UR MEDICINE | THOMPSON HEALTH

M.M. Ewing Continuing Care Center
Resident Admission Agreement

Resident _____ Date of Agreement _____
(Hereinafter referred to as "Resident" or "you")

BACKGROUND: M.M. Ewing Continuing Care Center (hereinafter referred to as the "Facility") is duly licensed under New York State law to provide skilled nursing facility services. The Resident's physician has determined that the Resident requires skilled nursing facility services.

The Facility admits and treats all residents who are appropriate for placement in a skilled nursing facility on a non-discriminatory basis in compliance with New York State and Federal Laws which prohibits discrimination in admission, retention, and care of residents on the basis of race, creed, color, blindness, marital status, disability, national origin, sex, sexual preference, source of payment, sponsorship, or age. The Facility will provide equal access to quality care for its residents regardless of severity of condition, diagnosis, or source of payment.

AGREEMENTS

The Facility, Resident, and/or other applicable Resident Agent (as detailed in this Agreement), agree to the following terms and conditions relating to the admission and provision of services to the Resident by the Facility:

1. Conditions to Admission of Resident

1.1 Personal Physician

a) You understand that the Facility cannot admit you except on a physician's order, and you have the right to choose a personal attending physician from among those with attending privileges at the Facility, who agree to abide by all applicable federal and state regulations and who are licensed to practice medicine in New York State.

b) You agree to authorize your physician to perform such examinations as may be required by state law or regulation for your admission, and will pay the cost of all physician visits not covered by any third party payer or other insurance coverage for which you may be eligible.

1.2 Resident Agents

a) Designated Representative: You are requested to designate some person (family member, friend, advisor) as your Designated Representative ("DR"). By signing this Agreement you designate the following as your DR:

_____ _____
Name of D.R. *Relationship to Resident*

_____
Address

_____ _____ _____
City *State* *Zip Code*

_____
Telephone

The DR shall receive information from Facility as required by Department of Health regulations.

Revised
February 1, 2024

b) Financial Representative: You are required to advise Facility as to the identity of any and all individuals who you have authorized to act on your behalf as to financial matters and who have control over and access to your income and/or accounts, such as Social Security, pension income, investment interest, securities, annuities, cash and/or other funds. Each such individual shall be known as a Financial Representative ("FR"). The FR may be your Attorney-in-Fact, DR, or other legally appointed representative and you agree to provide the Facility with a copy of all such legal documents reflecting such status, such as a Power of Attorney. You agree that each such FR shall execute and adhere to the terms and conditions stated within the accompanying "Financial Responsibility Agreement" with the Facility. Your FR shall cooperate with Facility in obtaining timely payment from available funds and to assist you in applying for all payment programs to which you may be entitled (such as Medicaid). You further agree to immediately notify Facility if you revoke any such FR designation.

c) Health Care Agent: You also authorize the Facility to discuss protected health information, including lab and other test results, with your Health Care Agent and anyone else that you choose to provide the following assigned HIPAA Privacy Number _____. Facility also encourages all Residents to carefully consider and to execute a Health Care Proxy, which is a form in which you may authorize an individual to make health care decisions for you in the event that you are no longer able to make those decisions for yourself. You agree to provide the Facility with all documentation reflecting the appointment of your Health Care Agent.

You may request a change in your DR, FR, Health Care Agent, HIPAA Privacy Number, or who may have access to your protected health information at any time. By signing this Agreement, you consent to the uses and disclosures of your protected health information for your care, payment for your care, and the Facility's health care operations, and for such other uses that are permitted or required under federal or state law without your consent or authorization. The Facility may disclose to a family member, other relative, a close personal friend, or any other person identified by you your protected health information directly relevant to that person's involvement with your care or payment for your care. You authorize Facility to contact your DR, FR, and/or Health Care Agent whenever it is deemed appropriate by you or by Facility to seek the assistance of a third party in discussing and/or conducting your affairs.

Each of the parties acting on behalf of the Resident referenced in this Section 1.2 shall be known as a "Resident Agent" in this Agreement.

2. Services Provided by the Facility

2.1 Basic Services. For the basic charge, the Facility provides the Resident:

a) Room Lodging, a clean, healthful, sheltered environment, properly outfitted. **Resident understands that room transfers may be necessary and agrees to cooperate in making such changes.**

b) Board Board, including therapeutic or modified diets, as prescribed by a physician.

c) Nursing Services, Assistance/Supervision Around-the-clock nursing care; assistance and supervision, when required, with activities of daily living, including, but not limited to, toileting, bathing, feeding and ambulation. You understand you will be touched by members of the Facility's staff in providing these services and you consent to all appropriate touching and physical contact.

d) Equipment The use of customarily stocked equipment including, but not limited to, crutches, walkers, wheel chairs, or other supportive equipment, including training in their use when necessary, unless such item is prescribed by your physician for your regular and sole use. You understand and agree that if any equipment is ordered at your request for your sole use, regardless of whether or not it requires a physician order, you will be charged a separate fee for

any such equipment if it is not covered by any applicable insurance or third party coverage.

e) Bed Linen Fresh bed linen changed regularly, including sufficient quantities as required for incontinent residents.

f) Gowns or Pajamas Gowns or pajamas as required by the clinical condition and needs. If Resident wishes he/she may furnish gowns or pajamas.

g) Laundry Service Laundry services for gowns or pajamas and other launderable personal clothing items used by Resident.

h) Medicine Cabinet Supplies General household medicine cabinet supplies, including but not limited to materials for routine skin care, oral hygiene, routine care of hair and so forth, unless such items are medically indicated and prescribed by your physician for your sole use.

i) Recreation Therapy A recreation therapy program including but not limited to, a planned schedule of recreational, motivational, social and other activities, together with necessary materials and supplies.

j) Social Work Social services as needed.

k) Dental Services A complete oral examination to be conducted by a licensed and currently registered dentist or dental hygienist within seven (7) days following completion of the annual comprehensive assessment and at least annually thereafter by a dentist. In addition, any oral hygiene measures, dental treatment, dental prosthesis (including repair), and other dental measures ordered or recommended by your personal or the Facility's consulting dentist will be provided. You understand and agree that certain dental services will not be covered by any third party payer or other insurance coverage and you will be responsible for the payment of all fees, co-payments, co-insurance, and/or deductible amounts. Treatment may be deferred based upon physical or mental contraindications for care and the Resident's informed choice.

2.2 Physician and Ancillary Services For services not covered by any third party payer or other insurance coverage for which you are entitled to receive the Facility agrees to make available under physician's orders the following on a **fee for service basis**:

a) Physical therapy
b) Occupational therapy
c) Speech therapy
d) Audiology
e) Lab and X-ray
f) Podiatry
g) Hospital services, transportation expenses
h) Mental health services
i) Eye care services/eyeglasses
j) Physician services
k) Prescription medications and Medicare Part D benefit - Charges for drugs prescribed by a physician are not included in the daily basic rate. If the Resident is a Medicare beneficiary, he or she may enroll in a prescription drug plan under Medicare Part D.

Pharmacy Approval - By signing this Agreement the Resident and/or applicable Resident Agent authorizes Omnicare (CVS) Pharmacy and F.F. Thompson Hospital Pharmacy to provide medications needed during the Resident's stay at the Facility. The Resident and/or applicable Resident Agent also authorize the Facility to assist with the selection of a Medicare Part D Prescription Drug Plan and, if needed, appeal any decisions the Prescription Drug Plan makes regarding drug coverage.

l) Other Services and Supplies Resident is responsible for and promptly pays (or where applicable submits for payment to Medicaid, Medicare or other insurer) for all supplies or services provided to Resident if prescribed or recommended by the attending physician and if such supplies and services are not provided by the Facility as part of the basic charge, including but not limited to diagnostic services, and outside medical consultants as ordered by a physician and not routinely provided by the Facility.

m) Personal Items Certain items and services such as those listed below are not covered under the daily basic service charge nor are they normally paid for by any third party payer. Resident and/or applicable Resident Agent are responsible to pay for any of the personal items listed below:
1) clothing and other effects
2) beautician, barber services
3) professional dry cleaning
4) newspapers and magazines
5) personal telephones and televisions
6) fax machine use
7) personal computers
8) copier use
9) other personal items

The Resident or applicable Resident Agent shall provide such personal spending money as may be necessary or desirable under the circumstances. If Resident is a Medicaid recipient, Resident, if eligible, may receive such personal needs allowance amounts as provided for by applicable law and regulations.

In the event the Resident fails to accept and promptly pay (either directly or through the Facility) for any and all additional services, the Resident indemnifies and holds the Facility harmless from all claims, actions, proceedings, costs, damages and liabilities, including reasonable attorney fees arising out of, connected with, or resulting from the lack of payment for such additional services or supplies.

2.3 Resident Personal Fund Account You have the right to manage your personal funds. The Facility will need written authorization to manage your funds. You may request that the Facility manage your personal funds for you. If you or your applicable Resident Agent choose to have the Facility manage your funds, amounts exceeding $50 will earn interest and you will receive that interest.

3. Payment for Services

3.1 Pre-Admission Room Reservation In accordance with the Room Reservation Addendum.

3.2 Monthly Payment.

a) If Resident is without a third party payer or other insurance coverage, he or she agrees to pay the Facility the **daily basic services charges** no later than the 10th day of each month in which they are due. Any **additional charges** that may be assessed shall be paid upon receipt by the Resident or applicable Resident Agent of the statement for such charges, but in no event later than the 10th day of the month following the month in which they are due. Monthly statements for those who are private pay will reflect the New York State Gross Receipt Tax/Assessment in addition to the daily basic service charge. **The Facility reserves the right to adjust the daily basic charge and charges for additional services upon giving sixty (60) days prior written notice.** Each resident's case is reviewed by the Facility in accordance with Medicare and any other insurance regulations to determine eligibility and length of coverage, if any. The Facility basic daily rates for private pay residents are as follows (with a 6.8% tax added to what is noted below):

Unit	Private Room v. Semi-Private	2024 Room Rate
Memory Care	Private	$528.00
Memory Care	Semi-Private	$517.00
Long-Term Care	Private	$523.00
Long-Term Care	Semi-Private	$511.00
Short-Term Rehab	Private	$523.00
Short-Term Rehab	Semi-Private	$511.00

If the Resident is private pay or partial private pay, the Resident or applicable Resident Agent must promptly notify the Facility when it is anticipated that Resident will be required to make application for financial assistance under Medicaid or other reimbursement programs. The notification is required when the Resident's remaining funds are approximately equal to sixty (60) days of the basic charge. It is the responsibility of the Resident or applicable Resident Agent to make application for Medicaid or other reimbursement programs including the preparation of any and all supporting documents that may be required of the Resident in connection with such application. As the Resident, you personally agree to ensure that your assets, income, Medicare and other insurance benefits, and other resources shall not be used, transferred, or in any way misused so as to prevent you from qualifying for Medicaid or other insurance benefits. The Facility agrees upon request to assist with such application.

All payments due under this Agreement are made by Resident or applicable Resident Agent until the Facility receives written notice of the Resident's eligibility to receive Medicaid or other reimbursement funds. For example, private pay funds must be made in full while a Medicaid application is pending or until it is denied. Any payments made from funds which do not belong to the Resident should be accompanied by a statement designating the source of the funds. The Facility will promptly refund to the designated source the amount of any payments made that are accompanied by such a statement and that are paid by Medicaid or other reimbursement funds on a retroactive basis.

b) Under current law, if Resident is a **Medicare recipient** and has met all of the **medical and technical** eligibility requirements, the Resident will be eligible to receive **up to** one hundred (100) days of Medicare coverage per benefit period. The Facility will notify you in writing if it determines that you are **not qualified** to receive Medicare coverage, and that you may request a coverage determination from Livanta.

c) If you participate in a **Medicare Advantage Plan** in which we participate, that plan's requirements for **medical and technical** eligibility for Medicare payments, deductibles, co-insurance, and covered services may be different from those discussed above. The Facility and/or the Medicare Advantage Plan will notify you in writing if it determines that you are **not qualified** to receive Medicare Advantage Plan coverage, and that you may request a coverage determination from Livanta.

d) If the Resident has **any health/long term care insurance other than** Medicare or a Medicare Advantage Plan, the Facility will bill your insurance. You will be responsible for any remaining balance that is not paid by your insurance.

e) If the Resident is a **Medicaid recipient**, Resident or applicable Resident Agent agrees to promptly pay the Facility the monthly contribution towards the cost of care (if any) as stated in the most current Department of Social Services (or similarly named agency) letter, for the basic services and additional services as specified. This monthly contribution towards the cost of care by you is typically referred to as the Net Available Monthly Income ("NAMI") amount. It is the Resident's and/or applicable Resident Agent's responsibility to comply as instructed by the Department of Social Services (or similarly named agency). All payments are due by the 10th day of the month. If requested by the Facility, you agree to have the Facility make arrangements for Social Security checks (and other recurring income checks as applicable) to become payable to M.M. Ewing

Continuing Care Center as “representative payee.” An Admissions Office representative will assist you with this arrangement.

f) If any portion of the basic services charges, additional charges or monthly contribution towards the cost of care to be paid by the Resident or applicable Resident Agent are not paid in full by the 10th day of the month, the Facility reserves the right to accrue a **late fee** at the rate of one percent (1%) per month on the outstanding balance due until paid in full. Any accrued late fees appearing on a statement will be due and payable with the charges for services rendered appearing on the same statement. No late fee will be assessed upon any unpaid late fee. However, payment will be applied first toward any outstanding late fee and then toward the balance due for services rendered. The Facility reserves the right to adjust the rate of the late fee from time to time upon sixty (60) days prior written notice to the Resident and/or applicable Resident Agent.

g) Resident will be charged the daily basic service charges for the day of admission. Resident will not be charged the basic service charges for the day of discharge; however, Resident will be charged for any ancillary services provided on day of discharge. A resident day constitutes the twenty-four (24) hour period from midnight to midnight. A resident admitted and discharged on the same day is charged for one (1) day.

h) Notwithstanding any other provisions, if any charge is not paid in full within thirty (30) days of the due date, the Facility has the right to discharge the Resident for nonpayment pursuant to section 415.3 of the New York State Rules and Regulations. If for any reason the Resident or applicable Resident Agent fails to pay for any charges, fees, expenses or other obligations incurred, including but not limited to any NAMI amount, the Facility shall determine the appropriate course of action to ensure payment of past-due accounts.

The Facility reserves the right to place the Resident's account in the hands of a collection agency and/or attorney for collection. The Facility reserves the right to have the Resident pay all reasonable collection charges, fees, interest and expenses, attorney's fees and court costs in addition to the amount due on the Resident's account.

4. Discharge of Resident, Reservation of Room, Room Changes

4.1 Discharge by Resident

a) The Resident is free to leave the Facility at any time but is requested to give seven (7) days prior written notice of the Resident's voluntary discharge from the Facility. In absence of such notice, the Resident may be charged for up to one (1) day’s basic rate in addition to any amount obligated for services already furnished.

b) The Resident agrees that in the event the Resident discharges himself/herself from the Facility **against the advice of the attending physician and the Facility**, the Resident assumes the risk of any consequences of that discharge and the Resident shall defend, indemnify and hold harmless the Facility, its parent corporation, and its employees and agents, against all claims, actions, proceedings, costs, damages and liabilities (including but not limited to, attorney’s fees) arising out of, connected with, or resulting from such discharge.

4.2 Discharge by Facility The Facility may transfer or discharge the Resident in accordance with New York State nursing home resident rights.

4.3 Refunds Subject to Section 4.1(b), the Facility agrees to refund promptly in accordance with all applicable legal requirements the portion of prepaid charges in excess of the portion obligated for services already furnished in the event the Resident leaves the Facility prior to the end of a payment period.

4.4 Reservation of Room during Temporary Absence

a) Private Paying/Medicare/Other Third Party Payer

If the Resident is **transferred to an acute hospital or leaves overnight for other than a hospitalization (therapeutic leave)**, the Facility is **not obligated** to reserve the bed until the Resident returns. However, if you wish to have the Facility reserve the Resident's bed, you may do so by agreeing to continue to pay the prevailing daily basic rate. A New York State Gross Receipt Tax/Assessment will be charged in addition to the basic daily rate. There is no limit to the number of days a Resident's room can be reserved. The reservation will remain in effect until the Resident or applicable Resident Agent notifies the Facility that the reservation is being cancelled.

Please indicate your preference by checking one of the choices below:

_____ I would **like** the bed to be reserved and to receive required notification after the bed has been reserved.

_____ I would **not like** the bed reserved, but understand that I will be notified as required.

_____ I **prefer to make the decision** regarding the bed reservation at the time of transfer and to receive notification as required.

b) Medicaid Recipients {Please see the Dear Administrative Letter Attached} _____

For Residents who are Medicaid recipients, Medicaid will only pay for a bed reservation when the Facility has a vacancy rate of no more than 5% on the first day of leave, when the Resident has resided in the Facility for at least thirty (30) days, and when all other legal requirements are met. The Facility will ***auto-initiate*** a reservation for Residents who are Medicaid recipients and who meet the residency requirements when they are either hospitalized for an acute condition or on leave of absence for other than a hospitalization (therapeutic leave).

- **Hospitalization for an Acute Condition** – If a Resident who is a Medicaid Recipient is transferred to an acute hospital, Medicaid will pay for a bed reservation only if the Resident is receiving hospice services within the Facility or if the Resident is under 21 years old. Medicaid payment for such bed reservations may not exceed fourteen (14) days in any twelve (12) month period for each Resident. The bed hold reservation begins on the first day that the Resident is hospitalized and is absent overnight.

- **Leave of Absence for Other Than a Hospitalization (Therapeutic Leave)** – If a Resident who is a Medicaid recipient leaves the facility on a leave of absence for other than a hospitalization (therapeutic leave), Medicaid will pay for a bed reservation. Medicaid payment for such bed reservations may not exceed ten (10) days in a twelve (12) month period. The bed reservation period begins the first day the Resident goes out of the Facility on leave and is absent overnight.

Medicaid payment for bed reservations cannot exceed a combined aggregate of fourteen (14) days in any twelve (12) month period regardless of the reason for leave. Medicaid payment for bed reservations is unavailable where Medicare is the Resident's primary third-party resource unless the Resident has resided in the Facility for thirty (30) days immediately before the hospitalization that resulted in Medicare coverage of the Resident's stay. If a Resident who is a Medicaid recipient is **ineligible for a bed reservation** paid for by Medicaid or if the bed reservation **expires,** the Resident or the applicable Resident Agent may request to pay privately for a bed reservation consistent with 4.4(a) of this Agreement.

c) All Residents

A Resident whose hospitalization or therapeutic **leave exceeds the bed-hold period**, or who goes out on such leave after residing in the Facility for at least thirty (30) days **without being given a bed reservation**, will be readmitted to the Facility upon the first availability of a semi-private room if the Resident requires the services provided by the Facility and is eligible for Medicaid nursing facility services or Medicare skilled nursing facility services.

The terms concerning bed reservations in this Agreement are subject to all other terms and restrictions in applicable federal and state law and regulations and may be revised at any time to ensure accordance therewith.

4.5 Room Changes This Facility complies with Department of Health room change regulations. Avenues of the Facility are created along service lines and have specific admission and discharge criteria. **Resident and applicable Resident Agent(s) will cooperate in making room changes when Resident needs or the needs of other residents make these changes necessary.** You will be consulted about room changes, except in emergencies, and every effort will be made to accommodate your wishes, but the final decision about room changes will be made by Administration. By signing this Agreement the Resident and/or applicable Resident Agent acknowledge understanding of avenue criteria and **agree to cooperate with room changes. Medicaid does not pay for a private room**; therefore, if the need arises and the Resident needs to apply for Medicaid at some point during the course of their admission at the Continuing Care Center, the Resident will be moved to a semi-private room.

4.6 Responsibility for Personal Items /Assets upon Transfer or Death Upon the transfer or death of a Resident, the Resident and/or applicable Resident Agent are responsible for the timely removal of all personal items within thirty (30) days of the Resident's transfer or death. Any items will be deemed abandoned if not removed from the Facility within thirty (30) days of notice from the Facility. The Facility has the right to dispose of the abandoned items in any way including, but not limited to, the sale of such items. Release of such items may be made to the applicable Resident Agent or estate representative.

5. Records

5.1 The Facility keeps such records on the Resident as are required by applicable law and regulations.

5.2 The Facility maintains the confidentiality of the Resident's records. However, the Facility is authorized by the Resident to disclose information from Resident's records to representatives of the State Health Department, other governmental bodies when required, appropriate health care professionals and associates treating Resident, and as required by third party contract payers.

5.3 If the Resident is transferred to a health, mental health, or residential care Facility, the Facility forwards a copy of all pertinent Resident records to that Facility. By signing this Agreement the Resident and/or applicable Resident Agent agree to release of information as specified in this paragraph.

5.4 The Resident and/or applicable Resident Agent agree to cooperate with the Facility in obtaining all documentation from the Resident and/or applicable Resident Agent that the Facility is required to obtain prior to the Facility disclosing the Resident's information in accordance with Sections 5.2 and 5.3 of this Agreement.

6. Miscellaneous Provisions

6.1 By signing this Agreement, Resident and/or applicable Resident Agent specifically designate the Facility as Resident's agent for the purpose of processing requests for Medicaid, Medicare and any other insurance eligibility and for appealing any and all denial of such eligibility in the event the Resident or their representative fails to do so. The Resident and/or Resident agent agree to

provide any and all records and supporting documents that may be required for this purpose, including but not limited to, all bank and financial records. The Resident and/or Resident agent authorize personnel of any banks or other financial institutions maintaining Resident's funds or other assets to release information to Facility representatives. Specifically, the Resident agrees that upon filing of a Medicaid application or recertification application, Resident appoints Facility as a limited power of attorney for the Resident solely for the purpose of obtaining banking and financial information necessary for Resident's completion of the Medicaid or other applicable application.

The Resident and/or applicable Resident Agent also hereby authorize personnel of the County and/or State Department of Social Services (or similarly named agency), Medicare and other third party payers to furnish information to Facility concerning Resident's eligibility for Medicaid, Medicare or other insurance. The Resident and/or applicable Resident Agent grants the Facility access to the Resident's Department of Social Services (or similarly named agency) Medicaid application and recertification file.

The Resident and/or applicable Resident Agent certifies that the information given by Resident in applying for Medicare payment under the Social Security Act is correct. Resident authorizes any holder of medical or other information about Resident to release to the Social Security Administration or its intermediaries or carriers any needed for a Medicare claim. Resident requests that payment of authorized benefits be made on the Facility's behalf.

The Resident and/or applicable Resident Agent assigns to Facility any and all rights Resident has to appeal or challenge determination by Medicare or the intermediary regarding Resident's placement in a particular "RUG" category or classification, including any reclassification to a different "RUG" category. Resident agrees to assist Facility in any such appeal.

6.2 The Facility will work with Resident, his or her family members, and the applicable Resident Agents to ensure the safety and availability of Resident's personal belongings, including cash and/or other personal items such as medical assistance devices, as detailed in this Section. The Facility is not automatically liable for the loss of any of Resident's personal belongings regardless of whether the Facility is notified of their presence in the Facility. The Facility, however, must be notified of the presence of Resident's personal belongings in order for the Facility to appropriately safeguard those personal belongings. Resident agrees to adhere to any plan proposed by the Facility to protect their personal belongings, which may include keeping high value property (cash, jewelry, medical assistance devices, etc.) in the Facility's safe or other secure area when not in use. For example, all electrical equipment and devices brought into the Facility must be checked by staff for approval prior to their use; approved devices will have an approval sticker applied to the item. The Facility will not make the Resident's personal belongings inaccessible to the Resident. Resident agrees to keep a minimum of valuables in his or her room and to avoid leaving valuables in the open or unattended. Locked storage space is provided in Resident rooms upon request. The Facility shall follow all applicable federal and state laws and regulations, and its applicable policies, relating to the loss or damage of dentures.

6.3 By signing this Agreement the Resident and/or applicable Resident Agent acknowledge and understand that the entire Thompson Health campus is a smoke-free environment. Smoking and/or vaping is not permitted in the Continuing Care Center or on the grounds. Resident may not keep cigarettes, matches, lighters or vaping materials in the Continuing Care Center.

6.4 By signing this Agreement the Resident and/or applicable Resident Agent acknowledge receipt of New York State Nursing Home Resident Rights and receipt of verbal and written information regarding the Medicaid and Medicare programs.

6.5 The failure of any party to require the performance of any term of this Agreement will not prevent a subsequent enforcement of such term nor be deemed a waiver of any subsequent breach.

6.6 In the event any of the provisions of this Agreement are held invalid or unenforceable

by any court of competent jurisdiction, such holding will not invalidate or render unenforceable any other provisions hereof.

6.7 This Agreement and the terms and conditions hereof are governed by the internal laws of the State of New York.

6.8 The Resident and/or applicable Resident Agent acknowledge and agree that they have read this Agreement and understand the terms and conditions set forth herein. The Resident and/or applicable Resident Agent further acknowledge that this Agreement was signed only after a consultation between the Facility and the Resident and/or applicable Resident Agent, either by telephone or in person, during which consultation the terms of this Agreement were reviewed with the Resident and/or applicable Resident Agent.

6.9 The Resident's facial photographs or recordings, and photographs or recordings of specific injuries or conditions, may be taken to use as identification or for other health care operations of the Facility, as necessary. Resident consents to the use of these photographs or recordings by the Facility and the Facility will maintain the confidentiality of these photographs or recordings, as required by law.

6.10 This Agreement remains in effect if the Resident is readmitted to the Facility after a hospitalization or temporary absence of less than thirty (30) days in duration.

6.11 By signing this Agreement the Resident and/or applicable Resident Agent certify that the information provided and contained on the admission application/financial statement, which is hereby made a part of this Agreement, is accurate and complete.

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

The undersigned have executed this Agreement this _____ day of _____20_____

FACILITY REPRESENTATIVE:

By: _____ _____
Signature of Facility Representative Title of Facility Representative

RESIDENT: **RESIDENT AGENT:**

By: _____ By: _____
Signature of Resident Name: Signature

_____
Relationship to Resident

STATE AND FEDERAL LAWS PROHIBIT DISCRIMINATION ON THE BASIS OF RACE, CREED, COLOR, BLINDNESS, MARTIAL STATUS, DISABILITY, NATIONAL ORIGIN, SEX, SEXUAL PREFERENCE, SOURCE OF PAYMENT, SPONSOR OR AGE IN THE ADMISSION, RETENTION AND CARE OF RESIDENTS WHO ARE APPROPRIATE FOR PLACEMENT IN A SKILLED NURSING FACILITY. THE FACILITY PROVIDES EQUAL ACCESS TO QUALITY CARE FOR ITS RESIDENTS REGARDLESS OF SEVERITY OF CONDITION, DIAGNOSIS, OR SOURCE OF PAYMENT.