LINCOLN HILL MANOR

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Introductory Admissions Packet

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A. Introduction

This is a Residential Care Facility Admission Agreement for the Lincoln Hill Manor Rest home. This is a legal document creating rights and obligations for each person or party signing the Agreement.

Please read the Agreement carefully before you sign it. If you do not understand any provision of this Agreement, you should not sign the Agreement until you obtain clarification of the provision you do not understand. You are encouraged to have this Agreement reviewed by your legal representative or by any other advisor you may have before you sign the Agreement.

I. References to the Parties

We believe that this Agreement will be more easily understood if we use, where practical, personal pronouns in referring to the parties to this Agreement.

References to "we", “our”, the "Facility", and to "our Facility" are references to Lincoln Hill Manor Rest Home.

References to "you and "your" are references to any person signing this Agreement as Resident.

There are also spaces for this Agreement to be signed by a Legal Representative and Responsible Party, if applicable.

A Legal Representative is an individual who, under independent legal authority, such as a court order has authority to act on the resident's behalf. Examples of a Legal Representative include a guardian, a conservator, and the holder of a Durable Power of Attorney executed by the Resident. Documents evidencing a person's Legal Representative status must be provided to us. If you have a court appointed guardian or conservator, they must sign this Agreement for it to be valid.

A Responsible Party is an individual who voluntarily agrees to honor certain specified obligations of the Resident under this Agreement without incurring any personal financial liability. Examples of a Responsible Party include a relative or a friend of the Resident. We may not require a person to sign this Agreement as a Responsible Party unless the person has legal access to or physical control of the Resident's available income or resources to pay for the care and services we provide. We may decline to admit any Resident who has no source of payment for all or part of the Resident's stay.

II. Limitations on the Obligations of a Legal Representative and Responsible Party under this Agreement.

If you sign this Agreement as a Legal Representative or Responsible Party, you incur no personal financial liability by doing so. We may not require a third party to guarantee payment to us as a condition of admission to, of expedited admission to, or of continued stay in our Facility.

III. Obligations of a Legal Representative or Responsible Party under this Agreement.

If you sign this Agreement as a Legal Representative or Responsible Party you agree to use the Resident's available income and resources (in contrast to your own income and resources) to pay for the Resident's care and services.

By signing this Agreement as a Legal Representative or Responsible Party, you also agree to apply for benefits to which the Resident may be entitled, such as Medicaid Program benefits, and to furnish third party payors, such as the Medicaid Program, with information and documentation concerning the Resident which reasonably is available to you and which is necessary to the processing of the Resident's application for third party payor benefits.

IV. Rights of Legal Representative or Responsible Party under This Agreement.

By signing this Agreement as a Legal Representative or Responsible Party, you have the right to participate in the care planning process for the Resident, and we agree to notify you when there is 1) an accident involving the Resident that results in injury and has the potential for requiring physician intervention, 2) a significant change in the Resident's physical, mental, or psychosocial status, or 3) a need to alter treatment significantly. You are also entitled to receive all notices required to be sent to the Resident by law or by this Agreement.

B. Identification of Parties to this Agreement

Resident	______________________________
Facility	__________Lincoln Hill Manor Rest Home__________
Resident's Legal Representative (If Applicable)	______________________________
Title	______________________________
Resident's Responsible Party (If Applicable)	______________________________
Relationship to Resident	______________________________

C. Payment

Beginning on the _____ day of _______________ we shall provide residential care and services to you in exchange for payment. You are responsible for paying for the facility care and services we provide to you as described below. We participate in Medicaid program and the EAEDC program.

I. Private Payment

You agree to pay us our monthly rate for each day of residential care and services we provide to you. Such payment shall be made one month at a time, one month in advance. Payment for a portion of a month shall be based on the number of days in the month we provide care and services to you.

The basic monthly rate includes payment for nursing services, use of a bed and the room in which the bed is located, linens, bedding, diapers and other incontinence supplies, routine laundry service, regular meals and snacks, certain equipment, social services, activities, and routine personal hygiene items which are required to meet your needs.

Certain items and services are not covered in the basic daily rate. Extra charges for those items and services are set forth in Appendix A to this Admission Agreement.

II. Third Party Payor Programs in General

We participate in the Medicaid and EAEDC Programs as a provider of Residential facility care and services. If you are eligible for benefits under either program, we agree to accept payment from the Program in lieu of our daily rate; however, you remain responsible for paying all co-payments, co-insurance, deductibles, patient paid amounts and charges for items and services that the Program does not cover.

We also participate as providers of residential facility care and services offered by other third party payors such as private insurance companies. If you are entitled to benefits under insurance offered by a non-Medicaid insurance program and if we participate as a provider under the program, we agree to accept payment from the program in lieu of our daily rate; however, you remain responsible for paying all co-payments, coinsurance, deductibles, patient paid amounts and charges for items and services that the program does not cover.

Information concerning coverage under the Medicaid and EAEDC programs, as applicable, is set forth in Appendix B to this Agreement.

III. Billing and Changes in Rates

We shall provide you with monthly statements itemizing all charges incurred by you. We shall provide you with at least 60 days written notice of any increase in the basic daily rate.

IV. Security Deposits

If you are eligible for Medicaid Program residential facility benefits, no security deposit shall be required.

If you are not eligible for the EAEDC or Medicaid Program, residential care facility benefits you shall pay to us a security deposit of $_______. This security deposit may be no more than the total of one month's per them charges. The security deposit will be deposited in an interest-bearing account with _________________Bank (Account No._____________). We will return this security deposit, along with accrued interest, to you or your Legal Representative or Responsible Party within 30 days after your death or transfer or discharge from our Facility, or within 30 days of our receipt of notice of your eligibility for Medicaid Program nursing facility benefits.

V. Collection Costs and Attorneys' Fees

We may not require you or your Legal Representative or Responsible Party to agree, as a condition of admission, expedited admission, or continued stay in our Facility to pay attorney's fees or any other costs incurred in collecting payment for residential facility care and services we provide to you.

VI. When We Hold a Bed for You

If we hold or reserve a vacant bed for you at your request and the charges for the bed are not paid by insurance or by any third-party payor, you are responsible for paying our daily charges for the bed for each day we hold or reserve the bed for you. The Medicaid Program has specific bed hold/reservation requirements. The Medicaid Program's bed hold requirements and our bed hold/reservation requirements are set forth in Appendix B to this Agreement.

VII. We Do Not Extend Credit

We neither extend credit nor accept payment in installments. Payments of the aggregate daily rate are due in advance on the first day of each month. All other fees are due and payable in full no later than 10 days after you receive the bill. Fees not paid when due shall be late payments and shall be subject to delinquency charges in the amount of 1.5 % per month. Payments properly made by you to us are not refundable except that, in the event of your death or transfer or discharge, we will refund the appropriate prorated portion of any advance payment made by you or on your behalf. Any payment made by you or on your behalf (for example, by an insurance company or governmental entity), which is less than the full amount due to us under this Agreement shall be treated as a partial payment on your account even if you or someone on your behalf places a statement or endorsement on a check that the lesser amount is payment in full.

VIII. Refunds Due to You

If you are discharged or transferred, we will refund to you any credit balance within a reasonable time not to exceed thirty (30) days after we have applied such balance toward outstanding fees for services provided by us.

IX. Notice to Us When You Leave Our Facility

You may leave our Facility at any time. However, for payment purposes we require two (2) days advance notice and may charge you for two days if you leave our Facility without two days advance notice.

D. Your Right to Remain In Our Facility

I. Voluntary Transfer and Discharge

You may discharge yourself from our Facility at any time, if you so desire, subject to our right to charge you for two (2) days if you leave our Facility without two days advance notice. We agree to cooperate as necessary in arranging for your voluntary transfer or discharge.

II. Involuntary Transfer and Discharge

a. Transfer Within the Facility

We may not transfer you from room to room within our Facility contrary to your wishes except to meet your health care or safety needs which otherwise could not be met, as documented in your clinical record by your attending physician.

b. Transfer from Unit or Discharge from Nursing Facility

We may involuntarily transfer or discharge you only for one of the following reasons:

1. The transfer or discharge is necessary for your welfare because Your needs cannot be met in our Facility;
2. The transfer or discharge is appropriate because your health has improved sufficiently so that you longer need the services of our Facility;
3. Your presence in our Facility endangers the safety or health of other individuals;
4. You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicaid or EAEDC) your stay at our Facility; or
5. We cease to operate as a facility.

We may not use your conversion to Medicaid Program benefit eligibility from private-pay status or Medicare Program eligibility as a reason for our transfer or discharge unless we are not certified to participate in Medicaid.

Before we involuntarily transfer or discharge you, we shall give you and your Legal Representative or Responsible Party written notice of the proposed transfer or discharge. This written notice shall be given at least 30 days before the proposed transfer or discharge, although we may give reasonable notice of less than 30 days if the reason for the proposed transfer or discharge is based on the safety or health of you or others, or if you have

resided in our Facility for less than 30 days. Among other things, the written notice shall specify the reasons for the proposed transfer, or discharge, the effective date of the proposed transfer or discharge, and the location to which you will be transferred or discharged. The written notice shall also notify you of your right to appeal the transfer or discharge decision, and provide you with the names and phone numbers of agencies available to furnish you with legal and other assistance.

E. Your Personal Property

I. Management of Your Funds

You have the right to manage your personal financial affairs. At your written request, we will hold and safeguard money for you, and will release this money upon your later written request. If the money we hold for you exceeds $50, we will place that money in an interest-bearing account. We will provide you with an accounting of these funds upon your request, and at least once every three (3) months.

II. Waivers of Liability Not Permitted

We may not require you, or your Legal Representative or Responsible Party, to agree to waive or limit our liability for *loss of* personal property suffered as a result of negligence on the part of, our administrator or of our employees or agents. However, we are only responsible for *loss* of personal property that is caused by our administrator, our employees, or agents. We will provide a lock box for your valuables and we encourage you to use a lock box for your valuables.

F. Medical Treatment

I. Right to Consent to or Refuse Medical Treatment

By signing this Agreement, you consent to receive the residential facility care and services we have agreed to provide you. You consent to routine nursing care and medical care, as recommended by your attending physician. You have the right to consent to or refuse any nursing care or medical treatment. If you are incapable of making your own medical decisions, or become so in the future, we will follow the direction of a legally authorized alternative health care decision maker such as a health care agent, holder of a Durable Power of Attorney or guardian. You have the right to be fully informed about the nursing care and medical care we provide to you, and we are available to answer your requests about the nursing care and services we have agreed to provide you.

II. Choice of Health Care Providers

a. Choice of Doctor

You have the right to receive care from an attending physician of your choice, and you agree to provide us with the name and telephone number of your attending physician. If you have no attending physician, or do not provide us with the information concerning your attending physician, we shall consult with you and assist you in selecting an attending physician of your choice. If after consultation, you do not select a physician, we will select an attending physician for you. If we select an attending physician for you, we shall make all reasonable efforts to ensure that the services of the physician are covered by your health insurance, if any, and we shall provide you

with the physician's name, phone number and specialty. In the event of a life threatening emergency, we will make reasonable efforts to contact your attending physician, and if we are unable to do so, we may obtain a physician's services for you. You are responsible for payment for physicians' services.

b. Choice of Pharmacy

While residing at our Facility, you agree to the use of the Pharmacy used at the facility.

III. Waiver of Liability Not Permitted

We may not require you or your Legal Representative or Responsible Party, to agree to waive or limit our Facility's liability for any injury suffered by you as a result of negligence on the part of our administrator or our employees or agents. However, we are only responsible for any injury suffered by you that is caused by our administrator, our employees, or agents.

G. Visitors

You may have visits from family members, physicians, or representatives of the Ombudsman Program at any time. Other persons may visit you during reasonable visiting hours.

H. Release of information

You consent to our release of medical and/or financial information regarding you to any person or entity we reasonably believe to be able for paying for nursing facility care and services rendered to you by our Facility, to the extent necessary to allow responsibility for payment to be determined and payment to be response made. You also consent to our release of all information regarding you to any provider or facility from which you are seeking treatment or services.

I. Our Rules and Regulations

You agree to comply with such reasonable rules' regulations, policies, and procedures as we from time to time establish and make available to you subject to reasonable accommodation of your individual needs and preferences. You agree that we have provided you with a current copy of our rules and regulations. We will provide you with 30 days advance notice of any change in our rules, regulations, policies, and procedures; however, there may be circumstances which necessitate that a change in our rules, regulations, policies, and procedures will take effect within a shorter time frame or immediately.

J. Advance Directives

You may provide us with advance directives specifying your wishes as to the care and services you desire to receive in certain situations. Such an advance directive may be a separate form or contained within a Durable Power of Attorney, or Health Care Proxy. While it is not a condition of admission, You may provide us with a Health Care Proxy designating an individual to make health care decisions for you in the event you become

incapable of doing so or in the event you are unable to communicate your health care decisions to us. If you require assistance in formulating an advance directive we will try to provide same to you as required by and in accordance with law. If you have expressed your wishes in an advance directive it is important that you provide us with a copy of the directive so that we may inform Facility staff to ensure that your wishes are respected.

K. Private Duty Nurses and Physicians

You may, at your expense, engage private duty nursing personnel and physicians. Any private duty nursing personnel and physician engaged by you will not become or be considered as our employee. We expect any private duty nursing personnel or physician to comply with reasonable rules that we may adopt, and we reserve the right to exclude from the Facility any private duty nursing personnel or physician who fails to comply with our rules.

L. Your Agreement to Seek Benefits From and Cooperate with Third Party Payors

If you are eligible for any third party payor benefit (whether under the Medicare Program, Medicaid Program, EAEDC program or other insurance plan), you agree to apply for any such benefit in a timely manner and to cooperate in complying with all requirements of such third party payor, including submitting any and all information necessary to process your application for coverage. We agree to assist you in applying for benefits from a third party payor. To facilitate our ability to assist you, we request that you notify us two (2) months prior to the time you anticipate being eligible for any benefits. We agree to apply any and all money we receive from you toward the cost of your maintenance before you make any application for assistance to any third party payor.

You agree, if applying for Medicaid or EAEDC benefits, to comply with Medicaid or EAEDC requirements in order to become eligible. These requirements may include providing correct and complete information about previous transfers of assets and other matters and may require liquidation of certain assets. If determined eligible for Medicaid, you agree to pay any patient pay amount determined by Medicaid, subject to any rights you have to appeal the patient pay amount determination. We agree not to discriminate against you because you have applied for or obtained any third party payor residential facility care and services benefit.

If you apply for Medicaid benefits or EAEDC benefits and your application is approved, you may be required to contribute to the cost of the care and services we provide to you from such sources as social security benefits and pension benefits. In such circumstances, you agree to pay to us from your benefits the amount determined to be your contribution toward the cost of the care and services we provide to you.

If you apply for Medicaid or EAEDC benefits and your application is denied, you agree that we may, if we so choose, appeal your denial of Medicaid or EAEDC benefits as your authorized representative.

In the event you fail to pay for your care, we will notify you and a person you designate. If you do not pay for your care or commence application for Medicaid or EAEDC benefits in a timely manner after our notification, we may apply for such benefits on your behalf as your representative.

We reserve the right to terminate our participation in any third party payor program, including, but not limited to, the Medicaid and EAEDC Programs. In the event of such termination, we agree to provide discharge planning to an appropriate facility.

M. Miscellaneous

I. This Agreement shall be interpreted and enforced in accordance with the laws of the Commonwealth of Massachusetts.

II. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the validity or enforceability of the remaining provisions. However, instead of such invalid or unenforceable provision, the parties agree that a court may add as part of this Agreement a provision as similar in terms to such illegal, invalid, or unenforceable provision as may be possible and as may be legal, valid, and enforceable.

III. This Agreement and the Appendices and the Addenda to this Agreement constitute the entire agreement and understanding between you and us with respect to the subject matter of this Agreement and supersedes all prior agreements and understandings relating to the subject matter of this Agreement. There are no agreements, understandings, restrictions, warranties, or representations between you and us other than those set forth in this Agreement, or incorporated in this Agreement by reference. This Agreement may be amended only by a document in writing signed by you and us, and no act or omission of an employee or agent of our Facility shall alter, change or modify any of the provisions of this Agreement.

IV. The waiver by any party to this Agreement of any breach or default of this Agreement by any other party shall not operate as a waiver of any subsequent breach or default by the other party.

N. The Parties Hereby Execute this Resident Admission Agreement

_____/_____/_____ ____
Date Representative of Nursing Facility

_____/_____/_____ ____
Date Resident

_____/_____/_____ ____
Date Resident's Legal Representative (If Applicable)

_____/_____/_____ ____
Date Resident's Responsible Party (If Applicable)

O. Appendix A

Extra charges or items and services which are not included in the daily rate and are not covered by EAEDC and SSI/Medicaid Programs are listed below.

If you or your Legal Representatives or Responsible Party requests one of these items or services, you shall make additional payment to the facility for the items or service at the rate listed.

Telephone	Arrange with the telephone company
Television for personal use	No charge
Hairdresser and Barber	\$12 – \$30
Transportation	\$30/hour, unless covered by MassHealth

P. Appendix B

A number of federal and state regulations govern a residential care facility's policies regarding medical and non-medical leaves of absence from the facility. These regulations, as well as this facility's policies for non-Medicaid reimbursed leaves, are described below.

I. Federal Regulations

Federal regulations require that a residential care facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed hold policy under the Medicaid state plan during which the resident is permitted to return and resume residence in the facility. This notice must be provided well in advance of any transfer and at the time of any transfer. For practical purposes, the first notice of bed hold policy is given residents at the time of their admission to the facility. In addition, a residential care facility is required to establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed hold period under the Medicaid state plan is to be readmitted to the facility upon the first availability of a bed.

II. State Regulations

Massachusetts MassHealth (Medicaid) regulations specify that Medicaid will pay to reserve beds in residential care facilities for up to 10 days for MassHealth residents during medical leaves of absence (MLOA). An MLOA is defined an inpatient hospital stay of a recipient who is a resident of a facility for up to 10 consecutive days at a Medicare hospital level of care. MassHealth regulations also specify that Medicaid will pay for temporary absences for residents of residential care facilities for up to 15 days per calendar year when the resident is absent from the facility for non-medical reasons. For purposes of determining these non-medical leaves of absence (NMLOA), a calendar year begins on the date of the resident's first NMLOA.

III. Facility Policies

In addition, this facility permits private pay residents whose leaves have exceeded the Medicaid-reimbursed 10 day bed hold period who so wish to pay from their own income to hold the bed. However, it should be stressed that if a Medicaid-eligible resident does not elect to pay to hold the bed, readmission rights to the next available semi-private bed are in accordance with the abovementioned federal regulations.