CORTLAND ACRES ASSOCIATION, INC.
Admission Agreement and Consents

AGREEMENT, made and entered this_____ _____ day of_ _____ _____ , 20____ by and between Cortland Acres Association, Inc. hereinafter called "Facility", and

_____ (Resident) or _____ (Legal Committee, Durable/Medical Power of Attorney, or Health Care Surrogate) hereinafter referred to as "Responsible Party", who agrees to the following terms, conditions and arrangements in the provisions of nursing home care for hereinafter referred to as "Resident".

FACILITY OBLIGATIONS

A. SERVICES

1. The Facility agrees to furnish room, board, laundry services, nursing care, and such other personal services as may be required for the health, safety, welfare, good grooming and well being of a Resident.
2. The Facility agrees to obtain the services of a licensed staff physician of Resident's choice wherever necessary, or the services of another licensed physician if a personal physician is not available, as well as to insure the availability and administration of such medications as a physician may order.
3. The Facility agrees to comply with the provisions of the Federal Civil Rights Act of 1964 and the West Virginia Human Relations Act, and the requirements imposed pursuant hereto, to the end that no person shall, on the grounds of race, color, national origin, ancestry, sex, or religious creed be excluded from participation in, be denied benefits of, or otherwise be subject to discrimination in the provision of any care or service. The nondiscrimination policy of the Facility applies to Resident's physicians, consultants and to all employees. Under no circumstances will the application of this policy result in segregation of buildings, wings, and rooms for reasons of race, color, national origin, ancestry, sex or religious creed.
4. The Facility agrees to uphold and promote Resident Rights as established by the Congress and disseminated by the Facility to each Resident/Responsible Party at the time of admission.

B. TRANSFERS/DISCHARGES/RE-ADMISSIONS

1. If a change occurs in a Resident's condition requiring care which the Facility does not provide, arrangements will be made to have the Resident transferred to another facility offering the required services. Suitable clinical notes and a list of physician's orders shall accompany a Resident when transferred to another medical facility.
2. The Responsible Party or other designated person will be notified of any significant change in a Resident's condition which may or may not require transfer to another facility.
3. The Facility agrees to arrange transfer for a Resident to a hospital when such transfer is ordered by the attending physician and to immediately notify the Responsible Party of the transfer.
4. Except in an emergency, the Facility will not transfer or discharge a Resident without an advance 30 day notice to the Resident and his/her Responsible Party. This condition does not apply if Resident/Responsible Party desires transfer or discharge before completion of 30 day notice.
5. The facility will not transfer a resident to a hospital or allow a resident to go on therapeutic leave without first providing written information to that resident and a family member or legal representative specifying the applicable bed hold policy, i.e., the period of time (if any) during which the resident is permitted to return and resume residence in the facility after

hospitalization or therapeutic leave. If a resident's hospitalization or therapeutic leave exceeds the state approved bed hold period (if any), and the resident continues to require the services of the facility after hospitalization or therapeutic leave and is eligible for Medicaid nursing facility services, such resident shall be readmitted to our facility as soon as a bed in a semi- private room becomes available. A resident or Responsible Party may choose to pay the Facility to hold a bed during a home leave or transfer to a hospital for days which are not covered by a benefit program (e.g. Medicaid Program). Charges for a bed reservation begins on the date leave exceeds the number of covered days to which the resident is entitled. The daily charge for a bed reservation is set at the same amount as the daily Medicaid rate in effect at the time the bed reservation is requested. Payment is handled in the same manner as for any other charges with the exception that the Facility may require that charges for a bed reservation be paid in full before successive bed reservations are granted. The Facility will hold the bed until contact is made with the Responsible Party to determine if payment will be made to hold the bed. A verbal decision will be accepted but must be immediately followed by a signed confirmation form which is initiated by the Facility and given/sent to Resident/Responsible Party.

6. If a Resident/Responsible Party elects to not hold the bed, the Resident will be given priority for readmission at the next appropriate opening, as long as the Facility is able to meet his/her needs.

C. PERSONAL FUNDS

1. The Facility will manage a Resident's personal funds if the Resident requests and provides the Facility with written authorization. Balances will be kept in interest bearing accounts.
2. If the Facility manages the personal funds it will provide the Resident/Responsible Party with an accounting of all financial transactions made on his/her behalf quarterly and at any other time upon request.

RESIDENT/RESPONSIBLE PARTY OBLIGATIONS

A. GENERAL

1. The Resident/Responsible Party agrees to abide by all rules and policies of the Facility as they pertain to Resident privileges and responsibilities.
2. Should the resident be deemed incapacitated by the physician, the Responsible Party agrees to assure that a legal representative is appointed for the resident.
3. Resident/Responsible Party agrees to provide such personal clothing and effects as needed or desired by Resident and as space permits. The Facility may give authorization for certain personal property to be retained in the Resident's room if it has been inspected and properly inventoried so long as it does not infringe on the space of the roommate or contribute to a sanitation or safety hazard.
4. Resident's selection of room and roommate will be given utmost consideration, and the Facility will make a reasonable effort to accommodate the Resident's selection. The Facility retains the right to make the final decisions on initial placement and any subsequent room changes. Reasonable notice will be given to Residents and Responsible Parties involved prior to a change.

B. FINANCIAL

1. If a Resident is eligible for any governmental Assistance program and the program is a service of the Facility, and covered, the Facility will submit a claim to the fiscal intermediary for payment. The fact that the Facility submits a claim for payment indicating that care and/or services may be covered does not relieve Resident from liability to the Facility if it is determined by the fiscal intermediary that care and/or services are not covered. The Facility will not require payment in advance for a service that may be covered by Medicare or Medicaid.

2. The financial agreement depends upon the benefits for which the Resident is eligible. The Resident/Responsible Party's initials by one of the following paragraphs below indicates the arrangement with the Resident/Responsible Party at the time of admission.

_____ The Resident is admitted on a private basis. Services will be based on the current charge structure.

_____ A Hospice Organization will participate in Resident's care. Reimbursement is based on Hospice Contract.

_____ The Resident is admitted with eligibility for Medicaid anticipated. The Resident/Responsible Party agrees to remit monthly, the amount determined by the Division of Health and Human Resources as the Resident's payment (resource amount) due for services.

_____ The Resident is admitted without confirmation of Medicare/Medicare Replacement coverage of services but requests that the bill be submitted for consideration. If coverage is not obtained, the Resident/Responsible has an obligation to make the payment according to the private pay charge structure. If coverage is approved then the Resident's obligation for payment is limited to that established by the Medicare / Medicare replacement program.

_____ The resident is admitted under Veterans Administration Contract for payment of care. Contract covers _____ month period.

The Facility does not require nor does this agreement constitute a third-party guarantee of payment as a condition of admission, expedited admission, or continued stay in the Facility. By this agreement responsible parties do not accept personal liability of payment for services. A responsible party may, however be required to make timely payment for services from the residents income or resources.

3. Billing, payment, and collection procedures are as follows:

- Billing statements are prepared within the first five days of each month and include ancillary charges for the preceding month and routine room and board charges for the current month.
- Payment is expected by the 15th of every month. Any old balance remaining on the first day of the next month will be considered delinquent and a late charge fee imposed of 1% per month.
- Written reminders on past due accounts will be issued on the 20th of each month.

– At such time that an account is 45 days past due (15 days delinquent) the Resident or Responsible Party will be issued a letter requiring payment within 10 days or the matter will be turned over for collection.

4. Prescription medications as ordered by the physician and physician services will be billed directly by the provider of the service to the Resident or Responsible Party except in the case of Medicare or Medicaid coverage of services.

5 Any refunds due to a Resident or his/her estate will refund within 30 days after discharge or upon confirmation of 3rd party payment.

6. Charges for services may change upon 30 days written notice.

TERMINATION

This agreement will remain in effect until a new agreement is made or one of the following conditions exists:

A. A discharge or transfer is necessary for the Resident's needs to be met.
B. A resident's medical condition no longer requires the services of the Facility.
C. The Resident presents a danger to the safety or health of others.
D. The Resident or Responsible Party fails to meet financial obligations.
E. The Facility ceases to operate.
F. Facility is unable to provide needed services.
G. A Resident/Responsible Party voluntarily elects to discharge.

The Resident/Responsible Party declares that this agreement has been fully explained and is understood and a copy has been provided to them. Resident/Responsible Party also declares he has been provided in writing, the current rates and charges for all levels of care and services provided by Facility.

CONSENT FOR TREATMENT

I, knowing that I am in need of extended nursing care, do hereby voluntarily consent to such care at Cortland Acres Association, Inc. encompassing nursing, routine diagnostic procedures and routine medical treatment by Dr. _____, designees or the nursing staff of the facility as it is necessary in the physician's judgment.

_____
Resident Signature Date

_____
Legal Representative Signature Date

_____
Facility Representative Date

CONTINUATION OF CONSENTS/ACKNOWLEDGEMENTS/RELEASES

RELEASE OF RESPONSIBILITY FOR VALUABLES

Cortland Acres supports resident's use of personal possessions to make their living space more inviting and home-like. We make every effort to protect possessions of our residents. We are particularly concerned for some items that can be easily lost or stolen. These items are primarily considered to be jewelry such as necklaces, rings, pins and earrings. Other items of consideration would be those of great sentimental value that would cause emotional harm if lost or damaged. In the best interest of the residents, it is our suggestion for these items not to be kept in your possession at the nursing home. Perhaps an appropriate substitute could be provided.

At the time of admission the Resident's belongings are listed on INVENTORY OF PERSONAL EFFECTS. The inventory list must be modified (updated) as items are added or deleted. It is the responsibility of the Resident/Responsible Party to make staff aware of needed modifications to the inventory listing.

At the time of death or discharge of a resident all resident belongings will be packed by staff and stored, unless prior arrangements have been made.

As the resident/legal representative, it is understood that if it is chosen not to follow the above suggested guideline, the resident/legal representative shall relieve the nursing home of any liability or responsibility in the event, such items are lost, stolen or damaged.

AUTHORIZATION TO TAKE PHOTOGRAPHS:

Knowingly and voluntary authorization is given to the facility to take such photographs of the resident as may be necessary for identification, publicity and/or medical purposes at any time during residence at the facility. This authorization is based on a full understanding of the resident's right to privacy and of the right not to consent to such photography, if so desired.

_____ Initial here if authorization is denied.

MEDICARE AUTHORIZATION/RELEASE

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 a related Medicare claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment to me.

MEDICAID AUTHORIZATION/RELEASE

I certify that the information given by me in applying for payment under Title XIX 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 of any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit a claim to Medicaid for payment to me.

ADMINISTRATION OF MEDICATIONS:

Residents have the right to have their medications given to them in a private location. Some residents, for example, may choose not to be given their medications in the dining room. It is acceptable to the resident/legal representative for medications to be administered in a public area (such as the dining room), unless requested otherwise.

_____ Initial here if the request is being made that medications be administered in private (such as by taking resident to his/her room, an exam room, or some other private location).

STUDENTS/TRAINEES:

As a resident of Cortland Acres, your direct care is provided on your behalf by your attending physician with other licensed professionals such as physician assistants and nurse practitioners. Other health care providers, such as the facility's medical director and nurses and nursing assistants, also provide care on your behalf. In addition, Cortland Acres has contracted with other health care services such as rehab therapists and pharmacy. All of these health care providers have access to your medical records for the performance of their duties.

Cortland Acres has an ongoing nursing assistant training program under the direction of licensed professionals. We also provide clinical training opportunities to formal programs including dental students. Cortland Acres, in cooperation with the training providers, would like to permit such students to assist in providing care on your behalf. In order for them to fulfill their duties, it may be necessary for them to have access to your medical records as part of their training program. As in all matters concerning your medical records, HIPAA privacy rules are fully maintained. By signing this contract, the resident/legal representative indicates no objection to a student/trainee assisting to provide care on the resident's behalf.

_____ Initial here if the resident/legal representative does not want a student/trainee to assist in providing care.

ACKNOWLEDGEMENT OF RECEIPT:

I acknowledge that I have been read and received a copy of the following materials:

[ ] THE RESIDENT BILL OF RIGHTS

[ ] CORTLAND ACRES PRIVACY NOTICE (HIPAA)

[ ] CORTLAND ACRES ADMISSION AGREEMENT AND CONSENTS PACKET

_____
Resident Signature Date

_____ _____
Legal Representative Signature Date Facility Representative Signature Date