# MEADOWBROOK CARE CENTER, INC.
320 West Merrick Road
Freeport, New York 11520

## ADMISSION AGREEMENT

Agreement dated ________________________ between **MEADOWBROOK CARE CENTER, INC.,** located at 320 West Merrick Road, Freeport, New York 11520 (hereinafter "Facility") and ________________________________ (hereinafter referred to as "Resident") whose residence is located at:

________________________________________________________________________________, and

______________________________________________(hereinafter Designated Representative") residing at

________________________________________________________________________________, and

______________________________________________ Resident's spouse ( if not listed as Designated Representative") residing at ________________________________________________________________________ and

______________________________________________(hereinafter Financial Sponsor) residing at:

________________________________________________________________________________.

**The Facility accepts the Resident for admission subject to the following terms and conditions:**

**I. ADMISSION AND CONSENT**

The undersigned hereby agrees, subject to both federal and state laws, rules and regulations, that the Resident will be admitted to the Facility only upon the order of a New York State licensed physician and upon a determination that the Resident satisfies the admission assessment criteria set by the New York State Department of Health and by the Facility. The Resident and/or Designated Representative hereby consent to such routine care and treatment as may be provided by the Facility and/or ancillary providers in accordance with the Resident's plan of care, including but not limited to, transfer to an acute care hospital when necessary, dental, medical and/or surgical consultation, examination by staff, routine diagnostic tests and procedures, and the administration of pharmaceuticals. The Resident and/or Designated Representative shall have the right to participate in the development of the plan of care and shall be provided with information concerning his or her rights, to consent or refuse treatment at any time to the extent allowable under applicable law. **The Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative hereby understand and agree that Admission to the Facility is conditioned upon the review and execution of this Agreement and related documents as more fully set forth herein.**

**II. MUTUAL CONSIDERATION OF PARTIES**

The Facility agrees to provide all basic (routine) services to the Resident, as well as either provide or arrange for available ancillary services, which the Resident requires. Attachment "A" lists the routine, ancillary and additional services provided and/or arranged for by the Facility. A list of private pay charges for certain ancillary and other available services is attached to this Agreement and included in your admissions package.

The Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative understand and agree that the Facility's acceptance of the Resident is based on the Resident's, Resident's Spouse, Financial Sponsor and/or Designated Representative's representation that the Resident has resources, insurance coverage and/or is eligible for government benefits (including Medicare and/or Medicaid) to cover the cost of care at the Facility. Furthermore, the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative agree to take all necessary steps to ensure that the Facility and its associated providers receive payment from these and/or other available sources consistent with this Agreement. The Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative may be required to make full and complete disclosure to the Facility of all income (including Social Security, pension and other periodic receipts), assets, insurance coverage and any other resources available to the Resident that could be available to pay for the cost of care. We require a complete five (5) year financial disclosure, including assets, property and trusts. We also require proof of U.S. citizenship.
**The Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative agree to comply with all applicable policies, procedures, regulations and rules of the Facility.**

## III. ANTICIPATED SERVICES

It is anticipated that the Resident will initially require the following level of care (should the Residents condition and level of care needs change, such change will be noted in the Resident's medical record):

☐ **Sub-Acute Care*** check one of the following: ☐ **Medically Complex** ☐ **Rehabilitation**

☐ **Long Term Care**

☐ **Palliative Care**

☐ **Other** ____________________________

*Meadowbrook Care Center, Inc. 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.

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 sub-acute 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. Residents and their Designated Representatives 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: In the event Resident is admitted for sub-acute services and subsequently, by virtue of his or her health condition, requires long term care placement, 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.**

## IV. FINANCIAL ARRANGEMENTS

### (a) Obligation of Resident / Designated Representative / Financial Power of Attorney

The Resident, Financial Sponsor and/or Designated Representative shall pay the Facility on a private pay basis, with private insurance, and/or by means of a third party government payor, such as Medicare or Medicaid. A Resident's obligation to guarantee payment is personal and limited to the extent of his/her finances, and, where consistent with applicable laws, rules and regulations, to the extent of his/her spouse's income and resources as well. The Financial Sponsor/Designated Representative is responsible for providing payment from the Resident's income and resources to the extent he/she has access to such income and resources without the Financial Sponsor/Designated Representative incurring personal financial liability. The Resident, Resident's Spouse, Financial Sponsor and Designated Representative agree to provide payment from the Resident's income and resources for any portion or all of the applicable private pay room and board rate and the ancillary charges incurred for services not covered by third party payers. Payment to the Facility shall be made on a monthly basis as billed.

If the Resident has no third party coverage or if the Resident remains in the Facility after any such coverage terminates because it is deemed no longer "medically necessary" or for any other reason consistent with applicable law, the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative agree to:

1. Provide payment, from the Resident's income and resources, for the private pay room and board rate and the ancillary charges incurred until discharge or until another source of coverage becomes available.
2. Refrain from using resident's assets in such a way as to render resident ineligible for Medicaid benefits.

The Facility will promptly notify the Resident, Resident Spouse, Financial Sponsor, and/or Designated Representative of a third party payor's discontinuation of payment (coverage).

<u>**Hospital Observation Stay**</u>: If the resident was on an **observation stay at the hospital and not admitted to the hospital**, the observation status may effect the resident's private insurance and /or Medicare coverage for admission to a skilled nursing facility (nursing home). The Resident, Resident's Spouse and/or Financial Sponsor understands that they are financially responsible for the private pay room and board rate and the ancillary charges incurred until discharge or until another source

of coverage becomes available in the event the Resident is not covered by private insurance and/or Medicare.

**"The execution of this Agreement by the Financial Sponsor/ Designated Representative can not, and shall not, serve as a third party guarantee of payment in violation of applicable law and regulation. Notwithstanding the foregoing, the Financial Sponsor/Designated Representative will be held personally responsible and liable if his/her actions or omissions have caused and/or contributed to non-payment of the Facility's fees. Such actions or omissions include, but are not limited to the following: (failing to utilize the Resident's funds to pay for the Resident's care at the Facility when the Financial Sponsor / Designated Representative has control over the Resident's funds by way of Power of Attorney, access to joint accounts and/or the like; (ii)misappropriating the Resident's funds; (iii)failing to remit the Resident's social security and/or pension income to the facility; (iv)failing to provide requested information and/or documentation to the Facility or third party payor, such as an insurer or Medicaid, and/or (v)providing false, misleading or incomplete information and/or documentation, regarding matters including, but not limited to, the Resident's financial resources, citizenship or immigration status, and/or third party insurance coverage, to the extent that the facility relies on such information and/or documentation to is detriment. Any failure of the Financial Sponsor/ Designated Representative to use the Resident's funds in accordance with the Agreement will constitute a breach of contract on the part of the Financial Sponsor / Designated Representative." This includes, but is not limited to the transfer of assets within the last five (5) years.**

**(b) <u>Anticipated Payor</u>**
The Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative represent to the Facility that it is anticipated that the cost of the Resident's care will be paid in whole or in part by (check all that apply, including both primary and secondary payers):

☐ Medicare ☐ Medicaid ☐ Veteran's Administration Benefits

☐ Managed Care Organization: (Specify Name of Organization):________________________________

☐ Other private insurance: (Specify Name of Insurance Company): ____________________________

☐ Private Payment ☐ No Fault Insurance Benefits ☐ Worker's Compensation Benefits

☐ Other (Please Specify):________________________________

**NOTE: The Resident and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative agree to provide the Facility with all relevant information and documentation regarding all potential third party payors. The Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative understand that if the anticipated payor does not pay the cost of care, then the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative will be responsible for paying for the cost of care through the funds legally available to the Resident and/or by securing coverage through another third party payor. This provision will be applied consistent with any agreement the Facility may have with a third party payor.**

**The Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative understand that, although the Facility will be available to assist the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative to apply for third party coverage, it is the responsibility of the Resident, Resident's Spouse / Designated Representative / Financial Power of Attorney to timely apply for and meet the requirements of third party payers (including, but not limited to Medicaid). A Resident who does not meet the eligibility criteria that govern payment by third party payers will be billed at the Facility's private pay room and board rate.**

**(c) <u>Private Payment</u>**
If the Resident is paying privately for the cost of his or her care, and part or all of such payment is not covered by a third party payor, the rate for room and board is $____________ per day, and the rate for room and board for a <u>vent bed</u> is $____________ per day. Effective 10/01/2011, the Nursing Home Assessment Tax, which is _________% of the daily rate,

will be added to the bills of private pay residents. This charge will be a separate charge on the bill and is deductible on your income tax. Ancillary services including, but not limited to, urinary care supplies, trach and ostomy supplies, surgical supplies, parenteral and enteral feeding supplies, pharmacy supplies, and occupational, speech and physical therapy will be billed to the Resident according to the Facility's and/or the provider of services' charge schedules. However, rates of payment to Facility may differ for individuals with additional sources of payment such as Medicare, Medicaid and third party insurance. A copy of the Facility charge schedule for ancillary services is attached to this Agreement and included in your admissions package. Payment must be made to the Facility upon receipt of the bill by the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative. The private pay room and board rate and additional services charges are subject to increase upon thirty (30) days written notice to the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative.

**(d) Private Pay Billing Policy and Security Deposits**

Unless otherwise noted prior to admission and/or restricted by law, the Facility requires a security deposit in cash or certified check for each Resident, equal to two (2) months security deposit plus the initial monthly rate for room and board at the Facility's daily basic rate. This money will be deposited by the Facility in an interest-bearing bank account. This security deposit, including any interest accrued, shall continue to be the property of the depositor. However, the Facility shall have the right to apply any or all of the security deposit toward the payment of any unpaid amounts due under this Agreement. If any or all of the security deposit is so applied, or if the Facility's daily basic rate increases, the Facility will notify the Resident, Resident's Spouse, Financial Sponsor and/or the Designated Representative and, within ten (10) days of receipt of the notice, additional security must be deposited so that the total security equals two (2) months of services at the Facility's daily basic rate. The Facility may deduct a fee of 1% per year from security deposit amounts to cover administrative costs and consistent with applicable law. Additionally, if private paying Residents leave the facility for reasons within the Resident's control without giving fifteen (15) days prior notice, the Facility will retain an additional amount not to exceed one (1) day's daily basic rate.

The Facility bills private pay individuals for the private pay room and board charges on a one month advance basis. Bills for ancillary charges are generated in the month following the month the services were rendered. All bills are generated by the tenth (10th) of the month and cover the next month of room and board charges and the previous month's ancillary charges. All payments are due 15 days after the date of the bill by the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative.

**NOTE: Security Deposits or advance payments are not required upon admission from individuals eligible for Medicare/Medicaid/Veterans Administration benefits. However, immediately upon the ineligibility of a Resident and/or the expiration or discontinuation of coverage for services at the Facility by Medicare, Medicaid or the Veterans Administration, the Resident will be required to remit a security deposit and advance payment at the Facility's basic room and board rate and in accordance with the above-mentioned policies of the Facility.**

**(e) Late Charges**

**Interest at the rate of fifteen (15%) percent per annum [1 ¼% per month] will be assessed on all accounts more than thirty (30) days overdue.**

**(f) Collection Costs, Including Attorney and Court Fees**

**If the Resident, Resident's Spouse, Financial Sponsor and/or the Designated Representative fail to make payments within fifteen (15) days of the date payment is due, the Resident shall pay all expenses incurred by the Facility, in connection with its attempts to collect the outstanding payment. Such collection costs will include, but may not be limited to, attorneys' fees, court costs and related disbursements. In addition, the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative shall pay all late charges as noted above.**

**(g) Third Party Private Insurance and Managed Care**

If the Resident is covered by a private insurance plan or under a managed care benefit plan that has a contract with the facility, payment of his or her care will be according to the rates for coverage of skilled nursing facility benefits set forth in the written financial agreement with the Facility and the third party insurer or managed care payor. Residents who are members of a managed care benefit plan that is under a contract with the Facility to provide specified services to plan members will receive those services with full coverage as long as the Resident meets the eligibility requirements of the managed care benefit plan. To the extent the Resident meets the eligibility requirements of the managed care benefit plan, he or she will be financially responsible only for those services that are not included in the list of covered services under his or her plan and applicable co-pays and deductibles.

If Resident is covered by a private insurance plan or under a managed care benefit plan that **does not** have a contract with the Facility, and where the insurance proceeds under the private plan are insufficient to cover the cost of care, the Resident

will be responsible for any difference. The Facility will bill the Resident for any such difference on a monthly basis as described in the "Private Payment" section above. The coverage requirements for nursing home care vary depending on the terms of the insurance or managed care plan. Questions regarding private insurance and managed care coverage should be directed to the social work staff, the business office and/or the Resident's insurance or managed care plan, carrier or agent.

If Resident is covered by a private insurance plan or under a managed care benefit plan for either all or a portion of the Facility's charges pursuant to the terms of the Resident's plan, by execution of this Agreement the Resident hereby authorizes the Facility to utilize participating physicians and providers of ancillary services or supplies, if required by the plan for full benefit coverage, unless the Resident specifically requests a non-participating provider with the understanding that there may be additional charges to the Resident for using such non-participating providers.

**NOTE: The Resident is responsible for timely advising the Facility of what benefits, if any, may be available from his or her private insurance and/or managed care plan. Charges may be assessed above the covered benefit for skilled nursing facility care depending on the insurance coverage, managed care plan and/or written agreement with the Facility. Furthermore, Resident's coverage may be subject to co-insurance, deductibles and/or co-payments which will be the Resident's responsibility and billed according to the terms for private payment stated above.**

**(h) Medicaid**

If and when the Resident's assets/funds have fallen below the Medicaid eligibility levels, and the Resident otherwise satisfies the Medicaid eligibility requirements, and the Resident is not entitled to any other third party coverage, the Resident should be eligible for Medicaid (see Attachment "B"), often referred to as the payor of last resort. **THE RESIDENT, RESIDENT'S SPOUSE, FINANCIAL SPONSOR AND/OR DESIGNATED REPRESENTATIVE AGREE TO NOTIFY THE FACILITY AT LEAST THREE (3) MONTHS PRIOR TO THE EXHAUSTION OF THE RESIDENT'S FUNDS AND/OR INSURANCE COVERAGE TO CONFIRM THE RESIDENT, RESIDENT'S SPOUSE, FINANCIAL SPONSOR AND/OR DESIGNATED REPRESENTATIVE HAS OR WILL SUBMIT A TIMELY MEDICAID APPLICATION AND ENSURE THAT ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET.** Services reimbursed under Medicaid are outlined in Attachment "A" to this Agreement.

If the Resident's care is covered by Medicaid, the Resident, Resident's Spouse, Financial Sponsor, and/or the Designated Representative agree to remit to the Facility the Resident's Net Available Monthly Income ("NAMI," for example Social Security income, pension income, etc.) on a timely basis, pursuant to the Resident's Medicaid budget (see Attachment "B"). The Resident's Medicaid budget and the NAMI amount will be determined by Medicaid. The Facility has no control over the determination of NAMI amounts. When the Resident is awaiting the issuance of a Medicaid budget, the Resident Resident's Spouse, Financial Sponsor, and/or Designated Representative shall remit to the facility the anticipated NAMI in a timely manner.

I authorize Meadowbrook Care Center to:
- obtain, if necessary, all financial records as required by Medicaid for the submission of a Medicaid application.
- apply for a fair hearing, if applicable, which survives incapacity and death of the resident.
- apply for a hardship waiver if necessary.
- apply for recertification.

**NOTE: If Medicaid denies coverage, the Resident, Resident's Spouse, Financial Sponsor, and/or the Designated Representative hereby agree to remit to the Facility any outstanding amounts for unpaid services not covered by other third party payers subject to applicable federal and state laws and regulations. Such amounts shall be calculated in accordance with the Facility's applicable prevailing private rates and charges for all basic and additional services provided to the Resident.**

**(i) Medicare**

If the Resident meets the eligibility requirements for Skilled Nursing Facility benefits under the Medicare Part A Hospital Insurance Program, the Facility will bill Medicare directly for Part A services provided to the Resident. Medicare will reimburse the Facility a fixed *per diem* or daily fee based on the Resident's classification within the Medicare RUGS III guidelines. If the Resident meets the eligibility criteria, Medicare may provide coverage of up to 100 days of care. The first 20 days of covered services are fully paid for and the next 80 days (days 21 through 100), of the covered services are paid for by Medicare subject to a daily coinsurance amount for which the Resident is responsible. Please note, an individual who is a Medicare beneficiary under both the Part A and Part B programs, and who subsequently exhausts their coverage under Part A or is no longer in need of a covered level of skilled care under Part A, may still be eligible to receive coverage for certain Part B services

(previously included in the Part A payment to the facility). BENEFICIARIES WHO USE A PROVIDER NOT UNDER CONTRACT WITH THE SNF, THAT PROVIDER WILL NOT BE REIMBURSED BY MEDICARE.

**NOTE: If Medicare denies coverage, the Resident, Resident's Spouse, Financial Sponsor and/or the Designated Representative hereby agree to remit to the Facility any outstanding amounts for unpaid services not covered by other third party payers subject to applicable federal and state laws and regulations. Such amounts shall be calculated in accordance with the Facility's applicable prevailing private rates and charges for all basic and additional services provided to the Resident.**

**For Further Information on third party payor sources, please refer to Attachment "B."**

## V. AUTHORIZATIONS AND ASSIGNMENTS FROM RESIDENT TO THE FACILITY

### (a) Authorization to Release Information

By execution of this Agreement, the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative authorizes the Facility to release to government agencies, insurance carriers or others who could be financially liable for any medical care provided to the Resident, all information needed to secure and substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care.

### (b) Assignment of Benefits and Authorization to Pursue Third Party Payment

By execution of this Agreement, the Resident, Resident's Spouse, Financial Sponsor, and/or Designated Representative hereby assigns to the Facility any and all applicable insurance benefits and other third party payment sources to the extent required by the Facility to secure reimbursement for the care provided to the Resident. The Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative authorize the Facility to seek and obtain all information and documentation necessary for the processing of any third party claim.

### (c) Authorization to Obtain Records, Statements and Documents

By execution of this Agreement, the Resident, Resident's Spouse, Financial Sponsor and/or the Designated Representative authorizes the Facility to obtain from financial institutions, including, but not limited to, banks, insurance companies, broker and credit unions, and government agencies, such as the Social Security Administration and Department of Social Services, records, statements, correspondence and other documents pertaining to the Resident.

### (d) Authorization to Represent Resident Regarding Medicaid

By execution of this Agreement, the Facility shall be authorized to have access to the Resident's Medicaid file, and, if the Facility so elects, to act on behalf of the Resident in connection with any and all matters involving Medicaid, including, but not limited to, representation of the Resident at Administrative Fair Hearings, or to apply for a hardship waiver.

### (e) Authorization to Take Resident's Photograph

By execution of this Agreement, the Resident, Resident's Spouse, Financial Sponsor and/or the Designated Representative authorizes the use of surveillance cameras (located in common areas of the facility) and the Facility to photograph the Resident upon admission for identification and in furtherance of treatment and/or administrative functions of the facility. All such photographs shall become part of the Resident's medical record at the Facility.

### (f) Authorization to Disclose Resident's Presence In Facility

**Do you wish to disclose that you reside at Meadowbrook Care Center (temporarily or permanently) when an inquiry is made by telephone _yes ___no / visitor ___yes ___no / family member yes___ no____**

**(g) By execution of this agreement, the facility is authorized to release Protected Health Information of a resident to third parties involved, with, or in furtherance of payment to the facility for the services furnished to the resident.**

## VI. TEMPORARY ABSENCE (also referred to as "bed hold"):

If the Resident leaves the Facility due to hospitalization or therapeutic leave, the Facility shall not be obligated to hold the Resident's bed available until his or her return, unless prior arrangements have been made for a bed hold pursuant to the Facility's "Bed Retention Policy" and pursuant to applicable law. The Resident may be placed in any appropriate bed available in the Facility at the time of his or her return from hospitalization or therapeutic leave.

Before a Resident is transferred to a hospital the attending physician or a Facility designee will inform the Designated Representative or responsible family member accordingly, except in an extreme emergency, when the Facility staff has tried but have been unable to reach the Designated Representative or family member. In that circumstance, the Designated Representative or family member will be forwarded a letter stating when and where the Resident was transferred and restating the Facility's bed hold policy and procedure.

**(a) Private Pay Residents** who elect to retain a bed in the Facility during a period of hospitalization or therapeutic leave may do so by:

1. Notifying the Admission Department by telephone;
2. Signing a bed guarantee letter with the Admission Department stating their intent to hold their bed at the Facility's private pay rate;
3. Continuing payment at the private pay rate.

Private Pay Residents may pay to authorize a bed hold if the resident is hospitalized by signing below:

___________ I wish to have the Facility retain my/the Resident's bed for a minimum of three days if hospitalized. By initialing this section I have agreed to ensure prompt payment, commencing from the day of discharge, of the Facility's private pay daily rate for the three-day bed hold period.

___________ I do not wish to authorize the Facility at this time to retain my/the Resident's bed if hospitalized. However, should I/the Resident be hospitalized, I will be consulted at that time as to whether or not I would choose to hold the bed.

**(b) Medicare Residents** are not entitled to reimbursement for hospitalization or therapeutic leave under the Medicare Program. Medicare Residents who are absent from the Facility past twelve (12:00) midnight on any given day are deemed to be discharged from the Facility. However, Medicare Residents may elect to retain a bed in the Facility by following the Private Pay Resident Bed Retention policy above.

**(c) Medicaid Recipients**: On 5/29/2019, NYS Department of Health amended Medicaid reimbursement of reserved bed-hold days due to hospitalization leaves of absence (Section 505.9 of 18NYCRR and Section 86.2.40 of 10 NYCRR). As of that date, Medicaid will no longer pay to reserve a bed for a recipient in a nursing home who is 21 years of age or older and is temporarily hospitalized, unless the recipient is receiving hospice services in the facility. A resident whose hospitalization exceeds the state plan, if any, returns to the facility to their previous room if available or upon the first availability of an appropriate bed in a semi private room. Bed hold for days of absence in excess of the State's bed-hold limit is a non-covered service which means the resident could use their own funds to pay for the bed-hold. If the resident does not elect to pay, the resident will be permitted to return to the next appropriate available bed.

If the resident, resident's spouse, financial sponsor and/or designated representative elects to pay to secure the same bed upon returning to the Facility, he/she must follow the private pay bed hold procedure as follows:

1. Notify the Admission Department by telephone;
2. Sign a bed guarantee letter with the Admission Department stating their intent to pay to hold their previous bed at the Facility's private pay rate.

If the resident, resident's spouse, financial sponsor and/or designated representative does not choose to pay to hold the previous bed at the private pay rate, Medicaid residents on hospitalization leaves of absence or therapeutic leave will be given priority for readmission when an appropriate bed becomes available, unless there are special circumstances which would preclude a Resident's return.

**Medicaid Recipients Therapeutic Leave**: Medicaid recipients residing at Meadowbrook for over thirty (30) calendar days (on Medicaid status) are eligible for therapeutic leaves (non-hospital stay). Therapeutic leaves are limited to ten (10) days per year based on a twelve (12) month period after the qualifying 30 day stay and are eligible for a bed hold pursuant to applicable law. If a resident on Medicaid is not entitled to therapeutic leave, the Resident may be placed in any appropriate bed available in the Facility at the time of his or her return from a therapeutic leave.

If the resident, resident's spouse, financial sponsor and/or designated representative does not choose to hold the bed privately, a Medicaid resident who is on a therapeutic leave will be given priority for readmission when an appropriate bed becomes available, unless there are special circumstances which would preclude a Resident's return.

**Please Note**: Medicaid Residents who are not entitled to bed hold or therapeutic leave and who choose to leave the Facility (i.e., family member chooses to take resident home for the weekend/holiday) may only secure their bed by following the Private Pay Bed Hold procedure stated above and paying the facility at the private pay rate.

## VII. DISCHARGE, TRANSFER AND INTRA-FACILITY ROOM CHANGES

### (a) Involuntary Discharge for Non-Payment

To the extent authorized by applicable law, the Facility reserves the right to discharge the Resident if the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative fail to pay for, or secure third party coverage of the Resident's care at the Facility.

### (b) Involuntary Discharge for Non-Financial Matters

The Facility may transfer or discharge the Resident if the Facility cannot meet the Resident's medical, and/or personal needs; the Resident's health has improved sufficiently and he or she no longer requires the services provided by the Facility; the Resident poses a risk to the health and/or safety of individuals in the Facility; and for any other reason permitted by applicable law.

### (c) Voluntary Discharge

If the Resident no longer requires the services provided by the Facility, or voluntarily wishes to be discharged, the Resident, Resident's Spouse, Financial Sponsor, and/or Designated Representative and Facility will cooperate in the development and implementation of a safe, appropriate, and timely discharge plan.

**NOTE: The Resident will be informed of his or her due process rights in the event that the Facility initiates a transfer or discharge and may appeal the Facility's determination in accordance with applicable regulations.**

### (d) Intra-Facility Room Change

The Facility reserves the right to transfer the Resident to a new room on an as-needed basis, consistent with applicable law. Residents that are admitted as sub-acute Residents who subsequently become long term Residents, will be the subject of an intra-Facility transfer to rooms that are better suited for long term Residents. By execution of this Agreement the Resident understands and agrees that if he/she, or any third party payor, no longer pays the private rate covering the private room or upon Medicaid coverage, he/she will move to a semi-private room if requested by the Facility unless the provision of a private room is medically necessary. The Facility may also initiate a room change for medical, safety or social reasons consistent with applicable law and the Resident's rights. In the event that a Resident not requiring sub-acute care is placed on the sub-acute unit, it is understood that a room change will be implemented as soon as a room becomes available elsewhere in the Facility.

## VIII. RESIDENT'S PERSONAL PROPERTY

Lost/damaged items must be reported at time of occurrence to the Social Service Department. Upon investigation, Meadowbrook will determine whether said items will be replaced/repaired by facility. The Resident has the option of keeping valuable personal property (such as jewelry, money and clothing) in a locked drawer in his or her room, or to request the Facility to hold such property for safekeeping. The Facility will not be liable for the loss of the Resident's valuable property that is kept in Resident's room. Lost personal property valued over $250.00 will be reported to the Police Department. Further, it is the responsibility of the Resident and/or Designated Representative to arrange for the disposition of the Resident's property upon discharge. Property left in the Facility for more than thirty (30) days after discharge will be disposed of at the discretion of the Facility.

## IX. RESIDENT'S PERSONAL ACCOUNTS

If the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative requests the Facility to retain the Resident's personal funds, all funds over $50.00 shall be kept in an interest-bearing account by Facility. The Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative will receive account statements on a quarterly basis, and all inquiries will be addressed in a timely fashion. If payment is due to the facility for either private pay, pending medicaid and nami, the facility can use the funds from the resident's personal funds, telephone or TV account upon discharge for any monies owed to the facility for services rendered. The Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative hereby agree to and acknowledge that upon the discharge of the Resident, and after any outstanding payments are made to the Facility, the account balance, if any, will be distributed to the Resident, Resident's Spouse, Financial Sponsor, Designated Representative, Resident's estate and/or the Department of Social Services, as permitted by law. **Please initial one of the lines below.**

____________ I wish to have the Facility retain my/the Resident's personal funds.

____________ I do not wish to have the Facility retain my/the Resident's personal funds.

(Please Note: The Financial Sponsor and/or Designated Representative must have legal authorization to handle the Resident's funds should they choose to receive the funds directly. If not, the Financial Sponsor and/or Designated Representative may

purchase items on behalf of the Resident and be reimbursed upon presentation of adequate documentation to the Facility Finance Department.)

## X. SMOKING / VAPING POLICY

The Facility is committed to maintaining a smoke-free environment. The Resident agrees that under no circumstances will he/she and/or his/her visitors smoke or vape anywhere in the Facility. Smoking / vaping is only allowed in designated areas outside of the Facility as per New York State Public Health Law - Article 13E.

## XI. VISITING HOURS

Visiting is permitted 24/7. For clinical reasons, the facility's suggested visiting hours are from 11:00 am to 9 pm.

## XII. GENERAL PROVISIONS

### (a) Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the State of New York. Any and all actions arising out of or related to this Agreement shall be brought in, and the parties agree to exclusive jurisdiction of, the New York State Supreme Court, located in Nassau, New York.

### (b) Binding Effect

This Agreement shall be binding on the parties, their heirs, administrators, distributees, successors and assignees.

### (c) Continuation of This Agreement

Temporary transfer of the Resident to another health care facility for medical or surgical treatment, or the Resident's authorized temporary absence from the Facility for any other purpose, shall not terminate this Agreement. Upon the Resident's return and re-admission in accordance with the admission assessment criteria set by the New York State Department of Health and by the Facility, this Agreement shall continue in full force and effect. For discharged residents returning to the facility within one year, the admissions agreement will continue to remain in effect.

### (d) Entire Agreement

This Agreement contains the entire understanding between the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative and the Facility. This Agreement cannot be modified orally and any changes must be in writing, signed by the parties to this Agreement.

### (e) Severability

Should any provision in this Agreement be determined to be inconsistent with any applicable law or to be unenforceable, such provision will be deemed amended so as to render it legal and enforceable and to give effect to the intent of the provision; however, if any provision cannot be so amended, it shall be deemed deleted from this Agreement without affecting or impairing any other part of this Agreement.

### (f) Counterparts

For the convenience of the parties hereto, this Agreement may be executed in counterparts and all such counterparts shall together constitute the same agreement.

### (g) Section Headings

The section headings used herein are for convenience of reference only and shall not limit or otherwise affect any of the terms or provisions hereof.

### (h) Medications

All prescribed medications will be in accordance with the Meadowbrook Care Center drug formulary.

### (i) Physicians

**All Medical and Dental Services shall be provided by Practitioners affiliated with the facility. Physicians are not employees of Meadowbrook Care Center.**

### (j) New York State Sex Offender Registry

**All incoming residents are screened to determine whether the resident appears in the registry.**

**(k) Non-Discrimination**

**IN ACCORDANCE WITH STATE AND FEDERAL LAW, THE FACILITY SHALL ENSURE THAT NO PERSON IN THE UNITED STATES OF AMERICA SHALL, ON GROUNDS OF RACE, COLOR, CREED, NATIONAL ORIGIN, GENDER, SEX OR SEXUAL ORIENTATION, SEXUAL PREFERENCE, GENETIC PREDISPOSITION, RELIGION, HANDICAP OR DISABILITY, AGE, MARITAL STATUS, BLINDNESS, SOURCE OF PAYMENT OR SPONSORSHIP, BE EXCLUDED FROM PARTICIPATION IN, BE DENIED THE BENEFITS OF, OR BE OTHERWISE SUBJECTED TO DISCRIMINATION UNDER ANY PROGRAM OR ACTIVITY PROVIDED BY THE FACILITY, INCLUDING BUT NOT LIMITED TO, THE ADMISSION, CARE AND RETENTION OF RESIDENTS.**

THE UNDERSIGNED HAS READ, UNDERSTANDS AND AGREES TO BE LEGALLY BOUND BY THE TERMS AND CONDITIONS AS SET FORTH HEREIN, AND IN ALL ADDENDA TO THIS AGREEMENT.

ACCEPTED AND AGREED:

| ________ | ________________________ | ________________________ |
|---|---|---|
| Date | Signature of RESIDENT* | Print Name |

| ________ | ________________________ | ________________________ |
|---|---|---|
| Date | Signature of WITNESS | Print Name |

* If Resident is unable to sign due to physical limitations, Resident should affix an "X" in the presence of a witness.

| ________ | ________________________ | ________________________ |
|---|---|---|
| Date | Signature of DESIGNATED REPRESENTATIVE | Print Name |

| ________ | ________________________ | ________________________ |
|---|---|---|
| Date | Signature of FINANCIAL SPONSOR | Print Name |

| ________ | ________________________ | ________________________ |
|---|---|---|
| Date | Signature of SPOUSE (if not Designated Representative) | Print Name |

| ________ | ________________________ | ________________________ |
|---|---|---|
| Date | Signature of FACILITY'S REPRESENTATIVE | Print Name and Title |

# MEADOWBROOK CARE CENTER, INC.

320 West Merrick Road
Freeport, New York 11520

Resident Name: ______________________

This is to confirm that I have received a signed copy of the Meadowbrook Care Center ADMISSION AGREEMENT.

_________________________________
Print Name

_________________________________      __________________
Signature      Date