIN, SEXUAL PREFERENCE, ACTUAL OR PERCEIVED SEXUAL ORIENTATION, GENDER, GENDER IDENTITY, GENDER EXPRESSION HIV STATUS, BLINDNESS, DISABILITY, SPONSORSHIP IN ADMISSION, SOURCE OF PAYMENT, AGE, OR AS OTHERWISE PROHIBITED BY LAW WITH RESPECT TO THE ADMISSION, RETENTION AND CARE OF RESIDENTS.

2. SERVICES PROVIDED BY THE FACILITY

2.1 **Services Included Under the Daily Basic Rate.** The following services are provided by the Facility under the daily basic rate:

(a) Lodging in a non-private room;

(b) Board, including therapeutic or modified diets, as prescribed by a physician (but excluding artificial hydration and nutrition);

(c) Twenty-four (24) hour per day nursing care;

(d) Fresh bed linens as required;

(e) Hospital gowns or pajamas as required and regular non-dry cleaning laundry services for these and other launderable personal clothing items;

(f) General household medicine cabinet supplies, including non-prescription medications, material for routine skin care, oral hygiene, care of hair, except for specific items that are medically indicated and needed for exceptional use for a specific Resident;

(g) Assistance and/or supervision when required with activities of daily living, including toileting, bathing, feeding and ambulation assistance (but excluding continuous one on one supervision);

(h) Services of members of the Facility staff performing their daily assigned patient care duties;

(i) The use of customarily stocked equipment, including crutches, walkers, wheelchairs, or other supportive equipment, and training in their use when necessary, unless such item is prescribed by a physician for the regular and sole use by a specific Resident;

(j) The use of all equipment, medical supplies and modalities usually used in the everyday care of the Resident, including catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads;

(k) An activities program, including a planned schedule for recreational, motivational, social and other activities, together with the necessary materials and supplies;

(l) Social services as needed; and

(m) Physical, occupational, speech and respiratory therapies, provided in accordance with a maintenance program (but not such therapies provided in accordance with a restorative program).

2.2 **Anticipated Services**

It is anticipated that the Resident will initially require the following level of care:

☐ Long Term Care

☐ Sub-Acute Care*

☐ Scheduled Short Term (Respite) Care**

* The Facility defines sub-acute care as goal oriented, comprehensive, inpatient care designed for an individual who has an acute illness, injury, or exacerbation of a disease process. It is generally rendered at the Facility immediately after, or instead of, acute hospitalization. Sub-acute care lasts for a limited time or until a condition is stabilized or a predetermined treatment course is completed.

** Respite care services provide the community caregiver a 3 to 30 days period for relief from caregiving responsibilities. The service may also afford an opportunity for a community based resident to benefit from services typically offered to long term care residents.

Residents admitted for sub-acute care services are admitted with the expectation that, unless continued placement in the Facility is medically appropriate, they will be discharged once short term services are no longer required. It is the mutual objective of the Resident and the Facility that the Resident returns to his/her home or a less restrictive setting, if appropriate. The Resident and his/her Responsible Parties agree to facilitate discharge as soon as medically appropriate, and hereby represent and agree that they will work with the Facility staff to secure an appropriate and timely discharge.

Note: Residents admitted for sub-acute care are responsible for any charges that may accrue after termination of their third party coverage if they remain in the Facility for any reason.

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In the event the Resident is admitted for sub-acute services and thereafter 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.

Initial:

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Resident/Responsible Party

2.3 **<u>Physician And Ancillary Services</u>**

Charges for physician visits and physician-ordered ancillary services are <u>not</u> included in the daily basic rate. Charges may be billed by the Facility or directly by the provider of the service. The

Resident is not obligated to pay for services paid for by Medicaid, Medicare (or other third party payor) except for deductibles and co-payments. Medicaid eligible Resident's physician services are normally covered by Medicaid/Medicare/Other Third Party Payor.

A listing of charges for ancillary services and prescription drugs which are provided by the Facility but which are not included in the daily basic rate is available to the Resident at the office of the Facility's administrator.

The Facility will arrange for physician visits, including by remote telehealth technology, as authorized under this Agreement and for ancillary services to be available to the Resident when prescribed by a physician. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. These services will be administered or supervised by practitioners affiliated with and/or approved by the Facility who meet the applicable New York licensing, registration and certification requirements.

The following ancillary services are normally covered by Medicare or Medicaid:

(a) Restorative Physical Therapy
(b) Restorative Audiology Services
(c) Restorative Occupational Therapy
(d) Speech Therapy
(e) Podiatry Services
(f) Psychiatric or Psychological Treatment
(g) Optometric Services
(h) Laboratory Services
(i) Radiology Services
(j) Electrocardiography Services
(k) Oxygen Therapy
(l) Dental Services
(m) Vascular Services
(n) Wound Services
(o) Dermatology Services

The Facility is responsible for furnishing directly, or arranging for, certain services for its residents. In arranging for the provision of such services, the Facility is required to enter into arrangements with outside providers. Further, in entering into such an arrangement, the Facility must exercise professional responsibility and control over the arranged-for services. In that regard, all

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services that the Resident requires must be provided by the Facility or an outside provider approved by the Facility. Resident is liable for all charges incurred by providers not approved by the Facility.

2.4 **Transportation Services**. Medicare will usually cover ambulance services that are medically necessary while Medicaid will usually cover ambulette services. In addition, some (although not many) managed care plans and third party insurance policies may provide coverage for certain transportation costs. The Resident will be responsible for payment of transportation costs that are not covered by Medicare, Medicaid or insurance carrier.

2.5 **Outside Services**. If the Resident desires to engage the services of an outside dentist, physician **or** other consultant, and the use of that consultant was not ordered by a Facility physician, the Resident is responsible for all costs associated with those services, including professional fees to the extent those fees are not covered by Medicaid, Medicare or an insurance carrier and accompanying Facility personal when transportation off-site with supervision is required. The Resident agrees to hold Facility harmless for any and all harm, injury, damage or loss the Resident might incur while away from the Facility unaccompanied by any Facility staff members.

2.6 **Prescription Drugs; Medicare Part D.** Charges for drugs prescribed by a physician are not included in the daily basic rate. To the extent that prescription drug charges are not covered by Medicaid, Medicare or insurance carrier, they must be paid by the Resident. A Resident eligible for Medicare Part D coverage agrees to enroll in a Medicare Part D prescription drug plan which has a contract with the Facility's vendor pharmacy at or prior to the date of admission, if eligible at such time or during the month the Resident first becomes eligible for Medicare Part D coverage, if such eligibility occurs after the date of admission. All prescription drugs must be provided or administered to the Resident by the Facility.

2.7 **Eyeglasses, Hearing Aids and Prosthetic Devices.** Eyeglasses, hearing aids, dental prostheses and other prosthetic devices can be facilitated through the Facility but are not covered under the daily basic rate. To the extent that they are not paid for by Medicaid, Medicare or insurance carrier, they must be paid for or charged against the Resident's account when the cost is incurred.

2.8 **Personal Items**. Certain items and services, such as those listed below, are not covered under the daily basic rate and they are not normally paid for by Medicaid, Medicare or insurance carriers. Such items are made available by the Facility but must be paid for or charged against the Resident's account when the cost is incurred.

(a) Barber and beauty parlor services;
(b) Private telephone, cable, television or computer in room, including installation, maintenance and monthly and service fees;
(c) Shoes (non-prescription) and personal clothing;
(d) Dry cleaning;
(e) Special transportation for personal use;
(f) Cosmetic and grooming items and services in excess of those included in the basic service;
(g) Specially prepared food, beyond that generally prepared by the Facility;
(h) Personal comfort items including tobacco products and confections; and
(i) Personal reading materials, including newspapers.

2.9 **Resident Consent for Care by Trainee.** The Facility employees and training staff work in health care as part of its normal operations process. To that end, nursing and therapy but not limited to certified nursing assistant trainees, graduate nurses, graduate therapists, social workers students; may be assigned with notice to provide care to you under close supervision from a licensed supervisor. You may, at any time refuse care from a trainee and can request care from only licensed/certified staff members. Your request for this can be made verbally, nursing/social work will document your preference at the time it is expressed.

3. THE RESIDENT'S AGREEMENT TO PAY FOR SERVICES

3.1 **Resident's Direction to His/Her Agents.** The Resident hereby directs the Responsible Party to ensure that all payment obligations under this Agreement are met from the Resident's assets and to cooperate in obtaining Medicaid coverage if necessary to meet the Resident's obligations under this Agreement.

3.2 **The Resident's Obligations.** Subject to Section 3.3 below, the Resident agrees to pay for, or arrange to have paid for by Medicaid, Medicare, managed care providers or other insurers, all services provided by the Facility under this Agreement as follows:

(a) Medicare or Medicaid Coverage. If the Resident qualifies for Medicaid or Medicare coverage, the Facility agrees to accept the payment from these programs, plus any related coinsurance, deductible and Medicaid surplus amounts owed by the Resident, as payment in full for the items and services covered by Medicaid or Medicare. Residents are responsible for payment of services not covered by Medicare or Medicaid. **Residents eligible for Medicaid are also required to pay over their net available monthly income as detailed in Section 3.5(c) below.**

Initial:

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Resident/Responsible Party

(b) Private Pay Status. If the Resident does not qualify for Medicaid or Medicare coverage or have other third party coverage in place, the Resident agrees to pay the Facility (i) the daily basic rate as set forth in Section 3.2(c) below (as may be increased on sixty (60) days written notice to the Resident or the Responsible Party); (ii) items and services not covered under the daily basic rate pursuant to section 2.1 above (including prescription drugs and other ancillary services); (the total of the charges set forth in Subsections 3.2(b)(i) and (ii) referred to as the "Private Pay Rate"). The Resident agrees to pay the Private Pay Rate to the Facility after other coverage has been applied or exhausted until the month in which the Resident's Medicaid eligibility covers such charges. In addition, a Resident paying the Private Pay Rate is responsible for paying the amount of the New York State assessment levied on the Resident's payments to the Facility, including the base assessment, as may be adjusted, and any additional temporary assessments imposed. (As of January 1 , 2025, the current combined assessment rate is 6.8%).

Monthly payment of the Private Pay Rate is due in advance, on the third of every month.

(c) Daily Basic Rate. The Facility has a variable room rate system based on the types and amount of health care services provided to each of our residents. A resident assessment system, established by The Federal Government's Centers for Medicare and Medicaid Services, classifies residents into one of 66 Resource Utilization Groups (R.U.G.). Each R.U.G. classification has a corresponding Case Mix Index (C.M.I.) that determines the relative value of the services provided. Upon admission the prospective resident is assessed by an Assessor and a Minimum Data Set (M.D.S.) summary is completed. This process results in an initial R.U.G. classification and a corresponding room rate.

This resident's assessment and M.D.S. Summary results in a R.U.G. classification of ________. Accordingly, the daily basic rate is $________.

The M.D.S. will then be updated quarterly based on the federally mandated schedule. The most recent M.D.S. R.U.G. score will be examined quarterly from March 1-14, June 1-14, September 1-14 and December 1-14. If these quarterly reviews result in a new R.U.G. classification and new room rate, the

change will be limited to adjacent room rate groups. For example, Group 3 can only move to Group 2 or Group 4 in one quarter. As always, sixty (60) day notification will be provided.

(d) Private Room Differential. If it is agreed upon admission that the Resident will be admitted to a private room, the resident accepts the private room with the knowledge that his/her insurance will only pay for semi-private room accommodation. The Resident will be responsible for the difference between the private room rate and the semi-private room rate, unless the private room is determined to be medically necessary. Medical necessity is generally defined to include (i) the need for isolation, where placement in a semi-private room would jeopardize the health of the resident or other residents; or (ii) admission is required and only private rooms are available. At such time as a semi-private room is available and the Resident elects to remain in the private room, the resident will accept responsibility for the cost difference as stated above.

3.3 **Third Party Agreements**

(a) Managed Care Agreement. Notwithstanding anything in this Agreement to the contrary but subject to Section 3.3(c) below, during such time as (i) a written agreement (the "Provider Agreement") is in effect between the Facility and a managed care company (the "Managed Care Company") for the reimbursement to the Facility for certain services ("Covered Services") to enrolled members of the Managed Care Company's plan; and (ii) the Resident continues as an enrolled Member of the Managed Care Company's plan, except to the extent permitted under the Provider Agreement the Resident will not be responsible to the Facility for the payment of any Covered Services covered under the Provider Agreement. However, the Resident will be liable to the Facility to the extent that the Facility does not receive full reimbursement due to the Resident's failure to inform the Facility of coverage, or a change of coverage, under the managed care plan or to inform the Facility of a pre-authorization requirement under such plan. **The Resident will remain liable for services for which the Facility is not entitled to reimbursement under the Provider Agreement, including deductibles, co-payments, co-insurance and/or payment for non-Covered Services.**

The Facility reserves the right to terminate its contractual relationship and its status as a network or authorized provider with a Managed Care Company at any time in accordance with applicable law and the terms of the applicable agreement. If the Facility terminates its contractual relationship with the Managed Care Company in which Resident is enrolled, The Resident may convert his or her coverage to a health plan for which the Facility is an authorized provider or transfer to a facility that is an authorized provider for Resident's Managed Care Company. The Facility shall provide thirty (30) days advance notice of its decision to withdraw as a participating provider from the Resident's Managed Care Company to enable Resident and the Managed Care Company to coordinate a transfer to another facility.

(b) Insurance Company Agreement. Notwithstanding anything in this Agreement to the contrary but subject to Section 3.3(c) below, the Resident will not be responsible to the Facility for the payment of any services provided by the Facility (the "Specified Services") to the extent the Specified Services are subject to reimbursement by the Resident's insurance company pursuant to a written agreement (the "Insurance Agreement") between the Facility and the Insurance Company. **The Resident will remain liable for payment for all services for which the Facility is not entitled to reimbursement under the Insurance Agreement, including deductibles, co-payments, co- insurance and/or payment for non-Specified Services.**

(c) Requirement to Provide Information. If the Resident does not timely provide the information required for the Facility to obtain pre-certification of the Resident's admission to the Facility from a Managed Care Company or an Insurance Company, the Resident will be responsible for all charges owed pursuant to Section 3.2 above to the extent the Facility is not reimbursed by the Managed Care Company or Insurance Company due to the Facility's inability to obtain the Resident's pre-certification for coverage.

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In addition, the Resident shall notify the Facility (i) immediately of any change in the Resident's insurance status or coverage made by the insurance carrier including, but not limited to, the insurance carrier's discontinuation of coverage for, or any decrease or increase in insurance benefits applicable to, the Resident, and (ii) before Resident is unable to meet Resident's insurance premium or before Resident implements an increase, decrease or termination from insurance coverage.

(d) Other Insurance Arrangements. To the extent that there is no written agreement between an insurance carrier and the Facility applicable to the Resident's charges under this Agreement, the Resident shall have the sole responsibility to collect or apply for any insurance benefits the Resident may be entitled to, including long term care insurance. The Facility assumes no responsibility to apply for or collect such insurance benefits.

3.4 **Security Deposit**

(a) In General. If the Resident is not qualified for Medicare Part A, Medicaid, managed care, or insurance coverage on admission, the Resident agrees to prepay an amount for basic services which shall equal ninety (90) days' payment at the daily basic rate. Prepayment will be placed in an interest-bearing account (the "Prepayment Account") and any interest earned shall be credited to Resident's Prepayment Account. The Prepayment Account must be maintained at all times at an amount equal to at least ninety (90) days at the Facility's room and board rate, and is not to be used for Resident's current care (except as otherwise provided herein). If the Resident is transferred to a more expensive room, or if the Facility's daily room and board rate increases, the Facility will notify Resident and/or the Responsible Party within thirty (30) days, and additional funds will be required to increase the prepayment to reflect the increased rate. If the Resident is spending down assets to the Medicaid limit, monies in the Prepayment Account will be applied toward current care and will be used to calculate the date when Medicaid coverage begins. Upon termination of Resident's stay at the Facility or eligibility for Medicare Part A, Medicaid, managed care or insurance coverage, any outstanding bills shall be paid from the monies in the Prepayment Account. The remainder of the Prepayment Account will be refunded, together with accrued interest, to the source of payment.

(b) Exhaustion of Medicare Benefits. If the Resident qualified for Medicare Part A, managed care or insurance benefits and these benefits become exhausted and the Resident is unable to supply satisfactory evidence of entitlement to Medicaid benefits, the Resident agrees to prepay an amount equal to thirty (30) days' payment at the daily basic rate as security for payment of any financial obligation of the Resident under this Agreement.

3.5 **Payment Obligations Under Medicaid and Other Third Party Payors**

(a) Obligations to Assure Third Party Payment. The Resident agrees to provide information pertaining to all potential third party payors, and either agrees to provide proof that a claim for coverage has been made or to provide the Facility with necessary information for the Facility to submit the claim.

(b) Duty to Arrange for Timely Medicaid Application. The Resident agrees to monitor the Resident's resources to assure uninterrupted payment to the Facility by making timely application to Medicaid (and/or other payors) as is necessary. The Resident will inform the Facility at least ninety (90) days prior to the Resident's exhaustion of the Resident's assets or insurance benefits. However, if the Resident's Managed Care or Insurance Company benefits are terminated due to a change in the Resident's condition, the Resident will inform the Facility upon termination of benefits.

(c) Monthly Income Payments under Medicaid. The Resident understands that if he/she receives monthly income and also qualifies for Medicaid, the County Department of Social

Services will require most of such income (referred to as "Net Available Monthly Income") to be paid to the Facility. In that event, the Resident guarantees that such income will be delivered to the Facility on or before the 3rd of each month or that it will be sent directly to the Facility from the income payor. If the Resident's liquid assets are exhausted or unavailable prior to a determination of Medicaid coverage, the Resident agrees to pay his/her monthly income to the Facility as partial payment for the Private Pay Rate.

Initial:

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Resident/Responsible Party

(d) Semi-Private Room. Medicaid covers the costs of a semi-private room. If the Resident has occupied a private room, the Resident understands and agrees that when he/she no longer pays the Private Pay Rate and does not have a medical condition requiring a private room, when the Facility otherwise has need for the room, or when Medicaid coverage begins, he/she will move to a semi-private room.

1. 4. THE RESPONSIBLE PARTY'S OBLIGATIONS TO THE FACILITY

4.1 **Acknowledgement of Consideration.** The Responsible Party desires to facilitate the Resident's admission to the Facility and acknowledges that the Facility has agreed to enter into this Agreement and admit the Resident to the Facility in consideration of the Responsible Party's representations and obligations to the Facility under this Agreement.

4.2 **Payment Obligation from Resident's Funds.** The Responsible Party personally and independently guarantees continuity of payment to the Facility from the Resident's funds for the cost of the Resident's care to the extent the Responsible Party has legal access to the Resident's funds. Unless the Responsible Party is otherwise obligated by law to pay for the Resident's care, as the Resident's spouse may be, the Responsible Party is not required to use his/her personal resources to pay for such care.

4.3 **Reliance on Spouse's Credit.** It is acknowledged that, to the extent that the Resident is married, the Facility is relying upon both the Resident and the Resident's spouse's credit for any charges incurred by the Resident.

5. RESIDENT OBLIGATIONS AND REPRESENTATIONS

5.1 **Documentation.** The Resident agrees to provide the Facility with copies of all Powers of Attorney, Guardianship Orders, Health Care Proxy or other documentation authorizing an agent to act for or on behalf of the Resident.

5.2 **Prohibition on Recording.** The Resident agrees that neither they nor their agents may record other residents of the Facility or staff of the Facility (including audio, video and still pictures) without their express written consent.

5.3 **Transfers By The Resident**. The Resident understands that the Resident's ability to qualify for Medicaid coverage could be impaired by certain transfers of assets by the Resident. They further understand that the purchase by the Resident or his or her spouse of an annuity contract, life estate interest in a home, loan, promissory note or mortgage will be considered a transfer under certain circumstances for Medicaid eligibility purposes. The Resident warrants and represents the following:

(a) Except as set forth below, the Resident does not have any knowledge of transfers by the Resident or his or her spouse within the last five (5) years (i) of assets for less than their fair value or (ii) to a trust of which the Resident is a beneficiary.

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(b) Except as set forth below, the Resident does not have any knowledge of the purchase by the Resident or his or her spouse of an annuity contract, life estate interest in a home, loan, promissory note or mortgage within the last five (5) years.

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6. TRUTHFULNESS OF INFORMATION PROVIDED

The Resident guarantees the truthfulness of all information that the Resident provides to the Facility (including information relating to the financial resources of the Resident and transfers by the Resident). By signing this Agreement, the Resident acknowledges that the Facility relies on such information, and the Resident agrees to pay on demand all damages directly or indirectly resulting from the Resident's misrepresentation of information provided to the Facility, including reasonable attorney's fees.

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______________________ ______________________
Resident/Responsible Party

7. LATE PAYMENTS AND NON-PAYMENT

7.1 **Late Charges**. In the event of late payment of any sums due from the Resident or Responsible Party under this Agreement, the Facility will be entitled to receive a fee computed at one and one-half percent (1-1/2%) per month of said amount or the maximum amount allowed by law, whichever is less, on all accounts overdue more than thirty (30) days.

7.2 **Discharge.** It is understood that the Resident may be discharged for non-payment of sums due under this Agreement or as otherwise permitted under New York State Department of Health Regulations.

7.3 **Collection Costs.** In case of non-payment of any sum due under the terms of this Agreement, the Resident agrees to pay interest as set forth above and reasonable collection fees, including but not limited to attorney's fees and expenses, incurred by the Facility in enforcing the terms of this Agreement.

7.4 **Damages.** If the Responsible Party fails to pay amounts owed by the Resident under this Agreement (including the Private Pay Rate, the Net Available Monthly Income, or the deductibles and co-insurance) from the Resident's funds to which the Responsible Party has legal access, the Responsible Party agrees to personally pay damages caused by such failure, including interest on late payments in accordance with Section 7.1 above and reasonable attorney's fees and expenses.

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Resident/Responsible Party

8. RESIDENT'S PROPERTY

The Facility has in place written policies and procedures to safeguard the Resident's property at the nursing home facility. The Facility is not liable for the replacement or reimbursement of the Resident's property except as required under the Facility's policies and procedures or applicable law.

It is the obligation of the Resident to arrange for disposition of all of the Resident's property upon discharge. The Facility may dispose of property left more than forty-five (45) days after discharge to the proper authorities.

The Resident agrees that, except as otherwise directed by Resident to the Facility at any time, any payment refunds payable upon Resident's discharge from the Facility may be paid to the payer of the Resident's charges, include joint account holders with the Resident.

9. AUTHORIZATION FOR PHYSICIAN VISITS

The Resident (or, if the Resident lacks consent and the Responsible Party has the authority make healthcare decisions on behalf of the Resident, the Responsible Party) agrees that a physician may visit the Resident in the Facility or remotely at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter, or as often as necessary to address the Resident's medical care needs.

10. OBLIGATIONS TO ABIDE BY FACILITY RULES AND REGULATIONS; NON-SMOKING FACILITY

The Resident agrees to abide by the Facility's Rules and Regulations, and to respect the personal rights and private property of all residents and staff. The Resident acknowledges that, except to the extent that the Facility may, at its sole discretion, provide designated smoking areas, the Facility is a non-smoking facility (including electronic cigarettes) and will abide with all rules of the Facility restricting smoking.

11. RELOCATION

The Resident may be relocated to another room or unit within the Facility if there is a change in medical condition. This includes the relocation of the Resident from the Facility's subacute unit to a long-term care unit. The Resident may also be relocated to another room if such a change is required to ensure that persons of the same gender share a room or to accommodate the clinical needs of another resident.

12. VIDEO SURVEILLANCE

The Facility common areas may be under twenty four hour video surveillance with access to the surveillance limited to the Administrator as part of the facilities Continuous Quality Improvement Process. The Facility does not routinely use video surveillance in resident rooms. The use of electronic monitoring/video surveillance in any resident/patient room, whether a private or shared room is strictly prohibited.

13. RESIDENT PHOTOGRAPHS

It is acknowledged that the Facility may arrange for photographs are Residents that are used solely for treatment, payment, or healthcare operations purposes.

14. CONSENT TO JURISDICTION AND GOVERNING LAW

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Except to the extent that a dispute is subject to arbitration pursuant to a separate agreement, each of the parties to this Agreement irrevocably (a) submits to the exclusive jurisdiction of the courts of the State of New York in the County of Chautauqua (and the Federal courts having jurisdiction in the State of New York, for the County of Chautauqua) for purposes of any judicial proceeding that may be instituted in connection with any matter arising under or relating to this Agreement or otherwise, (b) waives any objection that such party may have at any time to the laying of venue of any action or proceeding brought in any such court, and (c) waives any claim that such action or proceeding has been brought in an inconvenient forum.

15. GENERAL PROVISIONS RELATING TO THIS AGREEMENT

In addition to the parties signing this Agreement, the Agreement shall be binding on the heirs, executors, administrators, distributors, successors, and assigns of the parties. Notwithstanding anything in this Agreement to the contrary, the provisions of sections 3, 4, 5, 7, 8, 12, 13 and 14 shall survive the termination of this Agreement.

This Agreement represents the entire agreement among the parties and may not be amended or modified except in writing signed by the Facility and the Resident and/or the Responsible Party, except with respect to increases in charges as set forth in this Agreement and modifications required by changes in the law. Modifications to this Agreement necessitated by changes in statutory or regulatory requirements or their interpretations are deemed to become part of this Agreement. This Agreement shall be governed by and construed in accordance with the laws of the State of New York.

This Agreement shall remain in full force and effect upon the Resident's return to the Facility after the temporary transfer of the Resident to another facility for medical or surgical treatment or the Resident's temporary absence from the Facility when the Facility is required to readmit the Resident under applicable law.

Any spaces in the body of this Agreement for initials are for convenience only to ensure that certain provisions have the attention of the Resident or Responsible Party as to their responsibilities therein and all provisions of this Agreement shall be binding and in full force and effect even absent an initial is such spaces.

The failure of any party to enforce any term of this Agreement or the waiver by any party of any breach of this Agreement will not prevent the subsequent enforcement of such term, and the party will not be deemed to have waived any subsequent breach of this Agreement. Should any provision of this Agreement be void or unenforceable, that provision shall be deemed omitted, and this Agreement with such other provision omitted shall remain in effect.

This Agreement may be executed in any number of counterparts, each of which so executed shall be deemed to be an original, and such counterparts shall together constitute but one and the same Agreement. The parties shall be entitled to sign and transmit an electronic signature of this Agreement (whether be facsimile, PDF, or other email transmissions), which signature shall be binding on the party whose name is contained therein. Any party providing an electronic signature agrees to promptly execute and deliver to the other parties an original signed Agreement upon request.

Headings contained in this Agreement have been inserted for reference purposes only, and shall not be construed as part of this Agreement.

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The parties to this Agreement have read, been advised of, understand and agree to be legally bound by the terms and conditions set forth herein. We also certify that any information contained in the completed Admission Application is true, accurate and current.

In addition, we, the Resident and the Responsible Party, have received copies of the following:

- **the Resident's Statement of Rights;**
- **information on how Resident and their family members can look up complaints, citations, inspections, enforcement actions, and penalties taken against the Facility;**
- **physician's name, address and telephone number;**
- **New York State Department of Health "hot line" telephone number;**
- **New York State Office of the Aging Ombudsman Program telephone number;**
- **the Patient/Resident Handbook;**
- **information about Medicaid and Medicare eligibility;**
- **bed retention policy;**
- **information on right to make advanced directives or to refuse medical treatment;**
- **restraint and pain policy;**
- **the Facility's visitation policy;**
- **discharge time policy;**
- **beauty shop rates;**
- **administration/department head listing;**
- **Veterans Administration information;**
- **side rail education information;**
- **immunization information;**
- **health care proxy information;**
- **discharge agreement (as appropriate);**
- **safe food handling practices educational information;**
- **falls risk information and acknowledgement;**
- **skin integrity informed care memorandum; and**
- **NYS residential health care facilities disclosure requirement.**
- **Rep Payee**
- **Grievances**

ACCEPTED:

RESIDENT:

______________________________ ____________________

Signature Date

If signing on behalf of Resident:

__________________________ ________________________

(Name) *(Authority)*

RESPONSIBLE PARTY (including with respect to the obligations set forth in Section 4 above):

______________________________ ____________________

Signature Date

ACCEPTED:

FACILITY: BROOKHAVEN HEALTH CARE FACILITY

By: ___________________________________ ___________________________
Name/Title: Date

ADMISSION PACKAGE

PART A. **Resident Authorizations and Forms**

1. General Resident Authorizations
   - 1.1. Dental Service Acceptance/Declination
   - 1.2. HIV/AIDS Information
   - 1.3. Hepatitis C Testing
   - 1.4. Personal Spending Account Authorization
   - 1.5. Facility Directory Authorization
   - 1.6. Veterans Benefits
   - 1.7. Opening of My Mail
2. Credit Card Authorization Form
3. Assignments of Benefits and Release of Information
4. Agreement Regarding Resident’s Monthly Income
5. Health Consent Form
6. Photography Authorization Form

PART B. **Policies and Procedures**

I. Bed Reservations for Temporary Absences

II. Notice of Privacy Practices

III. Medicare Prescription Drug Coverage and Your Rights

IV. Medicare DMEPOS Supplier Standards

V. NYS Residential Health Care Facilities Disclosure Requirement

VI. NYS Ombudsman Program

VII. Authorizations and Declarations

VIII. Grievances

IX. Advance Directives Policy

RESIDENT AUTHORIZATIONS

I, ________________, make the below authorizations as a resident or prospective resident of _______________ (the "Facility"). I acknowledge the following in making these authorizations:

- I am not required to sign any specific authorization and may in fact refuse to sign all or any of these authorizations.
- The Facility will not condition my treatment or payment for my treatment on obtaining this authorization from me.
- I have the right to revoke any authorization at any time. My revocation must be in writing and submitted to _________________________________ [name, office or person in Facility]. If I do revoke an authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.

1.1 Dental Service Acceptance/Declination.

I understand that I have the right to continue to use my community dentist during my rehabilitative stay at the Facility. I have been advised of my right to change my decision at any time during my stay should a dental emergency arise or I wish to be seen for initial or routine services. I understand and take full responsibility for my decision to decline dental services at this time.

I have been encouraged and offered assistance in arranging to see my community dentist and have:

_______Accept Dental Service at the Facility: I have been advised of my right to change my decision at any time during my stay.

_______Use Community Dentist: ____.

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1.2 HIV/AIDS INFORMATION. For Residents/Patients 64 years and younger, complete below:

- HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV- infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.
- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality of HIV test results and other related information.
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
- The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

My health care provider, _____________________ will answer any questions I have about HIV/AIDS. I have been provided information with the following details about HIV testing:

_______I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing, which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive, I will be provided the result directly by my provider and receive post-test counseling, and with my consent, I will be provided follow-up HIV medical care. I may revoke my consent orally or in writing at any time. As long as this consent is in force, my provider may conduct additional tests without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will note this in my medical record.

_______I decline to be tested for HIV Infection at this time. I have been advised of my right to change my decision at any time during my stay.

1.3 HEPATITIS C SCREENING for Residents/Patients; please complete below:

- The Centers for Disease Control (CDC) and N.Y. State require healthcare providers to offer residents/patients a one-time screening test for Hepatitis C virus (HCV).
- Hepatitis C is primarily spread through contact with blood from an infected person.
- There are several reasons why someone should be tested for HCV. Knowing your HCV status will help to prevent HCV transmission to others and early detection and ongoing disease monitoring can also improve health outcomes.

- Better and more effective treatments are now available.
- This is a simple blood test.
- If the test comes back positive your medical provider may ask you to have further blood testing.

My health care provider, ______________________ will answer any questions I have about Hepatitis C testing. I have been provided information with the following details:

_______I agree to be tested for Hepatitis C. If the results show I have Hepatitis C, I understand that I may be asked to consent to further testing.

_______I decline to be tested for Hepatitis C at this time. I have been advised of my right to change my decision at any time during my stay.

1.4 RESIDENT PERSONAL SPENDING ACCOUNT AUTHORIZATION.

The Facility offers its residents the convenience of personal accounts with quarterly statements for incidental expenses. Amounts over $50, as required by law, are deposited in an interest-bearing bank account. Funds can be obtained seven days a week from the business office during its operating hours or a designee in the evening and weekends. I may receive a statement of my account at any time within one (1) business day of my request.

Refunds for the balance in the personal account, less amounts owed to the Facility, will be made to the Resident after discharge. Following a Resident's death, refunds will be made to the person or probate jurisdiction administering the Resident's estate or by use of a New York "small estate" affidavit unless the Resident's Facility charges are paid by Medicaid, in which case the balance will be deposited with the relevant county Department of Social Services.

Check One:

_____I authorize The Facility to open an incidental personal expense account which will act as a petty cash account. Any monies in this account in excess of fifty dollars ($50.00) shall automatically be deposited in an interest bearing account on my behalf.

______I will personally handle my personal funds through my incidental personal expense account at the Facility. I wish to receive my Quarterly Statements.

______I prefer to have my legal representative, ____ handle my personal expense account for me at this time, but I may do so at any time during my stay. My Legal Representative will receive the Quarterly Statement.

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_____I consent that upon my discharge, the Facility may withdraw from the account amounts owed to the Facility and return the balance to me, as applicable.

1.5 FACILITY DIRECTORY AUTHORIZATION.

The Facility directory is used to provide visitors, verbal inquiries and service providers with the following resident information as follows:

- Name
- Location within the Facility (which may be released to any person who requests information about resident by name).
- Religious affiliation (which may be released to any member of the clergy, even if they do not ask for the patient/resident by name).

Clinical information is not contained in the Facility directory.

_______I authorize the Facility to include my information in the Facility directory.

_______I request that the Facility not include the following information about me in the Facility directory ____

_______I request that the Facility restrict access to my directory information.

1.6 VETERANS BENEFITS.

New York State's Public Health Law Section 2805-o requires nursing homes and residential health care facilities to ask every new resident upon admission whether he or she is a Veteran, or the current or surviving spouse of a Veteran.

□ No, I am not a veteran or the current or surviving spouse of a Veteran.

(If no, skip ahead to the next section)

□ Yes, I am a veteran or the current or surviving spouse of a Veteran.

(If yes, review the rest of this section)

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I have been advised verbally and in writing that I can receive free Veterans' benefits assistance and I have received the contacts, phone numbers and websites for the New York State Division of Veteran's Affairs. I may also obtain a handbook by calling one of the listed phone numbers. I have been offered to give my contact information to the Division of Veterans' Affairs to obtain free benefits assistance for the resident.

1.7 OPENING OF MY MAIL.

□ I understand that I have the right to receive mail unopened. I may choose to permit the Facility to open my mail for convenience purposes.

□ I authorize the Facility business agent to receive and open mail on my behalf.

ASSIGNMENTS OF BENEFITS AND RELEASE OF INFORMATION

TO

BROOKHAVEN HEALTH CARE FACILITY

RESIDENT: ____

INSURANCE ID: ____

MEDICARE NUMBER: ____

MEDICAID NUMBER: ____

Release of Information.

I, ________________________________, or my Designated Representative on behalf of me hereby authorize any medical facility, healthcare provider or other holder of medical or other information pertaining to me to release this information to **BROOKHAVEN HEALTH CARE FACILITY** (the "Facility") any medical or personal information about me so that the Facility is able to prepare claims for submission on my behalf to Medicare, Medicaid or other third party payers.

I give my permission to the Facility and any other holder of medical information and other information about me to release the information about me to any entity which is, or may be, liable for the Facility's charges, including insurance carriers, managed care organization, the Social Security Administration, the Health Care Financing Administration or its intermediaries and any professional review organization associated with those entities.

I give authorization to release information and payment request on form UB-04 HCFA-1450, HCFA-1500 or any other claim forms. I certify that the information given by 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 related Medicare claims.

Assignment of Benefits.

I hereby assign payment for any unpaid charges for physicians listed on forms HCFA-1500 and UB-04 HCFA-1450 and any successor forms and for any other charges accrued in connection

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with the Medicare benefits under Titles 18A and 18B, Medicaid and other third party payors to the Facility and/or physicians of the visiting medical staff of ____. I authorize that the opening and disposition of Medicare correspondence be assigned to the Facility.

I authorize payment of Medicare benefits to be made directly to the vendors for any services furnished to me by that vendor. Such vendors are authorized to release to the Health Care Financing Administration and its agents any information needed to determine payment for those services.

Private Insurance.

I am ___, am not ___ aware of private insurance under which I may be currently covered, and give the Facility my permission to bill and submit medical documentations to the carriers. I understand that Medicare is a secondary payer, and must be informed of any insurance I may have at present. I realize that failure on my part to disclose insurance at this time could jeopardize my coverage by Medicare. I agree to submit to the Finance Department of the Facility a current copy of any insurance under which I may be presently covered.

My Responsibility.

I understand that I am responsible for any charges not covered by Medicare, Medicaid or other insurance coverage and agree to pay such coverages.

A photocopy of this Authorization shall be considered as effective and valid as the original.

____ ____________________

Signature of Resident or Personal Representative Date

____ ________________________________

Printed Name of Resident or Personal Representative Relationship to Resident

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PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NEW YORK STATE EXTERNAL APPEAL

The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans.

When an external appeal is filed, a consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol / substance use treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

If the patient or the patient's designee submits this application, by signing the Patient Consent to the Release of Records for New York State External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

Signature of patient is required below. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased, the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, power of attorney, healthcare proxy or executor, a copy of the legal supporting document should be included.

Signature:			
Print Name:			
Relationship to patient, if applicable:			
Patient Name:		Age:	
Patient's Health Plan ID#:			
Date: (required)			

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AGREEMENT REGARDING RESIDENT'S MONTHLY INCOME

This is an Agreement made ___________________ *(date)* between ___________________________ ("Rep Payee") and _______________________________________the "Facility") regarding _______________________ (the "Resident").

THIS AGREEMENT IS BASED ON THE FOLLOWING UNDERSTANDINGS:

(a) The Resident is, or is anticipated to be, eligible for coverage under the Medicaid program.

(b) Rep Payee has access to some or all of the Resident's monthly income, including Social Security and pension payments.

(c) Medicaid will reduce the amount it pays to the Facility for the Resident's care by the amount of the Resident's monthly income reduced (less $50 and relevant insurance payment) by a designated amount ("Net Monthly Income"). The Resident is required to pay the Net Monthly Income directly to the Facility.

THE PARTIES AGREE AS FOLLOWS:

1. Rep Payee warrants and represents that he/she has control of and access to all or a portion of the Resident's monthly income. Rep Payee agrees to cause the Resident's monthly income to be paid to the Facility as partial payment for the daily basic rate owed until Medicaid eligibility is established. Once Medicaid eligibility is established, the Rep Payee agrees to cause the Resident's Net Monthly Income (as determined by the County Department of Social Services) to be either paid to or deposited directly with the Facility.

2. By signing this Agreement, the Rep Payee acknowledges that the Facility relies on such information and Rep Payees agreement to make such payments, and agrees to pay on demand all damages directly or indirectly resulting from his/her misrepresentation of information provided to the Facility or failure to make the monthly payments.

ACCEPTED AND AGREED TO:

____

Rep Payee

By: ____

Authorized Signatory

BROOKHAVEN HEALTH CARE FACILITY

HEALTHCARE CONSENT FORM

I, ________________________________, or my Designated Representative on behalf of me, acknowledge and consent to the statements made in this form.

Consent to Health Care Services: I consent to treatment and care by **BROOKHAVEN HEALTH CARE FACILITY** (the "Facility") and by its physicians, employees and/or authorized agents of the Facility as they judge is in my best interest. This may include routine diagnostic, radiology, dental and laboratory procedures, photographs and/or recordings taken to help with a diagnosis and/or treatment of a condition, medication administration, and patient administration.

Telehealth Services: I understand that the Facility may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

Blood Testing: If a healthcare worker involved in my care and treatment becomes exposed to certain bodily fluids resulting in the possibility of transmission of a bloodborne disease, my blood will be tested for HIV, Hepatitis B, Hepatitis C, Covid-19 and other potential bloodborne communicable diseases to determine risk of exposure to the healthcare worker.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENTS.

______________________________ ______________________________

Signature of Resident or Personal Representative **Date**

______________________________ ______________________________

Printed Name of Resident or Personal Representative **Relationship to Resident**

The foregoing consent was read, discussed, and signed in my presence and in my opinion the person so signing did so freely and with full knowledge and understanding.

____

Signature of Witness

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BROOKHAVEN HEALTH CARE FACILITY

PHOTOGRAPHY AUTHORIZATION FORM

BROOKHAVEN HEALTH CARE FACILITY ("the Facility") periodically receives requests for articles and pictures about programs or special events at this facility. We believe that fostering links to the outside community and presenting a positive image of nursing facility life is important. We also respect each resident's right of privacy and recognize that individuals may not wish to participate in such publicity.

A. Resident Name: ______________________ Identification #: ______

B. I hereby authorize the Facility to make and disclose visual recordings of me (such as photographs and video) that will be disclosed as follows:

1. To visitors of the Facility's internet website(s);
2. In the Facility publications, including brochures and other promotional materials;
3. To the general public in connection with fundraising for the Facility and its affiliates.
4. To the media (TV, newspaper, magazine, other any other media); and
5. The following other disclosures authorized, if any: ________________________________.

C. This authorized use or disclosure is for the promotional, publicity, marketing and solicitation purposes of the Facility and its affiliates.

D. This Authorization will expire five years from the date I sign the Authorization, or after the photographs and recordings are no longer needed by the Facility for the use/disclosure that I have authorized, whichever date is later.

E. I understand and agree that any photographs, video recording, or other visual recordings authorized by me may also disclose my identity or other protected health information relevant to and related to my treatment or condition, and I authorize this disclosure.

F. I acknowledge the following in making this authorization:

- I am not required to sign this authorization and may in fact refuse to sign this authorization.

- The Facility will not condition my treatment or payment for my treatment on obtaining this authorization from me.

- The released information may be re-disclosed and would then no longer be protected by the federal regulations protecting privacy of an individual's health information ("HIPAA") and other applicable federal and state law.

- I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to [ ]. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization. A withdrawal of this authorization will not apply to photographs or visual recordings or other information already used in reliance upon this authorization. During the recording, I have the right to stop recording at any time.

- My protected health information will exist forever in either a recorded, printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used.

- If I have any questions about this authorization, I may contact _______________ at ( ) ___-____, who will provide me with more information about this authorization, or about the Facility's privacy practices.

I CERTIFY THAT I HAVE READ, SIGNED AND RECEIVED A COPY OF THIS AUTHORIZATION.

____ ________________

Name of Patient Date

____ ________________

Signature of Patient (or Patient's Representative) Date

____

Relationship of Patient Representative to Patient

PART B

POLICIES AND PROCEDURES

I. ____ ("FACILITY") BED RESERVATIONS FOR TEMPORARY ABSENCES

PRIVATELY PAYING 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 be given an option to hold a resident's bed if the Resident is expected to return to the FACILITY and providing the Resident's accounts are not in arrears. In instances of non-third party reimbursement, the resident and designated representative may be afforded the opportunity of reserving a bed for a period of time as determined by the aforementioned at the bed hold rate as detailed herein. For residents who desire to hold a bed during a hospitalization, those in Groups 1, 2, 3 and Sub-acute would be charged the Group 1 rate; Groups 4 and 5, at Group 3 rate.

During the Resident's absence, the daily rate under this Agreement is owed unless the FACILITY is notified to cancel the bed hold.

BED RESERVATIONS FOR MEDICAID COVERED RESIDENTS

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

- If the resident is under 21 years of age;
- The resident is in a Hospice Program and for up to 14 days.

If the Medicaid sponsored Resident takes a therapeutic leave of absence overnight for other than hospitalization, Medicaid may pay to hold the bed for up to eighteen (18) days in any twelve (12) month period if, on the day of the Resident's departure; the same conditions above have been met. The NAMI income/amount continues to be due and owed during the therapeutic bed hold.

If a Medicaid covered Resident is ineligible for a reserved bed, the Resident and/or the Undersigned have the option to pay to reserve the bed at the prevailing private pay rate, so long as the Resident's payments for care are not in arrears. If the bed is not reserved privately, the FACILITY will release the bed, but will give the Resident priority readmission for the next available semi-private bed.

BED RESERVATION THROUGH THE VETERANS ADMINISTRATION

During a hospitalization or leave of absence, the FACILITY will reserve the bed for the number of days during which the Veterans Administration ("VA") agrees to pay the VA contract charges. If the VA covered bed hold expires, the bed may be reserved for the prevailing private daily rate so long as the Resident's payments for care are not in arrears.

BROOKHAVEN HEALTH CARE FACILITY

II. 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.

We are committed to protecting privacy of your medical information. While you receive pharmacy services from us, we create records of the pharmacy services that we provide to you. We need these records to provide you with quality pharmacy services and to comply with law. This Notice describes your rights with respect to your medical information. This Notice also describes certain duties we have regarding your medical information and how we may use and disclose your medical information.

WHO WILL FOLLOW THIS NOTICE

The privacy practices described in this Notice will be followed by Procare MSO and the entities under common ownership or control of Procare MSO, LLC, among which are Tap Rx, LLC, Clarest Health of Syracuse, LLC, Clarest Health Pharmacy of CT, LLC, Clarest Health of MA, LLC, Clarest Health OHIO, LLC, Clarest Health OHIO Acquisition Co I, LLC, which together form an affiliated covered entity under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the HIPAA privacy rules (collectively referred to as “We” or “Us” in this Notice).

WE ARE REQUIRED BY LAW TO:

1. Maintain the privacy and security of your medical information,
2. Provide you with this Notice about our legal duties and privacy practices with respect to your medical information,
3. Provide you with notice if a breach occurs that may have compromised the privacy or security of your medical information,
4. Abide by the terms of this Notice.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding medical information we maintain about you: Right to Review and Receive a Copy. You have the right to review and receive a paper or electronic copy of your medical information. You may request that we send a copy of your medical information to a third party. To review and request a copy your medical information, you must submit your request in writing to our Compliance Officer. Under certain circumstances, we may deny your request. We may charge a reasonable cost-based fee for providing you with a copy of your records.

RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES

You have the right to ask us not to use or disclose your medical information for purposes of treatment, payment, or health care operations or to individuals who are involved in your care. To request a restriction, you must submit your request in writing to our Compliance Officer. In your request, you must tell us what information you want us not to use or disclose and to whom you want the restriction to apply (for example, disclosures to a certain family member). We are not required to agree to your request, and we will notify you if we don't agree. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer, and we will agree to such request unless a law requires us to share that information. If we agree to your request, we will comply with the restriction unless the information is needed to provide emergency treatment to you. Even if we agree to your request, we may still disclose your medical information to the Secretary of the Department of Health and Human Services and for certain other purposes described below for which disclosure is permitted without your authorization. We may end a restriction to which we previously agreed if we inform you that we plan to do so.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you in a specific way or at a specified location. For example, you can ask that we only contact you at a certain phone number or only send mail to a certain address. To make such request, you must submit your request in writing to our Compliance Officer. In your request, you must tell us how or where you wish to be contacted and to what address we may send bills for medications and services provided to you. We will not ask you about the reason for your request. We will agree to all reasonable requests.

RIGHT TO REQUEST AMENDMENT

You have the right to request that we correct your medical information if you believe it is incorrect or incomplete. You have this right for as long as the information is kept by us. To make this request, you must submit your request in writing to our Compliance Officer and explain why a correction is needed. We may deny your request if it is not in writing or does not include a reason for your request. We may also deny your request if you ask us to correct information that we did not create (unless the person or entity that created the information is no longer available to make the correction), is not part of the medical information kept by us, is not part of the medical information which you may inspect and copy, or if we determine that your medical information is accurate and complete. If we accept your request, we will inform you about our acceptance and make the appropriate corrections. If we deny your request, we will inform you and give you a chance to submit to us a written statement disagreeing with the denial. We will add your written statement to your record and include it whenever we disclose the part of your medical information to which your written statement relates.

RIGHT TO REQUEST ACCOUNTING OF DISCLOSURES

You have the right to request a list of the times we have shared your medical information for six years prior to the date of your request, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures. To request this list, you must submit your request in writing to our Compliance Officer. Your request must state a time period for which you want to receive the accounting. We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within twelve months. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

RIGHT TO RECEIVE BREACH NOTICE

You have the right to receive notice following a breach of your medical information which results in such information being compromised.

RIGHT TO CHOOSE SOMEONE TO ACT FOR YOU

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your medical information. We will make sure the person has this authority and can act for you before we take any action.

RIGHT TO RECEIVE COPY OF THIS NOTICE

You have the right to receive a copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you may still ask for a paper copy of this Notice at any time. You may obtain a copy of this Notice at our website, Clarest.com. To obtain a paper copy of this Notice, please contact our Compliance Officer at (877) 827-7901 ext: 363.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION:

We may use and disclose your medical information without obtaining your authorization as described below.

Treatment

We may use and disclose your medical information to provide you with pharmacy products and services. We may disclose your medical information to doctors, nurses and other health care providers who provide health care services to you. For example, a doctor prescribing medication for you may need to know what other medications you are taking to protect against harmful drug interactions. We also may use your medical information to contact you to provide refill reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Payment

We may use and disclose your medical information so we can bill and receive payment for medications and pharmacy services we provide to you from your insurance company or other responsible for payment party. For example, we may give your health insurance company information about what medications were provided to you, so that your insurance may pay us or reimburse you for the medications. We may also tell your health insurance company about a prescription that you need to obtain prior approval or check if your insurance will pay for the medication.

Health Care Operations

We may use and disclose your medical information for purposes of health care operations, which are various activities necessary to run our business, provide quality pharmacy services and contact you when necessary. For example, we may use and disclose your medical information to evaluate the performance of our staff and for quality improvement activities. We may use medical information about you to manage the provision of pharmacy services to you. We may disclose your medical information to pharmacists, pharmacy technicians, pharmacy students and other trainees for review and learning purposes.

Family Members and Friends Involved in Your Care

We may disclose to your family members, close friends or to any other person you identify your medical information relevant to such person's involvement in your care or payment for your care. If you are present, we may make disclose the information if either you agree to the disclosure, we provide you with an opportunity to object to the disclosure and you do not say no, or if we reasonably infer that you do not object to the disclosure. If you are not present, we may disclose your medical information that is directly relevant to the person's involvement with your care if we determine this is in your best interest. We may also use and disclose your medical information in the event of disaster to organizations assisting in disaster relief efforts so that your family can be notified of your condition and location.

Compliance with Law

We may disclose your medical information to the Secretary of the Department of Health and Human Services and as required by Federal or state law.

Public Health Activities

We may disclose your medical information for public health activities to public health or other governmental authorities authorized by law to receive such information. This may include disclosing your medical information to report certain diseases, report child abuse or neglect, report information to the Food and Drug Administration if you experience an adverse reaction from a medication, to enable product recalls or disclosing medical information for public health surveillance, investigations, or interventions.

Health Oversight Activities

We may disclose your medical information to governmental agencies so they can monitor, investigate, inspect, discipline or license those who work in the health care and engage in other health care oversight activities. Workers Compensation We may disclose your medical information for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

Lawsuits and Legal Actions

We may disclose your medical information in response to a court or administrative order, subpoena, discovery request or other lawful process, subject to applicable procedural requirements.

Law Enforcement

We may disclose your medical information to law enforcement officials to report or prevent a crime and as otherwise authorized or required by law.

Specialized Government Functions

We may disclose your medical information for special government functions such as military, national security and presidential protective services.

Coroners, Medical Examiners and Funeral Directors

We may disclose your medical information to coroners, medical examiners and funeral directors so that they can carry out their duties or for identification of a deceased person or determining cause of death.

Organ, Eye and Tissue Donation

We may disclose your medical information to organ procurement organizations as necessary for organ procurement, donation or transplantation.

Research

We may use or disclose your medical information for research purposes provided that we comply with applicable laws.

Abuse, Neglect and Domestic Violence

We may disclose your medical information to a governmental authority authorized by law to receive reports of abuse, neglect or domestic violence, if we reasonably believe that you are a victim of abuse, neglect or domestic violence, if the disclosure is required or authorized by law.

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Serious Threat to Health and Safety

We may disclose your medical information as necessary to prevent or lessen a serious threat to health or safety of a person or the public.

Correctional Institutions

If you are in the custody of law enforcement or a correctional institution, we may disclose your medical information to the law enforcement official or the correctional institution as necessary for health and safety of you or others, provision of health care to you or certain operations of the correctional institution.

Limited Data Sets

We may use or disclose a limited data set (which is medical information in which certain identifying information has been removed) for purposes of research, public health, or health care operations. We require any recipient of such information to agree to safeguard such information.

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III. MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

Your Medicare Rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an "exception"** if you believe:

- You need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- A coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- You need to take a non-preferred drug and you want the plan to cover the drug at the preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call 1-800-Medicare for more information.

Form CMS -10147 OMB Approval No. 0938-0975

IV. MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.

14. A supplier must maintain and replace at no charge or repair cost either directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

Effective July 2013

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V. NYS RESIDENTIAL HEALTH CARE FACILITIES DISCLOSURE REQUIREMENT

Effective October 1, 2021, residential health care facilities in New York are required to provide residents and their families with the information outlined below. This is geared towards increasing awareness among both residents and families regarding the availability of compliance information maintained by the Department of Health.

Website for information regarding complaints, citations, inspections for the facility:

https://www.health.ny.gov/facilities/nursing/about_nursing_home_reports

Website for information regarding enforcement actions and penalties:

https://www.health.ny.gov/facilities/nursing/federal remedies and section 12 fines/

NYS Nursing Home Profiles Website:

https://profiles.health.ny.gov/nursing_home/#5.79/42.868/-76.809

Enter the name of the facility in the search box. Once you have located the facility, you may click on the "Inspections" tab to access information regarding complaints, citations and enforcement.

Nursing Home Compare Website:

https://www.medicare.gov/care-compare/?providerType=NursingHome&redirect=true

Enter the name of the facility in the search box and click on "search." Once you have located the facility, you may click on the "Details" tab and scroll down to view inspection results, penalties and other information about the facility.

NYS DOH Nursing Home Complaint hotline: (1-888-201-4563)

If you have any questions, please contact our Admissions Office for further information.

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VI. OFFICE OF THE STATE LONG TERM CARE OMBUDSMAN

Under the federal Older Americans Act, every state is required to have an Ombudsman Program that addresses complaints and advocates for improvements in the long-term care system. Each state has an Office of the State Long-Term Care Ombudsman, headed by a full-time State Long- Term Care Ombudsman, who directs the program statewide. Professionally trained and certified staff and volunteers for this program are designated by the NYS Long Term Care Ombudsman across the state as representatives to directly serve residents and their representatives in long-term care facilities.

The NYS Ombudsman Program is an effective resource for older adults and persons with disabilities who live in long-term care facilities, inclusive of nursing home, assisted living and other licensed adult care facilities. It is an advocacy program that promotes and protects the health, safety, welfare and rights of long-term care residents. Ombudsmen, through education, empowerment, and advocacy, help residents understand and exercise their rights to good care in an environment that promotes and protects their dignity and quality of life.

The core mission of the Ombudsman Program is to receive, investigate and assist in resolution of complaints made by or on behalf of residents in long term care facilities. Additionally, Ombudsmen can support and promote the development of resident and family councils within facilities as well as inform governmental agencies, providers and the public about issues and concerns impacting residents of long-term care facilities. Ombudsman services are free of charge and can be accessed whenever a resident and/or their representative needs assistance with concerns within a long-term care facility. All matters shared with Ombudsman Program staff or volunteers are kept confidential unless permission is granted to share concerns with others.

Ombudsmen respond to a variety of issues about long- term care including:

- Resident rights
- Environmental concerns
- Discharge, transfer, eviction concerns
- Personal and quality of care concerns
- Quality of life issues

For information or assistance, please utilize the attached page to contact your local regional ombudsman office, or contact the State office at:

Office of the New York State Long Term Care Ombudsman Program

2 Empire State Plaza

Albany, NY 12223

1-855-582-6769

www.ltcombudsman.ny.gov

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LONG TERM CARE OMBUDSMAN PROGRAM DIRECTORY

LIFESPAN-Long Term Care Ombudsman Program Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, Yates Counties 1900 South Clinton Ave. Suite 13 Rochester, NY 14618 585-287-6414	**Catholic Charities Senior and Caregiver Support Services** Albany, Fulton, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington Counties 1462 Erie Boulevard, 2nd Floor Schenectady, NY 12305 518-372-5667	**Center for Independence of the Disabled New York** Bronx, Kings, New York, Queens, Richmond Counties 1010 Avenue of the Americas Suite 300 New York, NY 10018 Bronx, Manhattan & Richmond: 212-812-2901 Kings, Queens: 212-812-2911
Long Term Care Community Coalition-Tri County LTC Ombudsman Program Putnam, Rockland, Westchester Counties 10 North Street Cold Spring, NY 10516 914-500-3406	**Long Term Care Community Coalition-Hudson Valley LTC Ombudsman Program** Columbia, Dutchess, Greene, Orange, Sullivan, Ulster Counties 82 Washington St. Suite 201A Poughkeepsie, NY 12601 845-229-4680	**Tompkins County Office for the Aging** Chemung, Schuyler, Tompkins Counties 214 W Martin Luther King Jr./State St. Ithaca, NY 14850 607-274-5498
North Country Center for Independence Clinton, Essex, Franklin Counties 80 Sharron Avenue Plattsburgh, NY 12901 518-562-1732	**Northern Regional Center for Independent Living** Jefferson, Lewis, St. Lawrence Counties 210 Court St #107 Watertown, NY 13601 315-785-8703	**Resource for Independent Living: LIFE at RCIL** Herkimer, Madison, Oneida, Otsego Counties 131 Genesee St PO Box 210 Utica, NY 13503 315-272-1872
ARISE Child and Family Service Cayuga, Cortland, Onondaga, Oswego Counties 635 James St. Syracuse, NY 13203 315-671-5108	**Action for Older Persons** Broome, Chenango, Delaware, Tioga Counties 200 Plaza Dr., Suite B Vestal, NY 13850 607-722-1251	**Family Service League** Suffolk County 1444 5th Avenue Bayshore, NY 11706 631-470-6755
Family and Children's Association Nassau County 377 Oak Street, Fifth Floor Garden City, NY 11530 516-466-9718	**AIM Independent Living Center** Allegany, Steuben Counties 271 E. First Street Corning, NY 14830 607-962-8225	**People Inc.** Cattaraugus, Chautauqua, Erie, Niagara Counties 2747 Main St. 2nd Floor Buffalo, NY 14214 716-817-9222

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VII. AUTHORIZATIONS AND DECLARATIONS

Disclosure of Common or Familial Ownership of any Corporation Providing Services to the Operator or the Facility:

The McGuire Group Inc.
Vestracare Inc.
RCA Healthcare Management LLC
ProCare LTC of Syracuse LLC
Carpathian Gambit Indemnity Co

VIII. GRIEVANCES

Patient/residents have the right to voice grievances to the facility, or other agency or entity without discrimination or reprisal and without fear of discrimination or reprisal. Grievances may be anonymously submitted if the patient/resident wishes to do so. The facility will make prompt efforts to resolve grievances. Grievances may be made orally or in writing.

The Facility will attempt to:

1) Resolve concerns before they escalate into major problems.
2) Provide residents, families, and staff members with confidential, direct access to the Administrator.
3) Meet the regulatory requirement for an internal complaint procedure

INTERNAL COMPLIMENT/CONCERN PROCEDURES:

Compliment and Concern Form: utilized by staff, residents, and family members.

- Forms are to be available at the Reception desk, on the Nursing Units and in all appropriate departments.
- Forms are placed in a sealed envelope which is attached to the form and goes directly to the Administrator c/o reception desk.
- Administrator works closely with Department Heads to resolve issues.
- Summary of forms received and resolution is maintained.
- Follow-through and Department Head involvement are required as indicated.
- Written decision regarding grievances will be issued upon request.

Grievance Official: The facility Administrator is designated as the Grievance Official.

Contact information is as follows:

Brookhaven Health Care Facility
801 Gazzola Drive
East Patchogue, NY 11772
(631) 447-8800

State Agencies: Please refer to the handout out provided for state agency and other independent entities contact information.

IX. ADVANCE DIRECTIVES POLICY

In compliance with Public Health Law Article 29-C, the FACILITY shall comply with health care treatment decisions made in good faith by a Resident's health care agent appointed pursuant to a Health Care Proxy as set forth in the law. The Health Care Proxy Act permits an individual to appoint a surrogate or "agent" to make health care treatment decisions in the event the individual loses the capacity to make such decisions himself/herself.

In the absence of a Health Care Proxy, the FACILITY will follow the Family Health Care Decisions Act, Public Health Law Article 29-CC. Pursuant to this Article, health care decisions may be made on behalf of an incapacitated patient by a designated surrogate. The surrogate shall be designated in order of priority:

Article 81 Guardian

Spouse or domestic partner

Adult child

Parent

Adult sibling

Close, adult friend or other relative

The FACILITY shall not require a resident or applicant for admission to execute a Health Care Proxy. The FACILITY shall respect the resident's right to refuse medical treatment; to execute a Health Care Proxy and formulate Advance Directives.

It is the philosophy of the FACILITY to support the resident's informed choice in decision making, the agent's decision in the exercise of the Health Care Proxy, and/or the designated surrogate's decision made on behalf of the resident. This support includes the insertion and/or withdrawal of feeding tubes.

Should the FACILITY object to an agent's or surrogate's decision or to the resident's Advance Directives (including hydration and nutrition), the FACILITY Ethics Committee shall be convened to review the matter. Following the committee meeting and determination, the FACILITY may object to the agent's decision regarding hydration and nutrition, in which case the resident shall be promptly transferred to another FACILITY that is readily accessible under the circumstances and willing to honor the resident's or agent's decision.

In the absence of Advance Directives including those related to artificial nutrition and hydration, the FACILITY will follow the Family Health Care Decision Act. Pursuant to this Act, the resident's designated Surrogate shall provide an assessment of the resident's wishes and best interests, including the resident's religious and moral beliefs. If these interests are not known, or the resident does not have a Surrogate, the assessment of the resident's best interests shall include:

- Consideration of the dignity and uniqueness of every person;
- The possibility and extent of preserving the resident's life;
- The preservation, improvement or restoration of the resident's health or functioning;
- The relief of the resident's suffering;
- And any medical condition and other concerns and values as a reasonable person would wish to consider.

In all cases, decisions made for the resident shall be resident-centered, made on an individualized basis, and consistent with the resident's values to the extent those can be ascertained and to the extent reasonably possible.

The FACILITY may object to the desires of the involved party(s) regarding the resident's health care, in which case the resident shall be promptly transferred to another FACILITY that is readily accessible under the circumstances and willing to honor the involved parties' request.

The Ethics Committee shall convene if and when applicable.

Cardiopulmonary Resuscitation (CPR) - Statement of Policy:

- Residents are presumed to consent to initiation of CPR in the event of cardiac or pulmonary arrest in the absence of a written Advance Directive to the contrary. CPR is initiated by certified FACILITY staff awaiting the arrival of the community Advanced Life Support Services for continuance of the CPR and immediate transfer to a hospital.

The Health Care Proxy Law and Family Health Care Decisions Act provide immunity to providers and their employees from criminal or civil liability for honoring in good faith a health care decision by a duly appointed or designated agent or surrogate. Similarly, agents and surrogates are also protected from liability if they fulfill their obligations in good faith under the law.

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NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicaid Authorized Representative Designation/Change Request

Applicant/Recipient

Name ______________________________

Address ______________________________ Street ______________ Apt#

______________________________ City ______________ State ______________ Zip

Date ______________________

Case Number ______________________

If you have not previously provided an Authorized Representative to act on your behalf and would like to do so, please provide his/her name and address.

Name ______________________________

Address ______________________________ Street ______________ Apt#

______________________________ City ______________ State ______________ Zip

Phone # (______) ________–__________ ☐ home ☐ work ☐ cell ☐ other

If you previously provided an Authorized Representative and would like to discontinue or change to someone new:

☐ Discontinue Current Authorized Representative

Name ______________________________

Address ______________________________ Street ______________ Apt#

______________________________ City ______________ State ______________ Zip

Phone # (______) ________–__________ ☐ home ☐ work ☐ cell ☐ other

☐ Designate New Authorized Representative

Name ______________________________

Address ______________________________ Street ______________ Apt#

______________________________ City ______________ State ______________ Zip

Phone # (______) ________–__________ ☐ home ☐ work ☐ cell ☐ other

I understand my designated Authorized Representative will have access to my personal health information.
I would like my Authorized Representative to (check all that apply):

☐ Apply for and/or renew Medicaid for me

☐ Discuss my Medicaid application or case, if needed

☐ Get notices and correspondence

I understand this designation will remain in effect until I change or discontinue it.

______________________________ ______________
Signature of Applicant/Recipient Date

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NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Medicaid Enrollment and Exchange Integration

Authorization for Verification of Resources (Applicant)

This form authorizes Medicaid to request records from financial institutions for an individual applying for Medicaid.

This Authorization must be signed by the applicant if the applicant is:

- Age 65 or older
- Certified blind or certified disabled (of any age)

Please provide the information for the applicant below and sign the authorization.

Signing this Authorization is a condition of receiving Medicaid benefits. This is because eligibility depends on the amount of resources owned by the applicant. **Failure to sign and submit this Authorization may result in a denial or discontinuance of Medicaid benefits.**

I. INFORMATION FOR APPLICANT

Applicant's Name: Last Name ______ First Name ______ Middle Initial ______

Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___   Date of Birth ___ ___ – ___ ___ – ___ ___

II. AUTHORIZATION

I authorize verification of my resources with financial institutions for the purpose of determining eligibility for Medicaid.

This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I revoke this authorization in a written statement to my local Department of Social Services.

Signature of Applicant/Legal Representative* ____

Date Signed ___________________________________

**Note: If a legal representative is signing this authorization, also include the legal document giving him/her authority to act on behalf of applicant.*

Resident Consent to Participate in POINT CLICK CARE CONNECT Health Information Exchange

You may use this Consent Form to decide whether or not you would like to participate in Point Click Care Connect. Point Click Care is the software program where your medical record will be maintained for your stay at this facility.

Connect is an electronic network operated by Point Click Care, which is part of a national health information exchange. This network helps collect the medical records you have in different places where you receive health care, and make them available electronically to those rendering services to you.

A complete list of Connect participants can be found at: https://carequality.org/active-sites-search/. If you do not have internet access and would like assistance viewing the list of participants or need assistance completing this form, assistance will be provided to you by a facility designee. This form may be filled out now or at a later date.

Your choice to consent or decline will not affect your ability to receive medical care or health insurance coverage.

Yes ☐ **I agree to participate in Point Click Care Connect and give consent for my facility record to be added to the network.**

No ☐ **I do NOT wish to participate in Point Click Care Connect and do not wish for my facility record to be added to the network.**

Resident Signature

Print Last Name: ____ Print First Name: ____________________________

DOB: _____/_____/_____

Signature: ____ Date: _____/_____/_____

Resident Representative Signature

I am authorized to complete this form for the following resident:

Print Last Name: ____ Print First Name: ____________________________

DOB: _____/_____/_____

Representative's Last Name:____________________________________ Print First Name: ____________________________

Representative's Signature: ____ Date: _____/_____/_____

Relationship to resident: ____

Facility Witness

Print Last Name: ____ Print First Name: ____________________________

Signature: ____ Date: _____/_____/_____

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COVID-19 Vaccines in Long-Term Care

What You Need to Know

- CDC recommends everyone stay up to date with COVID-19 vaccines
- People who are moderately or severely immunocompromised may have additional recommendations for COVID-19 vaccines
- COVID-19 vaccines, including boosters, are effective at protecting people from getting seriously ill, being hospitalized, and dying
- Staying up-to-date on your COVID-19 vaccinations is the best protection

If you live or visit in a Long-term Care (LTC) setting, you can help protect yourself and the people around you by staying up to date with a your COVID-19 vaccines, including boosters as soon as possible.

COVID-19 vaccines are safe and effective—especially against becoming seriously ill, being hospitalized and dying—and very important for older adults.

- Older adults and people with certain health conditions are more likely to get very sick from COVID-19
- COVID-19 vaccines can help keep you from getting seriously ill if you do get COVID-19

Residents and their families can ask a LTC provider about the current COVID-19 vaccination rate among their staff and residents

If your loved one is not able to ask questions or otherwise communicate with the LTC staff, here's what to know:

- Consent for a COVID-19 vaccine is given by LTC residents (or people appointed to make medical decisions on their behalf)
- Residents who receive a COVID-19 vaccine also receive a fact sheet before vaccination. The fact sheet explains the risks and benefits of COVID-19 vaccination

COVID-19 vaccines are free of charge to all people living in the U.S., regardless of their immigration or health insurance status.

9/23

LIVING LEGENDS

THE McGUIRE GROUP | ABSOLUT CARE
TACONIC HEALTH CARE | VESTRACARE

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HOW TO GET A COVID-19 Vaccine

Take these steps to get a COVID-19 vaccine for you or your family member:

Talk with the LTC staff about getting vaccinated on site

If you have additional questions about how to get a COVID-19 vaccine, talk with your healthcare provider

To find additional COVID-19 vaccine locations near you:
Search vaccines.gov, text your ZIP code to 438829, or call 1-800-232-0233

COVID-19 FACTS

- COVID-19 vaccines teach our immune systems how to recognize and fight the virus that causes COVID-19. Sometimes this process can cause symptoms, such as fever. These symptoms are normal and are signs that the body is building protection against the virus that causes COVID-19.
- COVID-19 vaccines do NOT contain ingredients like preservatives, tissues (like aborted fetal cells), antibiotics, food proteins, medicines, latex, or metals.
- Getting a COVID-19 vaccination is also a safer way to build protection than getting sick with COVID-19. COVID-19 vaccination helps protect you by creating an antibody response without you having to experience sickness. Getting vaccinated yourself may also protect people around you, particularly people at increased risk for severe illness from COVID-19.
- Getting sick with COVID-19 can cause severe illness or death, and we can't reliably predict who will have mild or severe illness. If you get sick, you can spread COVID-19 to others. You can also continue to have long-term health issues after COVID-19 infection.

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New York State Hepatitis C Testing Requirements

What is hepatitis C?

Hepatitis C is a liver disease. It can cause severe liver damage, liver cancer, and even death if left untreated. However, people with hepatitis C can be successfully treated and cured with medications.

Hepatitis C is spread mainly by contact with the blood of people who have hepatitis C. This can happen by sharing equipment for injecting drugs, or for tattoos or body piercing. Hepatitis C can also be passed from a pregnant person to their baby during pregnancy.

What are New York State requirements for hepatitis C testing?

New York State requires a hepatitis C screening test be provided to:

- Everyone 18 years or older.
- People with a risk who are younger than 18 years.
- Every pregnant person during each pregnancy.

If a person accepts the offer of a hepatitis C screening test, and the result is reactive, or positive, the health care provider must make sure a hepatitis C RNA test is done to diagnose hepatitis C infection.

If the person tested is diagnosed with hepatitis C, the health care provider must either offer the person follow-up hepatitis C health care and treatment, or they must refer the person to a health care provider who can.

Why should all adults and pregnant people get tested for hepatitis C?

- New cases of hepatitis C are on the rise, particularly among younger adults and pregnant people.
- Most people with hepatitis C have no symptoms and they do not feel sick.
- Almost half of people with hepatitis C are unaware of their infection.
- Testing is the first step to getting treated and cured for hepatitis C.

When should someone younger than 18 years of age be tested for hepatitis C?

People younger than 18 years should be tested for hepatitis C if they:

- Have ever shared needles, syringes, or any other equipment for preparing and injecting drugs.
- Got a tattoo or body piercing from an unlicensed artist, such as on the street or while in jail.
- Snorted drugs.
- Have HIV.
- Were exposed to hepatitis C at birth.
- Were exposed to blood on the job through a needlestick, or through injury with a sharp object.

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How is hepatitis C testing done?

Hepatitis C testing is a two-step process. A health care provider may run both tests in one blood draw.

The first step is a hepatitis C screening test that looks for antibodies to the virus in the blood. This test can be done by collecting a blood sample that is sent to a lab, or by a fingerstick using a hepatitis C rapid antibody test.

- A non-reactive, or negative, antibody test means that a person does not have hepatitis C. However, if a person has been recently exposed to the hepatitis C virus, they will need to be tested again.
- A reactive, or positive, antibody test means that hepatitis C antibodies were found in the blood. The person may have hepatitis C. A person who has had hepatitis C will always have antibodies in their blood, even if they were treated and cured. A follow-up test, the hepatitis C RNA test, looks for virus in the blood to diagnose if a person currently has hepatitis C.

For more information on hepatitis C testing, go to: https://www.health.ny.gov/publications/1921.pdf.

What is the treatment for hepatitis C?

Hepatitis C can be cured with medications that are easy to take. All hepatitis C treatments are pills taken by the mouth for 8 to 12 weeks. Sometimes treatment is only one pill, once a day. Most people have few side effects.

For more information on hepatitis C treatment, go to: https://www.health.ny.gov/publications/1923.pdf.

Where can someone find free hepatitis C testing in New York State?

For testing locations in New York State go to:
https://www.health.ny.gov/diseases/communicable/hepatitis/hepatitis_c/providers/testing_locations.htm.

Where can someone find a health care provider for hepatitis C treatment in New York State?

The New York State Department of Health AIDS Institute's online directory provides easy access and information regarding all participating hepatitis C providers across New York State. To find a hepatitis C provider, go to: https://providerdirectory.aidsinstituteny.org.

For more information, go to: www.health.ny.gov/hepatitisc

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More information and help.

New York State Department of Health
health.ny.gov/diseases/aids/publications

New York State HIV/AIDS hotlines (toll-free)

English: 1-800-541-AIDS

Spanish: 1-800-233-SIDA

TDD: 1-800-369-2437

Voice callers can use the New York Relay System 711 or 1-800-421-1220 and ask the operator to dial 1-800-541-2437

NYSDOH Anonymous HIV Counseling and Testing Program

For HIV information, referrals, or information on how to get a free, anonymous HIV test, call the Anonymous HIV Counseling and Testing Program.

Albany Region: 1-800-962-5065

Buffalo Region: 1-800-962-5064

Long Island Region (Suffolk/Nassau): 1-800-462-6786

Lower Hudson Valley Region: 1-800-828-0064

Rochester Region: 1-800-962-5063; TDD: 1-585-423-8120

Syracuse Region: 1-800-562-9423

New York City: 311 to for information on DOHMH STD clinics

More information and help.

New York City HIV/AIDS Hotline
1-800-TALK-HIV (825-5448)

National Centers for Disease Control STD hotlines
English/Spanish 1-800-232-4636, TTY 1-888-232-6348

New York State HIV/AIDS Counseling Hotline
1-800-872-2777

New York State Partner Services:
1-800-541-AIDS

New York City Contact Notification Assistance Program:
1-212-693-1419

Confidentiality

New York State Confidentiality Hotline:
1-800-962-5065

Legal Action Center: 1-212-243-1313 or 1-800-223-4044

Department of Health

EXPECT THE TEST

This health care facility follows good medical practice and public health law by offering HIV testing to all patients aged 13 and older.

Routine Lab Tests

- ✓ Glucose
- ✓ Cholesterol
- ✓ HIV Test
- ✓ Complete Blood Count
- ✓ Lipid Profile

Worst HIV status: unknown
Testing puts you in control.

https://campaigns.health.ny.gov/BeyondStatus

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Key facts to know before getting an HIV Test.

- HIV testing is voluntary and all HIV test results are confidential (private).
- HIV can be spread through unprotected sex, sharing needles, childbirth, or by breastfeeding.
- Treatment for HIV is effective, has few or no side effects and may involve taking just one pill a day.
- Partners can keep each other safe by knowing their HIV status and getting HIV treatment or taking HIV pre-exposure prophylaxis (PrEP). Not sharing needles and practicing safer sex will help protect against HIV, hepatitis C and other STDs.
- It is illegal to discriminate against a person because of their HIV status.
- Anonymous HIV testing (without giving your name) is available at certain public testing sites.
- HIV testing is a routine part of health care but you have the right to object or decline an HIV test.
- If you wish to decline HIV testing, inform the health care provider.

HIV testing is especially important for pregnant women.

- A woman living with HIV can pass the virus to her child during pregnancy, child birth, or through breastfeeding.
- It is much better to know your HIV status before or early in pregnancy so you can make important decisions about your own health and the health of your baby.
- HIV testing is conducted as early as possible in your pregnancy and again in the third trimester with patient consent.
- If you are pregnant and have HIV, treatment is available for your own health and to prevent passing HIV to your baby.
- If you have HIV and do not get treatment, the chance of passing HIV to your baby is one in four. If you get treatment, your chance of passing HIV to your baby is much lower.
- If you are not tested during pregnancy, your provider will recommend testing when you are in labor. In all cases, your baby will be tested after birth. If your baby's test is positive, it means that you have HIV and your baby has been exposed to the virus.

Talk to your health care provider about how and when you will learn your HIV test results.

A person living with HIV who is on HIV treatment and virally suppressed for 6 months or longer has effectively no risk of passing HIV to a partner through sex. This is called Undetectable equals Untransmitable or U=U.

State law protects the confidentiality (privacy) of your HIV test results. It also protects you against discrimination based on your HIV status.

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New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Brookhaven Health Care Facility, LLC** to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for **Brookhaven Health Care Facility, LLC** to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for **Brookhaven Health Care Facility, LLC** access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date

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this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases
- Medication and Dosages
- Diagnostic Information
- Allergies
- Substance use history summaries
- Clinical notes
- Discharge summary
- Employment Information
- Living Situation
- Social Supports
- Claims Encounter Data
- Lab Test

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information**. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so **Brookhaven Health Care Facility, LLC** at or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice, in case of a minor until he/she turns 18 years of age, or until 50 years after your death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**