Oneida Health
Extended Care

FINANCIAL RESPONSIBILITY AND ADMISSION AGREEMENT

Resident: _____

Date of Admission_____

Oneida Health
Extended Care

FINANCIAL RESPONSIBILITY AGREEMENT

CAUTION: THIS IS AN IMPORTANT DOCUMENT. IT CREATES LEGAL OBLIGATION ON THE RESIDENT AND RESPONSIBLE PARTY WHICH CAN GIVE RISE TO FINANCIAL LIABILITY. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

ADMISSION AND FINANCIAL AGREEMENT

The staff of Oneida Health Extended Care Facility (ECF) and Rehabilitation Center warmly welcomes you. We take great pride in the fact that you have selected the Oneida Health Extended Care Facility and Rehabilitation Center to support your Rehabilitative and/or Long term Care needs. Recognizing that personal health changes are difficult and often stressful event in one's life, we feel privileged to assist you in this transition. By choosing Oneida Health Extended Care Facility and Rehabilitation Center, you have made a commitment to place your trust in us to provide you with state of the art health care services to meet your individualized needs. It is our intention and goal that throughout your stay at the Oneida Health Extended Care Facility and Rehabilitation Center, we will continually strive to achieve a fruitful partnership of understanding, friendship and growth.

At the time of admission to Oneida Health ECF, the prospective Resident/Responsible Party shall complete and sign the Financial Responsibility Agreement and all documents incorporated therein, including a complete list of his or her assets and liabilities. This

information allows the staff to submit an application on behalf of the Resident to the Department of Social Services for Medicaid financial assistance when the resident becomes eligible.

This agreement is put into place to help you better understand the financial requirements and needs related to you or your loved ones stay. Our goal is to help you understand which services are covered and which are not. Let's start with the covered services:

COVERED SERVICES

For the daily cost of care, you will receive:

- Lodging and Board
- Therapeutic or modified diets as prescribed by a physician
- Fresh bed linen changed at least twice weekly or as often as needed.
- Twenty-four hour nursing care and services-including activities of daily living: toileting, bathing, feeding, ambulation, etc.
- Activities program including a varied schedule of activities to meet your physical, psychological, emotional and individual needs.
- Pastoral care services including religious services, counseling and programs desired.
- Social Work services including an assessment of psychosocial needs, counseling services for residents and families, discharge planning and advocacy for all residents

- The provision and/or use of non-patient specific equipment and resources for the purpose of assessment and rehabilitation to sustain optimal functional ability and independence.
- General floor stocked medicine cabinet supplies materials for routine skincare, oral hygiene, and care of hair (except when specific items are medically indicated and prescribed by a physician).

There are also additional services that would be covered (in most cases) by Medicare or Medicaid, but would be an out of pocket cost for self-pay residents are listed below:

Additional Services, which are not included in the private pay daily rate: (sample)

- Physical Therapy
- Audiology Services
- Occupational Therapy
- Speech Therapy
- Podiatry Services
- Psychiatric or Psychological Treatment
- Laboratory Services
- Radiology/X-Ray Services
- Special Nurse, Companion, attendant at any type of outing/appointment, or intensive staff supervision
- Oxygen Therapy, including but not limited to supply of oxygen and administration of oxygen

- Dental Services
- Transportation Services
- Physician Ordered Medications (not floor stocked)
- Respiratory Therapy: Specialty equipment/supplies specifically ordered for the individual resident
- Other items not listed under covered services

RECITALS

A. **Oneida Health Extended Care Facility and Rehabilitation Center (ECF)**-the facility currently or soon to be providing nursing and other services to the Resident.

B. **Resident/Responsible Party/Power Of Attorney-** The Resident or the individual acting on behalf of the Resident who has control over and access to certain income and/or accounts of the Resident, such as Social Security, pension income, investment interest, securities, annuities, cash and/or other funds.

TERMS AND CONDITIONS

In consideration of and as a condition for continuation of nursing and other services to the Resident, or for admission of Resident to Oneida Health Extended Care Facility and Rehabilitation Center, the Resident and Responsible Party agree to the following terms and conditions:

1. **Payment for Services.** By signing this Financial Responsibility Agreement, Oneida Health Extended Care Facility and Rehabilitation Center obligates itself to provide nursing care and other services to resident, all as described in the Admission Agreement signed by the resident.

   The Resident promises to pay Oneida Health Extended Care Facility and Rehabilitation Center for such nursing and other services, and Resident and Responsible Party obligate themselves as set forth in this Financial Responsibility Agreement.

   Responsible Party specifically agrees that the nursing and other services provided by Oneida Health Extended Care Facility and Rehabilitation Center to Resident constitute fair and adequate consideration for the agreements, covenants and representations made by Responsible Party herein.

2. **Representations by Responsible Party.** Responsible Party hereby affirmatively makes to Oneida Health Extended Care Facility and Rehabilitation Center the following representations, with the knowledge that Oneida Health Extended Care Facility and Rehabilitation Center will rely thereon:

    a. Responsible Party has authority to act on behalf of Resident in connection with Resident's admission/continued stay at Oneida Health Extended Care Facility and Rehabilitation Center, and is not aware of any other person(s) acting on behalf of Resident or with authority to so act, whether by Power-of-Attorney, court order or otherwise. Submitted separately herewith is a validly executed Power-of-Attorney by Resident in favor of Responsible Party, and proof that same is in full force and effect. Resident and Responsible Party affirm that Responsible Party is not authorized to make any gifts on behalf of resident pursuant to said Power-of-Attorney.

    b. Responsible Party affirms that he/she is familiar with the financial resources of Resident and represents that the Financial Disclosure Statement submitted separately herewith is accurate and contains no material omission.

    c. Responsible Party acknowledges that he/she has no claim to the income and/or assets of the Resident, and is not aware of any other third party having a claim to such income and/or assets.

    d. Responsible Party affirms that he/she has not received from Resident or caused to be transferred from Resident to a third party any money or property for less than adequate consideration within three-year period immediately preceding the admission of Resident to Oneida Health Extended Care Facility and Rehabilitation Center, and further affirms that Responsible Party is unaware of any such transfers to any other third party.

    e. Responsible Party acknowledges receipt and review of a copy of Oneida Health Extended Care Facility and Rehabilitation Center's "Guide to Medicare and Medicaid," and states that Responsible Party has had adequate opportunity to review the content of such guide with the attorney or financial advisor of Resident.

    f. Responsible Party acknowledges that he/she has executed this Financial Responsibility Agreement of their own free will, free of any

duress or coercion by Oneida Health Extended Care Facility and Rehabilitation Center, its employees, agents, or other representatives.

g. Responsible Party further acknowledges that Oneida Health Extended Care Facility and Rehabilitation Center is or will be entitled to prompt payment from the Resident's income and/or assets in return for the care rendered to resident.

3. Affirmative Obligations of Resident/Responsible Party.
Resident/Responsible Party agrees that as long as the Resident receives nursing and other services from Oneida Health Extended Care Facility and Rehabilitation Center, Responsible Party shall comply with the following terms and conditions:

a. Resident/Responsible Party agrees to receive and hold, as trustee, all of the Resident's income, assets and/or financial resources as a trust fund. Before using any part of the Resident's income, assets and/or financial resources for any other purpose, Responsible party agrees to pay Oneida Health Extended Care Facility and Rehabilitation Center for nursing and other services rendered to Resident, and any and all ancillary charges incurred by Resident, from Resident's income, assets and/or financial resources. Responsible Party agrees that a breach of this provision shall be deemed a breach of fiduciary obligation, for which Oneida Health Extended Care Facility and Rehabilitation Center shall have recourse against Responsible Party in a court of law.

b. Resident/Responsible Party agrees *to* **immediately apply for Medicaid coverage for the Resident on or about two months prior to the Resident's income, assets, and/or financial resources having been spent down to Medicaid eligibility limits.** Any financial loss experience by Oneida Health Extended Care Facility and Rehabilitation Center due to a refusal or delay on the part of the Responsible Party in applying for Medicaid coverage for the Resident shall become the personal liability of Responsible Party and paid to Oneida Health Extended Care Facility and Rehabilitation Center on demand.

c. Resident/Responsible Party agrees not to transfer or otherwise dispose of or permit the transfer of the Resident's income, assets and/or resources in a manner, which would result in the Resident's ineligibility for Medicaid coverage. Any financial loss experienced by Oneida Health Extended Care Facility and Rehabilitation Center due to the Responsible Party transferring or permitting such transfer shall become the personal liability of the Responsible Party and paid to Oneida Health Extended Care Facility and Rehabilitation Center on demand.

d. In the event that the Resident should qualify for Medicaid, Responsible Party will receive and hold all funds designated by the County Department of Social Services Budget letter or the New York City Human Resources Administration Budget Letter as the Resident's **Net Available Monthly Income** (hereinafter called "NAMI" monies) as a trust fund, and will apply all NAMI monies to pay Oneida Health Extended Care Facility for the care rendered to Resident before using any part of the total of such NAMI monies for any other purpose. Payment shall be made to Oneida Health Extended Care Facility and Rehabilitation Center upon receipt of such NAMI monies and in no event later than the twentieth (20^{th}) day of the month. If requested by Oneida Health Extended Care Facility and Rehabilitation Center, Responsible Party shall authorize direct deposit of such NAMI monies to an account established at the Citizens Bank or other Oneida Health Extended Care Facility and Rehabilitation Center designated bank, in the name of the Resident, further authorizing such bank to transfer daily the balance in the Resident's account to the appropriate account. Responsible Party agrees to be personally liable to Oneida Health Extended Care Facility and Rehabilitation Center if at any time he/she fails to promptly pay the NAMI over to Oneida Health Extended Care Facility and Rehabilitation Center.

e. If the Resident is eligible for Medicare drug coverage, the Resident and/or Responsible Party agree to enroll the Resident in a **Medicare Part D prescription drug plan** the: (1) participates with Oneida Health Extended Care Facility and Rehabilitation Center's long term care pharmacy; and (2) whose formulary includes the Resident's prescription drugs. In the event that the conditions above cannot be met, the Resident and/or Responsible Party agree to timely initiate, fully participate in, and exhaust the exception and appeals process

applicable to the Part D plan in which the Resident is enrolled. Any financial loss experienced by Oneida Health Extended Care Facility and Rehabilitation Center due to a refusal or delay on the part of the Resident and/or Responsible Party in enrolling in a Part D plan that meets the conditions set forth above, or to fully exhaust the exception and appeals process, shall become the personal liability of the Resident and paid to Oneida Health Extended Care Facility and Rehabilitation Center on demand.

4. Security for the Payment of Bills for Care Rendered by Oneida Health Extended Care Facility and Rehabilitation Center. As security for the payment of bills rendered from time to time by Oneida Health Extended Care Facility and Rehabilitation Center to Resident for nursing and other services, Resident and Responsible Party, or Responsible Party on behalf of resident, as the case may be, agree as follows:

a. Resident/Responsible Party shall provide Oneida Health Extended Care Facility and Rehabilitation Center with monthly statements or at such intervals as may be requested, reflecting the account balances of Resident's funds and/or investments, including annuities and cash surrender values of life insurance policies, held by financial institutions, brokerage firms, insurance companies and other custodians.

b. Resident/Responsible Party hereby authorized Oneida Health Extended Care Facility and Rehabilitation Center to verify with such financial institutions, brokerage firms, insurance companies and other custodians the identification and value of all accounts, policies, annuities and other financial investments.

c. Resident/Responsible Party shall immediately disclose to Oneida Health Extended Care Facility and Rehabilitation Center any material change in the financial condition of the Resident, including any account, fund, investment, or transfer, which would result in the Resident's ineligibility for Medicaid coverage. Resident/Responsible Party shall immediately, and no later than ten (10) calendar days, inform Oneida Health Extended Care Facility and Rehabilitation Center in writing of the change of location of any funds and/or investments of the Resident.

d. Resident/Responsible Party hereby authorizes such financial institutions and applicable County Department of Social Services to release any and all information regarding account identification, balances, values, and other information, including, but not limited to, all information regarding or required by the Medicaid application and/or recertification thereof.

e. Resident/Responsible Party hereby grants to Oneida Health Extended Care Facility and Rehabilitation Center the security interest in and to any personal and/or real property of Resident for the purpose of securing payment of any and all bills for care rendered by Oneida Health Extended Care Facility and Rehabilitation Center to Resident, in the event that the Resident shall fail to comply with any of the terms and conditions of the Agreement, then Resident/Responsible Party shall, on demand, execute such assignments, deeds and other conveyances in favor of Oneida Health Extended Care Facility and Rehabilitation Center as Oneida Health Extended Care Facility and Rehabilitation Center in its sole discretion, shall deem necessary to secure the payment of bills for nursing and other services rendered to Resident. In the event that Responsible Party shall refuse or delay in

compliance with this requirement, then Responsible Party shall become personally liable to Oneida Health Extended Care Facility and Rehabilitation Center for the financial loss resulting there from.

f. Oneida Health Extended Care Facility and Rehabilitation Center understands that you are eligible for insurance coverage of all or a portion of the charges pursuant to the term of a third party payer's health benefit plan or program ("third party payor" or plan). Although Oneida Health Extended Care Facility and Rehabilitation Center has relied on insurance verification of eligibility and coverage, verification of coverage does not guarantee all coverage. Some plans review and deny coverage after the services are provided and continued coverage may be subject to specific additional preauthorization requirements, to modifications by the plan, and by its determination that recommended services are "Medically Necessary" as well.

g. Oneida Health Extended Care Facility and Rehabilitation Center is not responsible for benefit denials, limitations, or terminations by third party payers. Oneida Health Extended Care Facility and Rehabilitation Center will, however, make best efforts to (1) present information to support the medical necessity of treatment recommended by your care team; and (2) to notify you and/or your responsible party as soon as it is informed by the third party payor that coverage will cease or decrease.

5. **Miscellaneous.** Oneida Health Extended Care Facility and Rehabilitation Center and Resident/Responsible Party agree as follows:
   a. Resident and Responsible Party hereby acknowledge and agree that in the event of a breach of any of the terms and conditions of this Agreement resulting in nonpayment of any charges for nursing and other services, the Resident may be discharged from the facility in conformance with the rules and regulations of the New York State Department of Health. Under such circumstances, both Resident and

Responsible Party hereby agree to cooperate with and participate in the discharge planning process, including but not limited to location an appropriate alternative placement for the Resident, Further, Responsible Party hereby agrees that he/she will be personally liable for any financial loss suffered by Oneida Health Extended Care Facility and Rehabilitation Center for any refusal or failure to cooperate with said discharge process on the part of the Responsible Party.

b. Resident and Responsible Party further agree that in the event that the Responsible Party fails to adhere to the terms and conditions of this Agreement and that that the Resident is unable to do so by reason of incapacity, that both hereby consent to the appointment of Oneida

Health – Extended Care Facility as the guardian of the property of the Resident pursuant to Article 81 of the Mental Hygiene Law. The costs of any such proceedings shall be borne by Resident and/or Responsible Party.

c. Resident's accounts not paid in full and received by the twentieth (20^{th}) day of each month shall bear interest at the rate 1% per month (12% per annum) from the first calendar day of the month. Oneida Health Extended Care Facility and Rehabilitation Center, at its sole discretion, may waive any part or all of the interest charges due to third party payments and other circumstances.

d. In the event that it becomes necessary for Oneida Health Extended Care Facility and Rehabilitation Center to retain the services of an attorney/collection agency to enforce any of the terms and condition of the Agreement, then all costs of collection, including reasonable attorney fees, shall be paid by Resident/Responsible Party to Oneida Health Extended Care Facility and Rehabilitation Center.

e. This Financial Responsibility Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter hereof, and cancels and supersedes any prior understandings and agreements between the parties hereto. There are no representations, warranties, terms, conditions or collateral agreements, express, implied of statutory, between the parties other than expressly set forth in this agreement.

f. Resident and Responsible Party will from time to time execute and deliver all such further documents, assignments and other instruments, and do all acts and things as may be reasonably required to effectively carry out or better evidence or perfect the full intent and meaning of this Agreement.

RELEASE OF INFORMATION

The Resident/Responsible Party shall authorize release of clinical records or information needed by a third party payor for payment of services rendered. Refusal to authorize release of needed information to the third party payor shall be deemed valid conditions under which the facility may deny admission or initiate discharge of the resident from Oneida Health ECF.

MEDICARE A ELIGIBILITY

1. If the Resident meets the criteria for coverage under Medicare Part A, payment for basic services will be made by the federal Medicare program, less any co-insurance or deductible obligations.

This Facility accepts the Medicare Part A reimbursement as payment in full for the items and services listed under Paragraph A, Sections 1, 2, and 3, for the first 20 days. And for the remaining 80 days of the Medicare Part A benefit period the Facility accepts Medicare Part A reimbursement, but the reimbursement will be reduced by the amount of the current applicable co-insurance daily rate of **$209.50/day.** The Resident, who is not dually eligible for Medicaid benefits, agrees to remit payment of the co-insurance daily amount **$209.50**/day upon receipt of the billing statement from the Facility. The Resident, who is dually eligible for Medicaid, agrees to remit payment as delineated in the subsequent MEDICAID Sections herein.

2. In the event that the Facility determines that the resident is not eligible for Medicare Part A benefits at the time of admission or at a time PRIOR to the 100th day of services, the Facility shall notify the Resident and/or Sponsor. This notification shall be in the form an expedited Notice of Determination to Discontinue Medicare A benefits. The Facility will contact the Resident in person or the Sponsor in person (or by telephone if personal contact cannot be accomplished). The Resident/Sponsor will be advised by the Facility of the reason the Facility's deems the discontinuation of Medicare A coverage is necessary and shall advise the Resident/Sponsor of his/her rights to appeal the Facility's determination. The Facility will also mail a written notice/verification of the expedited notice given on the date the notice was provided to the Resident/Sponsor.

3. In the event the Resident receives services that continue to meet Medicare Part A eligibility requirements for the full 100 days, Medicare benefits will become exhausted on the 100th day. No further Medicare Part A benefits will be payable for skilled nursing coverage as of the 101st day unless the resident stops receiving services at a skilled-nursing and/or rehabilitative level for **60 CONSECUTIVE** days; at which time the CURRENT Medicare Part A benefit period would end. In order to begin a NEW Medicare Part A benefit period, the Resident will have to re-qualify for Medicare Part A benefits by meeting both the technical and clinical requirements anew.

4. When the Resident's Medicare Part A coverage expires, unless the Resident is dually eligible for Medicaid coverage, the Resident will be responsible for payment of the Basic Self-Pay Daily Rate and Ancillary Charges.

5. Medicare does NOT pay for bed reservations for hospitalizations or therapeutic leave days (except in very rare occasions of therapeutic leave on holidays such as Christmas Day). In the event that a resident requires a hospital stay, which will make them absent from the Facility at 12:00 AM, the Resident's bed may be requested to be reserved by the Resident/Sponsor. The Resident/ Sponsor agrees to pay the Basic Self-Pay Pay Per Diem Rate for the days of hospitalization.

MEDICARE PART B BENEFITS

Medicare Part B Benefits covering physician and other therapeutic services you receive will be applied for by Oneida Health ECF and will be paid to the facility on your behalf. The receipt of Medicare funds for physician and other therapeutic services will not reduce the daily charge for covered services that

you pay. You will be billed, as required by law, for all deductible and co-payments under the Medicare Part B program. If you have some form of wrap around insurance policy and provide that information to us, we will bill the insurance carrier on your behalf to facilitate reimbursement to you.

MEDICARE PART D

Beginning January 1, 2006, Medicare will cover certain prescription drugs through a new Part D program. Although the program is voluntary, New York State law requires Medicaid applicants and recipients to enroll in Medicare Part D as a condition of eligibility for Medicaid. Oneida Health ECF is available to assist you in selecting a prescription plan so that you will continue to have timely access to the medication you need

MEDICAID APPLICATION

Oneida Health ECF shall make timely applications to the Department of Social Services for Medicaid Financial assistance on behalf of the resident if and when he or she becomes eligible for such benefits. In order for Oneida Health ECF to successfully complete such applications for the Resident, it is essential that the Resident/Responsible Party provide complete and accurate information and records as requested. (See **3b** on previous page as a reference).

RESIDENT STATUS

For Census purposes the Oneida Health Extended Care Facility and Rehabilitation Center Recognizes those residents with a stay of less than 90 days as *temporary* status. Those people who stay beyond 90 days have a resident status of *permanent*. (That individual may still return home at some point in the future, this designates that they have been in the building 90 days or more).

PERSONAL PROPERTY/RESPONSIBILITY

Oneida Health ECF shall exercise reasonable care regarding your property, but we shall not be responsible for any of your valuables unless they are registered with us and kept in our safe.

DISCLAIMER: All personal property brought on the premises including personal property placed in the resident's room, the basement, storage rooms, or any other part of the building, shall be at the risk of the resident or the owner of such personal property. Oneida Health ECF shall not be liable for the loss, expense or damage to any such personal property due to fire, the accidental bursting or leaking of water or steam pipes, any act of negligence by any co-resident or other occupant of the building or any act or neglect of any other person. Resident must pay for damages suffered and money spent by Oneida Health ECF relating to any claim arising from any act of neglect of resident. Resident is responsible for all acts of resident's family, employees, guests and invitees. Resident is encouraged to obtain renter's insurance at Resident's expense. Nothing in this paragraph is intended to relieve Oneida Health ECF, its agents and employees of its lawful responsibilities.

TRANSFER AND DISCHARGE

Bed Hold Policy:
Medicare and Private Pay Residents: Medicare does not offer a bed hold program. For Medicare and Private Pay funded residents, who leave the facility for a short term or on a temporary basis and wish to "hold" the bed for return to the facility, may do so by paying the daily private room rate during the absence. Payment ensures that the bed will remain available upon the individuals' return.

Medicaid Resident's: Any Medicaid recipient that resides in a nursing facility over thirty (30) calendar days and who requires hospitalization shall have his/her bed retained by Oneida Health ECF for a period up to fourteen (14) days within a twelve month period provided that the physician and the receiving hospital ascertain that the Resident will be able to return within the fourteen (14) days' time frame.

Therapeutic leave: Medicaid funded residents who have depleted their Medicare coverage and have been solely funded by Medicaid for over 30 days, may leave the Oneida Health ECF for overnight or vacation up to ten (10) days for a therapeutic leave in a twelve month period.

Discharge Planning: Oneida Health ECF works cooperatively with all residents to assist them with achieving their highest level of independence. A part of this effort is active discharge planning. By signing this agreement, the resident agrees that if at any time their care needs can be effectively managed outside of a Skilled Nursing Facility, the resident will work cooperatively with Oneida Health ECF on discharge planning to an appropriate non-Skilled Nursing Facility, The most typical assessment tool used is the Patient Review Instrument (PRI). PRI scores of PA, PB, BA, or CA will automatically trigger review, as they are typically will served in non-Skilled Nursing programs.

***** Residents will not be discharged unless:**

a. The welfare of the resident cannot be met in the facility (such as medical needs requiring a higher level of care).
b. There has been an improvement in the resident's health.
c. The health and safety of the other individuals in the facility is endangered by the resident remaining in the facility.
d. Nonpayment of the resident or appropriate third party payor has continued after reasonable time and appropriate notice.
e. Generally, notice to the resident must be 30 days before a discharge except when the health and safety of individuals in the facility is endangered, the residents health improves sufficiently to allow a more immediate transfer or discharge, the transfer or discharge is required by the resident's urgent medical needs, or the resident has not resided in the facility for at least 30 days.
f. Residents in private rooms with private baths may be moved to a private room with a shared bath at the discretion of the facility. We will make every effort to involve the patient/resident as soon as we become aware of the possibility.

It is the responsibility of the Resident/Responsible Representative to arrange for the removal of the resident's property (furniture, pictures, clothing, etc.) from Oneida Health ECF within 7 days after death or discharge.

PHYSICAL RESTRAINTS

Oneida Health ECF is committed to an environment that promotes individual safety, dignity and enhanced physical and emotional health. We believe that restraint use in contrary to this philosophy. Oneida Health ECF has categorized physical restraints into two groups: low impact and high impact physical restraints. It is our policy not to utilize "high impact" physical restraints. Some examples of "high impact" restraints are seat belts, posey criss cross vests, full side rails, pelvic restraints and any restraint that ties in the back.

The clinical team will explore a variety of non-restraint options prior to considering the use of even a low impact restraint. In the event that a low impact restraint becomes necessary, you will be involved in the care planning process.
The use of low impact restraints will be continually evaluated in an effort to discontinue their use at the earliest possible time.

CHEMICAL RESTRAINTS

The use of chemical restraints at Oneida Health ECF will be in accordance with federally mandated guidelines aimed at curtailing the use of psychotropic drugs. Pursuant to these guidelines, we will (1) avoid the use of "Unnecessary" drugs and (2) adequately document the need for a particular psychotropic medication to be used in appropriate circumstances. In addition, other behavior modification techniques will be utilized in lieu of prescribing these drugs, whenever possible.

NO SMOKING STATEMENT

Given the threat posed by smoking to the health, safety, and will being of our residents, Oneida Health – ECF has undertaken a campus-wide smoke-free initiative.

WHEN DOES PAYMENT FOR SERVICES START?

Our final point of review is the actual payment for the stay and services. Payment for services rendered is expected as stated below if the resident is not eligible for insurance coverage or if all or part of the stay is not covered.

The Resident/Responsible Party is *required to provide payment to the Oneida Health ECF on the first day of each month for services to be rendered in the same month at a daily rate of:*

Rate Schedule

Self-Pay Room and Board Rates:	**EFFECTIVE 01/01/2025**
Skilled Nursing Semi-Private Room Daily Rate:	$550.00
Skilled Nursing Private Room Daily Rate:	$575.00
Ventilator Dependent Semi-Private Room Daily Rate:	$750.00
Ventilator Dependent Private Room Daily Rate:	$800.00
Medicare A Co-Insurance [days 21-100]	$209.50

Self-Pay Room and Board Rates:	**EFFECTIVE 01/01/2026**
Skilled Nursing Semi-Private Room Daily Rate:	$600.00
Skilled Nursing Private Room Daily Rate:	$625.00
Ventilator Dependent Semi-Private Room Daily Rate:	$750.00
Ventilator Dependent Private Room Daily Rate:	$800.00
Medicare A Co-Insurance [days 21-100]	$217.00

** To be published by Centers for Medicare Services.

Oneida Health Extended Care Facility began collecting a 6.8% Cash Receipts Assessment on all self-pay stays effective October 1st 2011. This is a NY State Tax on Long Term Care Services for private pay residents, and will appear on your bill as a separate line item. Please note that this tax fluctuates annually. Please ask your social worker or Business Office representative for the current tax rate.

Please note that there is a New York State personal income tax credit available to individuals who directly pay the assessment, for either the resident or the individual who pays the assessment. Form IT-258-Claim for Nursing Home Assessment Credit is available from the New York State Department of Taxation and Finance.

Subject to the following rules:

- We will notify you 30 days in advance of any changes in the daily rate.
- Charges are incurred for the day of admission, but not for the day of discharge. If a bed is "reserved" prior to admission, the per diem rate will be charged for each day that the bed is reserved.
- Any charges paid in advance will be refunded upon death or discharge. Please recognize that in the billing process not all charges will have cycled through by time of discharge. The billing cycle will have to be complete for the given time period in order to reconcile the amount returned or owed.
- Tips or gratuities to Oneida Health ECF or to any of its employees are prohibited.

IN WITNESS WHEREOF, this Financial/Admission Agreement has been executed by all parties specifically acknowledging that they have read and understand the intent and full meaning of the language contained herein, related to the Financial Responsibility Agreement and Admission Agreement.

ONEIDA HEALTH EXTENDED CARE FACILITY AND REHABILITATION CENTER:

Signature:_____

Print Name:_____

Title:_____

Date:_____ Time:_____

RESIDENT: Signature:_____

Print Name:_____

Date:_____ Time: _____

RESPONSIBLE PARTY:

Signature:_____

Print Name:_____

Date:_____ Time_____

Address:_____

_____

Telephone #_____

IN COMPLIANCE WITH NEW YORK STATE AND FEDERAL LAWS WHICH PROHIBIT DISCRIMINATION BASED ON RACE, CREED, COLOR, NATIONAL ORIGIN, AGE, SEX, SEXUAL ORIENTATION, DISABILITY, BLINDNESS, MARITIAL STAUS, RELIGION, SPONSORSHIP, OR SOURCE OF PAYMENT. THIS FACILITY ADMITS AND TREATS ALL RESIDENTS ON A NON-DISCRIMINARY BASIS.

FACILITY COPY

RESIDENT PERSONAL FUND ACCOUNT ADDENDUM

Resident Name: _____

There are certain items and services that are NOT covered by either Medicare OR Medicaid. In this case, the Resident is responsible for payment if such items or services are requested. Specific items and services that the Facility may charge the Resident, if requested by the Resident and payment is not made by Medicare or Medicaid, include, but are not limited to the following:

a. Telephone;
b. Television/Cable or Radio for personal use;
c. Personal comfort items;
d. Cosmetic and grooming items and services in excess of those for which payment is made by Medicare or Medicaid;
e. Personal clothing;
f. Personal reading matter/newspapers;
a. Gifts purchased on behalf of the Resident;
b. Flowers/plants;
c. Social events and entertainment offered off the premises and/ or outside the scope of the activities programs required under applicable Department of Health regulations;
d. Non-covered special care services such as private duty nurses and/or aides;
e. Specifically prepared or alternate food requested instead of the food generally prepared by the Facility, except for Kosher foods;
f. Massage Therapy;
g. Any care, services, or supplies that is not eligible for payment under the Medicaid or Medicare programs.

2. The Resident/Sponsor agrees to be responsible for providing spending money from the Resident's income/assets for incidental expenses as needed, desired, or requested by the Resident, such as those referenced in this Addendum. If the Resident/Sponsor authorizes the Facility, in writing, to manage his/her personal finances, the Facility shall hold, safeguard, manage, and account for these personal funds of the Resident deposited with the Facility in accordance with the following:

a. The Facility will deposit any resident's personal funds in an interest-bearing account that is separate from any of the Facility's operating accounts. Credit shall be given or all interest earned on all Resident accounts with average daily balances maintained at $50.00 or more.
b. The Facility shall establish and maintain a system that assures a full and complete accounting, according to the generally accepted accounting principles, of each resident's personal funds entrusted with the Facility on the resident's behalf. This accounting shall be provided to the resident and/or designated representative on a quarterly basis. The Facility shall also make this accounting available within one business day of any request made by the Resident/ Sponsor.
c. The Facility shall not impose a charge against the personal funds of any Resident for any item or services for which payment is made under the Medicaid or Medicare programs.
d. Refunds for the balance in the personal account, less any funds owed to the Facility will be made to the Resident/Sponsor within thirty (30) days of discharge unless the resident is deceased an does not have a living spouse. If the resident is deceased and has no living spouse, the refund will be made within thirty (30) days after the probate jurisdiction administering the Resident’s estate appoints an estate representative to formally request the refund. If the Department of Social Services claims funds from a deceased Resident’s personal account, the Facility is authorized by law to deliver these funds to the Department of Social Services.

RESIDENT PERSONAL FUND ACCOUNT ADDENDUM

Resident Name: _____

[ ] I, by my signature below, authorize the Facility to open an account for personal monies as delineated by the terms and conditions set forth in the Admission Agreement I signed with the Facility. I further authorize that the Facility pay for the personal services requested, as indicated by my initials below, from the monies in this personal fund account for services provided to me.

I understand that in order to discontinue services and/or initiate new services, that I must contact the Business Office and update this authorization with effective dates and my initials.

START DATE	INIT.	SERVICE	STOP DATE	/INIT
__/__/__	____	Beautician/Barber Services on a [ ] Weekly Basis [ ] Every Two-Week Basis [ ] As Requested Only.	__/__/__	_____
__/__/__	____	Cable Television Services [ ] *Basic Cable *Yes___ No___* **Yes implies that you will be providing a television for the resident and will be charged a monthly fee until Business Office is notifiied.otherwise.*	__/__/__	_____
__/__/__	____	Newspaper: [ ] Oneida Daily Dispatch	__/__/__	_____
__/__/__	____	Medical Insurance Premiums Name of Insurance: _____ Type of Payment: [ ] Monthly [ ] Quarterly [ ] Annually	__/__/__	_____
__/__/__	____	Massage Therapy Services Frequency of Therapy: [ ] Weekly [ ] Every Other Week [ ] As Requested Length of Therapy: [ ] 15 Minutes [ ] 30 Minutes	__/__/__	_____
__/__/__	____	Other _____	__/__/__	_____

I understand I will receive a quarterly accounting of monies spent from this account. I agree to maintain sufficient funds in the above-referenced account to pay for the services requested. I understand the Facility will continue to provide the personal services I have requested so long as they are available to residents of this Facility and as long as I maintain sufficient funds to pay for the requested services. The Facility shall remit payments from this personal account for only those items I have indicated above and/or for those items that I/my designated representative authorizes payment for in writing.

_____

Signature Date Time

Relationship to Resident: _____

[ ] I do not wish to have the Facility open an account for my personal monies.

_____
Signature Date Time
Relationship to Resident: _____

Oneida Health
Extended Care

ONEIDA HEALTH
Extended Care Facility
Resident Mail Account Authorizations

RESIDENT NAME:

I, _____, hereby grant permission/give authorization to the Oneida Health Extended Care Facility and Rehabilitation Center (hereinafter referred to as Facility) to handle any affairs on behalf of the above listed resident as indicated below:

A. Resident Mail

Business Mail: Mail from Medicare Medicaid, Hospital/Medical Bills, Insurance Statements, Social Security, Veterans' Administration and/or other governmental agencies.

[ ] I give permission for the Facility to process BUSINESS mail addressed to me/resident.
[ ] I wish to have my BUSINESS mail forwarded to: _____.
[ ] I wish to receive my BUSINESS mail, delivered by the Facility staff to my room here at the Facility.

Personal Mail: All other mail not falling into the description of "Business Mail". (i.e.: Personal letters, cards, magazine subscriptions, advertisement mail.)

[ ] I wish to have all PERSONAL mail addressed to me/resident, delivered by Facility staff to my/resident's room at the Facility.

[ ] I wish to have all my PERSONAL mail addressed to me to be forwarded to: _____

_____

_____

Signature Date Time

_____

Relationship to Resident