CENTRAL ISLAND HEALTHCARE
825 Old Country Road
Plainview, New York 11803-4979

ADMISSION AGREEMENT

Agreement dated _____ between **CENTRAL ISLAND HEALTHCARE**, located at 825 Old Country Road, Plainview, New York, 11803 (Hereinafter "Facility") and _____ (Hereinafter referred to as "Resident"), whose residence is located at:

_____

and / or

_____

(Hereinafter "Designated Representative") residing at:

_____

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

I. ADMISSION AND CONSENT

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

II. MUTUAL CONSIDERATION OF PARTIES

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

The Resident and/or Designated Representative understand and agree that the Facility's acceptance of the Resident is based on the Resident's and/or Designated Representative's representation that the Resident has resources, insurance coverage and/or is eligible for government benefits (including Medicare and/or Medicaid) to cover the cost of care at the Facility. Furthermore, the Resident and/or Designated Representative agree to take all necessary steps to ensure that the Facility and its associated providers receive payment from these and/or other available sources consistent with this Agreement. The Resident and/or Designated Representative may be required to make full and complete disclosure to the Facility of all income (including Social Security, pension, and other periodic receipts), assets, insurance coverage and any other resources available to the Resident that could be available to pay for the cost of care.

The Resident and Designated Representative agree to comply with all applicable policies, procedures, regulations, and rules of the Facility. Out on Pass for non-clinical recreational purposes cannot be granted

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during regular rehab hours. Such passes will have to wait until the later afternoon hours to be granted. This includes Saturday and Sunday. Not attending a therapy session can or will jeopardize or terminate a patient's financial coverage at our facility.

III. ANTICIPATED SERVICES

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

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

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

Residents admitted for sub-acute care services are admitted with the expectation that, unless continued placement in the Facility is medically appropriate, they will be discharged once sub-acute services are no longer required. It is the mutual objective of the Resident and the Facility that the Resident returns to his/her home or a less restrictive setting, if appropriate. Residents and their Designated Representatives agree to facilitate discharge as soon as medically appropriate, and hereby represent and agree that they will work with the Facility staff to secure an appropriate and timely discharge.

NOTE: In the event Resident is admitted for Sub-Acute services and subsequently, by virtue of his or her health condition, requires long term care placement, an intra-facility room changed 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.

___ Long Term Care **____ Hospice Care** **____ Other _____**

IV. FINANCIAL ARRANGEMENTS

(a) Obligation of Resident and Designated Representative

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

If the Resident has no third party coverage or if the Resident remains in the Facility after any such coverage terminates because it is deemed no longer "medically necessary" or for any other reason consistent with applicable law, the Resident, Resident's Spouse and Designated Representative agree to provide payment, from the Resident's income and resources, for the private pay room and board rate and the ancillary charges incurred until discharge or until another source of coverage becomes available. The Facility will promptly notify the Resident, Resident's Spouse, and Designated Representative of a third party payer's discontinuation of payment (coverage).

NOTE: Although the Designated Representative is not personally responsible for the cost of care from the Designated Representative's personal assets, the Designated Representative may be held personally responsible to the Facility for

non-payment to the extent that he or she has control over the Resident's assets, such as Power of Attorney, access to joint accounts and the like; and/or to the extent that the Designated Representative does not provide requested information and/or documentation to the Facility or a third party payer, such as an insurer or Medicaid; and/or to the extent that the Facility relies to its detriment on false, misleading, or incomplete information and/or documentation supplied by the Designated Representative regarding matters, including, but not limited to, the Resident's financial resources, citizenship, or immigration status, and/or third party insurance coverage.

(b) Anticipated Payor

The Resident, Resident's Spouse and/or Designated Representative represents to the Facility that it is anticipated that the cost of the Resident's care will be paid in whole or in part by (check all that apply, including both primary and secondary payers):

____ Medicare ____ Medicaid ____ Veteran's Administration Benefits

____ Managed Care Organization: (Specify Name of Organization): _____

____ Other private insurance: (Specify Name of Insurance Company): _____

____ Private Pay ____ Worker's Compensation Benefits ____ No Fault Insurance Benefits

____ Other (Please Specify): _____

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

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

(c) Private Payment

If the Resident is paying privately for the cost of his or her care, and part or all of said payment is not covered by a third party payor, the private room rate for room and board is $640.50 per day, the semi-private room rate for room and board is $603.75 per day, the club room rate for room and board is $572.25 per day. Ancillary services, including, but not limited to, urinary care supplies, trach and ostomy supplies, surgical supplies, parenteral and enteral feeding supplies, pharmacy supplies, and occupational, speech, and physical therapy will be billed to the Resident according to the facility's and/or the provider of service's charge schedules. However, rates of payment to Facility may differ for individuals with additional sources of payment such as Medicare, Medicaid, and third party insurance. A copy of the Facility charge schedule for ancillary services is attached to this Agreement and included in your admissions package. Payment must be made to the Facility by the 1st of the month. The private pay room and board rate and additional

services charges are subject to increase upon thirty (30) days written notice to the Resident and/or Designated Representative.

(d) Private Pay Billing Policy and Security Deposits

Unless otherwise noted prior to admission and/or restricted by law, the Facility requires a security deposit in cash or certified check for each Resident, equal to seventeen thousand, two hundred and fifty ($17,250.00) dollars. This money will be deposited by the Facility in an interest-bearing bank account. This security deposit, including any interest accrued, shall continue to be the property of the depositor. However, the Facility shall have the right to apply any or all of the security deposit toward the payment of any unpaid amounts due under this Agreement. If any or all of the security deposit is so applied, or if the Facility's daily basic rate increases, the Facility will notify the Patient and/or the Patient Representative and, within ten (10) days of receipt of the notice, additional security must be deposited so that the total security equals seventeen thousand, two hundred and fifty ($17,250.00) dollars. The Facility will deduct a fee of 1% per year from security deposit amounts to cover administrative costs and consistent with applicable law. Additionally, if private paying Residents leave the facility for reasons within the Resident's control without giving fifteen (15) days prior notice, the Facility will retain an additional amount not to exceed one (1) day's daily basic rate.

The Facility bills private pay individuals for the private pay room and board charges on a one month advance basis. Bills for ancillary charges are generated in the month the services were rendered. All bills are generated by the twenty fifth (25^{th}) of the month and cover the next month of room and board charges and the previous month's ancillary charges. All payments are due by the tenth (10^{th}) of the month.

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

(e) Late Charges

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

(f) Collection Costs, Including Attorney and Court Fees

If the Resident and/or the Designated Representative fails to make payments within thirty (30) days of the date payment is due, the Resident shall pay all expenses incurred by the Facility, in connection with its attempts to collect the outstanding payment. Such collection costs will include, but may not be limited to, attorney's fees, court costs, and related disbursements, In addition, the Resident and/or Designated Representative shall pay all late charges as noted above.

(g) Third Party Private Insurance and Managed Care

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

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Initial _____

If the Resident is covered by a private insurance plan or under a managed care benefit plan that **does not** have a contract with the Facility, and where the insurance proceeds under the private plan are insufficient to cover the cost of care, the Resident will be responsible for any difference. The Facility will bill the Resident for any such difference on a monthly basis as described in the "Private Payment" section above. The coverage requirements for nursing home care vary depending on the terms of the insurance staff and/or the Resident's insurance or managed care plan, carrier, or agent.

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

NOTE: The Resident is responsible for timely advising the Facility of what benefits, if any, may be available from his or her private insurance and/or managed care plan. Charges may be assessed above the covered benefit for skilled nursing facility care depending on the insurance coverage, managed care plan and/or written agreement with the Facility.

Furthermore, Resident's coverage may be subject to co-insurance, deductibles and/or copayment which will be the Resident's responsibility and billed according to the terms for private payment stated above.

(h) Medicaid

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

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

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

(i) Medicare

If the Resident meets the eligibility requirements for Skilled Nursing Facility benefits under the Medicare Part A Hospital Insurance Program, the Facility will bill Medicare directly for Part A services provided to the Resident. Medicare will reimburse the Facility a fixed *per diem* or daily fee based on the Resident's classification within the Medicare RUGS III guidelines. If the Resident meets the eligibility criteria, Medicare may provide coverage of up to 100 days of care. The first 20 days of covered services are fully paid for and the next 80 days (days 21-100), of the

covered services are paid for by Medicare subject to a daily coinsurance amount for which the Resident is responsible. Please note, an individual who is a Medicare beneficiary under both the Part A and Part B programs, and who subsequently exhausts their coverage under Part A or is no longer in need of a covered level of skilled care under Part A, may still be eligible to receive coverage for certain Part B services (previously included in the Part A payment to the facility) after they are no longer eligible for coverage under Part A.

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

For further information on third party payor sources, please refer to Attachment "B".

V. AUTHORIZATIONS AND ASSIGNMENTS FROM RESIDENT TO THE FACILITY

VI.

(a) Authorization to Release Information

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

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

By execution of this Agreement, the Resident and/or the Resident's Spouse and Designated Representative hereby 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. The Resident and/or Designated Representative authorize the Facility to seek and obtain all information and documentation necessary for the processing of any third party claim.

(c) Authorization to obtain Records, Statements, and Documents

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

(d) Authorization to Represent Resident Regarding Medicaid

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

(e) Authorization to Take Resident's Photograph

By execution of this Agreement, the Resident and/or Designated Representative shall allow the Facility to photograph the Resident upon admission and to observe or photograph any open wound on the Resident's skin. All such photographs shall become part of the Resident's medical record at the Facility.

VII.

BED HOLD POLICY (also referred to as "bed hold" or "bed leave")

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

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

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

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

Private pay Residents may also authorize a bed hold (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 my/the Resident's bed for a period of three days if I/the Resident is 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 date for the three day bed hold period.

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

VIII. 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 and/or Designated Representative has failed to pay for, or secure third party coverage of the Resident's care at the Facility.

(b) Involuntary Discharge for Non-Financial Matters

The Facility may transfer or discharge the Resident if the 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.

****PLEASE INITIAL EACH PAGE**&**FULL SIGNATURE ON PAGE 10****

Initial _____

(c) Voluntary Discharge

If the Resident no longer requires the services provided by the Facility, or voluntarily wishes to be discharged, the Resident, Designated Representative, and Facility will work cooperatively to develop and implement a safe, appropriate, and timely discharge plan.

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

(d) Intra-Facility Room Change

The Facility reserves the right to transfer the Resident to a new room on an as-needed basis, consistent with applicable law. Resident that are admitted as short term Residents, who subsequently become long term Resident, will be the subject of an intra-Facility transfer to rooms that are better suited for long term Residents. By execution of this agreement the Resident understands and agrees that if he/she, or any third party payor, no longer pays the private rate covering the private room or upon Medicaid coverage, he/she will more to a semi-private room is requested by the Facility unless the provision of a private room is medically necessary. The facility may also initiate a room change for medical or social reasons consistent with applicable law and the Resident's rights.

IX. RESIDENT'S PERSONAL PROPRERTY

The Resident has the option to keep valuable personal property (such as jewelry, money, and clothing) in a locked drawer in his or her room, or to request the Facility hold said property for safekeeping. Further, it is the responsibility of the Resident and/or Designated Representative to arrange for the disposition of the Resident's property upon discharge. Property left in the Facility for more than thirty (30) days after discharge will be disposed of at the discretion of the Facility.

X. RESIDENT'S PERSONAL BANK ACCOUNT

The Resident and/or Designated Representative requests the Facility to retain the Resident's personal funds, all funds over $50.00 shall be kept in an interest-bearing account by the Facility. The Resident and/or Designated Representative will receive account statements on a quarterly basis, and all inquiries will be addressed in a timely fashion. The Resident and/or Designated Representative hereby agree to and acknowledge that upon the discharge of the Resident, and after any outstanding payments are made to the Facility, the account balance, if any, will be distributed to the Resident, Designated Representative, Resident's estate and/or the Department of Social Services, as permitted by law. Please initial one of the lines below:

---------- I wish to have the Facility retain my/the Resident's personal funds.
---------- I do not wish to have the Facility retain my/the Resident's personal funds. (Please Note: The Designated Representative must have legal authorization to handle the Resident's funds should they choose to receive the funds directly. If not, the Designated Representative may purchase items on behalf of the Resident and be reimbursed upon presentation of adequate documentation to the Facility Finance Department).

XI. SMOKING POLICY

The Resident agrees that under no circumstances will they and/or their visitors smoke anywhere on the grounds or in the buildings of the Facility except for in designated areas.

XII. GENERAL PROVISIONS

(a) Governing Law

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

(b) Binding Effect

This Agreement shall be binding on the parties, their heirs. Administrators, distributes, successors, and assignees.

(c) Continuation of This Agreement

Temporary transfer of the Resident to another health care facility for medical or surgical treatment, or the Resident's authorized temporary absence from the Facility for any other purpose, where such transfer or absence does not exceed a period of thirty (30) 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.

(d) Entire Agreement

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

(e) Severability

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

(f) Non-Discrimination

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

By execution of this Agreement, Resident, Resident's Spouse and/or Designated Representative acknowledge receipt of the following documents and information:

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Initial _____

1. **Welcome Booklet: Visitor Information**
2. **Patient's Bill of Rights and Implementation Procedure**
3. **Central Island Healthcare's Philosophy on Patient's Rights, Including Restraint Reduction, Program Information**
4. **Patient Complaint Procedure, including (a) New York State Department of Health "Hot Line" Telephone Number, and (b) New York State Office of the Aging Ombudsman Program Telephone Number**
5. **Patient's Responsibilities**
6. **Designated Representative Information**
7. **PRI Classification / RUGS**
8. **Schedule of Coverage and Fees for Ancillary Services** (Attachment A)
9. **Information about Medicare and Medicaid Eligibility** (Attachment B)
10. **In-House Transfer Information**
11. **Food Policy**
12. **The Facility policy on Advance Directives, including forms (a) Planning in Advance for Your Medical Treatment, (b) Appointing Your Health Care Agent: New York State's Health Care Proxy Law, and (c) Do Not Resuscitate Orders: A Guide for Patients and Families**
13. **Statement regarding the use of the Medicare Minimum Data Sets (MDS) and the Privacy Act of 1974**
14. **Medical Treatment consent Form**
15. **Medicare Signature on File Form**

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:

_____	_____	_____
Date	**Signature of RESIDENT***	**Print Name**
_____	_____	_____
Date	**Signature of WITNESS**	**Print Name**

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

_____	_____	_____
Date	**Signature of DESIGNATED REPRESENTATIVE**	**Print Name**
_____	_____	_____
Date	**Signature of SPOUSE (if not Designated Representative)**	**Print Name**
_____	_____	_____
Date	**Signature of FACILITY'S REP**	**Print Name**

Initial _____