



**THE REHABILITATION CENTER AT DAUGHTERS OF SARAH**

**SHORT TERM STAY AGREEMENT**

This Agreement is made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ by and between **DAUGHTERS OF SARAH NURSING CENTER, INC.**, a not-for-profit corporation having a principal place of business at 180 Washington Avenue Extension, Albany, New York 12208, (hereafter referred to as the "Center"), and

\_\_\_\_\_  
*(Resident Name)*  
currently having a residence at \_\_\_\_\_

\_\_\_\_\_  
(hereafter referred to as the "Resident"). For ease of reference, this Agreement will refer to the Resident sometimes using the words "you", "your" or "I". This Agreement is intended to confirm your admission to the Center's short-term stay program.

When referenced herein, the term "Sponsor" shall refer to \_\_\_\_\_, who has also signed this Agreement.

The Center's short term stay program is designed for individuals who require skilled nursing and rehabilitation services of a limited duration. The goal of the Center's short term stay program is to stabilize and improve your physical condition and enable you to return home. By signing this short-term admissions agreement, you are agreeing to the following terms:

1. The Center has assessed your condition through its interdisciplinary care planning process. As a result, the Center has developed a plan of care covering your stay within the short term program.

**By signing this Agreement, you are consenting to be transferred from the short-term stay program when you have met the goals set out in the plan of care.** The determination will be

made by an interdisciplinary care team that either:

- (i) your condition has improved to the point where you can be discharged from the Center in accordance with your post-discharge plan of care; or
- (ii) your condition is such that you will no longer benefit from placement within the short-term program, but require long-term residential care.

2. If we determine that you can be discharged in accordance with the post-discharge plan of care, both you and your Sponsor agree to fully cooperate with the Center's discharge planning staff in conjunction with your discharge. You will receive advance notice of discharge regarding this decision along with a notice of termination of Medicare Part A benefits, if applicable.

3. If we determine that you no longer benefit from placement in the short-term stay program but that a discharge from the Center is inappropriate, and the Center is appropriately equipped to provide the continuing care you need, you and your Sponsor consent to an immediate transfer from the short-term stay program to the first available bed in a unit within the Center which is determined by the interdisciplinary care team to be the most appropriate for your care needs. The Resident and the Resident's Sponsor acknowledge that such transfer from the short-term stay program to another unit within the Center is a consensual room transfer. The Center will consult with you, your family and your Sponsor prior to such a transfer to assure that your needs will be accommodated within the facility. If your needs cannot be accommodated at the Center, you and your Sponsor will cooperate with the Center in finding the appropriate placement.

4. If you cannot be safely discharged and you require long-term residential care, the Center will assess whether the Center can continue to appropriately meet your longer term needs. If we determine that we are able to do so, and if we offer you a bed for long-term residential care, your rights and obligations within the Center will be governed by the terms the Center's ADMISSION AGREEMENT, a copy of which is provided to you herewith and incorporated herein by reference. You hereby agree to the terms set forth in the ADMISSION AGREEMENT. At all times during your stay at the Center, including at the time of your transition to the Center's long term care program, you agree to cooperate with our Business Office in providing financial information relating to your sources of payment for care on a long term basis. Your Sponsors and Powers of Attorney also agree to cooperate with regard to assuring that financial resources and income available to you will be used to pay for your care here at the Center. These obligations are further detailed in the ADMISSION AGREEMENT.

For your information, the services currently available at the Center and the current charges for such services are contained in the ADMISSION AGREEMENT. These services and charges may change from time to time. The Center advises all Residents of any changes as they occur.

The Resident and the Sponsor acknowledge that they have received, on this date, the Center's ADMISSION AGREEMENT.

5. The services you receive during your stay will be based on comprehensive assessments of your physical and mental conditions. This is called the care planning process. By signing this agreement, you are consenting to the care planning process and agree to receive all services which are identified as necessary once a care plan is developed or as are ordered by your attending physician. This includes the use of resident photographs for identification purposes and for use in photographing wounds regardless of origin. We must follow the regulations of the State Department of Health and the Federal Department of Health and Human Services in conducting assessments of your health status as follows:

- A. A comprehensive assessment will be completed within fourteen calendar days after the date of admission;
- B. An initial screening of your oral health status within forty eight hours of admission and an oral examination by a dentist or dental hygienist within seven (7) calendar days following the initial assessment and no less often than annually thereafter; and
- C. A comprehensive assessment promptly after any significant change in your physical, mental or psychosocial status and no less often than every twelve (12) months.

6. During your stay, you agree to have a physician visit you whenever your medical condition warrants medical attention and at regular intervals. The physician will visit you at least once every thirty days during the first ninety days after admission, and at least once every sixty days thereafter. At the option of the physician, the scheduled physician visits after the initial visit may alternate between your attending physician and a registered physician's assistant or nurse practitioner. You also agree that the Center may assign a physician to conduct such visits in accordance with State and Federal regulations.

7. At this time, you are also being provided with Statement of Resident Rights and Responsibilities under State and Federal law, Physician's Name, Address and Telephone Number (which is listed on the Frequently Asked Questions form), New York State Office of the Aging Ombudsman Program Telephone Number, New York State Department of Health "Hot Line" Telephone Number, Information on Advanced Directives, and Information about Medicaid and Medicare Eligibility. You acknowledge receipt of this information by signing below.

8. Post-acute care rehabilitation services are generally covered by private health insurance, Medicare Part A or other third-party sources (hereinafter referred to as a "Third-Party Payor"). Usually, the Third-Party Payor will pay for the costs of post-acute care rehabilitation services, except for co-insurance and/or deductible obligations, the later of which are the responsibility of the Resident. The Center will bill the Resident's Third-Party Payor for post-acute rehabilitation services to the extent they are covered by the Third-Party Payor plan. The Center will also bill the Resident for any applicable co-insurance and/or deductible obligation of the Resident. The Resident is responsible to pay to the Center the applicable co-insurance and/or deductible amount billed to the Resident within ten (10) days of the invoice date. The Sponsor agrees to ensure the

prompt payment of the Resident’s co-insurance and/or deductible obligation(s) from the Resident’s funds and resources.

The Resident and the Sponsor further acknowledge and recognize that Third-Party Payor coverage for post-acute care rehabilitation services may terminate for various reasons, including, but not limited to, exhaustion of benefits, disenrollment from the health plan, or the fact that the Resident is no longer receiving services that are covered under the health plan or Medicare Part A.

In the event that Third-Party Payor coverage is unavailable to pay for post-acute care rehabilitation services provided to the Resident or is otherwise terminated during the course of the Resident’s stay at the Center, the Resident agrees to pay the Center: (a) its daily private pay rate in effect at the time of admission to the post-acute care rehabilitation unit (and as is thereafter revised), or (b) to the extent that the Resident is eligible for Medicaid coverage, to arrange for Medicaid coverage for services provided.

If the Resident is eligible for Medicaid coverage, the Resident agrees to pay to the Center the Net Available Monthly Income (hereinafter referred to as “NAMI”) as determined by the local county department of social services at the time that Medicaid eligibility is determined. While the Medicaid application is pending, the Resident agrees to pay to the Center, all of the Resident’s monthly income, less a personal needs allowance of Fifty (\$50.00) Dollars. In the event such monthly payments exceed the amount of the NAMI established by the local county department of social services for any period of Medicaid eligibility, the Center will refund to the Resident the difference between the amount paid to the Center and the NAMI established by the local county department of social services. The Sponsor agrees to: (a) ensure the prompt payment of the Center’s daily private pay rate from the Resident’s funds and resources, or (b) to the extent the Resident is Medicaid eligible, to ensure the prompt payment of the Resident’s NAMI obligation from the Resident’s income and, pending the Medicaid determination, to ensure the prompt payment of the Resident’s monthly income (less the \$50 Personal Needs Allowance) to the Center. Payments required by this Section are due within ten (10) days of the date of the Center’s invoice for services. A late charge of 1.25% per month (15% per annum) will be added if payment is not made when due to cover the additional administrative costs to the Center caused by the delay.

**IN WITNESS WHEREOF**, the Resident, Sponsor and the Center have signed this on the day and year set forth above.

**DAUGHTERS OF SARAH NURSING CENTER, INC.**

	_____	_____
	<b>Resident</b>	<b>Date</b>
<b>BY:</b> _____	_____	_____
<b>Title:</b> _____ <b>Date:</b> _____	<b>Sponsor</b>	<b>Date</b>