

Daughters of Sarah Nursing Center, Inc.

AUTHORIZATIONS (CHECK ALL APPROPRIATE BOXES)

RESIDENT NAME: _____ ROOM NUMBER: # _____

OPTOMETRY

- I hereby authorize the optometrist provider credentialed by the Center to provide eye care as necessary while I am a resident at the Center.
- I choose to select an eye doctor outside of the Center. (I understand that, in making this selection, I will be responsible for any expense of such services, and will have to make all transportation arrangements.)

DENTISTRY

- I hereby authorize the dental provider credentialed by the Center to provide routine and emergency dental care as necessary while I am a resident at the Center.
- I choose to select a dentist outside of the Center. (I understand that, in making this selection, I will be responsible for any expense of such services, and will have to make all transportation arrangements.)

DENTURES (At all times, the Resident will remain fully responsible for the dentures in the event of a loss.)

- I wish to have my dentures labeled free of charge.
- I do not want to have my dentures labeled.
- Not Applicable.

PRIMARY CARE PHYSICIAN (For Residents Covered by a Managed Care Health Plan)

- I hereby request that _____ change my Primary Care Physician to Dr. _____ (Provider #: _____) effective immediately.
Member ID #: _____
- Not Applicable.

Signature of Resident or Authorized Representative

Date

(If Attorney-In-Fact, check here , and attach a copy of the Power of Attorney)

Daughters of Sarah Nursing Center, Inc.

CONSENTS/AGREEMENTS

(CHECK ALL APPROPRIATE BOXES)

RESIDENT NAME: _____ ROOM NUMBER: # _____

INSURANCE

- The Center will make every attempt to have skilled services authorized by all of your applicable insurance companies. If any of your companies fails to authorize or pay for such services, you hereby agree to pay for such charges in full.

SMOKING POLICY

- The Center is a **smoke-free** workplace. The following smoking guidelines shall apply:
- ❖ Residents may smoke only in designated areas.
 - ❖ Family members who accompany residents to designated smoking areas may only smoke while at the location with the resident.

ANCILLARY MONTHLY BILLS

- I hereby authorize the Center to pay the following bills from my Resident Trust Account, but only to the extent adequate funds are on deposit in the account:
- Verizon or other telephone service: _____
 - Time Warner Cablevision
 - Newspaper delivery with: _____
 - Other: _____
- I hereby agree to assume all responsibility for the payment of ancillary monthly bills.

DRESSER / CLOSET LOCK

- I do / do not want to receive a key for my bed side dresser. (Check one.)
- I do / do not want to receive a key for my closet. (Check one.)

Signature of Resident or Authorized Representative

Date

(If Attorney-In-Fact, check here , and attach a copy of the Power of Attorney)

Daughters of Sarah Nursing Center, Inc.

DISCLOSURES

RESIDENT NAME: _____ ROOM NUMBER: # _____

MEDICARE COVERAGE

Provided that the type and nature of the care you require qualifies under Medicare criteria, Medicare may cover your care for **up to** 100 days in a benefit period (which “benefit period” must be preceded by a 3-day qualifying hospital stay). Medicare coverage will end if you use up all 100 days in the benefit period, **or** you no longer meet the Medicare criteria for care needs.

Medicare provides structured guidelines as to the necessity of qualified care, which our staff must follow. Please note that, as a result, the necessity to receive Medicare care could end anywhere within the 100 day period. At such time that you no longer meet the Medicare guidelines, the Center will give a much notice as possible given your medical progress.

If Medicare does apply, the first 20 days of care are paid in full by Medicare Part A. Thereafter, you will be liable for payment of a co-insurance amount, which will be billed to you.

PRIVACY RIGHTS

Daughters of Sarah Nursing Center respects the privacy of your medical records, and we will take all reasonable precautions to secure and protect that privacy. Only when we deem it appropriate and necessary, we will provide the minimum needed information to those we feel are in need of your health care information for the purposes of treatment, payment, or health care operations. We also want you to know that we support your full access to your personal medical records in accordance with applicable provisions of the law.

The Center has prepared a “**Notice of Privacy Practices**”, a copy of which you hereby acknowledge has been provided to you. This notice outlines the Center’s practices and policies regarding your Personal Health Information (“PHI”). The Center reserves the right to amend its privacy practices at any time. If the privacy practices are amended, a revised Notice will be posted in the Center. Further, you may request a copy of the current **Notice of Privacy Practices** from the Privacy Officer at any time.

You may refuse to consent to the use or disclosure of your PHI or you may request that restrictions be made, but you must do in writing. However, if you refuse to disclose your PHI, we have the right to decline to treat you. If you consent to disclose your PHI, you may elect in the future to refuse to allow disclosure, but you may not revoke actions that were taken in reliance upon a previously signed consent.

I acknowledge receipt of the above Disclosures, receipt of the **Notice of Privacy Practices**, and I hereby consent to the disclosure of my Personal Health Information.

Signature of Resident or Authorized Representative

Date

Daughters of Sarah Nursing Center, Inc.

RELEASES

(CHECK ALL APPROPRIATE BOXES)

RESIDENT NAME: _____ ROOM NUMBER: # _____

RELIGIOUS WORSHIP

- I hereby give the Center permission to release my name to my place of worship.

Place of Worship: _____

Clergy name: _____

- I hereby give the Center permission to release my name to the Catholic Eucharistic Minister for purposes of receiving Communion/Sacrament of the Sick.
- Please do not release my name / I am not affiliated with any place of worship.

USE OF PHOTOGRAPHS

- I hereby consent to the use by the Center of photographs of myself for general publication in newsletters, distribution with press releases, and/or for use in brochures.
- I hereby decline to allow my photograph to be used by the Center for publication. (I recognize that my photograph must still be taken by the Center upon my admission for internal identification purposes.)

RESIDENT TRUST ACCOUNTS

- I request that quarterly statements be delivered to the Resident.
- I request that quarterly statements be sent to the following designee:

Signature of Resident or Authorized Representative

Date

(If Attorney-In-Fact, check here , and attach a copy of the Power of Attorney)

Daughters of Sarah Nursing Center, Inc.
INFORMATION RELEASE
(CHECK ALL APPROPRIATE BOXES)

RESIDENT NAME: _____ ROOM NUMBER: # _____

RELEASE OF MEDICAID INFORMATION

- I hereby authorize the _____ County Department of Social Services (hereafter the "Department") to release information about the above named Resident's Medicaid case to: **DAUGHTERS OF SARAH NURSING CENTER, INC.** having a place of business at 180 Washington Avenue Extension, Albany, New York 12203, or its agents (hereafter the "Facility").

This information may be used by the Facility to assist the Resident in obtaining Medicaid eligibility and annual Medicaid recertification. This information may include, but is not restricted to, income and resource information related to my Medical Assistance case.

RELEASE OF FINANCIAL INFORMATION

- I hereby authorize and direct any banking or financial institution, any mutual fund, any investment broker, advisor or manager, or any trustee or administrator of any pension fund (hereafter the "Institution") with whom the above named Resident currently maintains, or at any time within the five (5) years prior to the date of this Release has maintained, any banking or investment account to release copies of any of the Resident's banking records, investment records and other financial information in possession of the Institution to:

DAUGHTERS OF SARAH NURSING CENTER, INC. having a place of business at 180 Washington Avenue Extension, Albany, New York 12203, or its agents (hereafter the "Facility").

This information may be used by the Facility to assist the Resident in obtaining Medicaid eligibility and annual Medicaid recertification. This information may include, but is not restricted to, checking accounts, savings accounts, mutual fund accounts, purchase and sale records, pension or other tax deferred accounts, and tax reporting forms (1099's, etc.).

MEDICAID HARDSHIP APPLICATION

- If I am unable to qualify for Medicaid benefits due to an uncompensated transfer I may have made, in addition to any rights I may have to so apply, I hereby authorize Daughters of Sarah Nursing Center, Inc. to make application on my behalf to the Office of Social Services for the appropriate county for any available Undue Hardship Waiver. In granting this authorization I recognize that the Center is not promising that it will make any such application; that the Center may do so solely in its discretion; and that the Center will have no obligation or liability to me if it elects not to so apply.

Signature of Resident or Authorized Representative

Date

(If Attorney-In-Fact, check here , and attach a copy of the Power of Attorney)

Daughters of Sarah Nursing Center, Inc.

STATEMENT TO PERMIT PAYMENTS TO FACILITY

(CHECK ALL APPROPRIATE BOXES)

(Name of Resident)

(Medicare Number/ Insurance ID)

PAYMENT OF MEDICARE BENEFIT TO PROVIDER, PHYSICIANS AND RESIDENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Daughters of Sarah Nursing Center, Inc., including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services (and its agents) any information needed to determine these benefits or benefits for related services.

PAYMENT OF NO FAULT BENEFIT TO PROVIDER, PHYSICIANS AND RESIDENT

I request that payment of authorized no fault benefits be made either to me or on my behalf for any services furnished to me by or in Daughters of Sarah Nursing Center, Inc., including physician services. I authorize any holder of medical or other information about me to release to the no fault carrier and its agents any information needed to determine these benefits or benefits for related services.

PAYMENT OF INSURANCE BENEFIT TO PROVIDER, PHYSICIANS AND RESIDENT

I request that payment of authorized insurance carrier benefits be made either to me or on my behalf for any services furnished to me by or in Daughters of Sarah Nursing Center, Inc., including physician services. I authorize any holder of medical or other information about me to release to the insurance carrier (and its agents) any information needed to determine these benefits or benefits for related services.

PAYMENT OF PENSION OR OTHER TAX DEFERRED BENEFITS

I request that payment under any pension or similar tax deferred account or plan be made either to me or on my behalf for any services furnished to me by or in Daughters of Sarah Nursing Center, Inc., including physician services.

Signature of Resident or Authorized Representative

Date

(If Attorney-In-Fact, check here , and attach a copy of the Power of Attorney)

Daughters of Sarah Nursing Center, Inc.

DIRECT PAYMENT OF MONTHLY INCOME

If the Resident, and/or the Undersigned on the Resident's behalf, agrees below to arrange for direct payment of the Resident's Net Available Monthly Income ("Resident/NAMI") to the Center, such monthly income (less a small personal allowance which will be deposited in the Resident's Personal Account) will be applied by the Center as part of the monthly Medicaid payment. If the Resident's payments are in arrears, the monthly Resident/NAMI will be applied to satisfy prior unpaid charges for services, provided that the Department of Social Services pays the full Medicaid rate.

AGREEMENT TO ARRANGE DIRECT PAYMENT OF RESIDENT/NAMI TO THE CENTER

I agree to arrange for direct payment of the Resident's monthly income checks to **DAUGHTERS OF SARAH NURSING CENTER, INC.** ("Center") with the understanding that the Center will apply the amount from such income owed to the Center as the Resident/NAMI and will deposit the remainder in the Resident's Personal Account.

Resident: _____ Date: _____

Sponsor (Spouse): _____ Date: _____

Responsible Party: _____ Date: _____

N.B. If the Resident, and/or the Undersigned on the Resident's behalf, does not agree to arrange for direct payment of the Resident/NAMI to the Center, in order to facilitate continuity of payment, the Center requests the Resident or the Undersigned on the Resident's behalf, to notify all payors of income of the Resident's address at the Center and to request that such monthly income be sent directly to the Resident at the Center. Such Agreement is indicated by signing immediately below.

AGREEMENT TO CHANGE THE RESIDENT'S ADDRESS

I do not agree to arrange for direct payment of the Resident/NAMI to the Center. Accordingly, I agree to notify payors of monthly income of the Resident's address change so that the Resident's monthly income will be sent directly to the Resident at the Center.

Resident: _____ Date: _____

Sponsor (Spouse): _____ Date: _____

Responsible Party: _____ Date: _____