

PAZ HEALTHCARE MANAGEMENT, INC.

Assisted Living Facilities

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ADULT CARE FACILITY ADMISSION AGREEMENT

I. GENERAL PROVISIONS

This is the admission agreement between the operator(s) of **The Avalon** and

_____ and _____
Name of Resident Name of Resident's Representative

stating the terms and conditions of the resident's admission and living arrangements at **The Avalon** located at **1915 Route 376, Wappingers Falls, NY 12590**. This agreement is effective as of _____ and shall remain in effect until amended by the parties or until terminated by the parties in accordance with the provisions of Section VII of this agreement.

This agreement shall be attached to the application for admission provided by the facility.

The parties to this agreement understand that this facility is an adult care facility providing lodging, board, housekeeping, personal care and supervision services to the resident in accordance with New York State Social Services Law and the Regulations of the New York State Department of Social Services.

II. FACILITY SERVICES

The operator shall be responsible for the provision of the following:

- 1) A private () or semi-private () room (check one).
- 2) Board including three meals a day, served at regularly scheduled times; and a nutritious evening snack.
- 3) Personal care services as necessary on a twenty-four hour basis.
- 4) Twenty-four hour supervision.
- 5) Housekeeping services.
- 6) Linen Services.
- 7) Laundry of resident's personal washable clothing.
- 8) The following diet's when ordered by the resident's primary physician: (circle appropriate)
regular diet (2000 cal), no added table salt, no concentrated sweets,
reduced calories
- 9) An organized and diversified program of individual and group activities.
- 10) Case Management services.

III. RESIDENT RESPONSIBILITIES

The resident and the resident's representative shall be responsible for the following:

- 1) Payment of the required rate.
- 2) Supply of personal clothing and effects.
- 3) Payment of all medical expenses including transportation for medical purposes, except where payment is available under Medicare, Medicaid or third party coverage.
- 4) At the time of admission, a dated and signed medical evaluation which conforms to Department Regulations. Thereafter, a medical evaluation which conforms to Department Regulations at least once every twelve (12) months or more frequently if a change in condition warrants.
- 5) Informing the operator of change in health status, change in physician or change in medications.
- 6) In addition, the resident agrees to obey all reasonable rules of the facility and to respect the rights and property of the other residents.

IV. FINANCIAL ARRANGEMENTS

A. Rate

The resident and the resident's representative agree to pay and the operator agrees to accept the following payment in full satisfaction of the services which the operator must provide according to law and regulation:

*Monthly Rate \$_____ Payment due by 1st DAY FOR CURRENT MONTH

Prorated Rate \$_____ Due UPON ADMISSION for date of admission to 1st of month.

Daily Rate \$_____

*Must include payment made by a third party.

B. Supplemental Services

If the operator provides services and supplies beyond those required by law and regulation, he agrees to itemize in or attach to this agreement a listing of such services and supplies as well as the basis for additional charges, fees or assessments for such services or supplies. The operator guarantees that supplemental services or supplies shall be provided at resident option and charges shall be made only for services and supplies actually chosen by and provided to the resident. The operator agrees to provide these services and supplies to residents who receive Supplemental Security Income (SSI) or Home Relief (HR) payment at a charge that is reasonably related to the cost of the services or supplies.

C. Adjustments to the Rate/Supplemental Services Charges

The operator agrees not to charge additional fees or assessments in excess of those stated in this agreement with the following exceptions:

1) Upon the express written approval and authority of the resident or his representative; or,

2) To provide additional care, services or supplies upon the express order of the resident's primary physician; or

3) Upon thirty (30) days written notice to the resident and his representative of additional charges and expenses due to increased cost of maintenance and operation.

4) In the event of any emergency which affects the resident, additional charges may be assessed for the benefit of the resident as are reasonable and necessary for services, material, equipment, and food supplied during such emergency.

D. Reservation

The operator agrees to reserve the resident's residential space in the event of the resident's absence. The charge for this reservation shall be \$_____ per month. (The total of the daily rate for a one month period may not exceed the established monthly rate). The length of time the space shall be reserved is 30 days. A provision to reserve a residential space does not supersede the requirements for termination as set forth in Section VII of this agreement.

E. Gifts

If a resident wishes to voluntarily transfer money, property or things of value to the operator upon admission or at any other time, the operator shall attach a listing of the items to be transferred to this agreement. This listing shall become part of this agreement and include any agreements made by third parties for the benefit of the resident.

F. Tipping

The operator shall not accept, nor allow his staff or agents to accept any tip or gratuity in any form.

V. RESIDENT'S RIGHTS AND PROTECTION

The operator agrees to provide the resident with a copy of the Resident's Rights and Protection Pamphlet and to treat each resident in accordance with the principles stated therein.

VI. PERSONAL ALLOWANCE ACCOUNTS

The operator agrees to offer to establish a personal allowance account for any resident who receives either Supplemental Security Income (SSI) or Home Relief (HR) payments by executing a Statement of Offering (DSS-2853) with the resident or his representative.

The resident agrees to inform the operator if he/she receives or has applied for SSI or HR funds.

The resident or the resident's representative shall complete the following:

I receive funds as follows:

SSA PENSION VA PENSION OTHER _____

I receive SSI funds or I have applied for SSI funds

I receive HR funds [] or I have applied for HR funds []
I do not receive either SSI or HR funds []
I do not receive any other types of funds []

VII. TERMINATION

_____ This admission agreement and residency in the facility may be terminated in the following ways:

1. by mutual agreement of the resident and operator;
2. upon ____ days notice from the resident to the operator of the resident's intention to terminate the agreement and leave the facility;
3. upon 30 days written notice from the operator to the resident. Involuntary termination of an admission agreement is permitted only for the reasons listed below, and, if the resident objects to the action, only after the operator initiates a court proceeding and the court rules in favor of the operator.

The grounds upon which involuntary termination may occur are:

1. the resident requires continual medical or nursing care which the adult care facility cannot provide;
2. the resident's behavior poses imminent risk of death or imminent risk of serious physical harm to himself or anyone else;
3. the resident fails to make timely payment for all authorized charges, expenses and other assessments, if any, for services including use and occupancy of the premises, materials, equipment and food which the resident has agreed to pay pursuant to the resident's admission and services agreement. If failure to make timely payment resulted from an interruption in the receipt by the resident of any public benefits to which he is entitled, no involuntary termination can take place unless the operator, during the 30 day notice period, assists the resident in obtaining such benefits, or any other available supplemental public benefits. The resident must cooperate with such efforts by the operator;
4. the resident repeatedly behaves in a manner that directly impairs the well-being, care or safety of the resident or any other resident or which substantially interferes with the orderly operation of the facility;
5. the operator has had its operating certificate limited, revoked, temporarily suspended or the operator has voluntarily surrendered the operating certificate of the facility to the New York State Department of Social Services; or
6. a receiver has been appointed pursuant to Section 461-f of the New York State Social Services Law and is providing for the orderly transfer of all residents in the facility to other facilities or in making other provision for the residents' continued safety and care.

If the operator decides to terminate the admission agreement for any of the reasons given above, the operator will have hand delivered to the resident a notice of termination on a form prescribed by the State Department of Social Services. Such notice will include the date of termination and discharge, which must be at least 30 days after delivery of the notice, the reason for termination, a statement of the resident's right to object and a list of free legal and advocacy resources

approved by the State Department of Social Services. Copies will be sent to the resident's next-of-kin, legally responsible relatives, and to the appropriate regional office of the State Department of Social Services.

The resident may object to the operator about the termination and may be represented by an attorney or advocate. When the resident challenges the termination, the operator, in order to terminate, must institute a special proceeding in court. The resident will not be discharged against his will unless the court rules in favor of the operator.

VIII. TRANSFER

Notwithstanding the above, the operator may seek appropriate evaluation and assistance and may arrange for the transfer of a resident to an appropriate and safe location, prior to termination of an admission agreement and without 30 days notice or court review, for the following reasons:

1. when a resident develops a communicable disease, medical or mental condition, or sustains an injury such that continual skilled medical or nursing services are required. When the basis for the transfer no longer exists, and the resident is deemed appropriate for placement in an adult home, he shall be readmitted;
2. in the event that a resident's behavior poses an imminent risk of death or serious physical injury to himself or others;
3. when a receiver has been appointed under the provisions of New York State Social Services Law is providing for the orderly transfer of all residents in the facility to other facilities or is making other provision for the resident's continued safety and care.

After transfer, if return to the facility is not anticipated, the operator will initiate termination procedures as set forth in Section VII of this agreement.

IX. REFUND/RETURN OF RESIDENT MONIES AND PROPERTY

Upon termination of this agreement, the operator shall provide the resident with a final written statement of the resident's payment and personal allowance accounts at the facility. In addition, the operator shall return, within three business days of the termination of the agreement, any money, property or thing of value held in safekeeping or owed the resident. This shall include any money or property of the resident which comes into the possession of the operator after discharge.

The operator shall provide the resident with a refund based upon the daily charge and the date of termination if either the operator or the resident has given notice to terminate this agreement as provided for in Section VII above.

If the resident dies, the operator shall turn over the property of the individual to the legally authorized representative of the estate.

If a resident dies without a will and the whereabouts of the next-of-kin of the individual are unknown, the operator shall then contact the Surrogate's Court of the County wherein the facility is located in order to determine what should be done with the property of the individual.

X. WAIVER

Any modification or provision of this agreement not consistent with Social Services Law and the Regulations of the State Department of Social Services for Adult Care Facilities shall be null and void.

Waiver by the resident of any provision in this agreement which is required by law or regulation shall be null and void.

XI. AGREEMENT AUTHORIZATION

We, the undersigned, have read this agreement; have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

Date: _____

(Signature of Resident)

Date: _____

(Signature of Resident's Representative)

Date: _____

(Signature of Operator Designee)

SUPPLEMENTAL SERVICES AND SUPPLIES

This statement is a part of the admission agreement, and shall specify operator responsibility to provide and resident responsibility for payment of the following items:

ITEMS	BASIS FOR THE ADDITIONAL CHARGE
Dry Cleaning	[] _____
Professional Hair Grooming	[] _____
Personal Toilet Articles	[] _____
Commissary Goods	[] _____
Extraordinary Activities Supplies	[] _____
Special Cultural Events	[] _____
Transportation	[] _____
*Medical	[] _____
Recreation	[] _____
Long Distance Telephone Calls	[] _____
Other (Specify)	[] _____

Signature of Resident _____ Date _____

Signature of Resident's Representative _____ Date _____

Signature of Operator or Designee _____ Date _____

* Except where payment is available under Medicare, Medicaid or third party coverage.

YEAR _____

STATEMENT OFFERING PERSONAL ALLOWANCE ACCOUNT

For Supplemental Security Income (SSI) and Home Relief (HR) Recipients.

I understand that Social Services Regulations provide me, as an SSI or HR recipient with a personal allowance which may be used as I wish for clothing, personal hygiene items, and other supplies, services, entertainment, or transportation for my personal use.

I understand that the operator cannot accept my personal allowance to pay for supplies and services that the operator is required by law, regulation, or admission agreement. In addition my personal allowance may not be used to pay the operator for any services for which payment is available under Medicare, Medicaid, or third party coverage.

I understand that the operator must offer me or my representative a facility maintained personal allowance account to safeguard my personal allowance fund.

I understand that if I or my representative choose a facility maintained personal allowance account, the Department of Social Services Regulations require the operator to: make these funds available to me for my own use; tell me the business hours when I may deposit or withdraw my funds or review my personal allowance records; pay me interest (if my funds are in an interest bearing account); show or give me upon request, or at least every three month a summary of account which includes my current balance; tell me of any other important facts about my account.

I understand that I do not have to put my funds in a facility maintained account.

I understand that I may close my facility maintained account at any time and have my funds returned to me.

I understand that there are legal protection for my funds and account.

I understand that I may ask the Department of Social Services or legal/advocacy agencies to help me if I do not receive my personal allowance or have access to money in my personal allowance account.

CHECK ONE OF THE FOLLOWING BOXES:

I authorize the operator to establish a facility maintained personal allowance account.

I do not authorize the operator to establish a facility maintained personal allowance account.

As representative for _____, I agree to comply with the personal allowance requirements set forth above.

I do ____, I do not ____, authorize the operator to establish a facility maintained personal allowance account.

I am not an SSI or HR recipient. However the operator has offered to maintain a personal fund account for me, I hereby authorize such an account.

I am not an SSI or HR recipient. I do NOT wish to have a personal allowance account.

FACILITY NAME: AVALON

Signature of Resident _____

Date _____

Signature of Resident's
Representative _____

Date _____

Authorized Facility
Representative

Date _____