COLORADO STATE VETERANS HOME AT RIFLE

851 East 5th Street
Rifle, CO 81650
Phone: (970) 625-0842
FAX: (970) 625-3706
veteranshome.rifle@state.co.us

Resident Admission Agreement

This document is a binding legal contract. Please read it carefully before signing to ensure that you fully understand its terms and the obligations you are assuming.

This Agreement explains the services, charges, rules, regulations, rights, obligations, and responsibilities agreed upon by the Colorado State Veterans Home at Rifle, the Resident, and any other parties involved.

RESIDENT: ____
Please print.

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CHAPTER 1: PARTIES TO THE CONTRACT

This Resident Admission Agreement is a contract for residence, related goods, and related services at the Colorado State Veterans Home at Rifle. The Parties to this contract are the Colorado State Veterans Home at Rifle, the Resident, and potentially, a Responsible Party.

A. For the Facility

Hereinafter, "Facility Representative, or Designee."

Name: ____

Position: ____

B. Resident

Name: ____

Date of Birth: ____

Social Security Number: ____

C. Responsible Party

In the event that the Resident cannot enter into this contract, an individual designated as the "Responsible Party" can sign on their behalf. The Responsible Party personally assumes the role of ensuring payment to the facility. The Facility cannot require as a condition of the Resident's admission or continued stay that there be a Responsible Party other than the Resident to this agreement.

A Resident may designate a Responsible Party although he or she is capable of understanding and signing their own admissions paperwork.

The Responsible Party is required to provide contact information to the Facility. This contact information will be used to notify the Responsible Party in the case of an emergency and to resolve payment issues. In the event the Responsible Party's contact information changes, it is their duty to notify the facility.

If a different individual assumes Resident's financial obligations as Responsible Party, they are required to review this Agreement in full. In such a case, the later established Responsible Party is held responsible for knowing the content, obligations, and duties of this Agreement.

Responsible Party Contact Information

Name: ______________________________

Relationship to Resident: ______________________________

Legal Relationship: ______________________________

Home Address: ______________________________

____

Work Address: ______________________________

____

____

Home Phone: ______________________________

Work Phone: ______________________________

Mobile Phone: ______________________________

E-Mail Address: ______________________________

By initialing below, I acknowledge that I have reviewed, understand, and agree to the preceding terms set forth in this Resident Admission Agreement and the information supplied is accurate and complete.

RESIDENT: ______________________________

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date

☐ Responsible Party

CHAPTER 2: DEFINITIONS

Advanced Directives

"Advanced Directive" refers to a living will or written statement regarding a person's wishes regarding the continuation or termination of medical treatment in the case of terminal illness. Advanced directives must be on file with the Facility. In the event that no advanced directive is on file and it becomes necessary to respond to a Resident, the Facility's policy is to **always** begin resuscitation to the resident. The Resident is not required to have an advanced directive on file in order to receive treatment by the Facility.

Agreement

"Agreement" or "Admission Agreement" means this Resident Admission Agreement. This agreement is a legally binding contract that outlines the rights, benefits, responsibilities, and liabilities of each party involved. This Agreement is between the Colorado State Veterans Home at Rifle, the Resident, and any other parties involved.

Attending Physician

"Attending Physician" means the Resident's personal routine physician or his designee. The Attending Physician is selected by the Resident and/or the Responsible Party. The Resident retains the right to select and change the attending physician at any time.

Daily Rate

"Daily Rate" means the routine daily charge for services rendered to the Resident by the Facility under the terms of this Agreement. The Daily Rate is subject to change upon appropriate written notice.

Facility Representative or Designee

The party contracting on behalf of the Facility. For the purposes of this

agreement, the Facility Representative is: ________________________________.
Please print.

Medicaid

"Medicaid" means any applicable state programs authorized under Federal Title XIX medical financial assistance program.

Medicare

"Medicare" means any applicable Federal program authorized under Title XVIII assistance provided to citizens 65 or older.

Nursing Facility

"Facility" or "Nursing Facility" means the health care facility to which the person is being or has been admitted. For the purposes of this Agreement, the "Facility" is the Colorado State Veterans Home at Rifle, located at 851 East 5th Street, Rifle, CO 81650. Use of the term "Facility" also includes the actions of the agents and employees of the Facility.

Resident

"Resident" means the person being admitted to the Facility. For the purposes

of this agreement, the Resident is: ______________________________________.
Please print.

Responsible Party

"Responsible Party" means any individual or organization that personally assumes or is otherwise financially obligated for any part of the Resident's share of costs or liability to the Facility. The Facility cannot require as a condition of the Resident's admission or continued stay that there be a Responsible Party other than the resident to this Agreement.

☐ The Resident is the contracting party.

☐ The Resident has designated ______________________________________ as his or her Responsible Party. *Please print.*

Routine Medical Supplies

"Routine Medical Supplies" refers to supplies used in small quantities for the Resident during the usual course of treatment and not needed to treat a Resident's specific illness or injury in accordance with physician's order.

Routine Medications

"Routine Medications" means drugs or medicine required regularly for the maintenance of a specific, chronic health condition and not required to treat an acute health condition.

Routine Nursing Programs

"Routine Nursing Programs" mean those medical services required regularly for the maintenance of a specific, chronic health condition and not required to treat an acute health condition.

Self Pay/ Private Pay

"Self Pay" or "Private Pay" means the Resident/Responsible Party will pay for appropriate expenses from personal funds or secondary insurance.

Skilled Nursing Care

24-hour a day care provided by a Licensed Practical Nurse or a Registered Nurse under the direction of a doctor. Skilled nursing care is provided upon a doctor's order. Examples of skilled nursing care include tube feeding and intravenous medication.

United States Department of Veterans Affairs Per Diem

"Per diem" refers to the United States Department of Veterans Affairs payments to recognized state facilities. The rate of the per diem is established in accordance with 38 U.S.C. § 1741(c).

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CHAPTER 3: SERVICES RENDERED

Section 1: Services Included in Your Daily Rate

The Facility will provide the Resident with the following services and goods: (Note, some services are only provided if available or requested)

- Meals and snacks;
    - Including meals and snacks that reflect the Resident's dietary concerns
    - Alternate options are always available
- Basic cable services if available. Basis cable television service is available to all Residents. Residents desiring cable television service must provide their own television set and cable to connect to the cable system. Residents desiring an expanded cable package must make arrangements with the cable service provider and will be billed directly by the cable service provider for expanded cable;
- 24-hour nursing care;
- Physical, occupational, and speech therapy (third party payers billed when applicable) as requested by the Attending Physician;
- Routine medications, medical supplies, laboratory and radiology services, in compliance with the orders of the Resident's Attending Physician (third party payers shall be billed for all services that are applicable. You may be responsible for any co-pay amounts;
- Routine nursing programs including care and treatment conducted by nursing staff in compliance with the orders of the Resident's Attending Physician;
- In-house recreational activity programs;
- Social service assistance;
- Discharge assistance and planning services;
- Monthly resident council meetings;
- Family meeting: educational and social;
- Multi-denominational religious and spiritual programs;
- Daily housekeeping;
- Laundry service (dry cleaning is NOT included);
- Applicable third party billing assistance;
- Oxygen therapy;

- Personal products per facility formulary;
    - Including but not limited to toothbrushes, tooth paste, mouth wash, deodorant, soap, shampoo, body lotion, denture supplies, nail clippers, nail files, orange sticks, combs, brushes, lip balm, and facial tissues
- Initial and annual oral/dental examination;
- Vision services

By initialing below, I acknowledge that I have reviewed, understand, and agree to the preceding terms set forth in this Resident Admission Agreement.

RESIDENT: ______________________________________

Initials: ____________________ ____________________ ________

☐ Resident Facility Representative Date
☐ Responsible Party

<u>Section 2:</u> Services & Supplies Not Included in Your Daily Rate

Routine nursing services and supplies that are not included in your rate are as follows, but are not limited to:

- Special duty nursing care (one-on-one nursing or CNA care);
- Special equipment such as hearing aides, dentures, motorized scooters;
- Audiology and podiatry services available as needed. The provider or Facility will bill you, or your insurance, separately for these services;
- Personal items

The Resident/Responsible Party may request non-routine services and/or supplies. However, the Resident/Responsible Party will be financially responsible for any charges not covered by a third party pay source (e.g., Medicare, Medicaid, Insurance, etc.). The facility is under no obligation to provide these services/supplies.

By initialing below, I acknowledge that I have reviewed, and understand that certain services are not included in the Resident's daily rate, pursuant to the terms set forth in the preceding section of this Resident Admission Agreement.

RESIDENT: ______________________________________

Initials: ____________________ ____________________ ________

☐ Resident Facility Representative Date

CHAPTER 4: FINANCIAL AGREEMENTS

Section 1. Financial Agreement

By signing this Agreement, the Resident/Responsible Party agrees to pay for services and supplies provided by the Facility under the terms of this Agreement.

If the Resident is covered by a health insurance plan, managed care organization, Veteran's Administration Benefits or other third party pay sources (except Medicare or Medicaid), the Resident agrees to pay for any costs not covered by the third party pay sources. The Facility does not contract with any HMO (managed care corporation). (Example: Kaiser, Secure Horizons). The Resident must notify the facility of all third party insurance carriers. Delay in notifying the Facility of changes in insurance coverage may result in Resident liability for costs incurred by the facility.

A. Self Pay Resident:

The Resident/Responsible Party agrees to pay the Facility the daily private rate at the beginning of the month for which services will be provided. (The private pay rate is set by the facility).

1. Determining the Daily Rate

The Current Daily Rate is $__________. The daily rate may be changed upon thirty (30) days written notice to the resident. The rate may be determined, in part, by the type and location of the Resident's room and/or the level of routine services provided by the Facility. The daily rate includes all of the goods and services listed in Chapter 3, Section 1 and does not change based on use or non-use.

Private Pay Residents shall be charged for the day of admission and the day of discharge.

In addition to the daily rate, there may be additional charges for items or services not included in the daily rate. Such charges shall be billed at the end of the month and shall be due and payable with the daily rate charges for the following month.

Willful destruction of Facility property will be charged to the Resident in a separate billing.

2. Default

If charges are not paid by the tenth (10th) day of the month for which services are billed, the Resident and/or Responsible Party shall be deemed in default under the terms of this Agreement and the Resident shall be subject to discharge. **The charges not paid on time may in accordance with applicable law, accrue late charges beginning thirty days after the date due until the date paid, at the annual rate of 12% per annum**. Imposition of such charge shall not be deemed a waiver of the right of the Facility to demand payment in full when payments are due. If it becomes necessary for the Facility to refer the Resident's account for collection, the Resident and/or Responsible Party shall be obligated for payment of the Facility's reasonable costs of collection, including attorneys' fees and court costs.

3. Exhaustion of Funds

It is the Resident's and/or Responsible Party's obligation to apply for Medicaid services prior to the exhaustion of assets. Upon filing for Medicaid or similar government benefits programs for payment of Resident's care, the Resident/Responsible Party should notify the Facility. The Resident and/or Responsible Party shall be personally obligated for care rendered until Medicaid or similar government benefits program for payment of care is authorized.

4. Insurance Carriers

Resident/Responsible Party must notify facility of all third party insurance carriers. Delay in notifying the Facility will result in Resident Responsibility for charges incurred from delayed filing of claims. Charges from Medicare third party insurance carriers to an HMO could subject the resident to further financial obligations. Please contact the Facility with any changes in your Medicare or insurance Coverage.

B. Medicaid Beneficiary:

The Facility will bill Medicaid for those Medicaid-covered services and supplies provided to a Resident who is a Medicaid beneficiary (or a recipient of Medicaid benefits).

1. Resident's Share of Costs

The Resident/Responsible Party agrees to pay the Facility for any patient payment as determined by the County Department of Human Services on Form 5615. This amount shall be paid on the day of admission. It is understood by the Resident and/or Additional Party(s) that if eligibility for participation in the Medicaid program is established, the monthly amount to be paid to the facility as directed by the State agency, may be adjusted at any time based on the Resident's financial status. The Resident and/or Additional Party(s) agree that when the state agency makes adjustments, this agreement will then be automatically revised so that the Resident is responsible for the adjusted monthly amount due the Facility when it becomes effective. In addition, the Resident/Responsible Party agrees to pay for any additional services or supplies provided by the Facility during the time period not covered by Medicaid.

2. Eligibility

The Resident/Responsible Party is responsible for applying for and renewing Medicaid benefits. The Facility may assist the Resident/Responsible Party in this process, but the Facility does not guarantee that Resident shall be eligible for Medicaid. **If, at any time while residing in the facility, the Resident is determined to be ineligible for Medicaid benefits, his or her status for payment purposes becomes that of a self-pay resident and the Resident/Responsible Party is liable for payment at the current daily rate.**

A Resident seeking admission who has not yet been determined to be Medicaid eligible should allow a minimum of sixty (60) days from the date of application to the date of approval. Therefore, a Medicaid applicant is expected to pay for his/her stay each month, before services are rendered, after the date of application to Medicaid, until the Medicaid application is approved. The Resident is responsible for all patient payments during this time. If Medicaid eligibility is denied, the Resident shall be responsible for payment in full. The Resident and

additional party(s) agree to complete and furnish all forms and documents as required by the county of application and to make all reasonable efforts to complete the Resident's Medicaid application as soon as possible. The Resident and/or Responsible Party, if applicable, will be liable for all charges incurred up to the date of Medicaid approval.

It is understood that if the Resident is applying for, or now receiving, public assistance from a state or federal agency, initial or continued eligibility for such financial assistance cannot be guaranteed. If the Resident is denied eligibility for nursing facility payments by the agency for medical or financial reasons, the Resident and/or Responsible Party agree to pay a daily rate equal to the current established private pay rate beginning with the date equal to the current established private pay rate beginning with the date of admission or denial until the date of discharge. The Resident/ Responsible Party further agree that if, following denial, the financial obligation to the Facility cannot be met, the Resident will leave the Facility, by his/her own arrangement and expense, within a reasonable time from the date the Resident and/or Responsible Party is notified of that denial, as provided by government regulation.

3. Refunds

If the Resident is self pay and subsequently becomes eligible for Medicaid benefits, the Facility will, in accordance with applicable law, refund any payment made by the Resident/Responsible Party from the date of such Medicaid eligibility, in excess of the Resident's monthly Medicaid patient payment. In addition, the Facility will deduct from the refund amount any balance due from the Resident/Responsible Party for non-routine services and supplies provided by the Facility.

4. Certification

If the Facility's participation in the Medicaid program changes or ends, the Facility will send advance written notice to all Residents who are Medicaid beneficiaries.

5. Default

Medicaid Residents who fail to make the required "patient payment" by the tenth (10th) day of each month will be deemed in default under the terms of this Agreement and the Resident shall be subject to discharge. In the event of default, the Resident, or his/her attorney-in-fact, conservator, or guardian agrees to execute such documents as may be required in order to cause the Resident's income sources, including Social Security benefits, to be paid directly to the Facility. If it becomes necessary for the Nursing Facility to refer the Resident's account to collection, the Resident and/or Responsible Party, if any, shall be obligated for payment of the Facility's reasonable costs of collection, including attorneys' fees and court costs.

6. Services Covered by Medicaid

The care and services rendered must be consistent with the Resident's health care needs, which include an overall goal of restoration and maintenance to the Resident's highest level of independence and/or supportive care.

Nursing care and services include:

- Arranging for physician services
- 24-hour nursing care, pursuant to Attending Physician order
- Personal hygiene, such as shampoos, baths, general nail care, oral care and skin care
- Meeting medically related psychological needs as ordered by the physician
- Dietary services, which include nutritional meals, snacks and supplements
- Comfortable environment
- Safeguarding the Resident's rights

Supplies used for the provision of nursing care and services:

- Bedside equipment (pitchers, bedpans, elevated toilet seats, etc.)
- Materials and equipment used for incontinence care and management
- Personal items per Facility formulary.
- Medical supplies (alcohol sponges, thermometers, Band-Aids, etc.)
- Equipment for protective support
- Non-legend stock drugs and solutions (antiseptics, laxatives, anti-diarrheal medications, aspirin or equivalent pain relievers, salt or sugar substitutes)
- Medication (prescription)
- Medication supplies for specimen collection, simple irrigations and enemas, gloves, hypodermic syringes and needles
- Linen, personal and non-personal laundry service

Reusable Supplies:

- Ice bags
- Bedrails, footstools, traction equipment
- Walkers, wheelchairs, canes, crutches
- Emergency tray and aspirators
- Oxygen equipment.

7. Medicare Beneficiary

The Facility will bill Medicare for those Medicare-covered services and supplies provided to a Resident who is a Medicare beneficiary and who is eligible for Medicare benefits at the time of service. Medicare consists of four parts: Medicare Part A, B, C, and D.

8. Medicare A

"Medicare Part A" is a limited coverage insurance plan with Federal guidelines that determine the number of nursing home care days available. The Part A benefit is for short-term nursing home rehabilitation only and requires a minimum of a three (3) day hospital stay for eligibility. Each Medicare Part A benefit period is limited to a maximum of one hundred (100) days per spell of illness. The number of rehab days or Medicare days, that Medicare will pay for each

individual are based on assessments of medical needs and rehab progress shown following initial qualification. Medicare Part A coverage is temporary and does require a patient payment from day 21-100. The current Medicare Part A coinsurance payment (co-pay) is $__________ per day in 20____ and is often a covered benefit under a Medicare insurance supplement (Examples: AARP or BCBS). If Resident does not have supplemental insurance coverage, they are responsible for the Medicare coinsurance payment (co-pay).

9. Medicare Part B

"Medicare Part B" may be used when the beneficiary meeting qualifying conditions is no longer covered for Medicare Part A inpatient services, Medicare Part B may pay 80% of the following ancillary services and you (the beneficiary) may be billed 20% as coinsurance:

- Physical Therapy
- Occupational Therapy
- Speech/Language Pathology
- Tube Feedings
- Prosthetic Device
- Surgical Dressings
- Radiology
- Laboratory

10. Resident's Share of the Costs

The Resident/Responsible Party agrees to pay the Facility any required coinsurance charges, as determined by Medicare. In addition, the Resident/Responsible party agrees to pay the Facility for any additional services or supplies that were provided by the Facility to the Resident during the prior month, not covered by Medicare or this Agreement.

11. Demand Billing

I understand that my payment under Medicare A is temporary. I further understand that my assignment to a Medicare room is a temporary placement and is subject to Medicare eligibility. When I am determined no longer eligible for Medicare services, I understand that I am financially responsible for payment for the costs of services rendered to me.

If I disagree with the Medicare ineligibility determination, I still may ask to have Medicare billed. However, I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I have made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. If with demand billing, Medicare denies payment, I understand that I am responsible for the appropriate Medicare Rate of reimbursement.

12. Eligibility

The Resident/Responsible Party understands that Medicare coverage is established by federal guidelines and that eligibility for Medicare benefits may change from time to time by the actions of the federal government. The Facility will assist the Resident/ Responsible Party in applying for Medicare coverage, if possible. However, the Facility does not guarantee either Medicare eligibility or Medicare coverage of services during the Resident's current stay.

13. Services Covered by Medicare Part A

- Room and board
- Skilled nursing care
- Routine nursing programs and supplies
- Physician approved therapy services (including physical therapy, occupational therapy, speech and language pathology, respiratory therapy, intravenous services, and nutritional services)

Medical Equipment- Medically necessary for therapeutic and adaptive care of the resident:

- Wheelchair
- Trapeze
- Foot cradle
- Pressure-reducing mattress
- Cane
- Crutches

Durable Medical Equipment- While residing at the facility, sometimes durable medical equipment is prescribed by the Primary Care Physician as recommended by the Occupational and Physical Therapists for the treatment of the Resident. This may include oxygen, hydrogen tanks, emergency tanks, oxygen concentrator rental or oxygen humidifier.

Pharmacy- All pharmaceuticals as ordered by the Resident's Attending Physician are included in Medicare Part A coverage. This Facility provides prescriptions through its own pharmacy and/or contracted pharmacy provider while on this coverage.

Lab and x-ray- Lab and x-ray services as ordered by the Resident's Attending Physician are included in Medicare Part A coverage. The Facility provides lab and x-ray services through its own contracted providers while on this coverage.

Medical Supplies- Supplies needed to meet the medical needs of residents are furnished as directed by a Resident's Attending Physician. (Example: syringes, ostomy/colostomy supplies, bandages, etc.)

Personal Comfort Items- Personal comfort items or bedside items from our central supply (Example: tissue, lotion, powder, gloves, etc.) will be provided by the Facility or may be brought from home and should be clearly marked.

C. Service Connected Veteran:

The Department of Veteran Affairs will pay to the State Veteran Home either a pre-established rate for care of veterans with a service rating of 70% or greater to receive nursing home care or if the nursing home admission is directly related to a lesser service rated disability.

The Facility will provide you with, or make provisions for you to receive, all services listed in **Chapter 3, Section 1: Services Included in Your Daily Rate**, of this Resident Admission Agreement. In addition, if you meet the criteria to be covered as an approved veteran with a service rating as described above, you are also eligible to receive rehabilitation services if required by your condition as ordered by your attending physician. Services other then those as described above are not included in the Department of Veteran Affairs' payment for your care and will be billed separately if needed. The provider of service will bill you or your insurance, separately for specialized services that are not provided by Facility staff, for example some laboratory and radiology services.

The Resident/Responsible Party may request non-routine services and/or supplies. However, the Resident/Responsible Party will be financially responsible for any charges not covered by a third party pay source (e.g. Medicare, Medicaid, other insurance, etc). The facility is under no obligation to provide these services/supplies.

If charges are not paid by the tenth (10th) day of the month for which services are billed, the Resident and/or Responsible Party shall be deemed in default under the terms of this Agreement and the Resident shall be subject to discharge. **The charges not paid on time may in accordance with applicable law, accrue late charges beginning thirty days after the date due until the date paid, at the annual rate of 12% per annum**. Imposition of such charge shall not be deemed a waiver of the right of the Facility to demand payment in full when payments are due. If it becomes necessary for the Facility to refer the Resident's account for collection, the Resident and/or Responsible Party shall be obligated for payment of the Facility's reasonable costs of collection, including attorneys' fees and court costs.

☐ Check Here if Not Applicable

Medicare Part A Disclosure: I am aware that I am being admitted for Medicare Part A services only, and will not be requiring long-term care.

RESIDENT: ______________________________

Signature: ______________________________ ____________
☐ Resident Date
☐ Responsible Party

Signature: ______________________________ ____________
Facility Representative Date

Section 2. Payment Policy

A. Payment Due Date

All amounts owed under this Agreement are due and payable by the tenth (10th) day of the month. A service fee of $30.00 may be charged on any returned checks, plus applicable late fees.

If charges are not paid by the tenth (10th) day of the month, the Resident and/or Responsible Party shall be deemed in default under the terms of this Agreement and the Resident shall be subject to discharge. The Facility does not extend credit for services and does not accept payment terms or installment payments. The charges not paid on time may in accordance with applicable law, accrue late charges beginning thirty days after the due date until the date paid, at the annual rate of 12% per annum. Imposition of such charges shall not be deemed a waiver of the right of the Facility to refer to Resident's account for collection; the Resident and/or Responsible Party shall be obligated for payment of the Facility's reasonable costs of collection, including attorneys' fees and court costs.

B. Billing

The Resident and Responsible Party will receive a statement during the final week of the current month for the next month services. (I.e., the statement for June will be sent out the last week in May.)

C. Failure to Pay

The Resident/Responsible Party understands and agrees that the Resident may be discharged from the Facility if the Resident or Responsible Party fails to make, or arrange to be made, any required payment by its due date. Prior to discharge, the Facility will give the Resident or Responsible Party written notice of the intended date of discharge and place of relocation. The Resident/Responsible Party agrees that if the overdue charges are not paid to the Facility by the discharge date, the Resident must vacate the Facility on the date specified in the discharge notice. After discharge, the Resident/Responsible Party will continue to be financially responsible for all costs of relocation, as well as any charges incurred for care received, up to and including, the date of discharge.

Should it become necessary for the Facility to initiate any action or legal proceeding to obtain payment of any amounts due hereunder, the Facility shall be entitled to recover all costs incurred in such matters including attorney's fees, except where prohibited by law. A resident will not be readmitted to the Facility if any amount is owed from a previous stay.

Charges not paid on time may in accordance with applicable law, accrue late charges beginning thirty days after the date due until the date paid, at the annual rate of 12% per annum.

D. Third Party Payments

Where other sources of payments may be available such as Medicaid, Medicare, or private insurance, the facility will assist the Resident in determining coverage, or refer the Resident or Responsible Party to the appropriate agency. However, if after submitting this claim, it is

determined that the Resident is not eligible for coverage or only partially covered, the Resident/Responsible Party is liable for payment of all non-covered charges at the rate for self pay care.

The Responsible Party assumes responsibility for notifying the facility business office at least 90 days in advance of anticipated financial changes that may qualify the Resident for Medicaid benefits.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the payment policy set forth in the preceding section of this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident | Facility Representative | Date

☐ Responsible Party

<u>Section 3.</u> Assignment of Benefits

By the execution hereof, the Resident/Responsible Party requests and authorizes any insurance company or other third-party pay source to pay directly to the Facility for the services and supplies provided to the Resident, any insurance benefits or other payments owed to the Resident.

The Resident/Responsible Party further authorizes the Facility to release to said insurance company or other third-party pay source all information concerning treatment or services provided to the Resident for which payment is sought hereunder.

The Resident has the right to manage his/her own financial affairs. However, the Resident also has the right to assign his/her entitlement to monthly income to the Facility or to make the Facility the payee for income benefits and social security benefits. If the Resident's account becomes in default for failure to make payments as provided, the Facility, as a condition to the Resident's continued stay in the facility, may require the Resident or his/her attorney-in-fact, conservator, or guardian to execute such documents as may be required to cause the Resident's income sources, including Social Security benefits, to be paid directly to the facility.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the preceding terms set forth in this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident | Facility Representative | Date

☐ Responsible Party

<u>Section 4.</u> Private Health Care Costs

A. Physician Services

The Colorado State Veterans Home at Rifle provides primary physician care in the Facility by way of their contract physicians. Should a Resident desire the services of another physician other than a Nursing Home contracted physician, the Resident may obtain those services by giving written notice to the Nursing Home Administrator. The physician must agree to and complete the facility's credentialing and privileging criteria or her/she cannot practice at the facility. However, the Resident shall be personally responsible for all payments to all physicians, including the cost of medications and all other services prescribed by the physician. The Resident must also request the consulted physician to furnish pertinent medical information to the Nursing Home for continuity of the Resident's care.

I understand I have the right to change physicians at any time I choose.

Certain medical services the Resident may need may not be provided by this Facility under this Resident Admission Agreement. Additionally, they may not necessarily be covered by third party payers. These charges shall be the financial responsibility of the Resident and/ or Responsible Party.

B. Private Duty Personnel

The Resident/Responsible Party may hire the services of private duty personnel (e.g. nurses, aides, sitters) while in the Facility, but only with advance approval from the Facility's Administrator or Director of Nursing (DON) services. All private duty personnel must complete the Facility's credentialing criteria, before starting. The Resident/Responsible Party agrees to be financially responsible for any charges from private duty personnel. The Resident/Responsible Party acknowledges that under no circumstances can employees or agents of the Facility serve as private duty personnel. Any private duty personnel hired must at all times abide by the policies and procedures of the Facility. Failure to comply shall result in the loss of private duty service privileges for the outside personnel.

<u>Section 5.</u> Bed Holds

A. Overview

If the Resident leaves the Facility for a temporary stay in an acute care hospital or elsewhere, the Resident/Responsible Party may request that the Facility hold open the Resident's room and bed until the Resident returns. To commit the Facility to holding the bed, the Resident/Responsible Party must make this request in writing within twenty-four (24) hours after the Resident transfers to the hospital.

B. Situations When the Bed May Not Be Held

The Facility will not be required to hold the Resident's bed if:

- The Resident/Responsible Party fails to request the bed hold according to the above procedure.

- Upon the discharge from the hospital, the Resident requires a higher level of care than can be provided by the Facility.
- The Resident/Responsible Party fails to pay for or arrange payment for the bed hold period or the Resident/Responsible Party has other charges that haven't been paid.
- The bed hold period expires and the Resident/Responsible Party does not extend the bed hold using the above procedure.

C. Charges for the Bed

For self-pay and Medicare A Residents: the charges will be the current daily private pay rate.

For Medicaid Residents: the charge is the current Medicaid daily rate less $2.00. Medicaid will not pay bed holds for medical leave. A bed hold charge may not be applied to a Medicaid resident unless the Facility is at or above 90% occupancy. If the Facility occupancy rate is less than 90% at the time of transfer, the Resident's bed will be held at no charge until the Facility is notified that the Resident is not returning. The Resident/Responsible Party may be liable for patient payment to the Facility or Hospital when indicated. The Facility will bill Medicaid up to the maximum number of bed hold days covered by Medicaid.

If the bed hold period exceeds the number of days covered by the Medicaid program, or if Medicaid coverage is unavailable for the bed hold, the Resident/Responsible Party may voluntarily choose to pay privately to hold the bed. If the Resident/Responsible Party fails or refuses to pay for any non-covered bed hold days, the Facility will not be required to hold the Resident's bed, subject to applicable laws.

A Medicaid Resident who wishes to return to the Facility following hospitalization or therapeutic leave beyond any paid bed hold period and whose care needs can be met in the Facility, the Resident shall have the right to return to the first available appropriate semi-private bed.

For veterans admitted under the U.S. Department of Veteran Affairs' (VA) Service Connected program: If the Resident transfers out of the Facility and returns within 10 days, the full per diem will be paid under the veteran's benefits. If the Resident is out of the Facility for greater than 10 days, no per diem will be paid retroactive to the first day of transfer. The Resident may pay to hold the bed at the Facility's private pay daily rate, less the current per diem reimbursement provided by the VA, less the total food and linen service costs as computed from the most recent cost report submitted by the facility to the Colorado Department of Health Care Policy and Financing. If the Resident is absent greater than 10 days, the room charges for a Resident whose absence results in a loss of VA per diem payment will include the current per diem reimbursement provided by the VA retroactive to the Resident's date of departure.

CHAPTER 5: TREATMENT

Section 1. Consent for Treatment

A. Physician Services

The Resident shall be under the care and treatment of an Attending Physician while residing in the Facility. All services provided by the Facility will be in accordance with the general and specific instructions of such Attending Physician.

The Resident/Responsible Party may choose any physician licensed by the State of Colorado as his/her Attending Physician, as long as the Physician agrees to follow and abide by the rules, policies and procedures of the Facility, and by the applicable state and federal laws and regulations. The Resident is required to pay for any services provided by a non-contracting physician.

In order to ensure continuity of care and meet nursing home regulations, we require that each resident secure an Attending Physician willing to follow them during their stay. Physician selection must be completed with this Resident Admission Agreement prior to being admitted. The admissions staff will provide you with a list of physicians in good standing with the Facility. Pursuant to Colorado Law, a nursing home physician must visit each new resident on the following schedule: within three (3) days of being admitted to a facility, every thirty (30) days for the first three months, and, at a minimum, every 60 days thereafter.

(For the Resident)

I, ____, have reviewed the list of physicians currently in good standing and accepting residents at the Colorado State Veterans Home at Rifle, and I have chosen Dr. ____ to be my attending physician while I reside at the Colorado State Veterans Home at Rifle.

(For Responsible Party)

I, ____, as Responsible Party for

____, have reviewed the list of Physicians currently in good standing and accepting residents at the Colorado State Veterans Home at Rifle, and I have chosen Dr. ____ to be the Attending Physician.

B. Health Care Medical Consent

The Resident/Responsible Party, knowing that the Resident's condition requires health care, diagnosis and medical treatment, does hereby voluntarily agree to such diagnostic procedures and health care services, to such medical and nursing treatment and supplies, intravenous medications/feedings, injections, blood transfusions, oxygen, laboratory services and x-rays which may be administered to or performed on the Resident under the general or specific instructions of his/her Attending Physician, or assistants or designees of the Attending Physician,

his/her assistants or designees or otherwise specifically advised by the Resident, his/her attorney-in-fact, guardian or proxy decision maker as set forth in the admissions agreement.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the Health Care Consent provisions outlined in the preceding section of this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date
☐ Responsible Party

C. Authorization for Emergency Treatment

If, in the opinion of the nurse in charge at the time, emergency medical treatment is necessary for the health, safety or general welfare of the Resident, and the Resident is unable to give written or verbal consent to treatment because of his/her condition, the Facility is hereby authorized to provide such emergency treatment and care as may be required in the best judgment of the nurse in charge consistent with existing physician orders and Resident's advanced directives. Further, the Resident hereby consents to the Facility's obtaining the services of a physician other than the Resident's personal physician in the event the same is unavailable for an emergency involving the Resident.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the terms of the preceding section of this Resident Admission Agreement. Notably, I authorize the Facility to make necessary decisions regarding emergency treatment.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date
☐ Responsible Party

D. Pharmacy Authorization

All Facility medications are provided unless the medication charges are covered by private insurance, Medicare, Medicaid or the Veteran's Administration. If covered by private insurance, the Resident/Responsible Party requests and authorizes payment directly to the Facility or pharmacy.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the Pharmacy Authorization set forth in this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ ________

☐ Resident Facility Representative Date

☐ Responsible Party

E. Care Plan Meetings

On a quarterly basis, the Resident's overall care plan is reviewed and updated. Residents have the right to attend these conferences and to have input into the decisions regarding their care. Their input may be in the form of suggestions, or comments agreeing with or disagreeing with the care plan.

Residents have the right to decide if individuals outside of the Facility have access to the care conferences.

I, ______________________________________, ☐ Resident ☐ Responsible Party, give consent for the following persons to have access (only as it applies to care conferences) to any and all information shared at the care conference and shared from my medical record including, but not limited to, medical, psychosocial, mental, function, and psychiatric or mental health information. I have been informed and understand what a care conference consists of. This consent remains in full effect unless written revocation is presented to the facility.

Name Relationship Phone Email

1. ____

2. ____

3. ____

4. ____

F. Ancillary Services

The Colorado State Veterans Home at Rifle provides an initial and annual oral/dental examination by the contracted dentist at no charge to the Long Term Care Resident. The results of this examination will be provided to the Resident/Responsible Party in writing. The Resident/Responsible Party will be responsible for payment of any on-going dental work deemed necessary after the initial and/or annual examination. Medicaid at times will assist with payment for certain types/kinds of dental work through the Medicaid PETI process. The Facility Social Workers will assist the Resident with the application for Medicaid PETI should the Resident be eligible.

I _____ agree ______ do not agree to have an initial/annual oral examination by the facility-contracted dentist at no charge.

I _____ agree ______ do not agree to have an initial/annual visual examination by the facility-contracted provider at no charge.

G. Right to Refuse Treatment

The Resident/Responsible Party has the right to refuse any medical treatment, as defined by law, and to be informed of the consequences of refusing treatment.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the preceding terms set forth in this Resident Admission Agreement, acknowledging the Resident's right to refuse treatment.

RESIDENT: ____

Initials: ____________________ ____________________ ________

☐ Resident Facility Representative Date

H. Advanced Directives

The Resident has the right to accept or refuse medical treatments as provided by state law and has been informed of the Resident's right to formulate Advanced Directives. The Resident/Responsible Party understands that the Facility must have a current "Do Not Resuscitate" (DNR) form on file to effectuate that request. In the event that it is not on file and it becomes necessary to respond to a Resident, the Facility's policy is to **ALWAYS** begin resuscitation of the Resident.

The Resident/Responsible Party understands that the Resident is not required to have an Advance Directive in order to receive treatment by the facility.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the provisions regarding advanced directives set forth in the preceding section of this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date
☐ Responsible Party

I. Participation in Medical Education Programs

The Resident/Responsible Party understands that while the Resident has the right to privacy in medical treatment and personal care, the Facility may from time to time participate in medical education programs through which future medical providers gain professional experience. The Resident/Responsible Party hereby consents to treatment and care from student health care professionals who are under supervision of licensed staff. However, the Resident/Responsible party can discontinue participation in such medical education programs by notifying the Facility in writing.

J. Physical Restraint Policy

In accordance with Federal and State laws, the Facility has a very strict policy regarding the use of physical and chemical restraints for Residents. Our philosophy of providing residents with the highest possible quality of care and life is reflective in our belief that it is essential for our residents to maintain their dignity and independence by being permitted to take "the normal risks of everyday life." Restraints used in attempt to remove these normal risks of living violate the rights of Residents, greatly reduce their quality of life, and present physical and psychological risks.

For these reasons, and in accordance with Federal and State law, restraint use in our facility will only be considered to treat a medical symptom/condition that endangers the physical safety of the resident (or other residents) and under the following conditions: 1) as a last resort measure after a trial period where less restrictive attempts have been undertaken and proven unsuccessful; 2) with a physician order; 3) with the consent of the Resident or legal representative; and 4) when the benefits outweigh the identified risks. When all for conditions have been met and restraint use is deemed necessary, the goal will be to use the least restrictive type of restraint for the shortest period possible.

Every Resident of the Facility will be individually assessed upon admission regarding the need for appropriate restraint measures and will be periodically reassessed as their needs change throughout their stay at the Facility.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the Restraint Policy set forth in the preceding section of this Resident Admission Agreement.

RESIDENT: ______________________________________

Initials: ____________________ ____________________ ________

☐ Resident Facility Representative Date

☐ Responsible Party

Section 2. Non-Emergency Medical Transportation

Non-Emergency/Medically related transportation services are provided by the Colorado State Veterans Home at Rifle at no charge. Transportation services are available for medical appointments from 7:00 am to 5:00 pm Monday through Friday. Transportation services outside of these hours are available on an as needed basis. In the event of scheduling conflicts or the lack of availability of a driver, the Colorado State Veterans Home at Rifle does work with community agencies to provide transportation services on an as needed basis. The Facility will work with Residents requiring frequent non-emergency medical transportation to recurring appointments. However, this service is not guaranteed.

Section 3. Medical Records

A. Notice of Privacy Practices

Information contained in the Resident's medical records is confidential. For all uses and disclosures of an individual's Protected Health Information, Colorado State Veterans Home at Rifle will obtain a signed authorization form the individual, unless the use or disclosure is required, or otherwise permitted without an authorization for treatment, payment or health care operations or as otherwise permitted by 45 C.F.R. Part 164 (Health Insurance Portability and Accountability Act (HIPAA)) as follows:

The Colorado State Veterans Nursing Home at Rifle may access, use and or share medical information for:

- **Treatment-** to appropriately determine approvals or denials of your medical treatment. For example, Facility health care professionals who may review your treatment plan by your health care provider for medical necessity.

- **Payment-** to determine your eligibility benefits and payment. For example, your health care provider may send claims for payment to the Medicaid fiscal agent for medical services provided to you, if appropriate.

- **Health Care Operations-** to evaluate the performance of a health plan or a health care provider. For example, the Facility contracts with consultants who review the records of hospitals and other organizations to determine the quality of care you received.

- **Appointments-** The Facility may use your information to provide appointment reminders or other information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- **Fund Raising-** The Facility may use your information to contact you to raise funds for the Facility.

Disclosures Not Requiring Your Permission

The Facility can make the following disclosures only if it is directly related to running of the Medical assistance programs, a court order to disclose the information, or another law requires the Facility to disclose the information.

- **Other Government Agencies and/or Organizations Providing Benefits, Services, or Disaster Relief** – to disclose information with other government agencies and/or organizations for you to receive those benefits and/or services offered.

    - **Public Health**- to disclose medical information to agencies for public health activities for disease control and prevention, problems with medical products or medications, and victims of abuse, neglect, or domestic violence.

    - **Heath Oversight Activities** – to disclose information to approved government agencies responsible for the Medicaid program, the U.S. Department of Health and Human Services, and the Office of Civil Rights (including transmission of Minimum Data Set material to the appropriate government agency).

    - **Judicial and Administrative Hearings** – to disclose specific medical information in court and administrative proceedings

    - **Law Enforcement Purposes-** to disclose specific medical information for law enforcement purposes.

    - **Coroners, Medical Examiners, and Funeral Directors** – to disclose specific medical information to authorized persons who need it to administer their work.

    - **Organ Donation and Disease Registries-** to disclose specific medical information to authorized organizations involved with organ donation and transplantation, communicable disease registries, and cancer registries.

- **Research Purposes-** in certain circumstances, and under supervision of a privacy board, we may disclose medical information to assist medical/psychiatric research.

- **To Avert Serious Threat to Health, Safety, or Emergency Situation—**to disclose specific medical information to prevent a serious threat to the health and safety of an individual or the public.

- **Specialized Government Functions-** to disclose medical information for national security, intelligence and/or protective services for the President. CSVH-Rifle may also disclose information to the appropriate military authorities if you are or have been a member of the U.S. Armed Forces.

- **Correctional Institutions-** to disclose medical information to a correctional facility or law enforcement officials to maintain the health, safety and security of the corrections system.

- **Worker's Compensation-** to disclose medical information to workers' compensation programs that provide benefits for work-related injuries or illness without regard to fault.

- **Disclosures to Family, Friends, and Others-** CSVH-Rifle may disclose information to your family or other persons who are involved in your care. You have the right the right to object to the sharing of this information.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the sections regarding medical records set forth in the preceding section of this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date

For More Information or to Report a Problem:

If you need more information or feel that the Facility has violated your privacy rights, you may contact:

Privacy Liaison
Colorado State Veterans Center/Home
____
____

You may also file a complaint with:
DHHS – Office of Civil Rights
1961 Stout St., Rm. 1185 FOB
Denver, CO 80294-3538
303-844-2024
You have a right to file a complaint without fear of reprisal.

B. Your Rights to Privacy

Your medical information will not be shared and/or disclosed without your permission except as described in this Agreement or required by law. You may authorize other disclosures by completing an authorization form. You may also retract (in writing) this authorization at any time. CSVH-Rifle has procedures to assist you with your rights to your medical information. You may ask CSVH-Rifle staff for a copy of this notice at any time. An electronic copy of this notice is also available on CDHS website www.colorado.gov/cdhs/veteranshomes/rifle.

Any requests you may have of the Colorado State Veterans Nursing Home at Rifle must be submitted in writing. All required forms are available at the Facility offices and the Colorado Department of Human Services website. You have the right to ask the Facility to:

- Limit the use and/or disclosure of your medical information. However, the Facility is not required by law to agree to your request.
- Contact you by e-mail or fax, at a specific mailing address or phone number
- Look at or have a copy of part of the designated record set maintained by the Facility. You may be charged a processing and postage fee for this request.
- Change or add information to your designated record set. However, the Facility may not change its original document.
- Provide a list of disclosures of your medical information made after during your stay. This will not include disclosures for purposes of treatment, payment, health care operations; or disclosures made to you or with your permission.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the privacy policy set forth in the preceding section of this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date
☐ Responsible Party

C. Resident Right to Information

In 42 C.F.R. § 483.10(b)(i) it states that "the resident or his or her legal representative has the right, upon oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends or holidays)." In the event the resident or the representative wants a copy of the medical records, the facility is required to make copies, after 2 working days advanced notice, "at a cost not to exceed the community standard" pursuant to 42 C.F.R. § 483 10(b)(ii).

D. State Review of Resident Care

The Resident understands that the Facility participates in a routine survey process through the state and federal governments and other agencies. The Resident's care may be subject to review through this process. The Resident/Responsible Party understands that, on occasion, this process may result in a statement of deficiencies to which the Facility must respond as a legal requirement of participation in governmental reimbursement programs. The Facility expressly denies that the survey process establishes a standard of care for delivery of nursing or other services to the Resident. The Facility hereby notifies the Resident/Responsible Party that a decision by the Facility not to challenge a survey finding is not to be construed as an admission of an improper act or omission on the part of the Facility, its employees and/or agents or a failure by the Facility to meet its obligations to the Resident/Responsible Party under this Agreement.

E. Privacy Act Statement

This Section provides you the 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 or not disclosure is mandatory or voluntary.**

   Section 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act

   Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the Facility must obtain information from every Resident. This information is also used by the Federal Centers for Medicare and Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all such 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 the information to CMS. Because the law requires disclosure of this information to 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 will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing facilities that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing facilities to receive reimbursement for Medicare services.

3. Routine Uses

The primary use of this 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. 09-70-1517. Information from this system may be disclosed, under specific circumstances, (routine uses), which include: to the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title VI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators, (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMOs) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefit program or to a grantee of CMS administered grant program, (9) to another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter and detect fraud and abuse in those programs, (1) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program.

4. Effect on Individual for 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.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the preceding terms set forth in this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date
☐ Responsible Party

(The remainder of this page has been intentionally left blank)

CHAPTER 6: RESIDENT RIGHTS; RULES AND REGULATIONS

Section 1. Resident Bill of Rights

All Residents of the Facility are granted a federal statutory Bill of Rights:

1. The Resident has a right to a dignified existence, self-determination, communication with and access to persons and services inside and outside of the facility.
2. The Resident has a right to exercise his or her rights as a resident of the Facility and as a citizen or resident of the United States.
3. The Resident has a right to be free of interference, coercion, discrimination or reprisal from the Facility in exercising his or her rights.
4. The Resident has the right to be fully informed in a language he or she can understand of his or her total health status, including but not limited to, his or her medical condition.
5. The Resident has the right to refuse treatment and to refuse to participate in experimental research.
6. The Resident has the right to exercise his or her legal rights, including filing a grievance with the State survey and certification agency concerning Resident abuse, neglect and misappropriation of Resident property in the Facility.
7. The Resident has the right to manage his or her financial affairs.
8. The Resident has a right to choose an Attending Physician.
9. The Resident has a right to be fully informed in advance about care and treatment and any changes in that care or treatment that may affect the Resident's well being.
10. The Resident has a right to participate in planning his or her care and treatment or changes in care or treatment unless adjudged incompetent or otherwise found to be incapacitated under laws of the state.
11. The Resident has a right to personal privacy and confidentiality of his or her personal and clinical records.
12. The Resident/Responsible Party has the right upon oral or written request, to access all records pertaining to him or herself, including clinical records. After receipt of his or her records, the Resident/Responsible Party has the right to purchase (at a cost not to exceed the community standard) photocopies of the records or any portions of them upon request and with two day's advanced notice to the Facility.
13. The Resident may approve or refuse the release of personal 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 payment contract.
14. The Resident has a right to voice grievances with respect to treatment or care that fails to be furnished, without discrimination or reprisal for voicing grievances.
15. The Resident has a right to prompt efforts by the Facility to resolve grievances, including those with respect to the behavior of other residents.
16. The Resident has a right to examine the results of the most recent survey of the Facility controlled by Federal or State surveyors and any plan of correction in effect with respect to the Facility.
17. The Resident has a right to receive information from agencies acting as client advocates and be afforded the opportunity to contact the agencies.
18. The Resident has the right to refuse to perform services for the Facility.

19. The Resident has a right to agree to perform voluntary or paid services for the Facility if he or she desires, if there is no medical reason which would contradict the performing of the services, and if compensation for paid services is at or above prevailing rates.
20. The Resident has the right to privacy in written communications, including the right to send and receive mail promptly that is unopened. The Resident has a right of access to stationery, postage, and writing implements at the Resident's own expense.
21. The Resident has a right to immediate access to any of the following:
    a. Any representative of the Secretary of the U.S. Department of Health and Human Services.
    b. Any representative of the State.
    c. The Resident's individual physician.
    d. The State's Long-Term Care Ombudsman.
    e. Subject to the Resident's right to deny or withdraw consent at any time, immediate family or other relatives of the Resident or others who are visiting with the consent of the Resident.
22. The Facility must provide reasonable access to any Resident by an entity or individual that provides health, social, legal, or other services to the Resident, subject to the Resident's right to deny or withdraw medical consent at any time.
23. The Resident has a right to have reasonable access to the private use of a telephone.
24. The Resident has a right to retain and use personal possessions, including some furnishings and appropriate clothing, as space permits, unless to do so would infringe on the rights or health and safety of other residents.
25. The Resident has a right to share a room with his or her spouse when married Residents live in the same Facility and both spouses consent to the arrangement.
26. Each Resident has a right to self-administer drugs unless the Facility interdisciplinary team has determined for a particular Resident that this practice is unsafe.
27. The Resident has a right to be free from any physical restraints imposed or psychoactive drugs administered for the purpose of discipline or convenience and not required to treat the Resident's medical symptoms.
28. The Resident has a right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion.
29. The Resident has a right to choose activities, schedules and health care consistent with his or her interest, assessments and plans of care.
30. The Resident has a right to receive advance notice of transfers or discharges of the Resident as required by law. The Resident has a right to receive notice before the Resident's room or roommate is changed. The Resident has a right to refuse a room transfer if the purpose of the transfer is to move the Resident between a Medicare certified bed and a non-Medicare certified bed for purposes of Medicare eligibility.
31. The Resident has a right to organize and participate in Resident groups in the Facility and the Resident's family has the right to meet with families of other residents.
32. The Resident has a right to participate in social, religious and community activities that do not interfere with the rights of other residents.
33. The Resident has a right to reasonable accommodation of individual needs and preferences except where the health or safety of the Resident would be endangered.

34. The Resident has a right to freedom of choice of providers in accordance with applicable law and subject to the provider's compliance with all applicable laws and reasonable rules and regulations of the Facility.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the Resident Bill of Rights set forth in the preceding section of this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date

☐ Responsible Party

Section 2. Facility Policies

A. Resident Responsibilities

The Resident/Responsible Party agrees to comply with the rules, regulations, policies, and procedures of the Facility. The Facility will notify the Resident/Responsible Party of any changes to these responsibilities as required by law.

B. Smoking Policy

The Resident/Responsible Party understands and agrees that the Resident will refrain from smoking while inside the facility. This facility is in compliance with the Smoke Free Colorado Act. As required by law, the Resident may only smoke in designated outside smoking areas if this action does not threaten the health and safety of others.

Additionally, the following stipulations relate to the smoking policy:

- Smoking is allowed only in designated areas.
- If appropriate, personal cigarettes and smoking materials will be stored in a locked area.
- If appropriate, smoking must occur under staff supervision.
- If necessary, additional requirements may be imposed in the smoking policy.

A violation of the facility's smoking policies may result in the involuntary discharge of the Resident.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the Facility's smoking policy set forth in the preceding section of this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date
☐ Responsible Party

C. Electric Appliances

Due to fire and other safety concerns, the Resident/Responsible Party agrees that appliances of any kind cannot be brought into or used within the Facility without the prior written permission of the Facility's Administrator. If injury or damage results from the Resident's use or misuse of any appliance while in the Facility, the Resident/Responsible Party shall be held financially responsible.

D. Hazardous Chemicals

Certain chemicals are unsafe for residents to have open in their room. Examples include cleaning products like laundry detergent and bleach, over the counter medications, vitamins, and any products labeled "keep out of the reach of children" or "contact poison control if ingested." In order to protect the safety and wellbeing of all residents, these products are prohibited in the building. If you have questions regarding specific products, please ask a member of the facility's administration or the charge nurse before leaving the chemicals or medications in a resident room.

E. Resident's Personal Funds

The Resident/Responsible Party may choose to deposit personal funds with the Facility. These funds will be deposited into a designated trust account maintained by the Facility in accordance with federal and state requirements. Every Resident's funds in excess of $50.00 will be kept in an interest-bearing account, separate from the facility's operating account, as required by law. The Facility will give the Resident/Responsible Party quarterly account statements as required by law.

I, ____ ☐ Resident, ☐ Responsible Party do _____ do not _____ desire that the Facility set up a Resident Personal Needs Account for ____.

Please send quarterly statements of the Resident Personal Needs Account to:

Recipient: ____

Address: ____

____

Telephone ____

F. Valuables and Possessions

The Facility strongly discourages the keeping of jewelry, important papers, money over $25.00, and other items of value in the Facility. The Facility will make reasonable efforts to safeguard the Resident's property/ valuables which the Resident/ Responsible Party choose to keep in the Resident's possession.

The Resident/Responsible Party agrees to inform the Facility of all property upon admission and at any time new items are added to the Resident's possession. All lost or missing items should be reported to a member of the nursing staff or a social worker. Reported items will be investigated according to the Missing Articles procedure.

The facility is not responsible for loss or damage to valuable items. By bringing valuable items into the Facility, the Resident/Responsible Party assumes the risk of loss or damage.

G. Clothing and Laundry

I consent to have all clothing, removable oral, hearing, vision, and personal hygiene appliances clearly identified and marked in a permanent manner with my name. This shall apply, but not necessarily be limited to, full dentures, partial dentures, toothbrushes, hearing aids, hearing amplifiers, and glasses. All measures will be taken to make these markings inconspicuous.

Laundry services (excluding dry cleaning) are included in the Resident's daily rate. Family members may launder the Resident's clothing at home if they so choose. Government regulations require:

1. Laundry must be kept in an airtight container,
2. Laundry must be taken home weekly (or more often for soiled clothing), and
3. If an odor problem is identified with the laundry, clothing will be sent to the facility laundry.

H. Activity Outings Policy

The Recreation Department plans outings into the community. These outings may be lunch, plays, concerts, dinner, etc. Every effort is made to keep the expenses for these outings at a reasonable cost. The cost will be explained to the Resident prior to each outing. It is the Resident's choice to participate in these activities. The Facility may charge for any outing the Resident chooses to attend that is not covered by the Facility.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the Activity Outings Policy set forth in the preceding section of this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ ________

☐ Resident Facility Representative Date

☐ Responsible Party

I. Telephone Services

Local telephone service is available to all Residents, charged directly to the Resident at the cost of set up and monthly charges according to local phone company. Residents desiring bedside telephone service must provide their own telephone and telephone cord.

I do _____ do not _____ wish to have telephone services. I understand the charges incurred by my choice.

I do _____ do not _____ give my consent to release my personal telephone number to those persons that request it when calling in.

I do _____ do not _____ give my consent to publish my name, phone number, and room number in a Facility Directory.

J. Resident Mail

I authorize the Colorado State Veterans Home at Rifle to handle my mail as follows:

- Personal Mail

__________ Receive/open my personal mail and deliver it to me.

__________ Deliver my personal mail to me unopened.

__________ Deliver all my personal mail to my designated Responsible Party unopened.

- Business Mail

__________ Receive/open my business mail and deliver to me (e.g., Social Security Administration, third-party payers, financial statements, pension benefits, and medical providers.

__________ Deliver all business mail to me unopened.

__________ Deliver all business mail to my designated Responsible Party unopened.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the policies regarding Resident mail set forth in the preceding section of this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date
☐ Responsible Party

Section 3. Grievance Policy

The Colorado State Veterans Nursing Home at Rifle welcomes any input, positive or negative. If at any time, you or your family members and/or Responsible Party are not happy with services received, please feel free to speak with any department.

You may also fill out and submit a facility complaint/concern/compliment form that is located on each unit. If you have not reached resolution, please contact the Administrator at **ANY** time. If the problem has not been resolved to your satisfaction, please contact the Local Long Term Care Ombudsman at (303) 480-5630, or the Department of Public Health and Environment at (303) 692-2800.

Any Resident, family member, significant other may formally complain about any conditions, treatment or violations of the rights of any other Resident, regardless of the consent of the victim or the alleged improper treatment, condition or violation of rights by the facility or its staff. If you would like a copy of the Grievance Procedure, please ask your Social Services staff.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the Facility Grievance Policy set forth in the preceding section of this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date
☐ Responsible Party

Section 4. **Acknowledgement of Risks**

This Facility accepts residents of diverse cultures, religions, physical limitations, memory impairment, medically complex needs and mental illness. The Facility's open admission policies may result in certain risks that may be associated with living in a multi-complex environment. This may include residents with a history of assault, disruptive and other socially inappropriate behavior that is difficult to manage in a group setting.

The Facility will endeavor to do what is reasonable within its control to prevent the theft of a resident's property and to protect the resident from assault, abuse and mistreatment. However, due to the nature of the population, the Facility cannot guarantee the Resident will be free from assault, abuse, mistreatment or the theft of their property during placement in this facility.

I understand and accept the risks associated with choosing to live in this Facility. I understand that at any time I may seek alternate placement with the assistance of the Facility. However, I understand that the primary responsibility for finding another placement is mine.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the preceding terms set forth in this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date
☐ Responsible Party

Section 5. **Authorization for Photographs and Memory Boards**

The Resident/Responsible Party authorizes the Facility to take any photographs of the Resident that may be necessary for identification and/or medical purposes at any time during the Resident's stay at the Facility. The Resident/Responsible Party understands that the Resident has the right to privacy and these photographs cannot be used for any other purpose without the Resident's express written permission. This permission could also include photography for holiday activities, memory boards, cue boxes, promotional print materials, websites, newsletters and Resident of the Month.

The Resident/Responsible Party authorizes _____ does not authorize _____ the Facility to display written summary about the Resident's life history, hobbies, and/or personal information to provide Resident cueing and enhance quality of life.

CHAPTER 7: TRANSFERS AND DISCHARGE

A. Transfer Within the Facility

The Resident/Responsible Party understands that the Facility may find it necessary and/or appropriate (usually for medical reasons) to change the Resident's room or roommate during the Resident's stay at the Facility. If this occurs, the Facility will provide a five-day advance notice, unless waived, to the Resident/Responsible Party of any room or roommate change, unless an emergency requires that an immediate change be made.

B. Transfer to a Hospital

The Facility has written transfer agreements with one or more local hospitals. If the Resident's Attending Physician orders medical services or treatments for the Resident that are unavailable in the Facility, the Resident may be transferred to the hospital selected by such Attending Physician.

C. Voluntary Transfer or Discharge from the Facility

The Resident/Responsible Party may terminate this Agreement and voluntarily discharge at any time. However, the Resident/Responsible Party understands and agrees that the Resident/Responsible Party is legally obligated to pay any balance due to the Facility for services provided up to and including the date on which the Resident leaves the Facility. In addition, if the Resident leaves the Facility before his Attending Physician discharges the Resident, the Resident does so at their own risk.

D. Involuntary Transfer or Discharge from the Facility

The Facility may involuntarily transfer or discharge the Resident from the Facility for the reasons noted below:

1. The transfer or discharge is necessary for the Resident's welfare.
2. The Resident's care needs cannot adequately be met in the Facility.
3. The Resident no longer requires the services provided by the Facility because the Resident's health has improved sufficiently.
4. After reasonable and adequate notice, the Resident has either failed to pay or failed to arrange for a third party to pay charges incurred during the Resident's stay at the Facility.
5. The Resident's continued stay at the Facility would pose a health or safety risk to the Resident or others in the Facility.
6. The Facility is no longer certified to provide services to Medicare or Medicaid beneficiaries and the Resident fails to or is unable to pay privately for the charges incurred.
7. The Facility ceases to operate.

The Facility will notify the Resident/Responsible Party at least thirty (30) days in advance of any involuntary transfer or discharge whenever possible. This notice will be in writing and will state the reason for the transfer or discharge.

E. Exceptions to Advanced Written Notice Policy

The 30-day advance written notice for involuntary discharge is not required in any case in which:

- The health, safety or security of an individual or individuals in the Facility is endangered by the Resident's continued stay in the Facility.
- A more immediate transfer or discharge is required by the Resident's urgent medical needs.
- The Resident has resided in the Facility for less than thirty (30) days.

In the above cases, the Facility will attempt to give the Resident/Responsible Party as much advance notice of transfer or discharge as is practical.

F. Right to Appeal Involuntary Transfer or Discharge

If the Resident is involuntarily transferred or discharged, the Facility will notify the Resident/Responsible Party of the Resident's right to appeal the transfer or discharge.

G. Resident's Personal Property Upon Discharge

The Facility will attempt to reasonably safeguard the Resident's non-monetary personal property and belongings left in the facility, to the extent required by law and is described in this Agreement. The Facility will dispose of any non-monetary personal property and belongings that remain unclaimed 30 days after Resident's discharge from the Facility.

H. Discharge Planning

Prior to discharge, the Facility will assist the Resident in Discharge Planning. This may include review of medications and care issues that will continue post-discharge.

I. Resident Fund Monies Upon Discharge

The Facility will return the Resident's Personal Fund monies within 30 days after discharge less any monies owed to the Facility. If the monies are unclaimed after a period of time designated by state regulations, the Facility will give the money to the state.

By initialing below, I acknowledge that I have reviewed, understand, and agree to the transfer and discharge policies set forth in the preceding section of this Resident Admission Agreement.

RESIDENT: ____

Initials: ____________________ ____________________ __________

☐ Resident Facility Representative Date

☐ Responsible Party

CHAPTER 8: SIGNATURE PAGE

Section 1. Effect of Signatures

All signatures and initials in this Resident Admission Agreement carry the full force and effect of law. I attach my signature and initials under penalty of perjury. Furthermore, I certify that I am of sound mind and body and acting under proper authority to sign this agreement.

If changes in state or federal law result in any changes to any portion of this Agreement, the Agreement will be changed to comply with the law and the Resident/Responsible Party will be required to sign a revised copy of the Agreement.

Section 2. Key Terms

☐ I, ____, Resident, assent to the following:

(*Please initial each statement*)

__________ I have read the Resident Admission Agreement in full.

__________ I understand that this Resident Admission Agreement is a binding legal contract bearing the full force and effect of law.

__________ I understand that I have the opportunity to voice complaints, formally and informally, regarding any aspect of my care. I understand that I may do so by filing a grievance pursuant to this Resident Admission Agreement.

__________ I understand my financial duties and obligations under this agreement.

__________ I understand that payment is due on the 10th day of each month.

OR,

☐ I, ____, the designated Responsible

Party for ____, assent to the following:

(*Please initial each statement*)

__________ I have read the Resident Admission Agreement in full.

__________ I understand that this Resident Admission Agreement is a binding legal contract bearing the full force and effect of law.

__________ I understand that I have the opportunity to voice complaints, formally and informally, regarding any aspect of the Resident's care. I understand that I may do so by filing a grievance pursuant to this Resident Admission Agreement.

__________ I understand my financial duties and obligations under this Agreement.

__________ I understand that payment is due on the 10th day of each month.

__________ I understand that as Responsible Party, it is my obligation to ensure prompt and full payment of the Resident's bill.

__________ I understand that I must supply the facility with my full contact information. In the event that my contact information changes, I will notify the facility promptly.

__________ I understand that I must notify the facility if I am no longer serving as Responsible Party, regardless of whether the change was of my own choosing.

Section 3. Merger and Integration

This Agreement and the exhibits attached hereto contain the entire agreement of the parties with respect to the subject matter of this Agreement, and supersede all prior negotiations, agreements and understandings with respect thereto. This Agreement may only be amended by a written document duly executed by all parties.

Section 4. Severability

In the event that any one or more of the provisions contained herein shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this agreement, but this agreement shall be construed as if such invalid, illegal or unenforceable provisions had never been contained herein, unless the deletion of such provision or provisions would result in such a material change so as to cause completion of the transactions contemplated herein to be unreasonable.

Section 5. Choice of Law

This agreement shall be governed by the laws of the United States and the laws of the State of Colorado. Any litigation under this Agreement shall be resolved in the trial courts of the State of Colorado with proper jurisdiction.

Section 6. Waiver

The failure by one party to require performance of any provision shall not affect that party's right to require performance at any time thereafter, nor shall a waiver of any breach or default of this Contract constitute a waiver of any subsequent breach or default or a waiver of the provision itself.

SIGNATURES

I certify that I have reviewed this Resident Admission Agreement, understand its terms, and wish to enter a binding legal contract.

____

RESIDENT NAME

____ _______________

☐ Resident Date

☐ Responsible Party

____ _______________

Facility Representative Date