MAYFAIR
CARE CENTER

WELCOME

Mayfair Care Center Visiting hours are 24 hours a day
Suggested visiting hours are from 10:00am to 8:00pm
516.538.7171
Richard Sherman, Administrator
rsherman@mayfairnh.com

Guest Name: _____

Room Number: _____

The following are the names of the staff you may contact regarding the Guest:

Physician: _____

Social Worker: _____

THIS FACILITY DOES NOT DISCRIMINATE IN ADMISSION OR RETENTION OR CARE OF ITS GUESTS BECAUSE OF RACE, CREED, COLOR, NATIONAL ORIGIN, SEX, DISABILITY, AGE, SOURCE OF PAYMENT, MARITAL STATUS OR SEXUAL PREFERENCE.

ADMISSION AGREEMENT

Agreement entered on _____ , 20____ by Mayfair Care Center and

_____ residing at _____
(Guest)

and _____ residing at _____
(Responsible Party)

and _____ residing at _____
(Guest's Spouse or Sponsor)

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MAYFAIR CARE CENTER
ADMISSION AGREEMENT

Agreement dated _____, 20___ (hereinafter the "Agreement") between Mayfair Care Center at 100 Baldwin Road, Hempstead, NY 11550 (hereinafter "Facility") and _____ (hereinafter referred to as "Resident"), whose community residence is located at _____ and _____ (hereinafter "Resident Representative" or "Sponsor" if Resident's spouse) residing at _____ _____ .

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

I. ADMISSION AND CONSENT

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

II. MUTUAL CONSIDERATION OF THE PARTIES

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

By entering this Agreement, the Resident, the Resident's Sponsor and/or the Resident Representative on the Resident's behalf, understand and agree to the following Resident payment obligations. The Resident agrees to pay for, or arrange to have paid for by Medicaid, Medicare or other insurers, all services provided under this Agreement, and agrees to pay any required third-party deductibles, coinsurance or monthly income budgeted by the Medicaid program. The Resident, the Resident's Sponsor and/or the Resident Representative accept the duty to ensure continuity of payment, including the duty to arrange for timely Medicaid coverage, if Medicaid coverage becomes necessary.

The Resident, Resident Representative and Sponsor agree to comply with all applicable policies, procedures, regulations and rules of the Facility.

III. ANTICIPATED SERVICES

Generally, Residents are admitted to the Facility for one of the following reasons: sub-acute care*; long term care, or hospice care.

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

Residents, who are admitted for sub-acute care, are admitted with the expectation that they will be discharged once short-term services are no longer required, unless continued placement in the Facility is medically appropriate. It is the mutual goal of the Resident and the Facility that the Resident returns to his/her home or a less restrictive setting, if appropriate. The Resident, Resident Representative and/or Sponsor agree to facilitate discharge as soon as medically appropriate, and hereby represent and agree that they will work with the Facility staff to secure an appropriate and timely discharge. The Resident's failure to cooperate with discharge constitutes a waiver of any limitation that might otherwise apply to private collection.

Residents admitted for sub-acute care are responsible for applicable copayments, deductibles, and/or coinsurance, and for any charges that may accrue after termination of their third-party coverage if they remain in the Facility for any reason. Residents covered by Medicare Part A are responsible for a daily coinsurance amount for days 21 to 100 of a Part A covered stay.

If the Resident is admitted for sub-acute services and thereafter remains in the Facility for long term care, an intra-facility room change or transfer to a more appropriate setting may be necessary. Any such room change shall be carried out in accordance with applicable law and the Facility's policies and procedures.

IV. FINANCIAL ARRANGEMENTS

(a) Obligations of Resident, Sponsor and/or Resident Representative

i. **Resident and/or Sponsor.** A Sponsor, used herein to refer to the Resident's spouse, as defined in 10 N.Y.C.R.R. §415.2 is "the entity or the person or persons, other than the resident, responsible in whole or in part for the financial support of the Resident, including the costs of care in the Facility." Accordingly, the Sponsor may be personally responsible for paying for the costs of the Resident's care in the Facility from the funds of the Resident and/or his/her own funds.

The Resident and/or Sponsor agree to pay, or arrange for payment of, any portion or all of the applicable private pay room and board rate and the ancillary charges incurred for services not covered by third party payors and/or required third party deductibles and/or coinsurance including the monthly income contribution (NAMI) budgeted by the Medicaid program. If the Resident has no third-party coverage, or if the Resident remains in the Facility after any such coverage terminates because covered services are deemed no longer "medically necessary" or for any other reason consistent with applicable law, the Resident and/or Sponsor agree to pay or arrange for payment at the private pay rate for room and board and the ancillary charges incurred until discharge or until another source of coverage becomes available. The Resident and/or Sponsor agree to take the necessary steps to ensure that the Facility and its ancillary providers receive payment from all third-party payors, including the timely disclosure of available insurance coverage, timely appeal of insurance coverage denials, and production of information and documentation needed to meet the eligibility criteria of the Medicaid program (e.g., proof of income, resources, residency, citizenship, and explanation of past financial transactions).

ii. **Resident Representative.** The Resident Representative is the individual(s) designated, by either a Court of law, the Resident or a family member or other party(ies) having an interest in the well-being of the resident, including but not limited to the Resident Representative's self-designation by signing this Agreement, to receive information and assist and/or act on behalf of the Resident to the extent permitted by State law. Unless the Resident Representative is also the Resident's spouse or Sponsor, the Resident Representative is not a guarantor of payment and not obligated to pay for the cost of the Resident's care from his/her own funds. **Notwithstanding the foregoing,**

to the extent the Resident Representative breaches the obligations personally undertaken to ensure that the Resident has a payment source for his/her nursing home care (either from private funds and/or a third-party payor) he/she may be personally liable to the Facility for the damages caused by said breach. By signing this Agreement, the Resident Representative hereby represents and warrants that he/ she shall (i) utilize the Resident's funds to pay for the Resident's care at the Facility to the extent he/she has access or the ability to access such funds; (ii) timely provide information and documentation requested by the Facility or a third party payor including, but not limited to, insurance and/or Medicaid (e.g., a request for documentation needed to complete a Medicaid application or insurance policy information); and (iii) timely provide accurate and complete information and documentation to the Facility regarding such matters as the Resident's financial resources, citizenship or immigration status and third party insurance coverage. The Resident Representative hereby agrees to indemnify and hold the Facility harmless from any loss, damage or expense the Facility may suffer or incur as a result of a breach of the foregoing representations and warranties. The Resident Representative acknowledges that nothing herein constitutes an impermissible third-party guarantee of payment; rather, this Agreement sets forth independent obligations that are being voluntarily undertaken by the Resident Representative which if breached may result in personal liability. The provisions in this paragraph shall survive termination of this Agreement for any reason.

iii. ***Resident, Sponsor and/or Resident Representative.*** The Resident, Sponsor, and Resident Representative understand that the Facility is available to assist with securing third party coverage (including but not limited to Medicaid), but it is ultimately the responsibility of the Resident, Sponsor and Resident Representative and the Resident, Sponsor and Resident Representative shall take all necessary steps to apply for, and qualify for, such coverage in a timely manner. Care provided to a Resident who does not meet the eligibility criteria for coverage by third party payors will be billed at the Facility's private pay room and board rate.

The Resident, Sponsor and Resident Representative agree to provide the Facility in a timely manner with all relevant information and documentation regarding all potential third-party payors including, but not limited to, what benefits, if any, may be available from the Resident's insurance and/or managed care plan and to notify the Facility immediately of any change in Resident's insurance status or coverage. Depending on the insurance coverage, managed care plan and/or written agreement with the Facility, additional charges, including co-insurance, deductibles and/or co-payments, may be imposed. Furthermore, prior authorization by the insurance carrier or managed care plan does not guarantee coverage and/or reimbursement. In the event of denial of payment by a third-party payor, exhaustion of benefits and/or termination of coverage, the Resident and/or Sponsor shall be responsible for payment to the Facility. The Resident must promptly notify the Facility of any notice of a third-party payor's discontinuation of payment (coverage).

(b) Private Payment

If the Resident does not have a third-party payment source in place, his/her care will be billed at private pay rates. The private pay room and board rate ("Daily Basic Rate") is $_____ per day for a private room, $ _____ per day for a semi-private room, $ _____ per day for a 3-bed room, and $ _____ per day for a 4-bed room. Ancillary services are not included in the Daily Basic Rate. Ancillary services, such as physician services, rehabilitation therapies, oxygen, dental and diagnostic services, laboratory, x-ray, podiatry, optometry, pharmacy services, urinary care supplies, trach and ostomy supplies, surgical supplies, parenteral and enteral feeding supplies, transportation services, and extraordinary rehabilitative devices, are provided by independent service providers who contract with the Facility and will be billed separately according to the Facility's and/or the service providers' charge schedules. Rates of payment to the Facility may differ for individuals with additional sources of payment such as third-party coverage. A copy of the Facility charge schedule for ancillary services is attached to this Agreement and included in your admission package. In addition, certain items and services, such as beauty/barber services; personal telephone, newspaper delivery etc. (see Attachment "A" - Non-Clinical Services) are not covered in the Daily Basic Rate or by health insurance plans and the Resident is responsible to pay for such services. Room and board charges are billed monthly on a one-month advance basis. Ancillary charges are billed in the month following the month that the services were provided. Bills are generated at the end of each month and cover the next month of room and board charges ("Monthly Advance Payment") and the previous month's ancillary charges. All payments are due upon receipt of the monthly bill. The Daily Basic Rate and charges for ancillary and/or additional services are subject to increase upon thirty (30) days' written notice to the Resident, Resident Representative and/or Sponsor.

(c) Prepaid Deposits/Advance Payment

Unless otherwise specified herein, prior to admission and/or restricted by law, the Facility requires an advance payment in cash or certified check equal to three (3) months of services at the Facility's Daily Basic Rate from private pay residents. Such sum represents a two (2) month prepaid security deposit ("Prepaid Deposit") and the Monthly Advance Payment for the first month stay at the Facility. The Prepaid Deposit, including any interest accrued, shall continue to be the property of the depositor. However, the Facility shall have the right to apply, at its sole discretion, the Prepaid Deposit toward payment for services provided under this Agreement. The Resident, Sponsor and/or Resident Representative agree to deposit additional funds with the Facility to replenish the Prepaid Deposit to a sum equivalent to two (2) months of the current Daily Basic Rate within ten (10) days of written notice to the Resident. The Facility may deduct a fee of one percent (1%) per year from Prepaid Deposit amounts to cover administrative costs in accordance with applicable law. Upon Resident's discharge from the Facility, the balance of the prepaid amount in excess of outstanding bills will be refunded in accordance with Facility's policy within thirty (30) days of the discharge. However, if a private paying Resident leaves the Facility for reasons within the Resident's control without giving five (5) days' prior notice, the Facility will retain an additional amount not to exceed one (1) day's Daily Basic Rate.

Prepaid deposits/advance payment are not required upon admission from individuals eligible for Medicare, Medicaid and/or Veterans Administration benefits. However, immediately upon the ineligibility of a Resident and/or the expiration or discontinuation of coverage for services at the Facility by such government programs, a Prepaid Deposit and Monthly Advance Payment will be required in accordance with the above-mentioned Prepaid Deposit policies of the Facility.

(d) Late Charges

Interest at the rate of fifteen (15%) percent per annum [1¼ % per month] or the maximum allowed by State law will be assessed on all accounts more than thirty (30) days overdue.

(e) Collection Costs, Including Reasonable Attorneys' Fees and Related Expenses

In the event of any arbitration or litigation arising from this Agreement, the Facility shall be entitled to reasonable attorneys' fees. The Resident, Sponsor and/or Resident Representative shall be responsible for the expenses related to collecting damages hereunder, including but not limited to reasonable attorneys' fees and other collection-related costs and disbursements, in addition to the late charges imposed on any overdue payments.

(f) Third Party Private Insurance and Managed Care

If the Resident is covered by a private insurance plan or under a managed care benefit plan that has a contract with the Facility, payment will be according to the rates for coverage of skilled nursing facility benefits agreed upon by such plan and the Facility. Residents who are members of a managed care benefit plan that has a contract with the Facility to provide specified services to plan members will have such services covered as long as the Resident meets the eligibility requirements of the managed care benefit plan. To the extent the Resident meets the eligibility requirements of the managed care benefit plan, he or she will be financially responsible only for payment for those services not covered under his or her plan and for applicable copayments, coinsurance and/or deductibles.

If the Resident is covered by a private insurance plan or managed care benefit plan that **does not** have a contract with the Facility, and where the private insurance or managed care plan reimbursement is insufficient to cover the cost of care, the Resident will be responsible for any difference in accordance with federal and State laws and regulations. The Facility will bill the Resident for any such difference on a monthly basis as described in the "Private Payment" section above. The coverage requirements for nursing home care vary depending on the terms of the insurance or managed care plan. Questions regarding private insurance and managed care coverage should be directed to the social work staff and/or the Resident's insurance or managed care plan, carrier or agent. The Resident, Sponsor and/or Resident Representative shall notify the Facility immediately of any change in Resident's insurance status or coverage including, but not limited to, ineligibility, termination, discontinuation of coverage, and/or any decrease or increase in benefits.

If the Resident is covered by a private insurance plan or under a managed care benefit plan for either all or a portion of the Facility's charges pursuant to the terms of the Resident's plan, by execution of this Agreement the Resident hereby authorizes the Facility to utilize participating physicians and providers of ancillary services or supplies, if required by the

plan for full benefit coverage, unless the Resident specifically requests a nonparticipating provider with the understanding that there may be additional charges to the Resident for using such nonparticipating providers.

(g) Medicare

If the Resident meets the eligibility requirements for skilled nursing facility benefits under the Medicare Part A Hospital Insurance Program, the Facility will bill Medicare directly for Part A services provided to the Resident. Medicare will reimburse the Facility a fixed *per diem* or daily fee based on the Resident's classification within the Medicare guidelines. If the Resident continues to be eligible, Medicare may provide coverage of up to 100 days of care. The first 20 days of covered services are fully paid by Medicare and the next 80 days (days 21 through 100) of the covered services are paid in part by Medicare and subject to a daily coinsurance amount for which the Resident is responsible. A Resident with Medicare Part B and/or Part D coverage, who subsequently exhausts his/her Part A coverage or no longer needs a skilled level of care under Part A, may still be eligible to receive coverage for certain Part B services (previously included in the Part A payment to the Facility) and/or Part D services when Part A coverage ends.

Medicare will terminate coverage for Medicare beneficiaries receiving physical, occupational and/or speech therapy ("therapy services") if the Resident does not receive therapy for three (3) consecutive days, whether planned or unplanned, for any reason, including illness or refusals, doctor appointments or religious holidays. If such therapy was the basis for Medicare Part A coverage, the Resident would be responsible for the cost of his/her stay, unless another payor source is available.

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

MEDICARE PART A, MANAGED CARE, AND THIRD-PARTY INSURANCE

Except for specifically excluded services, most nursing home services are covered under the consolidated billing requirements for Medicare Part A beneficiaries or under an all-inclusive rate for other third-party insurers and managed care organizations (MCOs). Under these requirements, the Facility is responsible for furnishing directly, or arranging for, the services for its residents covered by Medicare Part A and MCOs. When not directly providing services, the Facility is required to enter into arrangements with outside providers and must exercise professional responsibility and control over the arranged-for services. All services that the Resident requires must be provided by the Facility or an outside provider approved by the Facility. Before obtaining any services outside of the Facility, the Resident must consult the Facility.

While the Resident has the right to choose a health care provider, the Resident understands that by selecting the Facility, the Resident has effectively exercised his/her right of free choice with respect to the entire package of services for which the Facility is responsible under the consolidated billing and third-party billing requirements. The Resident agrees that he/she will not arrange for the provision of ancillary services unless the Resident has obtained prior approval from the Facility.

(h) Medicaid

If and when the Resident's assets/funds have fallen below the Medicaid eligibility levels, and the Resident otherwise satisfies the Medicaid eligibility requirements and is not entitled to any other third-party coverage, the Resident may be eligible for Medicaid (often referred to as the "payor of last resort"). **THE RESIDENT, RESIDENT REPRESENTATIVE AND SPONSOR AGREE TO NOTIFY THE FACILITY AT LEAST THREE (3) MONTHS PRIOR TO THE EXHAUSTION OF THE RESIDENT'S FUNDS (APPROXIMATELY $50,000) AND/OR INSURANCE COVERAGE TO CONFIRM THAT A MEDICAID APPLICATION HAS OR WILL BE SUBMITTED TIMELY AND ENSURE THAT ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET. THE RESIDENT, RESIDENT REPRESENTATIVE AND/OR SPONSOR AGREE TO PREPARE AND FILE AN APPLICATION FOR MEDICAID BENEFITS PRIOR TO THE EXHAUSTION OF THE RESIDENT'S RESOURCES.** Services reimbursed under Medicaid are outlined in Attachment "A" to this Agreement.

Once a Medicaid application has been submitted on the Resident's behalf, the Resident, Sponsor, and Resident Representative agree to pay, to the extent they have access to the Resident's funds, to the Facility the Resident's monthly income, which will be owed to the Facility under the Resident's Medicaid budget. Medicaid recipients are required to pay their Net Available Monthly Income ("NAMI") to the Facility on a monthly basis as a co-payment obligation as part of the Medicaid rate. A Resident's NAMI equals his or her income (e.g., Social Security, pension, etc.), less allowed deductions. The Facility has no control over the determination of NAMI amounts, and it is the obligation of the Resident, Resident Representative and/or Sponsor to appeal any disputed NAMI calculation with the appropriate government agency. Once Medicaid eligibility is established, the Resident, Resident Representative and/or Sponsor agree to pay NAMI to the Facility or to arrange to have the income redirected by direct deposit to the Facility and to ensure timely Medicaid recertification. The Resident, Sponsor and Resident Representative agree to provide to the Facility copies of any notices (such as requests for information, budget letters, recertification, denials, etc.) they receive from the Department of Social Services related to the Resident's Medicaid coverage.

Until Medicaid is approved, the Facility may bill the Resident's account as private pay and the Resident will be responsible for the Facility's private pay rate. If Medicaid denies coverage, the Resident or the Resident's authorized representative can appeal such denial; however, payment for any uncovered services will be owed to the Facility at the private pay rate pending the appeal determination. If Medicaid eligibility is established and retroactively covers any period for which private payment has been made, the Facility agrees to refund or credit any amount in excess of the NAMI owed during the covered period.

V. AUTHORIZATIONS AND ASSIGNMENTS FROM RESIDENT TO THE FACILITY

(a) Authorization to Release Information

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

(b) Authorization to Obtain Records, Statements and Documents

By execution of this Agreement, the Resident, Resident Representative and/or Sponsor authorize the Facility, its agents, representatives, successors and assigns to obtain from financial institutions, including, but not limited to, banks, insurance companies, broker and credit unions, and government agencies, such as the Social Security Administration and Department of Social Services, records, statements, correspondence and other documents pertaining to the Resident for the purposes of payment to the Facility and/or securing Medicaid coverage.

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

By execution of this Agreement, the Resident, Resident Representative and Sponsor agree to assign to the Facility any and all applicable insurance benefits and other third-party payment sources to the extent required by the Facility to secure reimbursement for the care provided to the Resident and authorize the Facility to seek and obtain all information and documentation necessary for the processing of any third-party claim.

(d) Designation and Authorization for External Appeal of Medical Necessity Denials

Except where a designee is appointed, only a Resident may request an "external" or independent appeal of benefit denials based on lack of medical necessity. The Resident, Sponsor and/or Resident Representative appoints the Facility as designee authorizing it to request an external appeal of a health plan denial or limitation of coverage because of medical necessity and agrees to sign any form needed to effectuate such appointment.

(e) Authorization to Represent Resident Regarding Medicaid

By execution of this Agreement, the Facility, its agents, representatives, successors and assigns shall be authorized to have access to the Resident's Medicaid file, and, if the Facility so elects, to act on behalf of the Resident in connection with any and all matters involving Medicaid, including, but not limited to, representation of the Resident at Administrative Fair Hearings and Article 78 judicial appeals. The Facility will appeal a Medicaid determination only if it deems an appeal has merit and is necessary and prudent.

(f) Authorization to Take Resident's Photograph

By execution of this Agreement, the Resident, Resident Representative and/or Sponsor authorize the Facility to photograph the Resident for identification purposes and to photograph any part of the Resident to document certain physical conditions, e.g., wounds or skin discolorations, for treatment purposes. I understand that the Facility retains ownership rights to these photographs but that the Resident will be allowed access to view them or obtain copies.

VI. TEMPORARY ABSENCE (also referred to as "bed hold" or "bed reservation")

If the Resident leaves the Facility due to hospitalization or therapeutic leave, the Facility is NOT obligated to hold the Resident's bed until his or her return unless prior arrangements have been made for a bed hold pursuant to the Facility's "Bed Reservation Policy and Procedure" or it is required by law. In the absence of a bed hold, the Resident may be placed in any appropriate semi-private, 3-bed, or 4-bed in the Facility at the time of return from hospitalization or therapeutic leave provided a bed is available and the Resident's re-admission is appropriate.

VII. DISCHARGE, TRANSFER AND INTRA-FACILITY ROOM CHANGES

(a) *Involuntary Discharge for Non-Payment*

To the extent authorized by applicable law, the Facility reserves the right to discharge the Resident if the Resident, Resident Representative and/or Sponsor fails to pay for, or secure third-party coverage of the Resident's care at the Facility, including failing to pay applicable co-insurance and/or NAMI.

(b) Involuntary Discharge for Non-Financial Matters

The Facility may transfer or discharge the Resident if the transfer or discharge is necessary for the Resident's welfare and the Resident's needs cannot be met after reasonable attempts at accommodation in the Facility; the Resident's health has improved sufficiently so the Resident no longer needs the services provided by the Facility; the health or safety of individuals in the Facility would otherwise be endangered and all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem; and for any other reason permitted by applicable law.

(c) Voluntary Discharge

If the Resident no longer requires the services provided by the Facility, or voluntarily wishes to be discharged, the Resident, Resident Representative and Sponsor agrees to cooperate fully with the Facility in the development and implementation of a safe, appropriate, and timely discharge plan.

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

(d) Intra-facility Room Change

The Facility reserves the right to transfer the Resident to a new room on an as-needed basis, consistent with applicable law. Residents who are admitted as short-term residents who subsequently become long-term residents, will be the subject of an intra-Facility transfer to rooms that are better suited for long term Residents. If the resident occupies a private room, the Resident understands and agrees that when he/she no longer pays the private rate or upon Medicaid coverage, he/she may be moved to a semi-private, 3-bed or 4-bed room unless the private room is medically necessary. The Facility may also initiate a room change for medical, social and/or other reason consistent with applicable law and the Resident's rights.

VIII. RESIDENT'S PERSONAL PROPERTY

Each Resident may request a locked drawer in his/her room for the storage of personal property. Valuable personal property (such as jewelry, money, or other valuable items, etc.) should not be kept in the Resident's room. In the event of lost personal property, the Facility will conduct an investigation to determine the cause of the loss. Liability for the loss shall be borne by the party found responsible at the conclusion of the investigation. Further, it is the responsibility

of the Resident, Resident Representative and/or Sponsor to arrange for disposition of the Resident's property upon discharge or death of the Resident. Property left in the Facility for more than thirty (30) days after discharge will be disposed of at the discretion of the Facility.

IX. SMOKING POLICY

The Facility is a smoke-free facility and is committed to maintaining a smoke-free environment. The Resident agrees that under no circumstances will he/she and/or his/her visitors smoke anywhere in the buildings, or on the grounds or within 15 feet of the grounds of the Facility. The Resident agrees to comply with the Facility's smoke-free policies.

X. FACILITY SECURITY

In order to safeguard the safety and security of our residents and staff, the facility has implemented 24-hour video surveillance of the facility public/common areas in the facility, including the lobby, unit corridors, dining/day rooms and exit areas. The cameras do not record audio. All video recordings remain in the possession of the facility until erased or otherwise destroyed and will only be released in accordance with applicable State and federal laws and regulations. By executing this Agreement, you consent to the video surveillance system.

XI. GENERAL PROVISIONS

(a) ***Governing Law***

This Agreement shall be governed by and construed in accordance with the laws of the State of New York without giving effect to conflict of law provisions. Any and all actions arising out of or related to this Agreement against the Facility shall be brought in, and the parties agree to exclusive jurisdiction of, the New York State Supreme Court, located in Monroe County, New York.

(b) ***Assignment***

This Agreement may not be assigned by either party without the prior written consent of the other party. Notwithstanding the foregoing, this Agreement may be assigned by Facility in connection with the transfer of Facility operations to a new operator. Upon such assignment, Facility is relieved of further duties and obligations under the Agreement.

(c) ***Binding Effect***

Notwithstanding the foregoing, all covenants, conditions, and obligations contained herein shall be binding upon, and shall inure to the benefit of the parties and their respective heirs, executors, administrators, successors and assigns.

(d) ***Continuation of This Agreement***

Temporary transfer of the Resident to another health care facility for medical or surgical treatment, or the Resident's authorized temporary absence from the Facility for any other purpose, where such transfer or absence does not exceed a period of sixty (60) days, shall not terminate this Agreement. Upon the Resident's return and re-admission in accordance with the admission assessment criteria set by the New York State Department of Health and by the Facility, this Agreement shall continue in full force and effect.

(e) ***Entire Agreement***

This Agreement and addenda, which are incorporated herein, contain the entire understanding between the Resident, Resident Representative and/or Sponsor and the Facility. This Agreement cannot be modified orally, and any changes must be in writing, signed by the parties to this Agreement.

(f) ***Severability***

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

(g) ***Waiver***

The failure of any party to enforce any term of this Agreement or the waiver by any party of a breach of this Agreement will not prevent the subsequent enforcement of such term, and no party will be deemed to have waived subsequent enforcement.

(h) ***Counterparts***

For the convenience of the parties hereto, this Agreement may be executed in counterparts and all such counterparts shall together constitute the same agreement and facsimile and electronic signatures shall be accepted and deemed to be original signatures and shall be binding on the parties upon signing.

(i) ***Relationship between Parties***

Execution of this Agreement is not intended, nor shall it be deemed, to create a landlord-tenant relationship between the Facility and the Resident.

(j) ***Section Headings***

The section headings used herein are for convenience of reference only and shall not limit or otherwise affect any of the terms or provisions hereof. Wherever herein reference is made to "Resident, the same shall refer to, and include, Resident, Sponsor and/or Resident Representative for contractual and financial obligations to the extent permitted by law.

(k) ***Representations***

The Resident, Resident Representative and Sponsor warrant and represent that the information (both written and oral) provided during the admission process is complete and accurate, and acknowledge that the Facility has relied upon such information in entering into this Agreement and admitting the Resident.

(l) ***Attachments***

Attachments "A" and "B", as cited and referenced in this Admission Agreement, are intended to be informational only; they are not otherwise incorporated into the Admission Agreement, and they confer no legal rights or obligations.

(m) ***Non-Discrimination***

IN ACCORDANCE WITH FEDERAL AND NEW YORK STATE LAW AND REGULATIONS, INCLUDING THE PROVISIONS OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, THE AGE DISCRIMINATION ACT OF 1975, AND THE REGULATIONS OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ISSUED PURSUANT TO THE ACTS, TITLE 45 CODE OF FEDERAL REGULATIONS PART 80, 84, AND 91, NO PERSON SHALL, ON THE GROUNDS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, SEXUAL ORIENTATION, GENDER IDENTITY, RELIGION, CREED, DISABILITY, MARITAL STATUS, BLINDNESS, SOURCE OF PAYMENT OR SPONSORSHIP, BE EXCLUDED FROM PARTICIPATION IN, BE DENIED THE BENEFITS OF, OR BE OTHERWISE SUBJECTED TO DISCRIMINATION UNDER ANY PROGRAM OR ACTIVITY PROVIDED BY THE FACILITY, INCLUDING BUT NOT LIMITED TO, THE ADMISSION, CARE, AND RETENTION OF RESIDENTS.

THE REMAINDER OF THIS PAGE IS LEFT BLANK INTENTIONALLY.

By execution of this Agreement, Resident, Resident Representative and/or Sponsor acknowledge receipt of the following documents and information:

1. Schedule of Coverage and Fees for Ancillary Services (Attachment A)
2. Medicare and Medicaid Information (Attachment B)
3. Statement of Resident's Rights and Responsibilities; Facility Rules and Regulations
4. Contact information for the Resident's Attending Physician (name, address, and telephone number); and information and contact information for filing grievances, including the name, business address, email address, and phone number of the Facility's grievance official, and the telephone numbers for the NYS Department of Health "Hot Line" and the NYS Office of Aging Ombudsman Program
5. Information about advance directives including: A summary of the Facility's policy and DOH pamphlets: *Deciding about Health Care: A Guide for Patients and Families; Health Care Proxy: Appointing your Health Care Agent in New York; and Do Not Resuscitate Orders - A Guide for Patients and Families.*
6. Statement regarding the use of the Medicare Minimum Data Set (MDS) and the Privacy Act of 1974.
7. Required documentation necessary to determine Medicaid eligibility
8. Notice of Privacy Practices for Protected Health Information
9. Veterans Information
10. Addenda:
    - I. Social Security direct deposit and change of address forms
    - II. Request for facility to maintain personal fund account
    - III. Assignment of benefits form (Signature on File form)
    - IV. Designation and authorization for external appeal of medical necessity denials
    - V. Authorizations
    - VI. Bed reservation (bed hold) policy and bed reservation request form
    - VII. Acknowledgment of receipt of the Notice of Privacy Practices

THE UNDERSIGNED HAVE READ, UNDERSTAND AND AGREE TO BE LEGALLY BOUND BY THE TERMS AND CONDITIONS AS SET FORTH HEREIN, AND IN ALL ADDENDA TO THIS AGREEMENT.

ACCEPTED AND AGREED:

_____	_____	_____
Date	Signature (or Mark*) of RESIDENT	Print Name

*If Mark, signature of 2 witnesses: _____ _____

_____	_____	_____
Date	Signature of SPONSOR (if spouse) or RESIDENT REPRESENTATIVE	Print Name

MAYFAIR CARE CENTER

_____	By:_____	_____
Date		Print Name and Title

ATTACHMENT "A"

BASIC SERVICES

THE FOLLOWING ITEMS AND SERVICES ARE AVAILABLE TO ALL RESIDENTS AND ARE INCLUDED IN THE MEDICARE PART A, BASIC MEDICAID, AND THE PRIVATE PAY ROOM AND BOARD RATE:

- Board, including therapeutic or modified diets as prescribed by a physician (excluding enteral and parenteral feeding). The Facility follows Jewish dietary laws (Kosher) for all meals.
- Lodging; a clean, healthful, sheltered environment, properly outfitted
- 24-hours-per-day professional nursing care
- Use of all equipment, medical supplies and modalities for everyday care, such as catheters*, dressings*, pads, etc.
- Fresh bed linen, changed at least twice weekly, or as often as required for incontinent Residents
- Hospital gowns or pajamas as required by the Resident's clinical condition, unless the Resident, next of kin or sponsor elects to furnish them; and laundry services for these and other launderable personal clothing items
- General household medicine cabinet supplies, such as non-prescription medications; routine hair and skin care materials; oral hygiene materials; except for specific items that are medically indicated and needed for exceptional use for a specific Resident
- 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 assigned duties, by Facility staff members responsible for Resident care
- Use of customarily stocked equipment, including crutches, walkers, wheelchairs or other supportive equipment, including training in their use when necessary, unless such items are prescribed by a physician for regular and sole use by a specific Resident. "Customarily stocked equipment" excludes prosthetics
- Therapeutic recreation (Activities) program, including but not limited to a planned schedule of recreational, motivational, social and other activities; together with the necessary materials and supplies to make the Resident's life more meaningful
- Social Services as needed
- Complete dental examination upon admission and annually thereafter

* If these items or services are necessary for other than routine treatment, they may not be included in the basic Medicaid and Private Pay room and board rate and may be billable to the Resident, Medicare Part B or other third-party insurance. (see chart below)

IF YOU HAVE ANY QUESTIONS REGARDING CHARGES AND BILLING, PLEASE CONTACT THE BUSINESS OFFICE.

ADDITIONAL CLINICAL SERVICES

THE FOLLOWING ADDITIONAL CLINICAL SERVICES ARE AVAILABLE TO ALL RESIDENTS. THE CHART BELOW DESCRIBES MEDICARE, MEDICAID AND PRIVATE RATE COVERAGE OF THESE SERVICES.

Services	Medicare Part A	Medicare Part B	Medicaid	Private Pay (When Not Covered by Medicare or Medicaid)
Attending Physician Services	Not Covered	Covered	Covered	Physician Bills Patient
Physical Therapy Restorative	Covered	Covered (4)	Covered	Medicare Fee Schedule
Physical Therapy Maintenance	Covered	Not Covered	Covered	Medicare Fee Schedule
Occupational Therapy Restorative	Covered	Covered (4)	Covered	Medicare Fee Schedule
Occupational Therapy Maintenance	Covered	Not Covered	Covered	Medicare Fee Schedule
Speech Therapy Restorative	Covered	Covered (4)	Covered	Medicare Fee Schedule
Speech Therapy Maintenance	Covered	Not Covered	Covered	Medicare Fee Schedule
Ophthalmology Services	Varies (5)	Varies (5)	Varies (5)	Billed Direct to Patient
Optometry/Optician Services	Not covered	Not covered	Varies (5)	Provider Bills Patient
Audiology Services	Varies (5)	Varies (5)	Varies (5)	Audiologist Bills Patient
Dental	Not covered	Not Covered	Covered	Included
Pharmaceuticals	Covered	Not Covered	Covered	Included
Oxygen	Covered	Not Covered	Covered	Included
Oxygen Supplies	Covered	Not Covered	Covered	Included
Enteral Nutrition - Supplements	Not Covered	Covered (1, 4)	Covered	Medicare Fee Schedule (2)
Enteral and Parenteral Supplies	Covered	Covered (1, 4)	Covered	Medicare Fee Schedule (2)
Primary Surgical Dressings	Covered	Covered (1, 4)	Covered	Medicare Fee Schedule (2)
Urological Supplies	Covered	Covered (1, 4)	Covered	Medicare Fee Schedule (2)
Tracheostomy Supplies	Covered	Covered (1, 4)	Covered	Medicare Fee Schedule (2)
Ostomy Supplies	Covered	Covered (1, 4)	Covered	Medicare Fee Schedule (2)
Prosthetics and Orthotics	Covered	Covered (1, 4)	Covered	Medicare Fee Schedule (2)
Laboratory	Covered	Covered (1, 4)	Covered	Medicare Fee Schedule (3)
X-Ray	Covered	Covered (1, 4)	Covered	Medicare Fee Schedule (3)
EKG	Covered	Covered (1, 4)	Covered	Medicare Fee Schedule (3)
EEG	Covered	Covered (1, 4)	Covered	Medicare Fee Schedule (3)
Ambulance	Covered	Covered (1, 4)	Covered (1)	Medicare Fee Schedule (3)
Ambulette	Not Covered	Not Covered	Varies (5)	Fee Basis (3)

If your stay is covered under Medicare Part A:

- Medicare will pay up to 100 days for your stay (assuming eligibility criteria are met and benefits are still available).
- Co-insurance payments for 2022 are $194.50 per day for days 21 through 100.

** It is the responsibility of the Resident and/or Representative to verify co-insurance coverage by secondary insurance with the Business Office at (516) 538-7171, Extension _____.

If you are covered by Medicare Part B, for 2022:

- Annual Medicare Part B Deductible is $233.00.
- Co-Insurance payments are 20% of the approved Medicare Part B charge for all Part B covered services.

(1) May be billed by outside vendor to DMERC or Intermediary
(2) Billed by Facility.
(3) Billed direct by Provider or Vendor.
(4) Patient/Resident responsible for co-insurance and deductible.
(5) Coverage depends on services provided.

ADDITIONAL NON-CLINICAL SERVICES

THE FOLLOWING ADDITIONAL NON-CLINICAL SERVICES ARE NOT INCLUDED IN THE DAILY BASIC RATE AND ARE NOT PAID FOR BY MEDICARE AND/OR MEDICAID OR OTHER INSURANCE. IF REQUESTED, THE CHARGES FOR SUCH ITEMS WILL BE THE RESPONSIBILITY OF THE RESIDENT.

- Telephone, including a cellular phone
- Television/radio, personal computer or other electronic devices for personal use
- Personal comfort items, notions and novelties, and confections
- Cosmetic and grooming items and services, in excess of those for which payment is made under Medicaid, Medicare, or other insurance programs
- Beauty shop / barber services
- Personal clothing
- Dry cleaning
- Newspapers and other personal reading matter
- Items purchased on behalf of a Resident
- Flowers and plants
- Social events, special meals, and entertainment offered off the premises and outside the scope of the activities program provided by the Facility
- Non-covered special care services, such as privately hired nurses, aides, or companions
- Specially prepared or alternative food (other than Kosher food or food required by a therapeutic or modified diet prescribed by a physician)
- Private room (except when therapeutically required, such as for isolation for infection control)

IF YOU HAVE ANY QUESTIONS REGARDING CHARGES AND BILLING, PLEASE CONTACT THE BUSINESS OFFICE.

ATTACHMENT "B"

SPECIAL RULES REGARDING SELECTED PAYORS

PAYMENT FOR IN-PATIENT LONG TERM CARE SERVICES IS AN EXPENSIVE AND COMPLICATED PROCESS. THIS SUMMARY PROVIDES OUR RESIDENTS AND THEIR FAMILIES WITH BASIC INFORMATION THAT SHOULD SIMPLIFY THE PROCESS. NOTHING HEREIN SHOULD BE CONSIDERED LEGAL ADVICE. WE STRONGLY RECOMMEND THAT YOU CONSULT WITH AN INSURANCE AGENT, ATTORNEY AND/OR OTHER KNOWLEDGEABLE PROFESSIONAL(S) IN ORDER TO HELP MAXIMIZE AVAILABLE COVERAGE. FURTHER, AS THE INFORMATION PROVIDED BELOW IS BASED UPON STATUTE AND REGULATIONS, IT IS SUBJECT TO CHANGE WITHOUT NOTICE.

MEDICARE PART A PAYMENT

Medicare Part A Hospital Insurance Skilled Nursing Facility ("SNF") coverage is generally available to qualified individuals 65 years of age or older, and individuals under age 65 who have been disabled for at least twenty-four months, who meet the following five requirements: 1) The Resident requires daily skilled nursing or rehabilitation services that can be provided only in a skilled nursing facility; 2) The Resident was hospitalized for at least three consecutive days, not counting the day of discharge, before entering the skilled nursing facility; 3) The Resident was admitted to the facility within 30 days after leaving the hospital; 4) The Resident is admitted to the facility to receive treatment for the same condition(s) for which he or she was treated in the hospital; and 5) A medical professional certifies that the Resident requires skilled nursing care on a "daily basis." A Resident requires skilled nursing or skilled rehabilitation services on a daily basis when services are medically necessary and provided seven (7) days a week. There is an exception if they are only provided by the facility for five (5) days per week, due to staffing levels at the facility. Additionally, there may be a one to two day break if the Residents needs require suspension of the services.

Where these five criteria are met, Medicare may provide coverage of up to 100 days of care in a skilled nursing facility (SNF): the first 20 days of covered services are fully paid for; and the next 80 days (days 21 through 100), of the covered services are paid for by Medicare subject to a daily coinsurance amount for which the Resident is responsible. For 2022, the Medicare Part A co-insurance amount is $194.50 per day.

Additionally, Medicare Residents requesting a leave of absence from the facility should be aware of the Medicare rules regarding leave of absence and transfer within thirty (30) days. Medicare treats a leave of absence, where a Resident leaves the facility on a particular day and does not return by twelve (12) midnight that day, as an uncovered day. Additionally, the day in which a Resident begins a leave of absence (i.e., hospitalization), where the resident is absent for more than 24 hours, is treated as a day of discharge.

Except for specifically excluded services, nursing home services provided to Medicare Part A beneficiaries are covered under the consolidated billing requirements. Residents must consult with the Facility before obtaining any services outside of the Facility.

Medicare also has a thirty (30) day transfer requirement. A Resident must be transferred from a hospital or other SNF within thirty (30) days of discharge and meet the skilled care requirements in order to be eligible for SNF coverage.

If a Resident meets the eligibility requirements for Skilled Nursing Facility benefits under the Medicare Part A Hospital Insurance Program, Facility will bill Medicare directly for all Part A services provided to the Resident. Medicare will reimburse Facility a fixed *per diem* or daily fee based on the Resident's classification within the Medicare guidelines. These guidelines are a measure of the type of care the Resident requires and the costs to provide that care. Members of our professional staff will evaluate the Residents health condition based on a standardized assessment form (called the MDS 3.0) provided by the Centers for Medicare and Medicaid Services (CMS). Medicare uses the MDS 3.0 information to assign a case-mix classification for the Resident.

The Resident will be responsible for the daily co-insurance amount determined by Medicare. This amount is subject to increase each calendar year. With limited exceptions, a Resident who requires more than 100 days of SNF care in a benefit period will be responsible for private payment of all charges beginning with the 101st day. A new benefit period may begin when the Resident has either not been in a facility or has not been receiving a covered level of care in a skilled nursing facility for at least 60 days, returns to the hospital for another three-day stay, and then re-enters the SNF. A SNF may not request private payment until the Resident has received an official initial determination from Medicare that "skilled nursing" benefits are no longer available. While a SNF may make a determination of non-coverage, beneficiaries have a right to request an official Medicare determination of coverage (called a "Demand Bill"), which can be appealed.

MEDICARE PART B PAYMENT

Individuals who pay monthly premiums to enroll in Medicare Part B will be charged according to Facility's or the service providers' stated charge schedule for services they receive at Facility. Medicare Part B pays for a wide range of additional services beyond Part A coverage. Part B may cover some of a Residents care regardless of whether they are eligible for Part A benefits. Part B covers eighty (80%) percent of the Medicare approved charge for a specific service and the individual is responsible for the additional twenty (20%) percent. In general, Part B covers medical services and supplies. Part B covers such services as: physical, occupational and speech therapy, physician services, durable medical equipment, ambulance services and certain outpatient and clinical laboratory services. However, Part B benefits have limitations. For example, for 2022, there is an annual $233.00 deductible applicable to Medicare Part B benefits. The Resident is responsible for private payment of all therapy charges and any other ancillary charges above the Medicare Part B coverage limitations. The Facility can bill and receive payment if the Resident fills out a Medicare assignment of benefits form. If the Resident completes an assignment of benefits form, a health care provider cannot charge the Resident above the Medicare approved charge. In order to determine the Resident's Part B coverage you should contact the Social Security Administration.

In addition, Medicare Advantage programs and other alternatives may increase available Medicare benefits. To receive additional information about Medicare and Medicare Advantage programs, call the Social Security Administration at 800-772-1213 or the Centers for Medicare and Medicaid Services at 1-800-MEDICARE.

MEDICARE PART D - PRESCRIPTION DRUG COVERAGE

Individuals eligible for Medicare Part A or enrolled in Medicare Part B and who do not have prescription drug coverage from a privately operated health plan or a Medicare Advantage-PD plan are eligible to enroll in Medicare Part D for prescription drug coverage. Medicare Part D through the selected PDP will provide reimbursement for prescription drugs listed in the PDP's formulary subject to applicable premiums, deductibles and co-payments. Eligible individuals interested in obtaining prescription drug coverage through Medicare Part D must enroll in a PDP approved in the region. Upon admission to a skilled nursing home, individuals enrolled in a PDP in the community are permitted to continue with, or switch to a different PDP in the region.

Dual eligible Medicare/Medicaid beneficiaries are automatically enrolled in, and assigned to an approved benchmark prescription drug plan ("PDP") in the region. Medicaid does not pay for prescription drug cost for dual eligible individuals. Dual eligible residents in nursing homes will receive prescription drug coverage through Medicare Part D for the drugs listed on the selected PDP's formulary. As long as dual eligible residents are enrolled in benchmark plans in their region, they will not be responsible for premiums, deductibles and cost sharing obligations.

Please call 800-633-4227 or contact www.medicare.gov/pdphome.asp to obtain enrollment information.

MANAGED CARE

Residents who are members of a managed care benefit plan that is under a contract with the Facility to provide specified services to plan members will receive those services with full coverage so long as the Resident meets the eligibility requirements of the managed care benefit plan. To the extent the Resident meets the eligibility requirements of the managed care benefit plan, he or she will be financially responsible only for the required deductibles and co-insurance and for those services that are not included in the list of covered services. Residents who have not received a list of covered services and eligibility requirements from their managed care benefit plan are advised to contact their social worker and/or managed care benefit plan.

PRIVATE INSURANCE

Residents who are covered by a private insurance plan that does not have a contract with the Facility must exhaust all available insurance coverage before seeking Medicare or Medicaid coverage. Where the insurance proceeds under the private plan are insufficient to cover the cost of care, the Resident will be responsible for any difference. The coverage requirements for nursing home care vary depending on the terms of the insurance policy. Questions regarding private insurance coverage should be directed to the social work staff and/or the Resident's insurance carrier or agent.

MEDICAID

Medicaid is a publicly funded program of assistance that covers nursing home Residents who can demonstrate financial need. To qualify for Medicaid, an individual may have only limited assets (subject to annual increases); For example, in 2022, the individual resource limit is $16,800.00 plus any funds held in an "irrevocable burial trust" arrangement or up to $1,500.00 in a revocable burial account. Generally, most of the Resident's monthly income must be paid to the Facility, except for a $50 monthly "personal needs allowance" and the monthly cost of retaining a private health insurance policy. This monthly income obligation, called the Net Available Monthly Income (NAMI), is determined by the Medicaid agency. If the Resident has a spouse in the community, the spouse may be entitled to a contribution from the Resident's monthly income. During 2022, the "community spouse" is entitled to a minimum monthly income of $3,435.00 and resources of $74,820.00 or one-half the couple's resources as of the date of institutionalization to a maximum of $137,400.00. These figures are subject to increase each calendar year. Increases beyond these spousal allowances may be secured via a Department of Social Services Fair Hearing or Family Court support proceeding. The Resident's home may be exempt for Medicaid eligibility purposes if the equity value is less than $955,000.00 or if the spouse or a disabled or minor child resides there. Upon application, Medicaid looks back at financial transactions made within sixty (60) months from the date on which the person was institutionalized and applied for Medicaid coverage. A Resident or spouse who makes a transfer within this "look-back" period may create a period of Medicaid ineligibility. Private-pay Residents should apply for Medicaid about three months before their funds are depleted. A Medicaid application must include proof of the Resident's identity, U.S. citizenship or legal alien status, and past and present financial status (see required documentation list at page iv). Medicaid recipients are required to recertify eligibility each year in order to retain benefits. Medicaid is a complex program and a knowledgeable professional can advise Residents and their families as to their rights under the Medicaid program. To receive information about Medicaid, individuals can call their local Department of Social Services in the county in which the Resident resides.

WORKERS' COMPENSATION

Workers' Compensation benefits are available for an employee's work-related injuries. Benefits, including direct payments to a health care provider, are paid by the employer's insurance carrier. Workers' Compensation will provide primary coverage of nursing home care, as long as it is established that the nursing home care is necessitated solely by the Workers' Compensation injury. Claim forms must be submitted to the local Workers' Compensation Board Office within two years of the date of injury. It is advisable to consult with an attorney practicing in the Workers' Compensation area when pursuing a claim. For further information, you can contact your local Workers' Compensation Board office.

NO-FAULT INSURANCE

No-fault insurance coverage must be maintained by all automobile owners in New York State. When a driver or passenger suffers "serious injury" in an automobile accident, regardless of fault, the injured party is entitled to compensation under the owner's no-fault policy for "basic economic loss." Under the New York State Insurance Law, "serious injury" includes permanent limitation of use of a body part or body function, or a non-permanent injury which prevents an individual from performing "substantially all of the material acts which constitute such person's usual and customary daily activities" for at least 90 days during the 180 days immediately following the accident. By statute, the "basic economic loss" recoverable under a no-fault policy is limited to medical expenses and lost earnings up to $50,000. The injured party ordinarily assigns to the nursing home his or her benefits under the no-fault policy. It is advisable to consult with an experienced attorney when pursuing a no-fault claim. For further information, contact your automobile insurance carrier.

VETERANS' BENEFITS

Veterans with certain service-related conditions, former prisoners of war, Medicaid-eligible veterans, or veterans receiving pension benefits may be eligible to receive Veterans' Administration (VA) nursing home benefits. VA nursing home benefits are available for Residents in private non-VA facilities if: (I) the veteran requires nursing care for a service-connected disability following a stay at a VA hospital; (ii) the Resident is an Armed Services member who requires an extended period of nursing care and who will become a veteran upon discharge; (iii) a veteran who requires nursing home care for a service-connected disability, even where no hospital stay is first required; and (iv) a veteran who had been discharged from a VA hospital and is receiving VA hospital-based home health services. Generally, the VA will not authorize nursing home benefits for more than six months, except for veterans requiring care for a service-related disability. This six-month period can in some cases be extended when the veteran is: (I) awaiting Medicaid payment; (ii) planning to pay privately but there are obstacles to arranging the private payments; or (iii) terminally ill and expected to expire within six months. For further information, contact the Department of Veterans' Affairs at 1-800-827-1000

REQUIRED DOCUMENTATION NECESSARY TO DETERMINE MEDICAID ELIGIBILITY

IDENTITY/PROOF OF BIRTH:

Two of the following:

- ***Birth Certificate**
- ***Baptismal Certificate**
- ***Driver License**
- ***U.S. Passport**

U.S. CITIZENSHIP:

Provide one of the following:

- ***Naturalization Certificate**
- ***U.S. Passport**
- ***Permanent Resident Card**
- ***Voter Registration Card**

SOCIAL SECURITY NUMBER

Provide one of the following:

- ***Social Security Card/Application for duplicate (copy)**
- ***Printout from Social Security — TPQY Administration**

MARITAL STATUS:

Provide one of the following:

- ***Marriage Certificate**
- ***Legal Separation Agreement**
- ***Divorce Degree**
- ***Spouse's Death Certificate**

RESIDENCE:

Provide one of the following:

- ***Deed, Lease or Rent Receipt**
- ***Residence prior to admission to Nursing home must be verified**

INCOME:

- ***(EARNED) 4 most current pay stubs if weekly, 2 stubs if bi-weekly**
- ***(UNEARNED)**
- ***Copy of Social Security Check or TPQY**
- ***Pension Check and. Stub (must verify gross amount)**
- ***Interest, Dividends, Annuities, Partnerships, Rental Income**

RESOURCES:

Where your name or your spouse's name may be listed

- ***Any property that you owned within the last 60 months**
- ***Passbooks, bank statements (opened and closed accounts for the past 60 months)**
- ***Stocks, Bonds, Annuities**
- ***Investments/Brokerage Funds**
- ***Certificates of Deposit (CDs), Credit Union accounts, IRAs**
- ***Trust Agreement and Principal**
- ***Include any accounts/resources which may have been closed, cashed in, or transferred within the past 60 months**
- ***Income Tax returns, including 1099s (5 years)**
- ***Financial summary of any private payments made to a nursing home.**
- ***Verification and Clarification of any withdrawals or deposits over $2000 (copy of cancelled checks) deposit receipts**

LIFE INSURANCE:

- ***Assessed value of house/property either current OR transferred within last 5 years**
- ***Copy of policy and verification of cash value, name of owner and policy number**

HEALTH INSURANCE:

- ***Medicare Card**
- ***Identification Card for Health Insurance**
- ***Premium Amount**
- ***Proof of Payment**

VETERAN STATUS:

- ***Military Discharge papers for applicant or spouse**

OTHER DOCUMENTS:

- ***Copy of Power of. Attorney**
- ***Signed Authorization to represent form**
- ***Guardianship Papers**
- ***Itemized Irrevocable Burial Trust or Pre-need Agreement-(PAID IN FULL)**

MAYFAIR CARE CENTER

LIST OF ADDENDA

I. *Social Security Administration Direct Deposit Sign-Up Form*

Representative Payee and Change of Address Form

II. *Request to Maintain Resident's Personal Needs Account*

III. *Medicare Assignment of Benefits Form*

IV. *External Appeal Designation and Authorization*

V. *Authorizations*

Authorization for the Release of Information

Authorization to Apply for Medicaid on My Behalf

Authorization for Verification of Resources (Applicant)

Authorization for Verification of Resources (Legal Spouse)

Submission of Application on Behalf of Applicant

VI. *Bed Reservation (Bed Hold) Policy and Procedures Advance*

Bed Hold Reservation Form

VII. *Acknowledgement of Receipt of Notice of Privacy Practices*

VIII. *Voluntary Arbitration Agreement*

ADDENDUM I

Social Security Administration Direct Deposit Sign-Up Form

Standard Form 1199A (EG)
(Rev. June 1987)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☐ Other _____ *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE DATE

SIGNATURE DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE DATE

SIGNATURE DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME

GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME | SIGNATURE OF REPRESENTATIVE | TELEPHONE NUMBER | DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

Reset

NSN 7540-01-058-0224

PAYEE COPY

1199-207

Designed using Perform Pro, WHS/DIOR, Mar 97

SF 1199A (Back)

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Facilities Management Division, Property & Supply Section, Room B-101, 3700 East-West Highway, Hyattsville, MD 20782 or the Office of Management and Budget, Paperwork Reduction Project (1510-0007), Washington, D.C. 20503.

PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

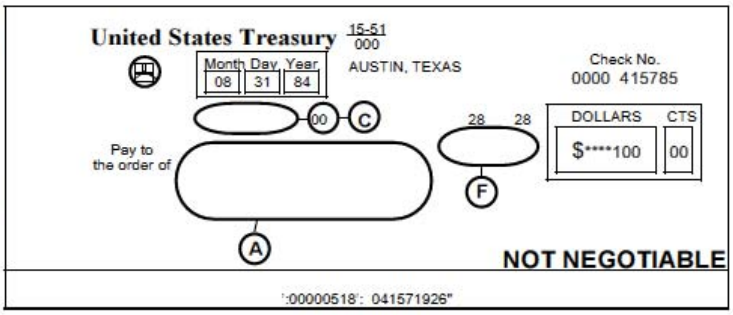
INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

Ⓐ Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.

Ⓒ Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.

Ⓕ Type of payment is printed to the left of the amount.



SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete a new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

Representative Payee and Change of Address Form

To: _____

_____

_____

Re: _____

SSN: _____

To Whom it May Concern:

I am / _____ is currently a resident of Mayfair Care Center.

I hereby authorize the Social Security Administration, Office of Personnel Management, and/or the above-referenced Pension Company to redirect my / _____'s monthly income checks to his/her/my attention, c/o Mayfair Care Center, 100 Baldwin Road, Hempstead NY 11550.

I further authorize the Administrator of Mayfair Care Center to be appointed as my / _____'s representative payee for purposes of receiving my/ his/her Social Security/Office of Personnel Management checks and applying them toward the cost of care at Rehabilitation and Nursing Center.

Finally, I authorize the cancellation of any previous direct deposit of such benefit checks.

_____

Relationship to beneficiary: _____

ACKNOWLEDGMENT

STATE OF NEW YORK)
) SS:
COUNTY OF _____)

On this _____ day of _____, 20_____ before me, the undersigned, a Notary Public in and for said State personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity and that by his/her signature on the instrument, the individual, or a person upon behalf of which the individual acted, executed instrument.

_____
Notary Public

A DUPLICATE OF THIS DOCUMENT WILL BE DEEMED AN ORIGINAL WHEN ACCOMPANIED BY AN ORIGINAL COVER LETTER FROM THE FIRM OF ABRAMS, FENSTERMAN, FENSTERMAN, EISMAN, FORMATO, FERRARA, WOLF & CARONE, LLP.

ADDENDUM II

MAYFAIR CARE CENTER

Request to Maintain Resident's Personal Needs Account

Resident Name:_____

MR /ID #:_____

The Resident, Sponsor, and/or the Resident Representative can request that Mayfair Care Center ("Facility") retain the Resident's personal funds in a personal fund account. All funds in excess of fifty ($50.00) dollars shall be kept in an interest-bearing account by Facility. Account statements will be generated by the Facility on a quarterly basis, and all inquiries will be addressed in a timely fashion.

Please initial one of the lines below.

_____ I **wish** to have the Facility retain the Resident's personal funds.

_____ I **do not wish** to have the Facility retain the Resident's personal funds.

Please Note: Only a **legal representative authorized to access the Resident's funds** may withdraw funds for the Resident's use from a Resident's personal account. However, the Resident Representative without legal authorization and/or Sponsor may purchase items for and on behalf of the Resident and be reimbursed upon presentation of adequate documentation to the Facility's Business Office.

Upon the Resident's discharge from the Facility, the Resident or the undersigned on the Resident's behalf consents to the payment of any outstanding debt owed to the Facility from the personal needs account, and the Facility will thereafter distribute the funds remaining in the account to the appropriate party as permitted by law.

_____ _____

Resident's Signature Date

_____ _____

Signature of Sponsor / Resident Representative Date

_____ _____

Print Name of Sponsor / Resident Representative Relationship to Resident

_____

Legal Authorization or Designation

ADDENDUM III

Medicare Assignment of Benefits Form

Signature on File (SOF) Form

RESIDENT: _____ Admission Date:_____

INSURANCE ID: _____

MEDICARE NO.: _____

MEDICAID NO.: _____

The Resident, or the undersigned on the Resident's behalf, assigns the benefits due to the Resident to Mayfair Care Center ("Facility") and authorizes the Facility to claim payment from Medicare or other insurance for covered services or supplies received by the Resident during the Resident's stay at the Facility.

The Resident, or the undersigned on the Resident's behalf, assigns the benefits for which the Resident is entitled to any physician ("Provider") for professional care and treatment provided by such Provider and authorizes the Provider to claim payment from Medicare or other insurance for such professional care and treatment received by the Resident during the Resident's stay at the Facility.

The Resident authorizes the release of medical or other information by the Provider and/or Facility, which is necessary to claim and receive such payments on the Resident's behalf.

_____ _____

Resident Date

_____ _____

Resident Representative Relationship to Resident

_____

Legal Authorization or Designation

ADDENDUM IV

External Appeal Designation and Authorization

Resident Name: _____ Admission Date: _____

Health Plan: _____ Medicare / HIC No. _____

By signing below, you give the facility authority to pursue appeals with and to seek payment from your health insurer, health maintenance organization, or other payor, including claims asserted under Title XVII and related provisions of Title XI of the Social Security Act ("Health Plan") for services provided to you by the facility, and you authorize the release of medical information for those purposes.

I am the above-mentioned resident ("Resident") or have the legal authority to appoint a representative for the Resident. I do hereby appoint Mayfair Care Center ("Facility") by its Administrator to be my designee and authorized representative to act on my behalf and to take all reasonable actions, as determined by the Facility, to pursue payment from my Health Plan and/or to pursue any appeals available to me under my Health Plan's policies or procedures and/or under applicable law including, but not limited to, external appeals of coverage denials or limitations based on lack of medical necessity. The Facility will not charge me for pursuing these appeals. By accepting this appointment, neither the facility nor its attorneys waives any rights otherwise available to them to pursue collection of the cost of the Resident's nursing home care. In pursuing such payment and/or appeals:

A. I authorize the Facility and my Health Plan to release all relevant medical information including, if applicable, any HIV-related, mental health or alcohol/substance abuse treatment information, which is necessary to pursue payment from my Health Plan. I understand that the Facility will release only the information it deems necessary to an external appeal agent, arbitrator, court of law or other independent third party reviewer responsible for deciding if a claim must be paid ("Independent Reviewer"), and that the Independent Reviewer will use this information to make a decision about payment. This authorization for the release of medical information is valid until all coverage issues with my Health Plan are deemed resolved by Facility;

B. I authorize the Facility to complete, execute, acknowledge, and deliver any consent, demand, request, application, agreement, authorization or other documents necessary including, but not limited to, to request an appeal with my Health Plan and/or an external appeal with the Centers for Medicare and Medicaid Services, NYS Department of Health, NYS Department of Insurance, U.S. Department of Labor and/or other applicable agency or body.

If the Facility pursues and wins these appeals, I authorize my Health Plan to pay any monies owed for Facility services directly to the Facility.

This Designation and Authorization may be revoked by me at any time. It shall not otherwise be affected by my subsequent disability, incompetence, or death.

IN WITNESS WHEREOF, I have signed my name this _____ day of _____, 20____

_____ _____

Resident or Authorized Representative Legal Authority (e.g., guardian, power of attorney)

_____

Address

ADDENDUM V

Authorizations

Authorization for the Release of Information

Consumer Name: _____ authorizes the release of all requested information and/or documentation to Mayfair Care Center (the "Facility") and/or its representatives, agents, successors, and assigns. This release shall apply equally to public, private, financial, and medical institutions, providers, and agencies, and their agents and assigns, and to information governed by the Privacy Act.

I hereby waive any and all privileges conferred by any statute in connection with the personal records that are the subject of this authorization. This information is being requested to secure payment and/or in relation to the health care operations of the Facility. This request for financial information is a permitted disclosure under 45 C.F.R. §164.512 ("HIPAA").

This authorization shall remain in full force and effect until full payment has been secured.

Dated: _____

_____ _____

Consumer or Authorized Representative

Legal Authority, if applicable
(e.g., guardian, power of attorney)

ACKNOWLEDGMENT

STATE OF NEW YORK)
) SS:
COUNTY OF _____)

On this _____ day of _____, 20____ before me, the undersigned, a Notary Public in and for said State personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity and that by his/her signature on the instrument, the individual, or a person upon behalf of which the individual acted, executed instrument.

_____
Notary Public

A DUPLICATE OF THIS DOCUMENT WILL BE DEEMED AN ORIGINAL

Authorization to Apply for Medicaid on My Behalf

I. Facility and Consumer Information

A. Consumer Information

Consumer Name: _____ SSN: XXX-XX-_____

Date of Birth: _____ Sex: M F Telephone Number:_____

Community Address: _____

_____

B. Facility Information

Facility Name: Mayfair Care Center

Address: 100 Baldwin Road, Hempstead NY 11550

Facility Contact Person: _____

Position/Title: _____

II. Reason for Submission

_____, hereby authorizes Mayfair Care Center and/or its representatives, agents, successors, and assigns, (collectively referred to herein as the "Facility") to represent _____ (the "Consumer") with regard to Consumer's Medicaid benefits, including but not limited to submitting documentation to, and obtaining documentation and information from, the Department of Social Services, Office of Temporary and Disability Assistance, Medicaid Managed Care Company, and/or any regulatory or governmental agency involved in the processing of the Consumer's application or appeal; appearing at any local conference; and handling any and all judicial and administrative Medicaid appeals, including but not limited to internal and external appeals, New York State Fair Hearings, and/or Article 78 proceedings. I hereby authorize the Department of Social Services, Office of Temporary and Disability Assistance, Medicaid Managed Care Company, and regulatory or governmental agency to recognize this appointment of representative, and provide any documentation and/or information with regard to the Consumer's Medicaid benefits requested by the Facility. By accepting this appointment, the Facility is not obligated to undertake the handling of the Consumer's Medicaid application/appeal and the Facility does not waive any rights otherwise available to them to pursue collection of the cost of the Consumer's nursing home care. This authorization shall continue until it is specifically revoked in writing and shall survive any incapacity of the Consumer.

Dated: _____

_____ _____

Consumer or Authorized Representative

Legal Authority, if applicable
(e.g., guardian, power of attorney)

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

Authorization for Verification of Resources (Applicant)

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

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

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

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

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

I. INFORMATION FOR APPLICANT

Applicant's Name | Last Name | First Name | Middle Initial |

Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐ Date of Birth ☐☐ – ☐☐ – ☐☐

II. AUTHORIZATION

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

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

Signature of Applicant/Legal Representative* _____

Date Signed _____

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

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

Authorization for Verification of Resources (Legal Spouse)

This form authorizes Medicaid to request records from financial institutions for the **spouse** of an individual applying for Medicaid.

This Authorization must be signed by the applicant's spouse if the applicant is:

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

Please complete all sections and sign the authorization.

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

I. INFORMATION FOR APPLICANT

Applicant's Name | Last Name | First Name | Middle Initial |

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

II. INFORMATION FOR APPLICANT'S SPOUSE

Spouse's Name | Last Name | First Name | Middle Initial |

Maiden Name or Other Name Known By

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

Address | Number | Street | Apt. Number |

| City | State | ZIP Code |

III. AUTHORIZATION

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

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

Signature of Applicant's Spouse/Legal Representative* _____

Date Signed _____

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

Submission of Application on Behalf of Applicant

COMPLETE THIS FORM IF SOMEONE OTHER THAN THE APPLICANT SIGNED THE MEDICAID APPLICATION

If you are signing a Medicaid application on behalf of an applicant who is age 18 or older, complete **Sections A** through **C** and submit this form along with proof of authorization (if applicable). **Failure to submit this form and/or proof of authorization may result in a denial or discontinuance of Medicaid benefits.**

The authorization in **Section D** may be used by the applicant to allow you to apply for Medicaid on his/her behalf.

SECTION A APPLICANT INFORMATION

Applicant's Name — Last Name | First Name | Middle Initial

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

SECTION B INFORMATION FOR PERSON SIGNING APPLICATION ON APPLICANT'S BEHALF

Name of Person Signing Application — Last Name | First Name

Relationship to Applicant _____ Phone ___ – ___ – ____

Address — Number | Street | Apt. Number

City | State | Zip Code

If a representative of a facility/company/agency is signing application, provide the following information:

Name of Facility/Company/Agency _____

Address — Number | Street | Suite Number

City | State | Zip Code

Name of Representative — Last Name | First Name

Title _____ Phone ___ – ___ – ____

SECTION C REASON FOR SUBMISSION

INSTRUCTIONS: If you are signing a Medicaid application on behalf of the applicant, you must provide the authorization/legal document authorizing you to apply on the applicant's behalf **OR** attest that the applicant is incompetent or incapacitated. **Please check the appropriate boxes below. Attach the authorization (if applicable) to this form and sign and date below.**

☐ I have authorization to apply for Medicaid on behalf of the applicant.
(Check the box for the type of authorization you have and submit the authorization OR complete Section D below.)

- ☐ Guardianship Document
- ☐ Power of Attorney (POA) Document
- ☐ Other Written Authorization (Specify) _____

☐ I attest that the applicant is incompetent or incapacitated. S/he is unable to sign the application herself/himself and is unable to provide written consent for me to apply on his/her behalf.

Signature of Person Completing This Form _____

Date Signed _____

SECTION D AUTHORIZATION TO APPLY FOR MEDICAID ON APPLICANT'S BEHALF

INSTRUCTIONS: If the applicant would like to provide the below authorization allowing you to represent him/her in applying for and/or renewing Medicaid, the applicant or his/her legal representative or spouse must sign the authorization below.

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

I authorize the person or the facility/company/agency named in **Section B** of this form to represent me in the Medicaid application and/or renewal process.

I authorize the release of necessary information/documentation between the local Department of Social Services/ Medicaid Program and the person or facility/company/agency named in **Section B** in regard to my application and/or continuing eligibility.

Signature of Applicant/Legal Representative/Applicant's Spouse _____

Date Signed _____

ADDENDUM VI

MAYFAIR CARE CENTER

Bed Reservation (Bed Hold) Policy and Procedures

If the resident leaves the facility due to hospitalization or a therapeutic leave, the facility shall not be obligated to hold the resident's bed available until his or her return, unless prior arrangements have been made for a bed hold pursuant to the facility's "Bed Reservation Policy and Procedure" and pursuant to applicable law. In the absence of a bed hold, the resident is not guaranteed readmission unless the resident is eligible for Medicaid and requires the services provided by the facility. However, the resident may be placed in any appropriate bed in a semi-private room in the facility at the time of his or her return from hospitalization or therapeutic leave provided a bed is available and the resident's admission is appropriate and meets the readmission requirements of the facility.

Private Pay Residents

Private pay residents who elect to retain a bed in the facility during a period of hospitalization or therapeutic leave may do so by notifying the Admission Department by telephone, signing a bed guarantee letter with the Admission Department stating their intent to hold their bed at the facility's private pay rate, and continuing payment at the private pay rate. The bed hold will be in effect until we receive written notice from the resident or Resident Representative to stop the bed hold or payment is discontinued.

Medicare Residents

Medicare beneficiaries are not entitled to reimbursement for bed hold or therapeutic leave under the Medicare Program. Medicare residents who are absent from the facility past twelve (12) midnight on any given day are deemed to be discharged from the Facility. However, Medicare residents may elect to retain a bed in the facility by following the private pay resident bed hold policy above.

Medicaid Recipients

Medicaid regulations provide that when a Medicaid recipient has been a resident in the Facility for a minimum of thirty (30) days and the facility's vacancy rate is less than five (5%) percent, the resident's bed will be reserved for the resident for hospitalization and health care professional therapeutic visits[1] or other leaves of absence. The Medicaid bed hold for both temporary hospitalizations and health care professional therapeutic visits is limited to a combined aggregate of fourteen (14) days in any twelve (12) month period. For other leaves of absence included in the resident's plan of care, the resident's bed will be held for a maximum of ten (10) days in a twelve (12) month period.

Medicaid recipients who do not meet the bed hold eligibility requirements or whose bed hold has expired or has been terminated, may elect to secure the same bed in the Facility by notifying the Admission Department by telephone and signing a bed guarantee letter with the Admission Department stating their intent to hold their bed at the facility's private pay rate.

[1] Health care professional therapeutic visits are visits to a health care professional that are expected to improve the Medicaid eligible patient's physical condition or quality of life and that are consistent with a plan of care ordered by a heath care professional.

In the absence of a bed hold, a Medicaid resident, has the right to, and will be given priority for readmission when an appropriate bed in a semi-private room becomes available, unless there are special circumstances which would preclude a resident's return.

For additional information, please contact our Social Services Department, Monday through Friday from 9 am to 5 pm, at (516) 538-7171.

Mayfair Care Center

Advance Bed Hold Reservation Form

Name of Resident: _____

Where there is no prior payment arrangement available for bed hold (see bed hold policy above), a Resident or the Resident's representative may authorize the Facility to hold the Resident's bed (if the Resident is hospitalized) in advance for a period of at least three days by signing below:

_____ I **wish** to have the Facility retain the Resident's bed for _____ days if hospitalized By initialing this section I have agreed to ensure prompt payment, from my/the Resident's funds, of the Facility's private pay daily rate for the amount of days the bed is held by the Facility.

_____ I **do not wish** to authorize the Facility at this time to retain the Resident's bed if hospitalized. However, should hospitalization be required, the undersigned will be consulted at that time as to whether or not the undersigned chooses to hold the bed.

By signing below, the Resident, Sponsor and/or Resident Representative acknowledge and agree to the terms provided above.

_____ _____
Resident's Signature Date

_____ _____
Signature of Sponsor / Resident Representative Date

_____ _____
Print Name of Sponsor / Resident Representative Relationship to Resident

ADDENDUM VII

MAYFAIR CARE CENTER

Acknowledgement of Receipt of Notice of Privacy Practices

Resident Name:_____

MR /ID #:_____

ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices, which discloses my rights and the Facility's legal duties with respect to the use and/or disclosure of my protected health information.

_____	_____
Resident's Signature	Date
_____	_____
Signature of Sponsor / Resident Representative	Date
_____	_____
Print Name of Sponsor / Resident Representative	Relationship to Resident

MAYFAIR CARE CENTER

This notice is intended to heighten awareness among residents and their families as to the availability of certain compliance information maintained by the NYS Department of Health (NYSDOH)and the Centers for Medicare and Medicare Services (CMS) with regards to residential health facilities.

Both the NYSDOH and CMS maintain information on nursing homes that includes performance on quality measures, complaints, inspection results, and citations and enforcement actions, as well as any penalties imposed on the nursing home. CMS has created a tool called Care Compare to help consumers search for and select nursing homes and other health care providers and the NYS DOH maintains a web site called Nursing Home Profiles.

According to CMS, the information it maintains on nursing homes should be used with other information you gather about providers and facilities in your area. In addition to reviewing the Care Compare information, you should talk to your doctor, social worker, or other health care providers when choosing a provider. Additional tips for selecting a nursing home can be found in CMS's guide to selecting a nursing home: https://www.medicare.gov/care-compare/en/assets/resources/nursing-home/02174-nursing-home-other-long-term-services.pdf?redirect=true.

The New York State Nursing Home Profiles website maintained by the New York State Department of Health can be accessed below:

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

  On the NYSDOH site, select the nursing home by name after selecting the appropriate Region/County from the dropdown menu, and open the Inspections tab to view any Complaints, Inspection results including any citations, and any enforcement actions against the nursing home.

The Nursing Home Compare website maintained by the U.S. Department of Health and Human Services can be accessed below:

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

  On the CMS Care Compare site, enter the name of the nursing home in the search box. Click on the name of the nursing home to view Inspection results as well as any penalties that have been imposed.