

Resident Admission Contract of [Name of Facility]

This Contract Has Been Approved by
The Maryland Department of Health and Mental Hygiene

*Denotes optional sections or paragraphs. The Facility should select the appropriate paragraph(s) before having the contract printed.

1. This Contract is between _____ (the "Facility", or "we", or "us") and _____ (the "Resident" or "you"). This contract contains your financial obligations, as well as your rights as a Resident of this Facility.

2. In consideration of your payment and promises made in this Agreement, the Facility agrees to do the following:

Health Care Services

A. We will provide you with general nursing care and nursing treatments such as administration of medication, preventive skin care, assistance with bathing, toileting, feeding, dressing and mobility. (Throughout this Agreement is information about which services are covered in the Facility's daily rate and which are available for an additional charge.)

B. When your doctor orders health care services which we do not have the capability to provide, with your approval we will arrange for the services to be provided by an outside provider, or we will arrange for your transfer to the hospital or other health care providers.

Personal Services

C. We will provide you with room and board, housekeeping services, recreational and social programs, and personal care.

D. We will provide you with a reasonable amount of storage space for your personal belongings.

E. At your request, we will maintain your personal funds in compliance with the laws and regulations relating to our management of your funds. See Exhibit 4.

3. Paying for Your Care.

A. Who Can be Required to Pay for Your Care.

Only you and your insurer can be required to pay for your care. No other person - e.g., a family member, friend, neighbor, legal agent or guardian - can be required to pay for your care from their own funds, although he or she may knowingly and voluntarily agree to pay for the cost of your care.

We require you or any other person responsible for making payments on your behalf to pay for your care under the terms of this contract in a timely manner. If you or anyone else with authority to pay for your care on your behalf fails to pay a Facility bill, we may request a court to order such payment.

You agree to provide all information requested by us about your health and financial status and to update this information while you are a resident here. You understand that if we later find that you knowingly or willfully provided us with incomplete or inaccurate information, we will consider that as a breach of this Agreement which gives us the right to pursue all legal remedies against you.

It is anticipated that your care will be paid for by:

- Γ The Medicare Program;
- Γ The Medicaid Program (also known as "Medical Assistance");
- Γ Other third-party insurer (please specify:

- Γ _____);
- Γ You with your own funds; or
- Γ Another person with your funds (please specify: _____);
- Γ Another person who has voluntarily agreed to pay with their own funds (please specify: _____).

It is understood that Medicare and Medicaid will make the determinations concerning your medical and financial eligibility for payment by those programs.

You agree to pay either directly or through a third party payor for all items and services provided to you by the Facility. You request that the Facility send your bills to: _____.

B. Private Pay Residents.

The items and services included in our daily rate of _____ include basic room, board and general nursing care as required by your medical condition and are listed in Exhibit 1. Payment for items and services that are included in the daily rate is payable one month in advance and due on the first of each month, and you (or your agent) agree to make timely payment.

You will be charged separately for additional items and services which you or your physician, with your approval, request and which are not included in our daily rates such as special nursing care, special equipment, pharmacy charges, laboratory charges and additional services such as telephone expenses, clothing, beauty and barber services and newspapers. A list of many of the ordinary items and services for which you may be charged is at Exhibit 1. If you (or your physician, with your approval) request items or services other than those listed in Exhibit 1, you will be notified of the cost. Payment for these additional items and services is due within thirty (30) days after you (or

your physician with your approval) have requested them, and you have received and have been billed for them. Within ninety (90) days of receiving an item or service, or within thirty (30) days of payment, you have the right to ask us for an itemized statement that briefly but clearly describes each item and service, the amount charged for it, and the identity of the payor billed for the service.

You understand and agree that you (or your agent) are responsible for paying the Facility for items and services provided to you during any period of time in which you are or were a resident of the Facility and during which you have not been determined eligible for Medical Assistance. If you (or your agent) do not pay the amount you owe us after receiving Facility bills, and we hire a collection agency or attorney, you agree to pay for their fees, expenses and costs.

If you do not pay what is owed the Facility, you agree to apply to Medical Assistance for a determination of your income and assets available to pay the cost of your care. Once Medical Assistance determines the income and assets available to pay for your care, you agree to use such income and assets to pay the Facility's bills.¹ (Your request for this determination is not the same as applying for Medical Assistance.)

You agree to notify the Facility promptly if you have insufficient income, funds or assets, to meet your financial obligations to

¹ If you do not request a determination by Medical Assistance, or if payment is not made with the income and assets determined to be available for your care, the Facility may ask the court to order you to obtain the determination or to make payment.

the Facility and you agree promptly to apply for Medical Assistance benefits. You agree to cooperate fully in applying for Medical Assistance and in the eligibility determination process. If you do not apply or cooperate fully in the process, the Facility may ask a court to order you to do so.

If you are no longer able to pay for your care at the Facility and you are not eligible for Medical Assistance, you will be notified of the Facility's intention to discharge you for non-payment. You agree to continue to pay the Facility's prevailing daily charges until the date of your departure.

NOTE: For nursing facilities where a resident has entered into a continuing care agreement with the possibility of charitable care (COMAR .28A(13)), the above paragraph needs to be revised to reflect this possibility by stating "If you are no longer able to pay for your care at the Facility and you are not eligible for Medical Assistance, you will be notified of the Facility's intention to discharge you for non-payment, unless we decide to wholly or partly subsidize you pursuant to the terms of your [insert title of continuing care agreement]. You agree to continue to pay the Facility's prevailing daily charges until the date of your departure."

If there is any dispute about whether you should be discharged, the notice and other requirements in Section 4.F. apply. If transfer or discharge becomes necessary because you or someone else abused your funds, the Facility will request that the Attorney General investigate which may result in prosecution.

If you believe that you may need to apply for Medical Assistance later, you may want to find out now if you are "medically eligible" for nursing home payment by Medicaid. See Exhibit 2B. This is not, however, the same as applying for Medical Assistance.

C. Medicare Residents

*We participate in the Medicare Program. Medicare may pay for some or all of your nursing home care. For information on Medicare, see Exhibit 2A. If you are eligible for Medicare, you have the right to have claims for your nursing home care submitted to Medicare. If Medicare agrees to pay for your care, you understand that Medicare requires a co-payment (for most covered services) and you agree to make the required co-payment, currently \$_____, which Medicare changes yearly. You also understand that some items and services offered by the Facility are not covered by Medicare and if you want any of these items or services, you agree to pay for them. (A list of the items and services not covered by Medicare and charges for them are at Exhibit 3.) If you also participate in Medicare, Part B, for physical, occupational, or speech therapy or other billable charges (which are not covered by Medicare, Part A), you agree to pay any required deductible, and any applicable co-insurance.

*We do not participate in the Medicare Program for inpatient services. If during the time you are a Resident you wish to have inpatient services reimbursed by Medicare, we will assist you in finding and transferring you to a facility that participates in the Medicare Program, unless you wish to remain here and pay privately for inpatient services.

D. Medicaid Residents.

[FACILITY: If you participate in Medicaid, use all paragraphs with one star (*). If you do not participate in Medicaid, use the paragraphs with two stars(**).

*We participate in the Medicaid program. For information on Medicaid, see Exhibit 2A. You are not required to give up any of your rights to Medicaid benefits to be admitted or to stay here. If your private funds are used up during your stay here and you are eligible for Medicaid, we will accept Medicaid payments.

*You are responsible for applying for and obtaining Medicaid benefits and we will assist you, by promptly providing Medical Assistance with all required information in our possession. We may not charge, ask for, accept or receive any gift, money, donation or consideration other than Medicaid reimbursement as a condition of your admission or continued stay here.

*If you receive Medicaid, most of your nursing home charges such as room, board and general nursing care are covered, although Medicaid may require you to pay some amount from your monthly income. The local Department of Social Services will tell you whether you have to pay part of the charge for your care and, if so, how much. You understand and agree to pay on a timely basis this contribution amount as determined and periodically adjusted by the local Department of Social Services. If you (or anyone else with authority to pay) fail to pay this amount, we may request a court to order such payment.

*A list of the items and services covered by Medicaid is posted (which is published at COMAR 10.09.10.04) in the Facility at the following location:

_____ . If you would like your own copy the Facility will give you one.

*Some of the items and services that we offer are not covered by Medicaid. If you want any items or services which are not covered by Medicaid, you or your agent will have to pay for them. A list of the items and services not covered by Medicaid and the charges for them are at Exhibit 3. Payment for items and services that are not covered by Medicaid is due after you or your physician with your approval have requested them and you have received and have been billed for them. Within ninety (90) days of receiving an item or service, or within thirty (30) days of payment you have the right to ask us for an itemized statement that briefly but clearly describes each item and the amount charged for it, and the identity of the payor billed for the service.

*You understand that non-payment of items and services not covered by Medicaid may result in a discharge action for non-payment of bills. If all of your personal needs have been met, you understand that money in your personal funds account may be needed to pay for items and services not covered by Medicaid which were requested by you (or your physician, with your approval) and are provided by the Facility.

**We do not participate in the Medicaid Program. If, after you are admitted here, you no longer have sufficient funds to remain, we will assist you in finding and transferring you to a facility that participates in the Medicaid Program. If there is any dispute about your transfer or discharge, the notice and other requirements described in Section 4.F. will apply.

E. Increases in Charges and Fees.

Any time we increase a fee or charge for an item or service or add a new item or service, we will provide you and your agent with forty-five (45) days advance written notice.

F. Interest Penalties.

We may not charge you a penalty if you pay your bill on time. Your payment is on time if it is made within 45 days of the date the itemized statement is postmarked, or 30 days after the end of the billing period, whichever is later. The interest penalty we charge is ____% of the amount due, calculated on either a () daily or () monthly basis. For any bill delinquent over one month, penalties will be calculated on either a () simple or () compound basis.²

² The Facility may not charge interest on a Medical Assistance recipient's contribution to the cost of care for covered services.

G. Private Duty Nurses/Geriatric Aides.

*1. We do not allow private duty nurses/geriatric aides.

*2. If you want a private duty nurse or a private duty geriatric aide, you are responsible for selecting a person licensed and/or certified according to Maryland laws and regulations. You are also responsible for paying him or her, and for letting us know that you have hired one. The person you hire is not an employee or agent of the facility, but he or she must meet our standards and follow our policies and procedures. Employees of the Facility may not serve as private duty nurses or private duty geriatric aides.

H. Limitations of Liability.

The Facility is obligated to take reasonable precautions to provide you and your personal belongings with security, including providing a reasonable amount of secured space for your belongings. The Facility, however, cannot be responsible for any loss or damage to your valuables or money that is not delivered into the custody of the Facility Administrator or his/her designee, unless that loss or damage is caused by the negligent or willful action of the Facility staff. The Facility's Policies and Procedures concerning your personal funds and your personal property are at Exhibit 4.

If, in spite of the Facility's best efforts, there is loss or damage to property, or injury or death to persons, which is mutually agreed to be or determined by an appropriate third party to be caused solely by you, you agree to be responsible for the damage, injury, or death. This responsibility includes payment for damages and all costs including reasonable attorneys fees and expenses required to defend a claim resulting from such damage.

In addition, although you have the right to make your own health care decisions, including the right to refuse treatment, you accept responsibility for any consequences resulting from your refusal to

accept nursing or medical treatment or service considered by your physicians to be necessary for your care.

4. Your Rights as a Resident.

As a Resident of this Facility, you have many rights under federal and State law. Some of those rights are listed in this section. You will be given a written description of all of your rights.

A. Your Right to Make Decisions.

You have the right to make your own medical decisions, to manage your personal affairs and to access your medical records as permitted by law. If you become incapable of making your own decisions, it may be necessary for someone else to make decisions for you. For this reason, we recommend that you make advance directives for medical decisions and appoint a Power of Attorney for financial decisions, but you are not required to do so. It is recommended that you consult with an attorney to prepare a financial Power of Attorney. As part of the admission process, you will be given a description of your legal rights to decide about your future medical treatment, as well as information about making advance directives. If you make an advance directive, you should provide the Facility with a copy.

B. Selection of a Doctor or Other Provider.

You may select your own doctor and other health care providers. Your doctor and other health care providers must follow our policies.³ You or your insurer, including the Medicaid Program, is responsible for your doctor's payment. If you do not have your own doctor, you may choose one from the list of physicians who practice here. This list is attached as Exhibit 5. If you or your agent are unable to

³ If your doctor and other health care providers do not follow Facility policies and procedures, the Facility will ask you to choose other providers.

choose your own doctor, we will assign one to you from this list. In case your doctor is not available when needed, our Medical Director, or designee, will take care of you until your doctor is available.

Some services you may require are available through outside providers. Some available outside providers and whether the Facility has a shared ownership interest with the Provider are at Exhibit 6.

C. Your Personal Property and Financial Affairs.

You have certain rights relating to your personal property and managing your financial affairs. The Facility's policy and procedure concerning these rights is at Exhibit 4.

D. Your Right to Make Complaints and Suggest Changes in Policies and Services.

You may make complaints about your care in the Facility and you may also suggest changes in the policies and services of the Facility. You will not be harassed or discriminated against for making a complaint or suggesting a change in a policy or service. You may present your complaints orally or in writing to Facility staff or the Administrator, or to one of the following State agencies:

Office of Health Care Quality
Bland Bryant Building
Spring Grove Hospital Center
55 Wade Avenue
Catonsville, MD 21228
(410) 402-8110
(877) 402-8219
(800) 735-2258 (TTY)
(410) 402-8234 (Facsimile)

Department of Aging
301 West Preston Street
Room 1007
Baltimore, MD 21201
(410) 767-1074
(800) 243-3425
(410) 767-1083 (TTY)
(410) 333-7943 (Facsimile)

If the Facility is unable to resolve your complaint, it will be sent to the Department of Aging and the Office of Health Care Quality. You may request a hearing from that Office.

E. Holding Your Bed if You Leave the Facility.

If you are hospitalized or on leave from the Facility, we will hold your bed for you as follows:

1. If you are a private-pay resident, or are receiving inpatient care reimbursed under the Medicare Program (and you are not covered under Medicaid), we will hold your bed for as long as you pay for it at the current daily rate unless you notify us otherwise.

2. If Medicaid pays for part or all of your nursing home care and you need to be hospitalized, we will hold your bed for up to the maximum number of days required under Medicaid regulations, currently ____ days. If you are away from the Facility on a leave of absence which is provided for in your plan of care and approved by your physician, we will hold your bed for up to the maximum number of days required under Medicaid regulations, currently ____ days each calendar year. While we are holding your bed, you are still required to pay the Facility any amount for which you are responsible as determined by the Medicaid Program.

If your hospitalization or leave exceeds the number of days paid by the Medicaid Program, you may pay privately to reserve your bed for the additional days. In any case, if your hospitalization or leave of absence exceeds the total number of days paid by the Medicaid Program or any other payer, you have the right to be readmitted to the first available gender-appropriate semi-private bed.⁴

The maximum number of days for which the Medicaid Program will pay to hold your bed for hospitalization or leave of absence may be increased or decreased based upon changes in the law

⁴ Semi-private means a two, three or four-bed room.

or the regulations established by the Maryland Medical Assistance Program.

3. If you have applied for Medicaid, your bed will be reserved in accordance with Paragraph 2. However, if you are found to be ineligible for Medicaid, then you are required to pay for the bed as a private pay patient as described in Paragraph 1.

4. Other third-party payors may or may not have a bed hold policy. We will discuss this if it applies to you.

F. Transfer and Discharge.

You have the right to remain here, and you may not be transferred or discharged against your will, except for the following reasons: (a) your condition has improved so that you no longer need the services we provide; (b) the transfer or discharge is necessary for your welfare and your needs cannot be met by the Facility; (c) the health or safety of an individual in the Facility is endangered; (d) you, after reasonable and appropriate notice, have failed to pay (or through your insurers have failed to pay) for a stay at the Facility; or (e) the Facility ceases to operate.

NOTE: For nursing facilities where a resident has entered into a continuing care agreement, the above paragraph should be revised as follows: “You have the right to remain here, and you may not be transferred or discharged against your will, unless both (i) the transfer or discharge is permitted under the terms of your [insert title of continuing care agreement]; and (ii) one of the following reasons exists for the transfer or discharge: (a) your condition has improved so that you no longer need the services we provide in this Facility; (b) the transfer or discharge is necessary for your welfare and your needs cannot be met by this Facility; (c) the health or safety of an individual in the Facility is endangered; (d) you, after reasonable and appropriate notice, have failed to pay (or through

your insurers have failed to pay) for a stay at the Facility; or (e) this Facility ceases to operate.”

If the Facility identifies one of these reasons for transfer or discharge, we will notify you and your family member, guardian, or representative by letter 30 days in advance. We also will notify the Office of Health Care Quality and the Department of Aging. If you are transferred because of an emergency situation, we will provide the required notice as soon as reasonable. The involuntary discharge letter will contain the reasons for the transfer or discharge and its effective date, the location to which you will be transferred or discharged, and your rights regarding discharge or transfer. The letter will also tell you how you can appeal our decision to transfer or discharge you, by requesting a hearing, and will tell you what agencies you can call for assistance.

NOTE: For nursing facilities where a resident has entered into a continuing care agreement, the first sentence of the above paragraph should be modified as follows: “If the Facility determines that the transfer or discharge is permitted under the terms of your [insert title of continuing care agreement] and identifies one of the reasons listed in (a) through (e) above for the transfer or discharge, we will (i) comply with the terms of your [insert title of continuing care agreement] with respect to the transfer or discharge and (ii) notify you and your family member, guardian, or representative by letter sixty (60) days in advance.”

If you are to be discharged involuntarily, we will comply with current law in making discharge or transfer arrangements.

You and your next of kin or legal agent must cooperate and assist in the discharge planning, including cooperating with and assisting other facilities considering admitting you and cooperating with governmental agencies. If you or the Facility believe that an abuse of funds contributed to the transfer or discharge for non-payment, you may, or the Facility will, ask the Attorney General to investigate and make referrals to other governmental agencies.

5. Your Right to End This Contract.

If you decide to end this Contract and leave the Facility, your bill becomes due and payable on the day you leave. You must give us _____ days notice to terminate this contract. If you leave before the end of that time, you must still pay for each day of the required notice unless we fill the bed before the end of the notice period.

In the event you die while a resident of the Facility, please designate who you want us to contact:

Relative	or	Friend:
<hr/>		
Funeral		Home:
<hr/>		

Unless you have instructed us otherwise, we will immediately contact the individual(s) listed above to make funeral arrangements. If we are unable to reach the individual(s), we will contact the funeral home directly.

6. Additional Documents.

It is not possible to cover everything that is important to your stay in our Facility in the body of this Contract. Therefore, we have included additional important documents as Exhibits. These Exhibits are part of this Contract. Please verify that you received the Exhibits and that the contents of the Exhibits were explained to you by placing your initials on the line next to the description of each Exhibit.

_____ Exhibit 1. Private Pay:

A. Items and Services Included in the Daily Rate;

- B. Items and Services Not Covered by the Daily Rate.

____ Exhibit 2.

- A. How to Apply For and Use Medicare and Medicaid Benefits.
- B. Medical Assistance Nursing Facility Services (Medicaid Medical Eligibility Form)

____ Exhibit 3. Items and Services Not Covered by Medicare or Medicaid.

____ Exhibit 4. Policies and Procedures Concerning Your Personal Funds and Your Personal Property.

____ Exhibit 5. Physicians Who Practice at the Facility.

____ Exhibit 6. Services Provided by Outside Health Care Providers.

7. Changes In Law.

Any provision of this Contract that is found to be invalid or unenforceable as a result of a change in State or Federal law will not invalidate the remaining provisions of this Contract and, it is agreed that to the extent possible, the Resident and the Facility will continue to fulfill their respective obligations under this Contract consistent with the law.

IN WITNESS WHEREOF, the parties have executed this Contract on this _____ day of _____, 20_____.

WITNESS:

[NAME OF FACILITY]

By: _____
Name: _____
Title: _____

WITNESS:

RESIDENT:

EXHIBIT 1

FOR PRIVATE PAY RESIDENTS

A. Items and Services Included in the Daily Rate.

The items and services included in the daily rate, and their related charges, are listed below:

Description of Items & Services Included In The Daily Rate*	
1.	Room
2.	Board
3.	Social Services
4.	Nursing care, including: <ul style="list-style-type: none">a. The administration of prescribed medications, provision of treatments and diet;b. The provision of care to prevent skin breakdown, bedsores and deformities;c. The provision of care to keep the resident comfortable, clean and well-groomed;d. The provision of care to protect the resident from accident, injury and infection;e. The provision of care necessary to encourage, assist and train the resident in self-care and group activities.
5.	Other:

* Revise this list to accurately reflect those items and services included in your Facility's Daily Rate.

B. Items and Services Not Included in the Daily Rate.

The items and services available in the facility that are not included in the daily rate are listed below. You may be charged for these items and services if you (or your physician with your approval) ask for them and you receive them. If you are eligible for Medicare and/or have private insurance and you believe that Medicare and/or your private insurance may cover an item or service listed below, you should ask us to submit the bill to Medicare and/or your private insurance. (The services marked (*) may have a separate supply charge. You will be notified of those charges at the time the supplies are ordered.)

Description of Items & Services Not Included in the Daily Rate	Charge
Beauty and Barber*	
Catheter Care*	
Colostomy Care*	
Decubitus Care*	
Feeding: hand, tube*, special diet	
Incontinent Care*	
IV Therapy*	
Laundry*	
Laboratory (Billed by the Laboratory; call _____ for charges)	
Oxygen Therapy*	
Pharmacy (Billed by the Pharmacy; call _____ for charges)	
Radiology (x-ray services) (Billed by the Radiologist; call _____ for charges)	

Description of Items & Services Not Included in the Daily Rate	Charge
Rental Fees: £walker; £geriatric chair; £wheelchair; £pressure mattress; £trapeze	
Suctioning*	
Tracheotomy Care*	
Other:	

EXHIBIT 2A
HOW TO APPLY FOR AND USE MEDICARE AND MEDICAID BENEFITS

The chart below summarizes the Medicare and Medicaid programs. It also tells you whom to call for more detailed information. If you have questions, our staff will also help you.

	MEDICARE	MEDICAID
WHAT'S COVERED	<ol style="list-style-type: none"> 1. Care in a hospital; 2. If you are admitted to an approved facility within thirty (30) days following a three-day qualifying hospital stay (not including the day of discharge) Medicare may cover up to 100 days of skilled nursing and rehabilitation care. This coverage depends on your medical condition, and whether your doctor orders the care on a daily basis (not including weekends). If these conditions are met, Medicare provides full coverage for the first 20 days. You must make a copayment after that. The following services are examples of skilled care: <ol style="list-style-type: none"> a. Injections & feedings given through an IV; b. Tube feedings; c. Application of a dressing that involves prescription medication; d. Treatment of pressure ulcers; 3. Dietary services; 4. Activities program; 5. Room/Bed maintenance services; 6. Routine personal hygiene items; 7. Medically-related social services; 8. Rehabilitation based on physician orders. 9. Medically necessary doctor's services. 	<p>Medicaid is a comprehensive program that will cover most of the costs of a nursing home stay.</p>
YOUR CONTRIBUTION	<p>Medicare does not pay 100% of the cost of covered services. You will be required to pay part of the charges. Your payment</p>	<p>Depending on your income, you may be required to make a</p>

	MEDICARE	MEDICAID
	<p>may be called a "copayment," "deductible" or "premium," depending on the type of care provided. If you receive Medicaid, Medicaid may pay for any payment that you are responsible for under Medicare.</p>	<p>contribution toward the cost of your care. The amount of any contribution will be calculated by the local Department of Social Services. You will need to pay this contribution to the Facility for every month in which you are eligible for Medicaid, including partial months.</p>
WHO'S ELIGIBLE	<p>People 65 years old or older who are eligible to collect old-age benefits under Social Security are eligible. Persons who receive Social Security disability benefits for at least 24 months, or have been found eligible for Medicare by the Social Security Administration because they have end stage renal disease requiring regular dialysis or kidney transplant are also eligible.</p>	<p>Eligibility is based on your income and resources (assets):</p> <p>1. <u>Resources</u>: The local Department of Social Services will evaluate your resources (assets) and tell you whether you qualify. Generally, you cannot have more than \$2,500 in resources. The following are examples of things <u>not</u> counted as resources:</p> <p>a. Your house if your spouse or dependent relative lives there or if you express an intent to</p>

	MEDICARE	MEDICAID
		<p>return there;</p> <ul style="list-style-type: none"> b. Household goods; c. Personal property in your possession in the nursing home; d. A certain amount of money for burial arrangements. <p>The value of other assets transferred within 36 months of your application for Medicaid may be considered as available to pay for your care at the Facility.</p> <p>1. <u>Income</u>: You should contact the local Dept. of Social Services to find out whether your income makes you eligible. That phone number is listed on the next page. If you</p>

	MEDICARE	MEDICAID
		<p>qualify, \$40 per month of your income is protected for your personal use while in the Facility.</p> <p>2. <u>Assets</u>: The local Dept. of Social Services will also be able to evaluate your assets and tell you whether you qualify . The following are examples of things <u>not</u> counted as assets: arrangements.</p>
		<p>NOTE: You will not be eligible for some period of time if you have transferred resources for less than fair market value to someone other than your spouse, or a blind or disabled child, within thirty-six months before you apply for Medicaid.</p> <p>2. <u>Income</u>: If your income is less than</p>

	MEDICARE	MEDICAID
		the facility's private pay rate, you may be eligible. If you qualify, \$40.00 per month of your income is protected for your personal use while in the facility. Medicaid may protect other portions of your income as well.
HOW TO APPLY	Contact the local Social Security Office at the following address and phone number:	Contact the local Department of Social Services at the following address and phone number:
WHO TO CONTACT IF YOU HAVE A QUESTION OR A PROBLEM	To learn more about Medicare coverage of nursing home expenses, and about how to appeal a Medicare denial of payment, contact Beneficiary Relations of the Centers for Medicare and Medicaid Services at 1-800-633-4227 or call the Senior Information and Assistance Program in your county.	If your application for Medicaid is denied, your coverage is terminated, or a service is not covered, you may appeal that decision according to the instructions contained in the notice provided to you.
RETROACTIVE COVERAGE	Not applicable.	The nursing home services that you received in the 3 months prior to your

	MEDICARE	MEDICAID
		application for Medicaid may be covered by Medicaid, if you specifically request this coverage.

**EXHIBIT 2B
MEDICAL ASSISTANCE
NURSING FACILITY SERVICES**

Important Information - Please Read Carefully

The Medical Assistance Program, also known as Medicaid, is a governmental program to help people pay their medical bills. To be eligible, one must be financially unable to pay the cost of medically necessary care. Eligibility, therefore, has two tests: (1) financial eligibility; and (2) medical eligibility. Financial eligibility is determined by the local Department of Social Services. Medical eligibility is determined by the Medical Assistance Program.

It is important to understand that even if you can no longer afford to pay for nursing facility care, Medical Assistance will not pay for nursing facility services unless you are also medically eligible for these services. You may obtain information regarding financial eligibility from the local Department of Social Services at no cost. If you want to know if you are medically eligible before you apply for Medical Assistance, for a nominal fee, you may obtain an assessment of your medical eligibility from the same contractor who currently functions as the State Review Agent for the Medical Assistance Program.

To obtain an assessment of your potential medical eligibility, you may call the current State Review Agent, KePRO, at 1-866-581-6773 or you may write to KePRO at:

KePRO
Executive Plaza II
11350 McCormick Road, Suite 102
Hunt Valley, Maryland 21031

Medical conditions of nursing facility residents change over time. Therefore, the assessment you receive is advisory only and is not binding on the Medical Assistance Program. The assessment will, however, assist you in making an informed decision regarding your need for nursing facility care or for less intensive community based care. Community alternatives to nursing facility services are available. Information about community alternatives can be obtained from your

Local Health Department, Geriatric Evaluations Services and from your local Area Agency on Aging Office.

If you want additional information regarding Medical Assistance nursing facility benefits, please do not hesitate to call (410)767-1712 and ask for the Nursing Facility Program Specialist.

**EXHIBIT 3
FOR MEDICARE AND MEDICAID RESIDENTS**

Items and Services Not Covered By Medicare or Medicaid

Items and services not covered by Medicare or Medicaid and related charges are listed below. You may be charged for these items and services if you (or your physician with your approval) ask for and you receive them. The services marked with an (*) may have a separate supply charge. You will be notified of those charges at the time the supplies are ordered.

<u>Item or Service</u>	<u>Charge</u>
Audiology Services;	
Beauty Salon and Barber Shop*;	
Cosmetic and Grooming Items;	
Dental Services (Billed by Dentist)	
Flowers and Plants;	
Newspapers (and other reading materials);	
Occupational and Physical Therapy Services*;	
(unless they are part of a specialized rehabilitative therapy services program meeting certain regulatory requirements);	
Personal Clothing;	
Personal Comfort Items (including smoking materials);	
Private Rooms**;	
Privately Hired Nurses and Aides;	
Services of Other Health Care Providers [Attach Facility Specific List];	

** If you receive Medicaid and the Facility places you in a private room, the Facility may not charge you or anyone else an additional cost for a private room.

Item or Service

Charge

Social Events and Entertainment Outside the Scope of the Facility's Activities Program;
Specially-Prepared or Alternative Food Requested Instead of Food Generally Prepared by the Facility;
Speech Therapy Services*;
Telephone;
Television;
Transportation by ambulance to a physician's office.

EXHIBIT 4
POLICIES AND PROCEDURES CONCERNING YOUR
PERSONAL FUNDS AND YOUR PERSONAL PROPERTY

A. Your Rights

1. You have the right to keep and use your personal property, including some furnishings and clothing, so long as there is enough space and other residents are not inconvenienced. You also have the right to security for your personal possessions.

2. You have the right to manage your financial affairs unless a court determines that you are disabled or the Social Security Administration selects an agent to receive Social Security funds for your use and benefit.

3. We cannot require you to deposit your personal funds with us. You may, however, choose any person to manage your funds, including the Facility.

4. If you decide to have us manage your personal funds, you may withdraw your money that we keep in the Facility during the Facility's business hours. If we have deposited any of your funds in a bank, you may obtain those funds within three banking days, provided the funds have cleared.

5. If you need help to perform your banking transactions, you may give an employee of our Facility who has been approved by the Administrator legal authority to access your account. This authority is called a "limited power of attorney." To give an employee this authority, you will need to complete a special form. The form has been approved by the Maryland Department of Health and Mental Hygiene and is available in the Facility.

6. You and your agent have the right, during normal business hours, to inspect our written records that concern your personal funds.

7. You or any other person acting on your behalf have a right to file a complaint if either of you believes that your funds, valuables or other assets have been stolen or damaged. The agencies to contact in order to make a complaint are listed below:

- a. The Maryland Department of Aging, for persons 65 years old or older:

301 West Preston Street
Baltimore, MD 21201
(410) 767-1074 - 800 243-3425 or
(410) 767-1083 (for the hearing impaired)
(410) 333-7943 (Facsimile)

- b. The local Department of Social Services for persons of any age:

{FACILITY: Please Provide Address & Phone #}

- c. The Office of Health Care Quality, regardless of your age:

Spring Grove Center
55 Wade Avenue,
Catonsville, Maryland 21228
(410) 402-8110 (877) 402-8219
(410) 735-2258 (for the hearing impaired)
(410) 402-8234 (Facsimile)

B. Our Responsibilities

1. We will provide a reasonable amount of secure space for you to keep your clothing and other personal property. We must investigate any damage to or loss of your personal property.

2. If you want us to manage \$50.00 or less of your personal funds, we will deposit this money in a non-interest bearing account or a petty cash fund.

3. If you want us to manage more than \$50.00 of your personal funds, we will deposit this money in an interest bearing account that is insured by the federal government. This account will be separate from the accounts we use to operate the Facility. In addition, we will credit you with all interest earned on your money.

4. We will maintain a full, complete and separate monthly accounting of your personal funds, which is available to you for inspection. We will also provide you with a quarterly statement of the activity of your account.

5. If you receive Medicaid benefits, we will notify you if your account balance becomes too high. If you are to remain eligible for Medicaid, your account balance must be under a certain dollar limit that is established by the federal government and may change periodically.

6. We may not use your personal funds to pay for an item or service that Medicare or Medicaid covers.

7. We will maintain adequate fire and theft coverage to protect your funds and personal property that are kept at the Facility. We shall also obtain a surety bond or otherwise assure* the security of your personal funds that are deposited with the Facility.

* CMS has determined that neither self-insurance nor FDIC insured accounts are an acceptable alternative.

8. If you are discharged, there are several things we must do:
 - a. We will immediately return your personal funds in our possession. If we have deposited your personal funds in a bank account, we will make this money available to you or your agent within three banking days; and
 - b. If we are your representative payee for Social Security benefits, we will promptly ask the Social Security Administration to name a new representative payee and we will transfer your money to that person.
9. In the event of your death, there are several things we must do:
 - a. We will convey your personal funds and a final accounting of those funds to the person in charge of administering your estate within 30 days;
 - b. We will immediately notify any government agency that paid for all or part of your care in our Facility. That agency shall have the right to assist us in determining what to do with your property;
 - c. If a government agency did not pay for your care, we will immediately notify your agent or next of kin to determine what to do with your property;
 - d. If we have your funds, valuables or other assets in our possession, we will hold them until the appointed personal representative of your estate presents a copy of the certified Letters of Administration to us, or until we receive authorization from another legal representative as established by State law;

- e. We will make reasonable attempts to locate your personal representative and your heirs. If no claim is made on your funds, valuables or other assets in our possession within six weeks of your death, we will write the State Office of the Comptroller for direction.

10. If we are in possession of your funds, valuables or other assets for more than one year from the date of your transfer or discharge, we will transfer your funds, any interest on your funds, and your valuables or other assets to the State Office of the Comptroller. We will also notify the Comptroller's Office of any account(s) in your name of which we have knowledge.

EXHIBIT 5

PHYSICIANS WHO PRACTICE AT THE FACILITY

Physician's Name	Physician's Address & Phone Number

EXHIBIT 6
SERVICES PROVIDED BY OUTSIDE HEALTH CARE PROVIDERS

Some of the services available in the Facility, such as pharmacy services, are provided by outside health care providers. These services, and information about the providers, appear below. You are free to pick your own provider or to use one of those listed below.

Type of Service	Provider's Name, Address & Telephone Number	Whether the Facility Has a Shared Ownership Interest with the Provider