



61-11 Queens Boulevard, Woodside, NY 11377 | Tel: (718) 205-0287 | Fax: (718) 803-0694 | WWW.QBECF.COM

NOTICE TO:

All Residents/Resident Representatives

Please be advised that if you receive coverage under Medicare Part-A during your stay at the Nursing Home, that this coverage falls under the terms of the “Skilled Nursing Facility Consolidated Billing arrangement”.

As such, the Nursing Home is responsible for the payment and allocations of any testing/diagnostic services that are rendered. Accordingly, then, you must notify the Nursing Home if you have any pre-scheduled or “second opinion” appointments with outside doctors or providers, during your stay at our facility.

This is necessary in order to coordinate and arrange for provisions of these services as well as ensuring proper oversight of care and appropriate payments for the rendered testing.

Please reference the Medicare website at:

<https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling>
for more information on “Consolidated Billing” or call our Facility.

Truly Yours,

A handwritten signature in black ink, appearing to read 'Jonathan Mawere', written in a cursive style.

Jonathan Mawere, LNHA, MHL, DPT, MD
Administrator & Chief Operating Officer



Queens Boulevard

EXTENDED CARE FACILITY

61-11 Queens Boulevard, Woodside, NY 11377 | Tel: (718) 205-0287 | Fax: (718) 803-0694 | WWW.QBECF.COM

Dear Resident/Family Member:

The New York State Department of Health is responsible for ensuring that the care provided in nursing homes is adequate, appropriate and dignified, and that resident/patient rights are respected. We are required to forward a copy of the New York State Department of Health's "Privacy Act Statement - Health Care Records".

The purpose of the Privacy Act Statement is to inform you that we are required by law to send certain information about the resident's medical condition to the New York State Department of Health in Albany and to CMS (Centers for Medicare and Medicaid Services) formerly the Health Care Financing Administration, which is a federal agency. The statement also explains why this is done. This letter is a summary of the information contained in the statement and explains the type of information that is sent to these government agencies.

When a resident or sub-acute patient is admitted to a nursing home anywhere in the United States, a thorough assessment of that person's medical, functional, cognitive, emotional and psychosocial status is done. This assessment is called an MDS (Minimum Data Set) assessment. This assessment, which is completed by members of the interdisciplinary team, helps clinical staff members pinpoint each resident's needs and allows the team to create a plan of care to address these needs. To provide the appropriate level of care, our care plan is based on this thorough assessment. After this initial assessment, future MDS assessments are done at intervals of three months or less. The data from each MDS assessment is then input in the computer and transmitted electronically to the state and federal agencies mentioned above.

The State Department of Health and the CMS use this data for several purposes. First of all, collecting this data helps these agencies protect nursing home residents because it allows them to take a look at the overall quality of care provided by each nursing home and to discover if there are patterns or recurring problems, which need to be addressed. Secondly, this data provides valuable information on the needs of nursing home residents/patients, and research data regarding the prevention of disease or the restoration of health. In addition, our facilities are reimbursed for the care provided to patients on Medicare based on the information contained in the MDS. Therefore, failure to provide this information could impact on coverage for the cost of care for a resident or patient.

If you have any questions regarding this information, please feel free to contact the Social Worker on the unit.

Sincerely,

Jonathan Mawere, LNHA, MHL, DPT, MD
Administrator & Chief Operating Officer

(Over)



Effective Date: March 26, 2013

NOTICE OF PRIVACY PRACTICES

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

This Facility is required by law to maintain the privacy of its residents' protected health information. Protected Health Information ("PHI") includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. The Facility is required to provide you with this notice of privacy practices ("Notice"), which describes our legal duties and privacy practices with respect to PHI and your rights to access and control your PHI under HIPAA. This notice applies to all of your health information created and/or maintained by our Facility including information about you that we received from other health care providers or facilities.

PERMISSIBLE USES AND DISCLOSURES

We may use or disclose your PHI for purposes of *treatment, payment and health care operations*. Although we have provided descriptions and examples below, not *every* use or disclosure is listed.

I. Treatment

We will use your PHI to provide, coordinate or manage your health care and any related services and products. For example, we may disclose your information to doctors, nurses, therapists, social workers, and other clinicians to coordinate and develop a plan of care and to provide you with appropriate health care services, including treatments, medications, lab work, x-rays, procedures, supplies or referrals,

II. Payment

Your PHI may be used and disclosed to obtain payment for the health care services provided to you. For example, we may tell your health insurance or other third-party payor about treatment you received in order to obtain payment. In addition, your PHI may be disclosed in connection with other activities necessary for reimbursement including billing, collections; claims management, determinations of eligibility, benefits and coverage, and other utilization review activities. For example, we may need to provide information about your medical condition to your health plan to determine if the services are covered.

III. Health Care Operations

Your PHI may be used or disclosed in connection with activities necessary for the operation of the Facility. These activities include, but are not limited to, quality assessment and improvement, facility administration, marketing, licensing, business planning, staff evaluation and training, and management activities. Your PHI may also be disclosed to the Facility's business associates that provide contracted services such as accounting, legal representation, claims processing, accreditation, and consulting. PHI use and disclosure by a business associate are subject to specific contractual requirements for the protection of PHI.

The Facility may:

- Combine and use health information about many Facility residents to decide: a) what additional services the Facility should offer; b) what services are not needed; and c) whether certain new treatments are effective.
- Combine and use PHI we have with health information from other facilities to compare and see where we can make improvements in the care and services we offer.
- Remove information that identifies you so others may use the de-identified health information to study health care services and delivery without knowing who the patients are.
- Use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Disclose information to doctors, nurses, health care technicians, medical students and others for review and learning purposes.

Note: HIV-related information, genetic information, alcohol and/or substance abuse and mental health records and other related information may have special confidentiality protections under State and federal law. Any such disclosures will be subject to these special protections.

OTHER USES AND DISCLOSURES

An authorization to use or disclose PHI is not required:

- a) to carry out treatment, payment or healthcare operations;
- b) pursuant to your verbal or written consent; or
- c) as permitted by law.

Other permitted or required uses and disclosures that do not require your authorization include the following:

IV. Uses and/or discloses without your written authorization

In limited circumstances, we may use or disclose your PHI without your written authorization, provided that prior to the use or disclosure, you are informed and given the opportunity to agree to, prohibit, or restrict the use or disclosure. We may verbally inform you of these disclosures and obtain your agreement or objection verbally. Such uses and disclosures include those made: a) for the Facility directory, b) to notify your family and friends of your location and/or condition; or c) to your family members, personal representative, or others involved in your care.

As required by law

We may use or disclose your PHI to the extent that it is required by law. The use or disclosure will be made in compliance with, and limited to, the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures of which we are aware.

Public health activities

We may disclose your PHI to a public health authority that is permitted by law to collect or receive the information for public health activities, such as public health and safety, controlling disease, injury al disability, reporting birth and deaths, tracking prescription drug and medical device problems and other health oversight activities.

Victims of abuse, neglect or domestic violence

If we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your PHI to the government entity or agency authorized to receive such information. The disclosure will be made consistent with the requirements of relevant federal and state laws.

Law enforcement purposes

We may also disclose your PHI, in accordance with applicable legal requirements, for law enforcement purposes. We may disclose your protected health information:

- a) in response to a court order, subpoena, warrant, summons or similar process;
- b) to identify or locate a suspect, fugitive, material witness, or missing person;
- c) as it pertains to the victim of a crime under certain limited circumstances;
- d) as it pertains to a death we believe may be the result of criminal conduct;
- e) as it pertains to criminal conduct on our premises; and
- f) in emergency circumstances, to report a crime; location of the crime or victims; or the identity, description or location of the person who committed the crime.

Facility directory

Unless you object, we will use and disclose in our Facility directory your name, your location within the Facility, your condition (in general terms), and your religious affiliation. All of this Information, except religious affiliation, will be disclosed to people who ask for you by name. Only members of the clergy will be told your religious affiliation.

To family, friends and others involved in your care

With your consent, we may disclose PHI to a family member, relative, close friend or other person you identify who is involved in your care or payment related to your care. If you are unable to agree due to incapacity or emergency situation, we may disclose such information, as necessary, if we determine that it is in your best interest. Additionally, we may use or disclose your PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Coroners, medical examiners and funeral directors

We may disclose your PHI to a coroner, medical examiner or a funeral director to enable them to carry out their lawful duties.

Serious and imminent threats

We may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Cadaveric organs, eye or tissue donation purposes

If you are an organ or tissue donor, we may disclose your PHI to facilitate your intent.

Research

Prior to disclosing your PHI for research, we will obtain written authorization from you, or an appropriate waiver from an IRB or Privacy Board, as required and in accordance with law.

Disaster relief efforts

We may disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

National security and intelligence

We may disclose your PHI to authorized federal officials, or others legally authorized, to conduct national security and intelligence activities.

Workers compensation

We may use or disclose your PHI to comply with workers' compensation laws and other similar legally-established programs that provide benefits for work related injuries or illnesses.

Health oversight activities

We may use or disclose PHI to a government agency authorized to oversee health care services or government benefit programs, and compliance with civil rights laws or regulatory program standards.

Lawsuits and disputes

Your PHI may be disclosed in the course of a legal proceeding in response to a court or administrative order, and, in certain cases, in response to a subpoena, discovery request or other lawful process.

Fundraising

We may contact you to raise funds for the Facility. If you do not wish to receive any further fundraising communications, you must follow the opt-out procedures contained in the communication.

Marketing

In the course of your face to face treatment or care, you may on occasion receive products or services of nominal value. No other communications about products or services which you may be encouraged to purchase or use, will be made without your written authorization as noted below.

V. Uses and/or discloses that require your written authorization

other uses and disclosures, not otherwise specified in this Notice, require your written authorization. You may revoke your authorization in writing at any time, except to the extent that we have acted in reliance on your authorization. The following uses and disclosures will be made only with your authorization:

- a) Uses and disclosures of psychotherapy notes;
- b) Uses and disclosures of PHI for marketing purposes;
- c) Uses and disclosures constituting the sale of PHI; and
- d) Other uses and disclosures not described in this notice of privacy practices

YOUR RIGHTS

VI. Access to your health information

With some exceptions, you have the right to inspect and obtain a copy of your PHI that is maintained by the Facility. Your request to access your records must be in writing. If you request a copy of your PHI, we may charge you a fee for making copies for you. Under applicable federal law, however, you may not inspect or copy the following records:

- (a) psychotherapy notes.
- (b) information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.
- (c) information that is subject to law that prohibits access to PHI.
- (d) PHI that was created or obtained by the Facility in the course of research that includes treatment. Access may be temporarily suspended for as long as the research is in progress.
- (e) records that are subject to the Privacy Act.

- (f) PHI obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

If we deny your request to access your information, we will notify you in writing. In some circumstances, you may request in writing to have this decision reviewed by another licensed health care professional designated by the Facility. If you have questions about access to your medical record, please contact our Privacy Officer.

VII. Restrictions

You have the right to request restrictions on how we use and disclose your PHI for treatment, payment or health care operations. We are not required to agree to a restriction that you request, except for one exception. We are required to honor your request for restriction of PHI that relates to a health care item or service for which you paid for out of pocket in full. Other than that exception, the Facility can deny your request. However, if we do agree to the requested restriction, we will comply with your request unless the information is needed to provide emergency treatment. You may request a restriction by forwarding a written request to the Privacy Officer at the address listed below specifying (1) what information you want to restrict; (2) whether and how you want to restrict our use, disclose or both; and (3) to whom you want the restrictions to apply.

VIII. Confidential communications

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. For example, you may only want to have PHI sent by mail or to an address other than your home. While we are not required to agree to all requests, we will accommodate all reasonable requests for confidential communications. Please make requests for such communications in writing to our Privacy Officer at the address below.

IX. Right to amend protected health information

If you believe your PHI is incorrect or incomplete, you have the right to request us to amend your PHI. The request must be in writing and specify what needs to be changed and why. We will respond to your request in writing, either accepting or denying your request. We may deny your request if the information:

- (a) was not created by us;
- (b) is not part of your medical or billing records or other records used to make decisions about you;
- (c) is not available for inspection as set forth above; or
- (d) is accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and we have the right to rebut your statement. If you have questions about amending your health record, please contact our Privacy Officer.

X. Right to receive an accounting of disclosures

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI, and that we are aware of, for up to six prior years prior to your request, except for disclosures made:

- (a) to carry out treatment, payment and health care operations as provided above;
- (b) incident to a use or disclosure otherwise permitted or required by applicable law;
- (c) pursuant to your written authorization or consent;
- (d) to you about yourself;
- (e) for national security or Intelligence purposes as provided by law;
- (f) to correctional institutions or law enforcement officials as provided by law; or
- (g) as part of a limited data set as provided by law.

The right to receive this information is subject to certain exceptions, restrictions and limitations.

XI. Right to Notification upon Breach of Unsecured Protected Health Information

You have the right to or will receive notifications of any breach of your unsecured PHI.

XII. Revisions to Notice

We reserve the right to change the terms of this Notice and our privacy practices. Changes are effective for all PHI that we maintain. We post a copy of the current Notice in the Facility and on our website (if active) and we will provide you with a copy of the current Notice upon request.

XIII. Complaints

If you believe that your privacy rights have been violated, you may file a complaint with this Facility by sending a written complaint to the Privacy Officer at the address below, or by sending a written complaint to the Secretary of the United States Department of Health and Human Services at: Office for Civil Rights, U.S. Department of Health and Human Services, 26 Federal Plaza, Room 3312, New York, NY, 10278; Voice Phone (212) 264-3313; Fax (212) 264-3039; TDD (212) 264-2355. The complaint must name the Facility complained about and describe the acts or omissions believed to be a violation of the privacy of your health information. The complaint must be filed within 180 days of when you knew or should have known that the act or omission that you are complaining about occurred. (This time limit may be waived by the Secretary for good cause.) The Secretary may investigate your complaint including the circumstances regarding any alleged acts or omissions.

You will not be retaliated against for filing a complaint.

XIV. Copy of this Notice

You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept a copy electronically.

To request a copy of this Notice, or obtain additional information about this Notice, you may contact:

Queens Blvd. Extended Care Facility's Privacy Officer: _____

By telephone at (718) 205-0287, Extension _____

Or in writing to:

Queens Boulevard Extended Care Facility
61-11 Queens Boulevard
Woodside, NY 11377
Attn: Privacy Officer

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), and including Kosher food provided upon the request of a Resident who as a matter of religious belief wishes to follow Jewish dietary laws
- 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 2021 are \$185.50 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 718-205-0288, Extension__.

If you are covered by Medicare Part B, for 2021:

- Annual Medicare Part B Deductible is \$203.00.
- 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/Res/dent 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 (7) days 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 2021, the Medicare- Part A co-insurance amount is \$185.50 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 2021, there is an annual \$203.00 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 800-772-213 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 2021, the individual resource limit is \$15,900.00 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 2021, the “community spouse” is entitled to a minimum monthly income of \$3,259.50 and resources of \$74,820.00 or one-half the couple's resources as of the date of institutionalization to a maximum of \$130,380.00 (these figures are subject to increase each calendar year); increases beyond these amounts are possible, but a Department of Social Services Fair Hearing or Family Court support proceeding may be required. The Resident's home may be exempt for Medicaid eligibility purposes if the equity value is less than \$96,000.00 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.

VETERAN S' 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 t 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)

QUEENS BOULEVARD EXTENDED CARE FACILITY

ADMISSION AGREEMENT

I.	ADMISSION AND CONSENT	1
II.	MUTUAL CONSIDERATION OF THE PARTIES	1
III.	ANTICIPATED SERVICES	2
IV.	FINANCIAL ARRANGEMENTS	2
	(a) <i>Obligations of Resident, Sponsor and/or Resident Representative</i>	2
	(b) <i>Private Payment</i>	3
	(c) <i>Prepaid Deposits/Advance Payment</i>	4
	(d) <i>Late Charges</i>	4
	(e) <i>Collection Costs, Including Reasonable Attorneys' Fees and Related Expenses</i>	4
	(f) <i>Third Party Private Insurance and Managed Care</i>	4
	(g) <i>Medicare</i>	4
	(h) <i>Medicaid</i>	5
V.	AUTHORIZATIONS AND ASSIGNMENTS FROM RESIDENT TO THE FACILITY	6
	(a) <i>Authorization to Release Information</i>	6
	(b) <i>Authorization to Obtain Records, Statements and Documents</i>	6
	(c) <i>Assignment of Benefits and Authorization to Pursue Third Party Payment</i>	6
	(d) <i>Designation and Authorization for External Appeal of Medical Necessity Denials</i>	6
	(e) <i>Authorization to Represent Resident Regarding Medicaid</i>	6
	(f) <i>Authorization to Take Resident's Photograph</i>	6
VI.	TEMPORARY ABSENCE (also referred to as "bed hold" or "bed reservation")	7
VII.	DISCHARGE, TRANSFER AND INTRA-FACILITY ROOM CHANGES	7
	(a) <i>Involuntary Discharge for Non-Payment</i>	7
	(b) <i>Involuntary Discharge for Non-Financial Matters</i>	7
	(c) <i>Voluntary Discharge</i>	7
	(d) <i>Intra-facility Room Change</i>	7
VIII.	RESIDENT'S PERSONAL PROPERTY	7
IX.	SMOKING POLICY	8
X.	FACILITY SECURITY	8
XI.	GENERAL PROVISIONS	8
	(a) <i>Governing Law</i>	8
	(b) <i>Assignment</i>	8
	(c) <i>Binding Effect</i>	8
	(d) <i>Continuation of This Agreement</i>	8
	(e) <i>Entire Agreement</i>	8
	(f) <i>Severability</i>	8
	(g) <i>Waiver</i>	9
	(h) <i>Counterparts</i>	9
	(i) <i>Relationship between Parties</i>	9
	(j) <i>Section Headings</i>	9
	(k) <i>Representations</i>	9
	(l) <i>Attachments</i>	9
	(m) <i>Non-Discrimination</i>	9
	Attachments A and B	
	Addenda	

QUEENS BOULEVARD EXTENDED CARE FACILITY

ADMISSION AGREEMENT

Agreement Dated _____, 20__ (hereinafter the "Agreement") between Queens Boulevard Extended Care Facility Management, LLC d/b/a Queens Boulevard Extended Care Facility at 61-11 Queens Boulevard, woodside, New York 11377 (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 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 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, Resident Representative and/or Sponsor 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 insurer, 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, Resident Representative and/or Sponsor 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/or 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.

* Queens Boulevard Extended Care Facility 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 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 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 payers 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 payer'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 and \$_____ per day for a semi-private 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 Service") 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 [$1^{1/4}$ % 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 An 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 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 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, except in designated areas. The Resident agrees to comply with the Facility's smoking 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 grounds and 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 shall be brought in, and the parties agree to exclusive jurisdiction of, the New York State Supreme Court, located in 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 (MOS) 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

QUEENS BOULEVARD EXTENDED CARE FACILITY MANAGEMENT, LLC
D/B/A QUEENS BOULEVARD EXTENDED CARE FACILITY

Date By: _____ Print Name and Title

QUEENS BOULEVARD EXTENDED CARE FACILITY

HOW DID YOU HEAR ABOUT US?

Family and friends referral

Website

QBECF.com

Other. Specify: _____

Facebook

Nursing Home compare

Hospital Discharge Planner

Recommended by my doctor

Please specify name of doctor: _____

Recommended by social worker

Other. Please specify: _____



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**STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS
TO PROVIDER, PHYSICIANS AND PATIENT**

Resident Name: _____

Date of Birth: _____

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of Medical or other information about me to release to the Social Security Administration and Health Care Financing.

Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

X

Beneficiary/Designated Representative

X

Date



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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, authorize Queens Boulevard Extended Care Facility to release medical information to _____. I understand that most insurance carriers require medical case review for the purpose of continuation of benefits as assigned.

X

Witness

Date

Resident/Guardian

Date

ASSIGNMENT OF BENEFITS

I, _____, hereby authorize payment to Queens Boulevard Extended Care Facility the insurance benefits specified on my admission form.

X

Witness

Date

Resident/Guardian

Date



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Resident Name:

Room No.

PERSONAL PROPERTY

All residents of the facility can avail themselves of locked storage space for personal property (jewelry, money, personal items). The facility will provide locked storage space in the resident's room, upon request. Residents may also request that personal property be held for safekeeping in the Business office safe.

We also suggest that residents do not keep large sums of money in their rooms. Personal funds can always be withdrawn as needed during regular business hours through the business office on the first floor. Social work staff is always available to discuss any questions you may have relative to property needs and storage.

We ask that you adhere to these requirements since the facility will not be liable for the loss of a resident's property not safeguarded in the above listed ways.

In addition, the Facility reserves the right to remove personal items that do not conform with National Fire Protection Agency/Life Safety requirements. Such items include but are not limited to wall curtains, holiday decorations, recliner chairs, etc. Any furnishings/decorations brought into a resident's room should be cleared by our Engineering Department.

X

Resident/Designated Representative

X

Date

Facility Representative

Date



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STATEMENT OF RESIDENT RIGHTS

INTRODUCTION

The facility shall insure that all residents are afforded their rights to a dignified existence, self-determination, respect, full recognition of their individuality, consideration of privacy in treatment, and care for personal needs and communication with and access to persons and services inside and outside the facility. The facility shall protect and promote the rights of each resident and shall encourage and assist each resident in the fullest possible exercise of these rights.

I. PROTECTION OF LEGAL RIGHTS

- Each resident shall have the right to exercise his/her rights as a resident of the facility and as a citizen or resident of the United States and New York State, including the right to vote, with access arranged by the facility, and to this end may voice grievances without his/her right to adequate and proper treatment and care established by any applicable statute, rule, regulation or contract.
- Each resident shall have the right to recommend changes in policies and services to the facility staff and/or to any outside representatives free of interference, coercion, discrimination, restraint or reprisal from the facility, and to obtain prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.
- Each resident shall have the right to exercise his/her individual rights or have his/her rights exercised by a person authorized by state law.
- Each resident shall have the right to inspect and purchase, at cost of production not exceeding the cost incurred by the provider, photocopies of all records pertaining to the resident, upon written request and 48 hours to notify the facility or such greater period as state statute may permit.
- Each resident shall have the right to examine the results of the most recent survey of the facility conducted by Federal or state surveyors, including any statement of deficiencies, any plan of correction in effect with respect to the facility, and any enforcement actions taken by the Department of Health. The facility shall also post the survey results in a place readily accessible to residents.
- Each resident shall have the right to receive information from agencies acting as resident advocates and be afforded the opportunity to contact these agencies.
- Each resident shall have the right to be free from verbal, sexual, mental, or physical abuse; free from corporal punishment and involuntary seclusion; and free from chemical and physical restraints, except the restraints authorized in accordance with the New York State Health Code.
- Each resident shall have the right to exercise his/her civil and religious liberties, including the right to independent personal decisions and knowledge of available choice, which will not be infringed.
- Each resident shall have the right to request, or have the resident's Designated Representative request, and be provided information concerning his/her specific assignment to a patient classification category contained in the "Patient Categories and Case Mix Indices Under Resource Utilization Group (RUG-11) Classification System."

II. RIGHT TO PRIVACY

- Each resident shall have the right to personal privacy and confidentiality of his/her personal and clinical records, which shall reflect the following:
 1. Accommodations, medical treatment, written and telephone communications, personal care, associations and communications with persons of his/her choice, visits, meeting of family and resident groups. Resident and family groups shall be provided with private meeting space, and resident shall be given access to a private area for visits or solitude. Such requirements shall not require the facility to provide a private room for each resident.
 2. The resident's right to approve or refuse the release of his/her personal and clinical records to any individual outside the facility, except when:
 - (a) The resident is transferred to another health care institution;
 - (b) Record release is required by law or third-party contract.
- Each resident shall have the right to private written communications including:
 1. The right to send and receive mail promptly that is unopened.
 2. The right to have access to stationary, postage, and writing implements at the resident's own expense.
- Each resident shall have the right to regular access to the private use of a telephone that is wheelchair accessible and usable by hearing impaired and/or visually impaired residents.

III. RIGHT TO CLINICAL CARE AND TREATMENT

- Each resident has the right to adequate and appropriate medical care, and to be fully informed by a physician (in the language or in the form that the resident can understand, using an interpreter when necessary) on his/her total health status, including, but not limited to his/her medical condition, diagnosis, prognosis, and treatment plan. The resident shall have the right to ask questions and have them answered.
- Each resident shall have the right to refuse to participate in experimental research and to refuse medication and treatment after being fully informed and understanding the probable consequences of such actions.
- Each resident shall have the right to choose a personal attending physician from among those who agree to abide by all Federal and State regulations, and who are permitted to practice in the facility.

- Each resident shall have the right to be fully informed in advance about his/her care and treatment and about any changes in care or treatment that may affect the resident's well-being.
- Each resident shall have the right to participate in planning his/her care and treatment or any changes in his/her care and treatment. A resident adjudged incompetent or otherwise found to be incapacitated under the laws of the State of New York shall have such rights exercised by a Designated Representative who will act on the resident's behalf in accordance to state law.
- Each resident shall have the right to self-administer drugs, unless the Interdisciplinary Team has determined for each resident that this practice is unsafe.

IV. RESIDENTIAL RIGHTS

- Each resident shall have the right to refuse to perform services for the facility. The resident, if he/she chooses, may perform such services only when:
 1. There is work available in the facility that the resident is capable of performing.
 2. The facility has documented the need or desire for work in the resident's Plan of Care.
 3. The Plan of Care specifies the nature of the services performed and whether the services are voluntary or paid.
 4. Compensation for paid services is at or above prevailing rates.
 5. The resident agrees to the work arrangement described in the Plan of Care.
- Each resident shall have the right to retain, store securely, and use personal possessions (including some furnishings) and appropriate clothing, as space permits, unless to do so would infringe upon the rights of health and safety of the resident or of other residents—in which case the facility shall explore alternatives through discussion with the resident, the Resident Council or the Interdisciplinary Team and provide or assist in the arrangement of storage for possessions. The resident shall have the right to locked storage space in his/her room.
- Each resident shall have the right to share a room with her/his spouse, relative, or partner when these residents live in the same facility and both consent to the arrangement. If a spouse, relative, or partner resides in a location out of the facility, the resident shall be assured of privacy for his/her visits.
- Each resident shall have the right to participate in the established Resident Council.
- Each resident shall have the right to meet with and participate in activities of social, religious, and community groups at his/her discretion.
- Each resident shall have the right to receive, upon his/her request, kosher food, or food products prepared with the Hebrew Orthodox religious requirements, when the resident, as a matter of religious belief, desires to observe Jewish Dietary laws.

V. FINANCIAL AFFAIRS

- Each resident shall have the right to manage his/her financial affairs or to authorize, *in writing*, the facility manages his/her personal finances.

VI. TRANSFER AND DISCHARGE RIGHTS

- Each resident shall have the right to remain in the facility, and not be summarily transferred or discharged from the facility.
- Each resident shall have the right to be notified – or have his/her designated representative notified – of a transfer or discharge and the reasons therefore, at least 30 days before his/her transfer or discharge under any of the following circumstances:
 1. The safety of the individuals in the facility would be endangered;
 2. The health of individuals in the facility would be endangered;
 3. The resident health improves sufficiently to allow a more immediate transfer or discharge;
 4. An immediate transfer or discharge is required for the resident's medical needs; and
 5. The transfer discharge is being made in compliance with a request by the resident.
- Each resident shall have the right to appeal his/her transfer or discharge through the appropriate agency as designated by law.
- Each resident has the right to an on-site pre-transfer hearing under the auspices designated by law, provided that the resident has appealed the transfer or discharge within 15 days of receiving transfer or discharge notice, except in cases involving imminent dangers to others in the facility.
- Each resident shall have the right to: (1) remain in the facility pending an appeal determination; (2) a post-transfer or post-discharge hearing within 30 days of the discharge if the resident did not request a hearing prior to his/her transfer or discharge; and (3) the right to return to the facility, to the first available bed if the resident wins the appeal.
- Each resident shall have the right to examine his/her medical records.

This facility's *Resident Rights/Facility Responsibilities Manual* is available for review on request of a resident and/or resident's Designated Representative.

I have received a copy of the "Statement of Resident Rights."

X
 Signature: _____ Date: _____
 X

(Print Name)

Check one: Resident Family Member Other

"Family Member" or "Other" provide details of relationship to Resident: _____

Witness Signature: _____ Date: _____

(Print Name)

QUEENS BOULEVARD EXTENDED CARE FACILITY

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS FORM PROVIDES YOU WITH ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY**

(Sections 1819(f), 1918, 1819(b) (3) (A), 1919(b) (A), 1804 and Social Security Act.)

Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain interaction from every resident. This information also is used by the Federal Center for Medicare and Medicaid Services (Formerly, the Health Care Financing Administration) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all the facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the CMS contractor in the State government, which in turn transmits this information to CMS.

Because the law requires disclosure of this information to the Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long Term Care System of Records.

2. **PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED**

The information is to be used to track changes in health and functional status (of residents) over time for purposes of evaluating and improving the quality of care provided by nursing homes that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing home to receive reimbursement for Medicare Services.

3. **ROUTINE USES**

The primary use of the (assessment) information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy and research functions. This system will collect the

minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1516. Information from this system may be disclosed, under specific circumstances to:

- (1) A congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of that individual;
- (2) The Federal Bureau of Census;
- (3) The Federal Department of Justice;
- (4) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health;
- (5) Contractors working for CMS to carry out Medicare/Medicaid functions, collating or analyzing data or to detect fraud or abuse;
- (6) An agency of a State Government for purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State;
- (7) Another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds or to detect fraud or abuse;
- (8) Peer Review Organizations to perform Title XI or Title XVIII functions;
- (9) Another entity that makes payment for or oversees administration of health care services for preventing fraud or abuse under specific conditions.

4. **EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION.**

The information contained in the Long-Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

- I have been advised of the foregoing information.
 A copy of the Privacy Act Statement was supplied to the Resident Representative at time of admission.

X _____ X _____
Signature of Resident/Representative Date

Signature of Facility Representative Date



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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Resident Name _____

Social Security Number _____

Date of Birth _____

I, hereby authorize _____, to disclose my individual identifiable
(Name of Health Care Provider)

health information as described below (please initial):

Transfer Summary

Consults

Nurses Notes

Physicians Orders

Physicians Progress Notes

Rehab Notes

Immunization

X-Ray Reports

Lab Reports

Other _____

Purpose for which records will be used: _____ Follow up care _____ Legal Review

I am requesting the following medical record(s) dated: ___/___/___ to ___/___/___.

Name and address of person(s) or organization(s) requesting record, if different than resident

Name and address of person(s) and organization(s) to receive records:

Queens Boulevard Extended Care Facility

61-11 Queens Boulevard

Woodside, NY 11377

Telephone: (718) 205-0288

Fax: (718) 205-0667

Please fax requested information

I wish to have the following records copied.
I will pick them up at the facility

I am requesting an appointment
to review the records

I am requesting the facility copy the following
records and send the records to the above address

AUTHORITY FOR REQUEST (PLEASE INDICATE)

- I am the Resident noted above.
- I am the Resident’s Designated Representative.
- I am the resident’s attorney-in-fact, and I have attached to this authorization a valid power of attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the resident’s medical records. I understand that the resident’s DPAHC is effective only when the resident’s attending physician has determined that the resident has lost the capacity to make informed health care decisions.
- I am the resident’s legal guardian, and I have attached to this authorization a valid appointment of guardianship from the probate court.
- If the resident is deceased: I am the executor/administrator of the resident’s estate, and I have attached to this authorization a valid appointment as such from the probate court.
- The resident has executed a legally binding instrument granting me the authority to obtain his/her medical records, and I have attached a copy of that instrument to this authorization.
- The resident’s legally authorized representative has executed a legally binding instrument granting me the authority to obtain the resident’s medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so (e.g., a power of attorney or probate court order).

UNDERSTANDINGS AND AGREEMENTS OF REQUESTOR

1. This authorization is voluntary and I understand that the facility cannot condition treatment based on the signing of this authorization, unless the authorization is (a) for research-related, or (b) solely for the purpose of creating health information for the use or disclosure to a third party.
2. This authorization will expire ____ days from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against the facility for the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the facility.
6. I understand that I must provide the facility with at least twenty-four (24) hours’ notice before coming to the facility to review records.
7. I understand that after I have reviewed the records, I must provide the facility with at least two (2) working days advance notice of any copies of the records that I would like to pick up at the facility.
8. I understand that if I request that records be copied and sent to me that the facility will make a good faith effort to send those records to me in a reasonable amount of time.
9. I understand that if I wish to have copies of records made, then the facility will assess a fee for copying the records.
10. The facility will notify me of the total amount due for copying and shipping of the requested records; I agree that the facility will only send me the requested information once it has received payment in full for those records.

X

X

Signature of the Patient/Personal Representative

Date

Personal Representative & Relationship to Patient

Sworn or Affirmed to before me
On this ____ day of ___. 20__

Witness or Notary Public

WITNESS or NOTARY (This authorization must be notarized if completed and signed away from Facility)

QUEENS BOULEVARD EXTENDED CARE FACILITY

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*

ADDENDUM I

Social Security Administration Direct Deposit Sign-Up Form

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.

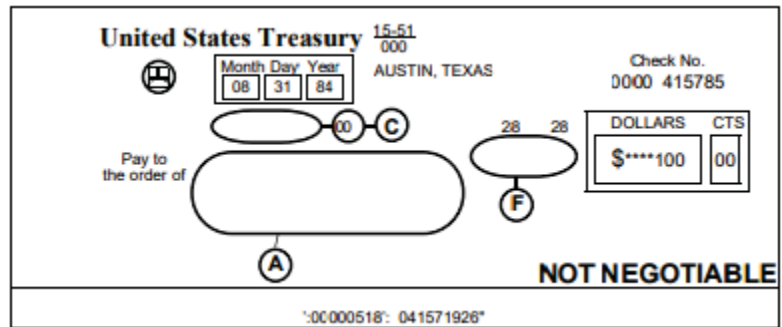
PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 208 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:

- A** Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.
- C** 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.
- F** 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 contact the paying agency with updated financial account information. It is recommended that the payee maintain accounts at both financial institutions until the transaction 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.

ADDENDUM II

QUEENS BOULEVARD EXTENDED CARE FACILITY

Request to Maintain Resident's Personal Needs Account

Resident Name: _____

MR / ID #: _____

The Resident, Sponsor, and/or the Resident Representative can request that Queens Boulevard Extended Care Facility (“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 on 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 of Queens Boulevard Extended Care Facility (“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 and other information by the Provider and/or Facility, which is necessary to claim and receive such payments on 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 Queens Boulevard Extended Care Facility Management LLC (“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 waive 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 Queens Boulevard Extended Care Facility (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 my personal records that are 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 WHEN ACCOMPANIED BY AN ORIGINAL COVER LETTER FROM THE FIRM OF ABRAMS, FENSTERMAN, FENSTERMAN, EISMAN, GREENBERG, FORMATO & EINIGER, LLP.

Authorization to Apply for Medicaid on My Behalf

I. Facility and Consumer Information

A. Consumer Information:

Consumer's Name: _____ SSN: XXX-XX-_____

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

Community Address: _____

B. Facility Information:

Facility Name: _____

Address: _____

Facility Contact Person: _____

Position/Title: _____

II. Reason for Submission

_____, hereby authorizes Queens Boulevard Extended Care Facility 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 Medical 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 the 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)

**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.*

**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 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 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	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>

II. INFORMATION FOR APPLICANT'S SPOUSE

Spouse's Name	Last Name	First Name	Middle Initial
Maiden Name or Other Name Known By	<input type="text"/>		
Social Security Number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	Number	Street	Apartment 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 applicant.*

Submission of Application on Behalf of Applicant

**COMPLETE THIS FORM IF SOMEONE OTHER THAN
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 to Medicaid on his/her behalf.

SECTION A APPLICANT INFORMATION

Applicant's Name	Last Name	First Name	Middle Initial
Social Security Number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Name of Person Signing Application	Last Name	First Name	
Relationship to Applicant	<input type="text"/>	Phone <input type="text"/>	
Address	Number	Street	Apartment 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	<input type="text"/>		
Address	Number	Street	Apartment Number
	City	State	Zip Code
Name of Representative	Last Name	First Name	
Title	<input type="text"/>	Phone <input type="text"/>	

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 _____

CERTIFICATION

The rules of the Medicaid program have been explained to me by the facility. In response to same, I, _____, do hereby certify that all information disclosed to and relied upon by the facility on behalf of _____ is true and
(Resident's Name)
accurate. No information that would bear on the resident's present or future eligibility for Medical Assistance has been withheld.

Date: _____

X

Print Name

X

Signature

ADDENDUM VI

QUEENS BOULEVARD EXTENDED CARE FACILITY

Bed Reservation (Bed Hold) Policy and Procedures (Effective May 29, 2019)

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 and signing a bed hold reservation form with the Admission Department stating their intent to hold, and pay for, for the 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 of discontinuance by the resident/designated representative 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 (1) residents under 21 years of age for temporary hospitalization and therapeutic leave; (2) residents 21 and over who are receiving hospice services for temporary hospitalization. The Medicaid bed hold is limited to fourteen (14) days in any twelve (12) month period; (3) residents 21 and over for non-hospitalization therapeutic leaves of absence ("Therapeutic Leave"). The Medicaid bed hold for Therapeutic Leave is limited to ten (10) days in a twelve (12) month period.

There is no Medicaid paid bed hold for resident 21 years of age and older who is temporarily hospitalized unless such resident is receiving hospice services within the Facility.

Medicaid recipients who are not eligible for bed hold or whose bed hold has expired or has been terminated, may elect to reserve/hold the same bed in the Facility by notifying the Admission Department and signing the Advance Bed Hold Reservation Form with the Admission Department stating their intent to hold the bed at the Facility and paying the Facility its private pay rate.

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 if the resident requires the services provided by the facility and is eligible for Medicaid nursing home services, 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 (718) 205-0288 Ext. 253.

QUEENS BOULEVARD EXTENDED CARE FACILITY
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 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

QUEENS BOULEVARD EXTENDED CARE FACILITY

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

ATTACHMENT "C"

AUTHORIZATION TO ACT AS REPRESENTATIVE
and
AUTHORIZATION FOR RELEASE OF FINANCIAL RECORDS

I hereby authorize Queens Boulevard Extended Care Facility Management LLC, and/or any representative thereof, to represent me in all matters pertaining to my eligibility to receive, and any application for, government benefits, including, but not limited to, Social Security Disability benefits, Supplemental Security Income benefits, and Medical Assistance ("Medicaid") benefits.

In connection therewith, I hereby authorize the release of any and all of my financial records to Queens Boulevard Extended Care Facility Management LLC, and/or any representative thereof, including all bank statements, be they monthly, quarterly or annual statements, brokerage account statements and mutual fund account statements from all banks and other financial institutions wherein I maintain or maintained an account during the past five (5) years.

X

Resident's Signature

X

Date

Signature of Resident Representative

Date

Sworn to me this _____

Day of _____, 20____

Notary Public

AUTHORIZATION TO ACT AS REPRESENTATIVE

I do hereby consent to and authorize Queens Boulevard Extended Care Facility Management LLC and/or any representative thereof, to represent me in all matters pertaining to my eligibility to receive any application for, government benefits, including, but not limited to, my application for Medical assistance benefits and related follow up matters/activities.

X

Resident's Signature

X

Date

Signature of Resident Representative

Date

AUTHORIZATION TO CONSENT TO PURSUE HARDSHIP WAIVER

I do hereby consent to and authorize Queens Boulevard Extended Care Facility Management LLC and/or any representative thereof to represent me in a hardship waiver application and proceeding, including any appeal thereof, pursuant to the Deficit Reduction Act of 2005 (Sec. 6011(d)) where the application of the Medicaid transfer of assets provisions would deprive me of medical care such that my health of life would be endangered or I would be deprived of food, clothing, shelter or other necessities of life.

X

Resident's Signature

Signature of Resident Representative

X

Date

Date

AUTHORIZATION TO ACT AS REPRESENTATIVE
AT FAIR HEARING

I hereby authorize Queens Boulevard Extended Care Facility Management LLC and/or any representative thereof, to represent me in all matters pertaining to my eligibility to receive, and any application for, government benefits, including, but not limited to, my application for Medical Assistance benefits (“Medicaid”) and related follow-up activities, including representation at Fair Hearing or other Court proceeding (i.e. Article 78 proceeding). This authorization shall survive my incapacity and/or death.

X

Resident’s Signature

X

Date

Signature of Resident Representative

Date

**ARBITRATION AGREEMENT
VOLUNTARY AGREEMENT TO ARBITRATE**

**THIS AGREEMENT GOVERNS IMPORTANT LEGAL RIGHTS. PLEASE READ IT
CAREFULLY BEFORE SIGNING.**

This is a voluntary agreement to resolve any dispute that may arise in the future between the parties under the American Health Lawyers Association's Rules of Procedure for Arbitration. In arbitration, a neutral third party chosen by the parties issues a final, binding decision. When parties agree to arbitrate, they waive their right to a trial by jury and the possibility of an appeal.

The Facility will provide you with the same care or treatment, without delay, even if this Voluntary Agreement to Arbitrate is not signed.

This Voluntary Agreement to Arbitrate may be revoked within 10 days after being signed.
Otherwise this Agreement will be given full force and effect.

NOTICE: BY SIGNING THIS AGREEMENT, THE PARTIES TO THIS CONTRACT ARE WAIVING ALL OF THEIR RIGHTS TO HAVE ANY DISPUTE BETWEEN THEM DECIDED IN A COURT OF LAW BEFORE A JUDGE OR JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

What is Arbitration? Arbitration is generally a cost effective and time-saving method of resolving disputes without involving the courts. In Arbitration, the disputes are heard and decided by a private individual or individuals, called an arbitrator. The dispute will not be heard or decided by a judge or jury.

Article 1: Binding Agreement to Arbitrate: It is understood that any action, dispute, claim, or controversy of any kind, whether in contract or tort, statutory or common law, legal or equitable, or otherwise, now existing or hereafter arising between the Parties involving, related to or arising from (a) the provision of health care, nursing services and/or any other goods or services to the Resident by the Facility, its affiliates, agents, servants, employees, independent contractors, agents and/or representatives and (b) any survival action or wrongful death claim, shall be resolved by binding arbitration (the "Arbitration") and not by a lawsuit, or other resort to court process, except to the extent that applicable state or federal law provides for judicial review of arbitration proceedings or judicial enforcement of arbitration awards. Notwithstanding the previous statement, the Parties agree that any claims brought by the Facility for the collection of unpaid bills by the Resident or any payor may, in the Facility's sole discretion, be pursued through legal action in a New York State Court of Law.

Article 2: Binding Effect. It is the intention of the Parties to this Agreement that this Agreement shall inure to the direct benefit of, whether signatories to this Agreement or not, and bind the Parties, including the Resident, any parent, spouse, child, guardian, executor, administrator, legal representative, or heir of the Resident, as well as any survivor or wrongful death claim, Power of Attorney, Designated Representative, Health Care Proxy, and any person who executed this Agreement or the Admission Agreement on behalf of the Resident, and all persons whose claims derive through, or on behalf of, the Resident, and the Facility, its agents, employees, servants, contractors, directors, members, board, affiliates, management company, parents and associated entities.

Article 3: Arbitration of All Claims: Except as provided herein, the Parties agree that any and all claims, disputes, controversies, based upon the same incident, transaction, or related circumstance shall be arbitrated in one proceeding. A claim shall be waived and forever barred if on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable statute of limitations, or the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 3b: Small Claims Opt Out: Regardless of any contract provision to the contrary, any party to this Agreement, may opt to file in a small claims court with jurisdiction over a dispute rather than file an arbitration claim.

Article 4: Grievance: Notwithstanding the provisions of Articles 1 and 2, nothing in this Agreement prohibits or discourages the Resident or anyone else acting on the Resident's behalf, from communicating with federal, state, or local officials, including federal and state surveyors, other federal or state health department employees, or representatives of the State Long-Term Care Ombudsman.

Article 5: Federal Arbitration Act Applicable: The Parties agree that the provision of health care services is a commercial transaction involving interstate commerce and the agreement to arbitrate herein is presumptively valid, irrevocable and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract. The Parties also agree that the Federal Arbitration Act applies to this Agreement and pre-empts any state law to the contrary.

Article 6: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all Parties. Any demand for arbitration shall state (i) the claim asserted, (ii) the facts alleged to support the Claim, and (iii) the remedy being sought. Any such arbitration claim shall be resolved by binding arbitration administered by the American Arbitration Association (“AAA”) under the AAA Rules and Procedures then in effect. If the AAA does not enforce pre-dispute arbitration agreements, then any other reasonably comparable arbitration association chosen solely by the Facility shall be an acceptable replacement. Any dispute arising out of or relating to this contract or the subject matter thereof, or any breach of this contract, including any dispute regarding the scope of this clause will be resolved through arbitration administered by the American Health Lawyers Association Dispute Resolution Service and conducted pursuant to the AHLA Rules of Procedure for Arbitration. Judgment on the award may be entered and enforced in any court having jurisdiction.

Article 7: Place of Arbitration: The seat or place of arbitration shall be «venue» County, New York.

Article 8: Costs of Arbitration: Each Party shall pay their own costs and expenses of the Arbitration, except where the Arbitrator determines that the Resident's claim is frivolous, the apportionment of such costs is prohibited by applicable law, or the arbitrator determines it fair to require the parties to split arbitration costs.

Article 9: Rights of Parties: Each party shall have the right a) to assert in arbitration any claims or defenses which could be raised in a court of competent jurisdiction; and b) counsel of his/her or its choice. The party that raises a claim in the arbitration shall bear the burden of proof with respect to the claim unless prohibited by applicable law. The extent of discovery, if any, shall be determined by the Arbitrator.

Article 10: Motion to Compel Arbitration: If any party is required to file a lawsuit to compel arbitration pursuant to this Agreement, or defend against a lawsuit filed in court contrary to this Agreement's mandatory arbitration provision, such Party, if successful, shall be entitled to recover such party's reasonable costs and attorneys' fees incurred in such an action, including costs and attorneys' fees incurred in any appeal. The Resident and Facility hereby expressly agree that judicial review as to a motion to compel arbitration or similar petition shall be limited to the determination of whether a valid agreement to arbitrate exists. All other disputes shall be determined solely by the Arbitrator.

Article 11: Damages: The Parties agree that damages awarded, if any, in the arbitration shall be determined in accordance with the provisions of the state or federal law applicable to a comparable civil action including any statutory caps or limitations on such damages. It is further agreed that the Arbitrator will have no authority to award punitive or other damages not measured by the prevailing party's actual damages, except as may be required by statute. The decision of the Arbitrator shall be final and binding on the parties except to the extent that applicable state or federal law provides for judicial review of arbitration proceedings or judicial enforcement of arbitration awards.

Article 12: Confidentiality: The Parties agree that except as may be required by law, neither Party, nor the Arbitrator, may disclose the existence, content, or results of any arbitration hereunder without the prior written consent of the parties.

Article 13: Rights of the Resident: By execution of this Agreement, it is understood and warranted that (1) the Resident and/or Resident's Authorized Representative has received a copy of this Agreement and has had an opportunity to read the Agreement and ask questions about the Agreement before signing; (2) The Resident and/or Authorized Representative has the right to seek legal counsel concerning the terms of this Agreement.

Article 14: Revocation: This Agreement may be revoked by written notice delivered to the Facility within ten (10) days of signature otherwise this Agreement will be given full force and effect.

Article 15: Retroactive effect: It is intended that this Agreement govern services rendered from the date of admission regardless of the date upon which the Agreement was signed.

Article 16: Modification of Agreement Prohibited: This Agreement cannot be modified except in writing signed by both Resident and the Facility and supersedes any and all other agreements, either oral or in writing, express or implied, between the Resident and the Facility relating to dispute resolution.

Article 17: Severability: If any term, provision, subparagraph, paragraph or section of this Agreement is adjudged by any court to be void or unenforceable in whole or in part, this adjudication shall not affect the validity of the remainder of this Agreement, including any other term, provision, subparagraph, paragraph or section. To the extent unenforceable, the Arbitrator may sever any term or portion of this Agreement, and such severance shall not affect the validity of the remainder of this Agreement.

Article 18: Mutual Consideration: The Parties recognize the potential cost-effectiveness and time-savings offered by arbitration, which seeks to avoid the expense, delay and uncertainty associated with the court system. The Facility has therefore adopted arbitration as the preferred means of resolving disputes. Additionally, the Parties recognize that often, the Resident is elderly and may have a limited life expectancy, and therefore, selecting a faster method of resolution than the Court system is potentially to the Resident's advantage.

Article 19: Facility Obligations: By choosing to ask Resident and/or Resident's Authorized Representative to enter into this Agreement for binding arbitration, Facility warrants that:

- i. The Agreement for binding arbitration is in plain language.
- ii. The Agreement has been explained to the Resident and his or her representative in a form and manner and language that the Resident and his or her representative understands;
- iii. The Resident acknowledged that he or she understands the Agreement; and
- iv. In the event that the Facility and the Resident resolve a dispute through arbitration, a copy of the signed Agreement for binding arbitration and the Arbitrator's final decision will be retained by the facility for 5 years and be available for inspection upon request by CMS or its designee.

Article 20: Section Headings: The section headings of this Arbitration Agreement are intended solely for the convenience of reference and shall not in any manner amplify, limit, modify or otherwise be used in interpretation of any provision herein.

Article 21: Construction: The Arbitration Agreement shall not be interpreted for or against any Party on the basis that such Party caused part or all of this Agreement to be drafted. The term “Resident”, shall also be included to mean Resident’s Authorized Representative, Agent and/or Health Care Proxy where applicable.

Article 22: Capacity: In the event that the Resident lacks capacity to understand the terms of this Agreement or execute it, Resident’s Authorized Representative, upon signing below, certifies that she or he is a person authorized by the Resident or otherwise authorized by law to execute this binding Arbitration Agreement.

Article 23: Manner of Acceptance: Acceptance of this binding Arbitration Agreement can be accomplished by signing below; or by any other manner of acceptance recognized by law or contract.

Article 24: Waiver: Any waiver by either party to this Agreement of a breach of any term or condition of this Agreement shall not constitute a waiver of any subsequent breach of the same or any other term or condition of this Agreement.

NOTICE: BY SIGNING THIS AGREEMENT, THE PARTIES TO THIS CONTRACT ARE WAIVING ALL OF THEIR RIGHTS TO HAVE ANY DISPUTE BETWEEN THEM DECIDED IN A COURT OF LAW BEFORE A JUDGE OR JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

In Witness thereof, the Parties have signed and sealed this Agreement as of the _____ day of, _____, 20_____.

Resident

Print Resident’s Name: _____

Resident’s Signature: _____

Print Name of Resident’s Authorized Representative _____

Signature of Resident’s Authorized Representative _____

Facility: Queens Boulevard Extended Care Facility Management LLC

d/b/a Queens Boulevard Extended Care Facility

By: _____

Title: _____

Daily rates:

Semi-Private Room: \$500 per day (private pay)

Private Room: \$550 per day (private pay)

Executive info:

Anthony Clemenza Jr. (managing partner)

James Clemenza (managing partner)