ADMISSION AGREEMENT

Between
Enter Name of Facility: St. Luke Health Services
And
Enter Resident's Name:
Enter Resident Address:

Effective Date:

Welcome to St. Luke Health Services, a smoke free facility. This Admission Agreement ("Agreement") explains the services the Nursing Home will provide to you as well as the Nursing Home's obligations to you during your stay. It also explains your obligations, including financial obligations, as a resident of the Nursing Home. Be sure that you, and/or your Designated Representative or Financial Representative, read through the entire Agreement, and please ask your Nursing Home representative questions about any part of it that is not understood. This is very important because when you and/or your Designated Representative or Financial Representative sign this Agreement, you will be indicating that you understand, and agree to comply with and be bound by, all of its terms.

Terms and Definitions

Resident: The person admitted to the Nursing Home for care and treatment.

Designated Representative: The person (usually next of kin) who shall receive information, along with the Resident, and who shall assist and/or act on behalf of the Resident to the extent permitted by State law to make decisions regarding care, treatment and well-being if the Resident lacks the capacity to make such decisions. The designation occurs by court order, by resident (assuming resident has capacity to make such a designation) or by family members or others who have an interest in the well-being of the resident. The Designated Representative cannot act with the authority of a health care agent (unless also appointed under a Health Care Proxy), but may be considered the surrogate under the Family Health Care Decisions Act.

Financial Representative: The person, such as an attorney or a Power of Attorney, legal guardian, conservator, joint tenant or representative payee, who has legal access to and authority to handle the Resident's assets and financial information, and who agrees to assist the Resident in meeting his/her financial obligations under this Agreement.

Guardian: A person, corporation or public agency appointed by the New York State Supreme Court, Surrogate's Court or County Court to act on behalf of an incapacitated person in providing for personal needs and/or property management.

Health Care Agent: The person designated under a health care proxy to make health care decisions on behalf of the Resident.

Net Available Monthly Income ("NAMI"): The Resident's income from Social Security,

pensions and other sources used to offset the cost of their nursing home care.

1. Admission Standards

The Nursing Home will accept and retain only those residents for whom it can provide adequate care. Prior to admission, you will have been evaluated by a designated physician, who will recommend prescribed admission procedures for the purpose of determining the appropriate level of care. The Nursing Home does not discriminate based upon race, creed, color, religion, veteran status, national origin, age, sex, sexual preference or sponsorship, marital status, disability, blindness or source of payment in its admission policies, and the Nursing Home does not consider these qualities when deciding whether to accept you for admission.

The Nursing Home will not accept applicants who pose a risk of harm to themselves or to the other residents. The Nursing Home is not required to admit or retain residents who, because of behavioral disorders, are a danger to themselves or others, or whose behavior is so unacceptable that it interferes with the care and comfort of other residents. For your own safety as well as the safety of other residents, if you suffer from a communicable disease, you will not be admitted or retained unless a physician certifies in writing that the risk of transmissibility is negligible and you pose no danger to other residents, or if the Nursing Home is equipped and staffed to manage such cases.

As required by law, the Nursing Home is a smoke free facility. This ban applies to smoking both indoors and outside on the Nursing Home grounds. Upon request, the Nursing Home will provide you with a copy of its smoking policy.

Finally, the Nursing Home requires you to comply with all its rules and regulations, as well as with all reasonable requests of the Nursing Home Administrator and other duly authorized persons.

2. Financial Responsibility

It is important to realize that **when you apply for admission to the Nursing Home, you are agreeing to pay the cost of the care that will be provided to you**. Whether you pay for this care directly or whether your care is paid for by a third party, the Nursing Home requires payment in order to be able to provide services to you. In many instances, the source of payment for your care will change over time, and may involve private insurance, Medicaid or Medicare or others who may pay part or all of the cost of your care. For example, if you exhaust resources and/or deplete assets set aside to pay for your care at the Nursing Home, you (and/or your Financial Representative on your behalf) should apply for Medicaid so that the Nursing Home is paid for providing care to you. If the source of payment changes, you and/or your Financial Representative will be expected to take steps to secure payment from a collateral source, such as Medicaid, and/or to help the Nursing Home in its efforts to obtain payment for your care from these other sources.

A. Resident Responsibilities for Cost of Care

By signing this Admission Agreement, you agree to the following:

1. You will be charged a daily rate for the care and services provided to you, and billed on a monthly basis. You agree to pay the Nursing Home on the first day of each month

the full amount for the upcoming month.

2. The daily rate for your room selection is $ $419.00 . Should you request a change to your room or should your medical needs require a change to your room, your daily rate will be adjusted to the then current daily rate in place for such room at the time of your transfer. If you qualify for Medicare, Medicaid, or other insurance coverage with which the Nursing Home has negotiated a daily rate, the Nursing Home will accept such negotiated daily rate in lieu of the daily rate for the services and supplies covered by such third-party payers. Charges for additional physician or physician-ordered services are payable directly to the Nursing Home or to the other provider of services.

3. Your insurance company, Medicare, Medicaid or a third party may only pay part of the daily rate on your behalf. In such situations, you agree that you will pay any amount that is not covered by your insurance company, Medicare, Medicaid or any other third party.

4. The Nursing Home will at times need to increase the daily rate to cover the cost of care. This increase is separate and apart from any daily rate change due to your decision to transfer to a different room. You will receive thirty (30) days written notice before any new rate is to be implemented. If you decide to remain in the Nursing Home at the new daily rate, then this Agreement will remain in full force and effect and you agree to pay any increases in that daily rate.

5. As you reside in the Nursing Home, you may find that you become eligible for federal, state or county assistance to pay for the cost of your care. You agree that you will take all required steps in a timely fashion or in the time frame indicated by the Nursing Home (such as accurately completing and signing any applications, financial disclosures or other required forms; and attending hearings or other proceedings), and work with the Nursing Home, in good faith, to complete any application or recertification process necessary to obtain such assistance. In addition, if you become eligible for Medicaid, the Nursing Home will become representative payee for such amounts in order to ensure that you are appropriately paying for your care.

6. If you qualify for Medicare, there are co-pays and other contributions for which you remain financially responsible. You agree to pay those amounts to the Nursing Home. Please note that Medicare does not pay for days when you are not in the Nursing Home (for example, if you are transferred to a hospital). If you wish the Nursing Home to hold your bed in your absence, you must pay the entire daily rate for those days you wish the bed be reserved for you. Additional information regarding the Nursing Home's bed retention policy can be found in Section 5 below.

7. If you qualify for Medicaid and are receiving a pension, Social Security income or other federal benefits, Medicaid expects that you will use those benefits as your Net Available Monthly Income (NAMI) to contribute to the cost of your care and will reduce its payment to the Nursing Home accordingly. By signing this Admission Agreement, you are voluntarily agreeing to a) use your pension and federal benefits, including your Social Security income, to contribute to the cost of your care; and b) assign those benefits to the Nursing Home. To assist you in fulfilling this obligation, the

Nursing Home will become representative payee for such pension and federal benefits including your Social Security income if you wish. See Addendum IV.

8. You agree to provide updated financial information when requested. You also agree that you will alert the Nursing Home to any unexpected or sudden change in your financial condition. Because of the delay in the Medicaid application process, you may be asked to begin that application process two (2) months or more before your financial resources reach the point where you would be eligible for Medicaid.

9. If you apply for Medicaid and then your liquid assets are exhausted or unavailable before you become a Medicaid recipient, you agree to pay your monthly income to the Nursing Home as partial payment for the daily rate.

10. The Nursing Home is providing care to you, and you agree to pay for the cost of such care. Since the Nursing Home is entitled to payment for services rendered, you and any Financial Representative (collectively, the "Undersigned"), personally and independently guarantee continuity of payment to the Nursing Home for the cost of your care. Unless the Financial Representative or Designated Representative is legally obligated by law to pay for your care (as your spouse may be), the Financial Representative and Designated Representative are not required to use their personal resources to pay for your care. However, if necessary to pay the Nursing Home for your care and without incurring the obligation to pay personally from his/her funds, the Financial Representative and Designated Representative personally agree to use your income, assets and resources for payment amounts due hereunder.

B. Financial Representative Responsibilities for the Benefit of the Resident

Intending to be legally bound, the Financial Representative agrees to undertake the following obligations for the benefit of the Resident:

1. The Financial Representative understands that he/she is a Financial Representative of the Resident because the Financial Representative has access to the Resident's income, assets, resources and financial information.

2. The Financial Representative understands the Resident must pay for the care received at the Nursing Home as described in this Agreement and agrees that the Resident wishes the Financial Representative to comply with the obligations set forth in this section.

3. The Financial Representative wishes to assist the Resident and to facilitate the Resident's admission to the Nursing Home.

4. The Financial Representative agrees and acknowledges that the Nursing Home will be relying on the Financial Representative's agreement to provide the following assistance to the Nursing Home:

(a.) **Financial Representative will use Resident's financial resources to pay the Resident's bill at the Nursing Home:** Without incurring the obligation to pay for the cost of the Resident's care from the Financial Representative's own funds, the Financial Representative personally agrees to use the Financial Representative's access to the Resident's income, assets, resources and financial information to aid the Resident in meeting his/her obligations under this Agreement.

(b.) **If the Resident runs out of money to pay the Nursing Home, the Financial Representative must complete a Medicaid application on behalf of Resident:** If the Resident's income, assets and resources are depleted and if the Financial Representative has access to the Resident's income, assets, resources and financial information, the Financial Representative agrees: 1) to timely and thoroughly complete the Medicaid application and recertification processes; 2) to keep the Nursing Home apprised of the status of the Resident's Medicaid application and recertification; and 3) to seek the assistance of the Nursing Home should a difficulty arise during the Medicaid application or recertification processes.

(c.) **The Financial Representative will use Resident's money to pay the Nursing Home:** More specifically, the Financial Representative will use his/her access to the Resident's income, assets, resources, and financial information to ensure continued satisfaction of the Resident's payment obligations to the Nursing Home and/or Community Wellness Partners agrees not to use or transfer the Resident's income, assets, resources or financial information in such a way as to place the Nursing Home in a position where the Nursing Home Community Wellness Partners cannot receive payment from either the Resident's funds or Medicaid. Should it later be determined that a transfer of the Resident's income, assets, or resources has occurred which creates a Medicaid penalty period or otherwise prevents the Resident's full and timely qualification for Medicaid, the Financial Representative will take any and all steps necessary to return such income, asset or resource to the Resident's full use for payment to the Nursing Home of charges incurred.

(d.) **If Resident receives Medicaid and if Medicaid states that Resident must pay a portion of the Nursing Home bill, Financial Representative will pay that portion of the bill from the Resident's money:** If the Resident becomes Medicaid eligible and if the Financial Representative has access to the Resident's income, assets, resources and financial information, the Financial Representative personally agrees to assure that the Nursing Home is paid from such income, assets and resources any excess resources as calculated by the Medicaid agency and that portion of the monthly Medicaid rate which the Medicaid agency may direct the Resident to pay towards the cost of his/her care (NAMI).

(e.) **The Financial Representative must provide accurate information about the Resident's finances:** The Financial Representative personally agrees to assist in meeting the disclosure of information obligations under this Admission Agreement if necessary and if requested, by providing to the Department of Social Services or other entities, timely and complete financial information and/or documentation of the Resident's income, assets, resources or financial information to which the Financial Representative has access; and

C. Breach of Resident's and/or Financial Representative's Obligations

1. In the event you (the resident) fails to pay for the cost of your care, fails to assign to the Nursing Home benefits you are receiving that are for the cost of your care, or otherwise fails to comply with the obligations in section 2(A) above, you will be in breach of this Agreement and agree to pay damages the Nursing Home may incur, including but not limited to attorneys' fees and court costs.

2. In the event the Financial Representative fails to comply with the obligations in section 2(B) above, the Financial Representative will be in breach of this Agreement and agrees to pay damages the Nursing Home may incur,including but not limited to attorneys' fees and court costs.

3. Please note that the Nursing Home will rely on all of the financial resource information you provide to it. If you provide false information or misrepresent your financial resources, or withhold or fail to disclose material financial information such that the Nursing Home cannot recover reimbursement for your care, you will be in breach of this Agreement. In that case, you may be held liable for any damages that the Nursing Home may incur, including attorneys' fees and court costs.

4. In addition, in the event of any breach under the Admission Agreement, you agree to voluntarily discharge yourself from the Nursing Home as soon as a safe discharge plan is arranged.

5. In the event of any breach under the Admission Agreement and the Nursing Home cannot safely discharge you, you agree to reimburse the Nursing Home for the full cost of any care provided to you, without limits, during the time in which you remain at the Nursing Home until a safe discharge can be arranged.

6. If you are discharged from the Nursing Home for failure to pay for the cost of your care, the Nursing Home will collect any outstanding amounts from you, including attorneys' fees and court costs.

7. The Nursing Home reserves the right to assess a charge on a monthly basis at a rate of 2% per year on any private pay balance that has not been paid within thirty (30) days from the billing date. You also agree that the Nursing Home may use any personal fund balances to pay outstanding unpaid charges for deductible and coinsurance amounts, and for any other amounts due the Nursing Home under this Agreement.

3. Nursing Home Services

This Agreement describes the services that will be provided to you by the Nursing Home once you are accepted into it. Please note that there are three (3) types of services that you may receive: 1) Basic Services, which the Nursing Home provides to all residents and which are included in the daily rate; 2) Special Services, for which a resident must pay in addition to the daily rate; and 3) Medicaid-covered Services, which are provided to residents who are Medicaid recipients. These services are described more fully below.

A. Basic Services

The following services are included in the cost of your daily rate, and there is no additional charge for your use of them:

- Room and Board, including special diets as prescribed by your physician
- 24 hour Skilled Nursing Care
- Assistance and/or supervision when required with activities of daily living, including but not limited to, toileting, bathing, feeding and ambulation assistance
- Services in the daily performance of their duties by the Nursing Home's staff concerned with resident care
- Social Work and Spiritual Care services as needed
- Therapeutic recreation services
- Customarily stocked equipment including, but not limited to crutches, walkers, wheelchairs or other supportive equipment, except when a specific item is prescribed by a physician for regular and sole use by you. In such case, it is your responsibility to purchase those items on your own
- Standard equipment, medical supplies, and modalities in a quantity usually used in your everyday care including, but not limited to, catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads
- General household medicine cabinet supplies including, but not limited to non-prescription medication and materials for routine skin care, oral hygiene and care of hair, except when specific items are medically indicated by a physician and provided by you for exceptional use. If you desire a medicine cabinet item which the Nursing Home does not supply, then you are financially responsible for the purchase of such item
- Gowns as required by your clinical condition (unless your designated representative elects to furnish them) and laundry services for these and your other launderable personal clothing items
- Clean bed linen as needed, changed at least twice weekly
- Kosher dietary products prepared in accordance with religious requirements, when requested, should you desire to observe Jewish dietary laws

B. Special Items/Services

The following services are not included in the daily rate. If these services are provided to you through the Nursing Home, pursuant to Nursing Home policy, physician orders, or your election to receive such services, then you agree through this Agreement to be responsible for payment of their costs. The following are examples, and not a complete listing, of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:

- Physician Services
- Podiatry Services
- Radiology Services
- Laboratory Services
- Electrocardiogram
- Respiratory Therapy Services and Supplies
- Transportation
- Ophthalmology Services
- Dental Services
- Speech Evaluation and Supplies
- Physical Therapy Services
- Occupational Therapy Services
- Pharmaceutical Services
- Audiology Services
- Telephone, including a cellular phone.
- Television/radio, personal computer or other electronic device for personal use
- Personal clothing
- Personal comfort items, notions and novelties and confections
- Personal reading matter
- Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare
- Gifts purchased on behalf of a resident
- Flowers and plants
- Cost to participate in social events and entertainment outside the scope of the activities program
- Non-covered special care services such as privately hired nurses or aides
- Private room, except when therapeutically required (for example, isolation for infection control)

- Medicaid-covered Services

If you have qualified for Medicaid and your cost of care is paid for by Medicaid then, in addition to all the Basic Services, you are entitled to receive the following services at no additional cost above the daily rate. These services are included in the daily rate for Medicaid recipients only.

- Physician Services
- Dental Services
- Speech Evaluation and Supplies
- Physical Therapy Services

- Occupational Therapy Services
- Pharmaceutical Services
- Audiology Services
- Medical Appointment Transportation

4. Prescription Medications

Charges for prescription drugs prescribed by a physician (excluding over-the-counter medications) are not included in the Basic Services. To the extent that prescription drug charges are not covered by Medicare, Medicaid or other third-party payers, the costs must be paid by the Resident.

In certain circumstances, if the Resident is a Medicaid Beneficiary but Medicaid does not cover the Resident's prescription drug charges, the Nursing Home may cover such costs.

If the Resident is a Medicare beneficiary, the Resident shall enroll in a Prescription Drug Plan ("drug plan") under Medicare Part D. Upon request, the Nursing Home will assist the Resident or designated representative or financial representative in selecting a drug plan that best meets the Resident's needs.

5. Transportation Services

Transportation Services are not a covered expense for residents.

This is not a covered expense for Medicare A, Managed Medicare or Private Pay residents.

The Nursing Facility will provide assistance to arrange transportation to medical appointments upon request; however, it is the responsibility of the resident and/or the Resident's Responsible Party to make payment arrangements with the transportation provider in advance of the appointment. It is up to the resident and Resident's Responsible Party to notify the Nursing Unit of any transportation arrangements that they have made, in advance of the scheduled appointment to assure the resident is ready for the appointment.

Medical Appointments for Medicaid Residents - Medicaid has its own Transportation Section Medicaid Transportation "requires" prior notification of all trips, to have them approved before Medicaid Transportation will pay for them.
The facility sends these notifications in advance and waits for a decision from Medicaid Transportation. When the decision arrives that Medicaid Transportation will pay for the trip, the facility bills them and payment is made on behalf of the resident.
However, should Medicaid Transportation deny the payment, the resident or Responsible Party must pay the facility from resident's funds and submit the bill to Medicaid Chronic Care. Once Medicaid Chronic Care receives the bill, they will process a downward adjustment to the resident's applied income thus allowing the recoupment of the cost of the Ambulette trip.

6. Bed Hold Policy

A Resident may find that a medical illness or other matter may require that the Resident be away from the Nursing Home for some period of time. Medicare, Managed Care, Medicaid* and Private Pay do not have a bed hold program.
Residents who leave the facility may choose to pay the daily room rate for their bed, if they wish to hold that bed, as long as their facility account is not in arrears. Please note that most insurance companies (including Medicare) do not pay for a bed hold, and if you choose to retain your bed in your absence, you may be liable for the full amount of the daily rate.
When a bed is released that means that the bed will be open for a new admission unless the Resident or someone on behalf of the Resident agrees to pay the daily rate to the Nursing Home for each day the Resident is not in the Nursing Home."

When a Resident with no bed hold wishes to return to the Nursing Home, the Nursing Home shall offer the Resident priority readmission. "Priority readmission" means that the Resident is entitled to the first available semi-private room. You should know that any Resident is entitled to priority readmission after a hospitalization or therapeutic leave even if the Resident has no bed hold or had a bed hold but it expired. So, without a bed hold, the room you return to with priority readmission may not be the same room that you previously were in, but you will still be entitled to a room unless you have been discharged and are no longer a resident.

7. Responsibilities of the Nursing Home

The Nursing Home strives to provide an environment that is safe, clean, comfortable and welcoming to its Residents and their family and friends. A copy of the Nursing Home Resident's bill of rights and Resident Handbook will be made available. These publications explain the Resident's bill or rights and responsibilities and serve as guidelines for resident at the Nursing Home. The resident agrees to adhere to these rules and regulations.
In addition to the services listed above, the Nursing Home will also provide and/or arrange for the following services:

A. Laundry Service

Personal clothing is laundered on the premises at no additional charge to the resident. Whether this service is utilized or an independent source of laundering is used, we ask that all clothing items be marked with the Resident's name. Please notify nursing staff of any clothes brought in for a Resident.

B. Personal Services

The Nursing Home will assist you in arranging for the following services. Please note that you are responsible for the fee for them unless otherwise specified below.

- Beautician and barber services
- In room telephone service within the local calling area is available through our in house program. Telephone service beyond the local calling area or long distance is available for an increased rate. Costs associated with telephone services are the responsibility of the resident

C. Physician Visit

To ensure our Residents' health and well-being while at the Nursing Home, the Nursing Home requires that you receive regular medical visits from a physician on the Nursing Home Medical Staff or from nurse practitioners or physician assistants who are credentialed and authorized to provide services to our Nursing Home residents. Outside Primary Care Visits are not permitted during the Nursing Home stay. The Medical Director will make arrangements for another physician, or nurse practitioner or physician assistant to see you if the attending physician is not available for regular or emergency visits. You agree to a medical visit at least every thirty (30) days for the first ninety (90) days of your stay at the Nursing Home, and every sixty (60) days thereafter. You also agree to have more frequent visits when medically indicated, and to have an annual dental examination. In addition, you shall report unexpected changes in your condition to the nursing staff and/or responsible physician.

If your physician orders a diagnostic study, medical care or treatment which cannot be performed in the Nursing Home, then you shall be transferred to another appropriate health care facility. Such transfers shall be made at the request of or with the approval of the attending physician.

You will have the opportunity to participate in your care plan and proposed treatment. You have the right to refuse to participate in experimental research and to refuse any medication and treatment after being fully informed and understanding the consequences of such actions. By doing so, you accept responsibility for your own outcome.

D. Safeguarding Valuables

Although not required, a Resident may wish, for security reasons, that personal money be managed by a Resident's Financial Representative or deposited in a personal account with the Finance Department a Community Wellness Partners. Money should not be left in the Resident's room. Personal money can be deposited or withdrawn through a designated CWP Business Office staff member at any time. For withdrawals over $50.00, the Nursing Home requests a two (2) business day notice. Deposits and withdrawals from personal accounts are documented on receipts and monthly statements provided to the Resident or his/her Financial Representative. If you are discharged, any refunds from your personal account will be made pursuant to Nursing Home policy.

The monetary and emotional worth of valuables (e.g. jewelry, collectibles) must be closely considered prior to bringing them to the Nursing Home. Although a locked drawer is available for each Resident, there have been unfortunate situations where a drawer was not used or was not locked and a valuable has been misplaced. If valuables cannot be maintained by the family, we encourage that they be deposited in the Nursing Homes safe. This can be done through the Social Work Department. Residents will have access to deposit or withdraw from the safe Monday through Friday 9:00 a.m. to 4:00 p.m.

The Nursing Home will not be liable for the loss of any personal property by the Resident during

their stay here, unless said loss is caused by the negligence of the Nursing Home or violation of the Public Health Law by the Nursing Home. The nursing home shall not be liable or responsible for damage to the Resident's personal property unless such damage is caused by the negligence of the Nursing Home or a violation of the Public Health Law by Facility.
You agree that the Nursing Home is not responsible for money, valuables or personal belongings that are not given to the Nursing Home for safekeeping.

E. Recommendation/Complaint Policy

Residents, family and friends can assist in the care of their loved ones by bringing recommendations and complaints to the attention of staff members as quickly as possible. The staff will contact the appropriate department and the situation will be addressed as quickly as possible. Residents, family and friends are encouraged to relate, either orally or in writing, any unresolved recommendation or complaint to the Nursing Home staff or Administrator. The staff will notify the Administrator or Social Worker who will respond as soon as possible.

F. Resident Responsibilities

The comfort and well-being of all Residents depends upon each Resident's willingness to follow the Nursing Home's regulations and policies. By signing this Agreement, you agree to obey all existing regulations of the Nursing Home as they now exist or may be amended in the future, and to fulfill the Resident responsibilities as attached to the Resident Bill of Rights. In addition, you agree:

- To notify the Nursing Home of any change of address or phone number of your Designated Representative, Financial Representative, Guardian or Health Care Agent changes;
- To notify the Nursing Home if your Designated Representative, Financial Representative, Guardian or Health Care Agent changes;
- To remove all furniture and personal items such as clothing and jewelry, at your expense, within seven (7) days of discharge; unless alternate arrangements have been made and have been approved by the Nursing Home. The Nursing Home reserves the right to remove the personal items from the room into a storage area within 24 hours, and dispose of remaining items after the 7 day time period;
- To utilize the Nursing Home's designated pharmacy for all medications;
- To allow the Nursing Home to take your photograph for the purpose of identification;
- To utilize the options outlined above to help safeguard your funds, valuables, and personal belongings (i.e. a locked drawer in your room available upon request, Nursing Home safe, personal fund account). The Nursing Home cannot be responsible for the loss of money, valuables or personal belongings that are not given to the Nursing Home for safekeeping; and
- To provide such personal clothing and effects as needed or desired by the Resident.
- In the event Facility is required to engage legal counsel to collect the basic daily charge, NAMI Monies or other charges imposed herein from the Resident, the Resident agrees to pay the Nursing Home's attorney's fees, together with any and all costs

incurred in the institution of any legal action to collect such charges

8. Discharge and/or Transfer

In order to care for and protect all of its Residents, the Nursing Home may determine that it is appropriate to transfer a Resident to a different facility upon the following: a significant change in your medical condition for which the Nursing Home cannot provide adequate treatment; to protect your welfare or the welfare of another resident; and for certain emergency situations. In these circumstances, the Nursing Home will seek appropriate evaluation and assistance and make arrangements for your transfer to an appropriate and safe location prior to termination of this Agreement. After transfer to a hospital, in the community or other level of care, without a bedhold, you will be given priority readmission to the Nursing Home. After discharge from the Nursing Home, readmission is subject to the Nursing Home having a suitable room available. In the event that it becomes inappropriate for the Nursing Home to provide the level of care you require, you authorize the release of medical and financial information to other health care facilities for the purpose of determining admission eligibility.

In addition, and in accordance with above, the Nursing Home may terminate this Agreement and discharge you for your non-payment of services provided to you. You agree that your failure to pay for the cost of your care constitutes a breach of this Agreement and that you will voluntarily discharge yourself from the Nursing Home. Furthermore, you agree that prior to your discharge from the Nursing Home, whether voluntarily or involuntarily, adequate arrangements will be made with the Nursing Home for the payment of any amount due to the Nursing Home for your care.

In the event of the Resident's death, the Nursing Home will endeavor to notify a member or members of his/her family and/or the Responsible Party. It is expected that they will promptly provide for and bear the expense of the Resident's burial. Facility will reconcile the Resident's accounts within 30 days. Resident and Responsible Party agree to use Resident's trust funds toward any outstanding balance. All remaining funds and personal property shall be returned to the individual appointed by an appropriate Surrogate's Court to administer the Resident's estate. If Facility is not notified within thirty (30) days of the Resident's death of the appointment of a personal representative of the Resident's estate, Facility shall transfer all funds and personal property of the Resident to the chief fiscal officer of the Resident's county of residence prior to admission or to an appropriate Public Administrator, whichever is applicable.

Nursing Home assumes no financial obligations arising out of the death of a Resident. All funeral expenses are to be paid from the estate of the Resident or by relatives legally responsible therefore or by funds made available by law, unless the Resident has made specific prior arrangements with Facility.

The Resident authorizes funeral arrangements to be made by Nursing Home on his/her behalf if there is no family or next of kin, or if no funeral arrangements are made within 24 hours of death. The expenses for same shall be paid by the estate of the Resident or from funds made available by law for that purpose, without any further liability by the Nursing Home for the exercise of such authority.

9. Short Term Stay Responsibilities and Agreement

A. Based on clinical needs, some Residents are admitted for a short term stay (typically less than 12 weeks) to receive rehabilitative or other services. The Resident, Financial Representative and Designated Representative understand and, in addition to the obligations contained in this Agreement, agree that when the short-term services are completed they will cooperate with the Nursing Home to effect a safe and appropriate discharge or transition to long term care.

B. When the short-term services are completed, and if the Resident does not need long term care at the Nursing Home, a discharge plan will be developed, and the Resident may be discharged from the Nursing Home and return to his/her home in the community or other community residence.

1. We agree to maintain the Resident's residence in the community during his/her short-term stay.

2. For Residents requiring home care after completion of the short-term rehabilitation, we agree to cooperate with the Nursing Home in arranging for home care.

C. If the Resident requires residential skilled nursing care when the short-term rehabilitation is completed, the Resident may remain at the Nursing Home under this Agreement (without the need to re-execute) or be transferred to another Nursing Home.

1. If long-term care is needed, we agree to comply with all financial responsibilities and will pay over the Resident's Net Available Monthly Income as required by County Department of Social Services.

10. Conclusion

By signing below, you indicate your understanding of, and agreement to be bound by all of the terms of this Agreement. You have been given the opportunity to ask questions and all of your questions have been answered. The Attached Addenda shall become part of this Agreement. You will be given a copy of the signed Agreement and Addenda. Please provide complete, accurate and current information regarding your Designated Representative, Financial Representative, Guardian and Health Care Agent. You agree to notify the Nursing Home of any changes to this information and provide the Nursing Home with updated documents within ten (10) days of such change.

Resident: Print Name: _____

Signature _____ :Date _____

Witness Signature: _____ **Date:** _____

[Additional Signatures Below]

The Designated Representative for the Resident is: (Decision maker/HCP)

Name: _____ Relationship: _____

Address and phone: _____

Appointed by:

_____ A. Resident _____ Date: _____
(Resident's signature)

_____ B. Court Order (attach copy)

_____ C. Family member or other individual(s) who have an interest in the well-being of the Resident and the resident lacks the capacity to make such a designation.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

The Financial Representative for the Resident is: (POA)

Name: _____ Relationship: _____

Address and phone _____

Appointed by: ☐ A. Power of Attorney (attach copy) ☐ C. Representative Payee

☐ B. Court Order (attach copy) ☐ D. Other (attach)

The Guardian for the Resident is (if different than Financial or Designated Representative):

Name: _____ Date of Appointment _____

Address and phone: _____

(Attach copy of Court Order and/or commission)

Admission Agreement

Addendum I

Resident's Certification, Authorization to Release Information and Payment Request

Resident: _____
(Print Name)

Certification

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. I request that payment of authorized benefits be made on my behalf.

Release of Information

I authorize St. Luke Health Services including all entities and affiliations to use and disclose my health and financial information to any other provider to treat me and arrange for my medical care; to seek and receive payment for services given to me; and for the business operations of Community Wellness Partners, including its facilities, programs, employees, medical staff and independent providers.

Consent for Assignment

I request that payment under Medicare, Medicaid, other federal health care programs, and private insurance be made directly to St. Luke Health Services on any unpaid bills for services furnished to me.

_____ _____
Signature Date

_____
Print Name

_____
Relationship if Signed by Authorized Representative

Admission Agreement

Addendum II

Authorization for Information and Representation

I hereby authorize and request that each of the following persons, agencies, companies and organizations give full, detailed and relevant information regarding me, to the representative(s) of St. Luke Health Services for the purpose of applying for and/or maintaining (including recertifying) Medicaid, Medicare, Financial Assistance Programs, Insurance Coverage, Workers' compensation, No-Fault and/or other entitlement and Community Based Programs to which I may be entitled:

- All Local, State and Federal agencies and departments including Social Services, Health and Vital Statistics, Workers' Compensation, Labor, Law Enforcement, Correctional Services, Social Security Administration, Health Care Finance Administration, Immigration and Naturalization Services and Bureau of Veterans Affairs
- Pension Plan Administrators
- Utility Companies (Gas, Electric, Telephone, Cable, etc.)
- Current and/or Former Employers
- Current and/or Former Landlords
- Banks, Credit Unions and/or other Financial and Investment Institutions which now hold or have held my funds or within which I have a safe deposit box
- Funeral Homes
- Fraternal/Union Affiliations
- Health Care Providers holding financial information
- Insurance companies which are holding or have held funds payable to me and which are holding or have held medical, life, no-fault or other coverage for me
- Attorney or other Legal Representatives such as Guardians, Attorneys in Fact and Health Care agents
- Trustees
- Executors
- Other _____

In addition, I authorize St. Luke Health Services and its subsidiaries/affiliates, to act as my representative in applying for and maintaining (including recertifying) Medicaid, Medicare, Financial Assistance Programs, Insurance coverage, Workers' Compensation, No-Fault and/or Entitlement and Community Based Programs to which I may be entitled, and to act as my representative at any conference, administrative review, or fair hearing, as necessary.

This authorization includes the filing of and representation in the appeal of a denial of Medicaid eligibility or benefits (including participation at the Medicaid Fair Hearing), or of re-budgeting decisions, should such appeal or representation become necessary because I am and/or my Financial Representative is unable or unwilling to make such appeal, provided Community Wellness Partners determines that such appeal is necessary and prudent. Community Wellness Partners shall be authorized, but not obligated, to file on its own initiative a Medicaid application or Medicaid recertification application on my behalf in the event that I am, or my Financial Representative is unable or unwilling to do so. I understand that by signing this Authorization, the Nursing Home DOES NOT UNDERTAKE ANY OBLIGATION TO FILE ANY SUCH APPLICATION OR APPEAL of Medicaid benefits on my behalf unless the Nursing Home determines that the application or appeal is necessary and prudent.

These Authorizations will continue without expiration unless indicated otherwise here:

_____(Expiration date of Authorizations).

I can rescind these Authorizations at any time with written notice.

Patient Name	Date of Birth

Signature of Patient or Patient Representative	Date	Relationship to Patient

Admission Agreement

Addendum III

Payment of Estimated NAMI to the Nursing Home

During the period of time following the submission of a Medicaid application and before the Department of Human Services' ("DHS"), also known as the Department of Social Services eligibility decision, the Nursing Home staff will review the information provided to DHS during the Medicaid eligibility process and, based on such information, will estimate the Net Available Monthly Income ("NAMI") to be paid to the Nursing Home.

The Nursing Home will tell the Resident and Financial Representative of the estimated NAMI. **The Resident and Financial Representative agree to pay the estimated NAMI by the 10th day of each month. An interest charge of 1.25 percent per month (15 percent per annum) will be applied, if said NAMI Monies are not received by the 10th of the month. Payment will be made from the Resident's income, assets or resources, including but not limited to Social Security and pension income.** After the Nursing Home receives the eligibility notice from DHS, the Nursing Home will review DHS's calculation of the NAMI to be paid to the Nursing Home and will adjust the Resident's account balance accordingly.

Even though the Resident and Financial Representative pay the estimated NAMI, the Resident may still have an outstanding account balance due, for example, the denial of Medicaid eligibility or a Medicaid penalty period. **Even though the estimated NAMI is paid, the Resident and Financial Representative still have to pay the Resident's outstanding account balance from the Resident's income, assets or resources.**

Please answer the following question, as applicable, and provide any additional information where requested.

☐ The Resident is currently receiving Social Security:

☐ The Resident is currently receiving a pension –

If the Resident is receiving a pension, please provide

the following information:

Pension is payable by _____:

Pension amount: _____

_____ _____

Resident Date

_____ _____

Financial Representative Date

St. Luke Health Services

Admission Agreement Addendum

IV

(Applies to Long Term Residents ONLY)

Social Security, Supplemental Security Income, Special Veterans Benefits and/or Pension Benefits

I authorize any and all Social Security, Supplemental Security Income, Special Veterans Benefits and/or pension plans to pay such benefits for _____ directly to:

Name & Address of Facility:

St. Luke Health Services

299 E. River Rd

Oswego, NY 13126

I authorize the Nursing Home to become representative payee for such benefits.

Resident or Authorized Representative:

Signature _____ Date _____

Print Name

Relationship if signed by Authorized Representative

Admission Agreement Addendum

V

Private Pay Agreement

THIS AGREEMENT, made and entered into this _____ day of _____, 202_ by and between St. Luke Health Services (hereinafter Nursing Home") and _____ residing at _____ (hereinafter "Responsible Party").

WHEREAS, Responsible Party has access to the income and/or assets, including resources, of _____ (hereinafter "Resident") which are available to pay for services rendered by the Nursing Home.

NOW, THEREFORE, in consideration of the mutual promises contained herein and other good and valuable consideration, the parties hereto agree as follows:

1. Responsible Party agrees to pay the Nursing Home its basic daily private pay rate for services rendered to Resident and any and all ancillary charges incurred by Resident from Resident's income and/or assets.

2. Responsible Party agrees to immediately apply for Medicaid coverage for Resident when Resident becomes eligible for such Medicaid coverage. Pending the processing of the Medicaid application, should the Resident's assets be exhausted or insufficient to pay the basic daily private pay rate, Responsible Party agrees to pay St. Luke Home the Resident's monthly income as partial payment of the basic daily private pay rate, subject to the St. Luke Home's obligation to refund any excess amounts received based on the Medicaid determination and establishment of the Resident's Net Available Monthly Income contribution.

3. In connection with any application for or recertification of Medicaid coverage for Resident, the Responsible Party agrees to fully cooperate with the County Department of Social Services in the Medicaid application/recertification process. The Responsible Party further agrees to provide complete information and documentation to the appropriate County Department of Social Services as necessary to complete the Medicaid application or Medicaid recertification or as otherwise requested by the County Department of Social Services, including, but not limited to, the disclosure of a description of any interest that the Resident or the Resident's spouse has in an annuity. All such information, documentation and disclosures are to be provided within the time frames requested by the County Department of Social Services.

4. Subject to Section 6 - herein below, Responsible Party agrees not to transfer or otherwise dispose of Resident's assets which Responsible Party has access to in such a manner which would result in Resident's ineligibility for Medicaid coverage.

5. Subject to Section 6 herein below, in the event the Medicaid application or Medicaid recertification is denied due to a transfer of assets within the applicable Medicaid "look-back" period or due to an equity interest in the Resident's home that exceeds the current equity interest limitation, Responsible Party agrees to take one or more of the following actions, as appropriate, in order for the Resident to qualify for or to continue eligibility for Medicaid:

a. return any assets transferred to Responsible Party by the Resident or the Resident's spouse or pay or arrange for the payment to the Resident or the Resident's spouse the fair market value of any assets transferred. In addition, undertake all reasonable efforts necessary, on behalf of the Resident or the Resident's spouse, to have assets transferred to a third-party returned to the Resident or to

obtain the fair market value for the assets transferred;

b. to the extent authorized by power of attorney or otherwise, cause the designation of the state in any annuity purchased by or on behalf of the Resident or Resident's spouse as the remainder beneficiary in either the first or second position, as appropriate, under applicable Medicaid laws and regulations and cause to be restructured any such annuity as necessary, including, but not limited to, the removal or elimination of any deferral or balloon payments, the provision for payments in equal amounts during the term of the annuity, ensuring that the annuity is actuarially sound, ensuring the annuity is irrevocable and non-assignable; or

c. to the extent authorized by power of attorney or otherwise, with respect to home equity interest in excess of the Medicaid limit, cause the sale of the home at fair market value or arrange for a reverse mortgage or home equity loan to reduce the equity interest in the home below the Medicaid limit.

6. Responsible Party agrees not to transfer or otherwise dispose of Resident's assets in conjunction with the Resident's purchase of a promissory note, loan or mortgage (hereinafter individually or collectively referred to as "Debt Instrument"), unless: (a) the Debt Instrument (i) has a repayment term that is actuarially sound, (ii) provides for payments to be made in equal amounts during the term of the Debt Instrument with no deferral or balloon payments, (iii) prohibits the cancellation of the balance upon the death of the Resident; and (iv) is non-negotiable and non-assignable; and (b) payments to the Resident pursuant to the terms of the Debt Instrument are sufficient to pay the Nursing Home's private pay rate and ancillary charges for the period of Medicaid ineligibility resulting from such transfer of assets. In addition, in the event of any such transfer of assets, the Responsible Party agrees to fund or replenish any required security deposit during the period of Medicaid ineligibility from the Responsible Party's own assets (and not those of the Resident's) which will be refunded to the Responsible Party upon the earlier of the Resident's death, the Resident's discharge or the effective date of Medicaid coverage for nursing home care, provided no amounts are due to the Nursing Home. The Responsible Party's obligations under subsection (a) of Section 5 hereinabove will be applicable to any such transfer where: (a) a Medicaid application for the Resident is denied because the Debt Instrument (i) does not have a repayment term that is actuarially sound, (ii) does not provide for payments to be made in equal amounts during the term of the Debt Instrument and/or the Debt Instrument provides for deferral and/or balloon payments, (iii) provides for the cancellation of the balance upon the death of the Resident, or (iv) is negotiable or assignable; and/or (b) payments under the Debt Instrument are insufficient to pay St. Luke Home's private pay rate and ancillary charges for the entire period of Medicaid ineligibility.

7. Responsible Party will have no personal liability to the Nursing Home hereunder unless: (a) Responsible Party breaches or otherwise fails to comply with any of Responsible Party's obligations hereunder or Responsible Party is otherwise in default hereunder; and/or (b) any representation or warranty made by Responsible Party herein is false or otherwise misleading, in which case, Responsible Party shall be liable to St. Luke Home for damages resulting from: (a) such breach or default; and/or (b) St. Luke Home's reliance upon such false or misleading representation or warranty.

8. In the event the Nursing Home is required to engage legal counsel to enforce this agreement Responsible Party agrees to pay the Nursing Home's attorneys' fees, together with any and all costs incurred in the institution of any legal action to enforce this agreement.

IN WITNESS WHEREOF, this Agreement has been executed by the parties as of the date written above.

By: _____ _____
Resident Signature Witness Signature

Representative Signature (if present): _____

Date of signature: _____

St. Luke Health Services

Mail Handling

All personal mail will be given directly to the resident.

I request business mail to be: (please select)

( ) Opened and managed by Community Wellness Partner's Business Office.

( ) Given directly to resident

( ) Forwarded to the following individual:

Name: _____

Relationship: _____

Address: _____

City, State, Zip _____

_____ Resident/ Representative Signature:

_____ Witness _____ Date

PRIVACY NOTICE OF AFFILIATED COVERED ENTITIES

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

I hereby acknowledge that I have received a copy of the Community Wellness Partners Privacy Notice of Affiliated Covered Entities.

_____ **Signature of Resident/Representative**

_____ **Date**

_____ **Signature of Witness**

Electronic Communication Agreement

Electronic communications (e-mails) provide an opportunity to communicate relative to issues that are non-emergent, non-urgent, or non-critical. Electronic communications are not a replacement for direct conversation with our staff of healthcare professionals.

Important Considerations:

- CWP (Community Wellness Partners) will treat Electronic Communications with the same degree of privacy and confidentiality as written Medical Records.
- CWP has taken reasonable steps with internal information technology systems to protect the security and privacy of personal identifying and health information in accordance with federally mandated laws
- Standard email services (including, but not limited to AOL, Hotmail and Gmail) are not secure. This means that the email messages are not encrypted and can be intercepted and read by unauthorized individuals.
- Transmitting email that contains protected health information through an email system that is not encrypted may not meet the security guidelines as required by HIPAA

Agreement:

I have read and understand the above description of the risks and responsibilities associated with Electronic Communications with CWP. I acknowledge that commonly used Electronic Communications are not secure and may fall outside the security requirements set forth by HIPAA.

I understand that I can withdraw this consent to communicate with me via email at any time by written notification
I release and hold harmless CWP, its staff, employees, affiliates, agents, officers and directors from any and all expenses, claims, actions, liabilities, attorney fees, damages, losses of any kind that I may have resulting from Electronic Communications between CWP and myself based on this authorization to communicate with me via email.

Having been informed of the risks associated with Electronic Communications, I still desire to communicate with CWP via email. In consideration for my desire to use email as an adjunct to in-person visits, I hereby authorize staff to engage in Electronic Communication with me.

_____ _____

Signature of resident/family member *Date*

E-MAIL ADDRESS: _____

Received by: _____ Date:

Media Release Form

(Voice/Photo/Video)

Resident Name: _____ **Date:** _____

Community Wellness Partners (CWP) is committed to providing a culture and environment that treats all of our residents with respect and dignity, while maintaining their self-worth and individuality. All photographs/Videos/Recordings shall be used with resident approval (or their designated representative).

Fully recognizing the level of confidence our resident's and families have in our organization, we are committed to only utilizing these images in a manner that will benefit and enhance our residents quality of life.

Therefore:

I hereby grant permission for the use of my image, likeness and/or sound of my voice as recorded on audio or video by Community Wellness Partners (CWP). I understand that my image may be enhanced to approve the quality prior to being displayed, published or distributed.

By signing this release I understand this permission signifies that photographic or video recordings of me may be used electronically and displayed via the Internet. This release applies to photographic, audio or video recordings without any geographic limitation(s) on where these materials may be distributed. Additionally, I waive any right to any compensation arising or related to the use of my image or recording.

By signing this form I acknowledge that I have completely read and fully understand the above release. I hereby hold and release Community Wellness Partners and its Affiliates from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrator, or any other person acting on my behalf, or on the behalf of my estate, have or may have by reason of this authorization.

I further agree that all photographs/videos/recordings connected to this release shall be and remain the property of CWP (Community Wellness Partners).

I understand I may revoke this release at any time by submitting a written request.

Resident's Signature _____

Signature of Designated Representative: _____

St. Luke Health Services

New York State Department of Health

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

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

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 Community Wellness Partners to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network.
HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on 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 Community Wellness Partners to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for Community Wellness Partners to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

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)

St. Luke Health Services

Insurance coverage while in rehab

Resident Name: _____ **Admission Date:** _____

☐ **Does Not Apply**

Primary Insurance: _____ **Days available:** _____.

You have _____ **days available with your insurance, however this does not necessarily mean that you will need to use all these days during this admission. The amount of days you use is based on your need during this admission.**

Start of care date: _____

20th day: _____ **100th day:** _____

Secondary Insurance: _____

What does the secondary insurance cover _____

Deductible: _____ **OOP:** _____

Please note – this information is provided as a courtesy only – it is each resident/family's responsibility to know their own health insurance coverage and responsibilities.

You will be responsible for any copays or deductibles that are due. Please make sure to communicate with the social worker on the unit to make sure that you are planning for discharge accordingly. This information was based on information provided from your insurance company on the date of your admission to our facility. Your co-pay is: _____

Resident Signature: _____ **Date:** _____

Admissions Signature _____ **Date:** _____

St. Luke Health Services

Resident Name: _____

Letter signed: _____ **(Date)**

PERMISSION to ADMINISTER COVID-19 Testing:

I hereby grant authorization for Routine or Outbreak COVID-19 testing to be performed as recommended by the NY State Department of Health.

I understand the risks vs. benefits of this testing, and have had the opportunity to have my questions answered.

_____

Signature & Title

As per the NYSDOH Health Advisory – Residents who have not been tested (i.e. refused testing)

Residents should be cared for using transmission-based precautions and should be separated from other residents and remain there as follows:

- Residents who remain asymptomatic should stay in their room for a minimum of 14 days from the date of last potential exposure.
- Residents who continue to refuse testing, if transmission is ongoing then facilities could consider keeping them in their room beyond the above duration until 14 days from the date the facility completes outbreak testing.
- Residents who are symptomatic should remain in their room until they meet the symptom-based criteria to discontinue transmission- based precautions and for 14 days from the date of last exposure or longer as described in the bullet above.
- Residents who have not tested positive and who develop symptoms that are concerning for COVID-19 should remain on their room and be cared for using the appropriate transmission- based precautions and should be prioritized for testing.
- Residents who have not tested positive and are exposed to COVID-19 should be placed in quarantine and cared for using appropriate transmission-based precautions.

St. Luke Health Services

GENERAL INFORMATION & GUIDELINES FOR RESIDENTS & VISITORS

1. RESIDENTS MAY CONTINUE TO VOTE IF THEY DESIRE. BOARD OF ELECTIONS WILL BE IN BEFORE ELECTIONS TO OFFER ASSISTANCE WITH ABSENTEE BALLOTS IF DESIRED. THIS INFORMATION WILL BE POSTED WITH DATE, TIME AND LOCATION.

2. EACH RESIDENT WILL HAVE A LOCKED STORAGE SPACE IN THEIR ROOM, AND A KEY WILL BE PROVIDED TO EACH RESIDENT.

3. ON EACH NURSING UNIT THERE IS A BULLETIN BOARD POSTED WITH PERTINENT INFORMATION; BILL OF RIGHTS, LONG TERM CARE OMBUDSMAN PROGRAM INFORMATION, TELEPHONE NUMBERS OF NEW YORK STATE DEPT OF HEALTH DEPARTMENT HOTLINE FOR COMPLAINTS OF ABUSE, NEGLECT AND MISAPPROPRIATION OF RESIDENT PROPERTY IN THE FACILITY, RESIDENT COUNCIL OFFICERS, UNIT REPRESENTATIVES, AND COMMISSION ON QUALITY OF CARE FOR THE MENTALLY DISABLED.

4. THERE ARE POSTAGE STAMPS AVAILABLE AT THE FRONT DESK, OR IN GIFT SHOP. MAIL IS DELIVERED UNOPENED AND IS SENT OUT UNOPENED. THE GIFT SHOP IS OPEN FOR RESIDENTS CONVENIENCE, HOURS ARE POSTED.

5. ALCOHOLIC BEVERAGES ARE DISPENSED ONLY WHEN A PHYSICIAN WRITES AN ORDER ALLOWING OR PERMITTING IT, AND ALCOHOL IS NOT ALLOWED TO BE STORED IN RESIDENT ROOMS.

6. RESIDENTS WILL BE ENCOURAGED TO BRING IN PERSONAL FURNISHINGS UPON APPROVAL BY SOCIAL SERVICES PERSONNEL. ELECTRIC BLANKETS, HEATING PADS, ELECTRIC HEATERS AND RUGS ARE NOT ALLOWED FOR RESIDENTS SAFETY.

   A. ALL ELECTRICAL EQUIPMENT MUST BE APPROVED BY OUR BUILDING SERVICES DEPARTMENT BEFORE BEING PUT INTO USE.

   B. FAMILIES AND RESIDENTS ARE REQUESTED NOT TO PLACE ITEMS ON WALLS IN RESIDENT ROOMS. IN ORDER TO PROTECT THE WALL COVERINGS, ALL WALL HANGINGS WILL BE INSTALLED BY OUR BUILDING SERVICES DEPARTMENT.

7. NO OUTSIDE MEDICATIONS WILL BE ACCEPTED, OR BROUGHT INTO THE FACILITY, UPON ADMISSION OR ANYTIME THEREAFTER.

St. Luke Health Services

GENERAL INFORMATION & GUIDELINES FOR RESIDENT & VISITORS

8. A RELEASE OF RESPONSIBILITY MUST BE SIGNED BY THE RESIDENT OR RESPONSIBLE PARTY WHEN A RESIDENT LEAVES THE FACILITY. MEDICATIONS WILL BE RELEASED TO THE RESPONSIBLE PARTY AS NEEDED ONLY WHEN A PHYSICIAN WRITES AN ORDER ALLOWING OR PERMITTING TO DO SO.

9. THERE MAY BE SITUATIONS OF VISITATION BEING LIMITED OR RESTRICTED IF A VISITOR OR FAMILY CLEARLY DEMONSTRATES A THREAT TO THE HEALTH AND SAFETY OF THE RESIDENTS AT THE FACILITY, OR THE SAFE OPERATION OF THE FACILITY. NO FIREARMS ALLOWED IN THE FACILITY.

10. IN THE EVENT OF A NEED TO EVACUATE RESIDENTS FROM THIS FACILITY IN AN EMERGENCY, RESIDENTS WILL BE EVACULATED TO A SAFE LOCATION, THROUGH OUR LOCAL, REGIONAL AND STATE PLAN. FAMILIES WILL BE NOTIFIED OF ANY/ALL TRANSFERS IN THE EVENT OF AN EVACUATION. IF EVENT IS WIDE SPREAD THERE ARE OTHER LOCATIONS AGREEING TO ACCEPT RESIDENTS AND FAMILIES WILL ALWAYS BE KEPT INFORMED OF RESIDENTS LOCATION. OUR GOAL IS FOR RESIDENTS TO BE SAFE IN ALL SITUATIONS.

    (PLEASE BE AWARE THAT THE ST. LUKE HOME CAMPUS IS LOCATED IN FLOOD ZONE A. THE FACILITY HAS AN EMERGENCY EVACUATION PLAN THAT HAS BEEN APPROVED BY THE NEW YORK STATE DEPARTMENT OF HEALTH. IN THE EVENT OF AN EMERGENCY, PLEASE BE ASSURED THAT ALL RESIDENTS WILL BE SAFELY MONITORED AND WE WILL FOLLOW APPROPRIATE GUIDELINES TO ENSURE THE SAFETY OF ALL RESIDENTS.)

11. AFTER A RESIDENT IS DISCHARGED ALL PERSONAL BELONGINGS NEED TO BE PICKED UP WITHIN 30 DAYS THROUGH ENVIRONMENTAL SERVICES.

12. RESIDENTS HAVE ACCESS TO WITHDRAW MONEY FOR THE WEEKEND BY REQUEST

13. THE PALLIATIVE CARE ACCESS ACT (PCAA) WENT INTO EFFECT 9/27/2011 IN THIS FACILITY TO PROVIDE ACCESS TO INFORMATION AND COUNSELING REGARDING OPTIONS FOR PALLIATIVE CARE APPROPRIATE TO RESIDENTS WITH LIFE LIMITING CONDITIONS AND ILLNESSES. INFORMATION AND COUNSELING WILL BE PROVIDED.

14. ALL WINDOWS, AS A DEPARTMENT OF HEALTH REQUIREMENT, ARE TO BE OPENED NO MORE THAN 6 INCHES. WINDOW STOPS ARE IN PLACE AND ARE NOT TO BE REMOVED.

RESIDENT/SPONSOR SIGNATURE

DATE

St. Luke Health Services

Resident Personal Belongings Inventory

Instructions: Inventory Form shall be completed at the time of Admission. The Admissions Rep. and the resident or the resident's guardian or agent will sign. The document shall be scanned and filed in the resident's Misc. Tab in PCC.

DATE OF ADMISSION: _____

RESIDENT'S NAME	**UNIT**
CONTACT LENSES ☐ YES ☐ No	**DENTURES** ☐ YES ☐ No
EYE GLASSES ☐ YES ☐ No	**HEARING AID(S)** ☐ YES ☐ No
JEWELRY	**WATCH**
MONEY/CHECK BOOK/CREDIT CARDS	

*All electronic devices need to be approved by the Maintenance Department prior to using. Please fill out a Work Order for this approval.

NO.	ITEM	DESCRIPTION
	Sheets	
	Pillows	
	Blankets	
	Comforter	
	Cell Phone*	
	IPad*	
	Electric Razor*	
	Electrical Chargers*	
	TV (Make and Size)*	
	Radio*	
	Clock*	
	Walker/Cane	
	Wheelchair (Model)	

St. Luke Health Services

CLOTHING – Items of Value: Please list items here. (additional items may be written on back of page)

Value:	Item Description

Statement: I have read and agree that this is an accurate list of my belongings:

RESIDENT SIGNATURE	DATE	HCP/SURROGATE/GUARDIAN'S SIGNATURE	DATE

Witness:

Staff Member

Date

Original: June 2025
Revised:

St. Luke Health Services

299 East River Road
Oswego NY 13126

Release of Responsibility for Refusal of Dental Treatment

I, _____, hereby refuse to have a dental examination and dental treatment during my short term stay at St. Luke Health Services. I understand that dental treatment (examination) is a prerequisite. I take full responsibility and absolve the management, all personnel, and the attending physician in the event that my actions are contradictory to my well being.

Comments:

_____

_____

_____ _____

Date Signature of Resident or Designee

_____ _____

Date Witness

St. Luke Health Services

AUTHORIZATION FOR PROTECTED HEALTH INFORMATION (PHI) EXCHANGE

Name:		Date of Birth	
MR #		Unit & Room	

Name of Representative *(if not completed by resident)*_____

Many times our patients/residents want family members such as a spouse or a child (other than the Health Care Proxy) to be able to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without your consent.

If you wish to allow us to share any of this information you must sign this form. Signing this form will allow us to share the information with only the individual(s) listed below.

Please note, this form does not apply to the release of records

I authorize Community Wellness Partners affiliates to share my medical and/or billing information with the following individual(s) *(please fill out all information and select the ability to release Financial or Clinical information-or both)*

	Name	Relationship	Address/Phone	Financial	Clinical
1.				☐	☐
2				☐	☐
3.				☐	☐
4.				☐	☐
5.				☐	☐

** Please use additional form for additional authorizations**

Patient/Resident Information:

I understand that I have the right to revoke this authorization in writing at any time and that I have the right to be notified of the information to be disclosed.

I understand that the information disclosed to any above recipient is no longer protected by federal or state law, and may be subject to re-disclosure by the recipient.

SIGNATURE:_____ **DATE:**_____

WITNESS SIGNATURE:_____ **DATE:**_____

St. Luke Health Services

RESIDENT RIGHTS & INFORMATION SIGNATURE PAGE:

I HAVE RECEIVED INFORMATION ON:

Welcome Letter
Bed Hold
Business Office
Covid
Pet Visits

Facility Contact Telephone Numbers
Nursing Dept. Roles
Physician Services
Specialty Units
Supplies that are provided
Not allowed items

Advance Directives
Annual Survey
Grievance Notification
NYS Complaint/Inspection Information
Optum Information
Resident Council
Smoking Information
Veterans Information

Activities
Dining & Nutritional Services
Laundry services
Maintenance
Ombudsman Information
Pastoral Care

Beauty Shop Rates
Cable TV & Telephone Rates
Current Daily Rates
PT/OT/ST Fees
Transportation

Notice of Privacy _____

RESIDENT RIGHTS: I have received a copy of the Resident Rights & Responsibilities and reviewed them with the Admissions Department

PRIVACY: I have receives of copy of the Privacy Practices.

MEDICATION ADMINISTRATION: I have been informed that I have the right to self-administer medications and I am choosing not to while I am a resident of the Community Wellness Partners Campuses.

RECEIPT : I have read and understand the above information. I have had the opportunity to review my admission paperwork, ask questions and have all my questions answered to my full satisfaction.

I am requesting this information be emailed to me instead of receiving a hard copy:

Email address: _____

_____ _____

Signature of Resident/Responsible Party Date

_____ _____

Signature of Facility Representative Date