CALIFORNIA STANDARD ADMISSION AGREEMENT FOR SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

State of California
Health and Human Services Agency
California Department of Public Health

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Resident Name: _____

Admission Date: _____ **Resident Number:** _____

Facility Name: RCJL _____

CALIFORNIA STANDARD ADMISSION AGREEMENT FOR SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

I. Preamble

The California Standard Admission Agreement is an admission contract that this Facility is required by state law and regulation to use. It is a legally binding agreement that defines the rights and obligations of each person (or party) signing the contract. Please read this Agreement carefully before you sign it. If you have any questions, please discuss them with Facility staff before you sign the agreement. You are encouraged to have this contract reviewed by your legal representative, or by any other advisor of your choice, before you sign it.

You may also call the Office of the State Long Term Care Ombudsman at 1-800-231-4024, for more information about this Facility. The report of the most recent state licensing visit to our facility is posted at the entrance to the unit, and a copy of it or of reports of prior inspections may be obtained from the local office of the California Department of Public Health (CDPH), Licensing and Certification Division
850 Marina Bay Pkwy. Building P Richmond, CA 94804
(Location of District Office)

If our facility participates in the Medi-Cal or Medicare programs, we will keep survey, certification and complaint investigation reports for the past three years and will make these reports available for anyone to review upon request.

If you are able to do so, you are required to sign this Agreement in order to be admitted to this Facility. If you are not able to sign this Agreement, your representative may sign it for you. You shall not be required to sign any other document at the time of, or as a condition of, admission to this Facility.

II. Identification of Parties to this Agreement

DEFINITIONS

In order to make this Agreement more easily understood, references to "we," "our," "us," "the Facility," or "our Facility" are references to:

Home for Jewish Parents
(Insert the Name of the Facility as it appears on its License)

Attachment A provides you with the name of the owner and licensee of this facility, and the name and contact information of a single entity responsible for all aspects of patient care and operation at this facility.

References to "you," "your," "Patient," or "Resident" are references to _____, the person who will be receiving care in this Facility. For purposes of this Agreement, "Resident" has the same meaning as "Patient."

The parties to this agreement are the Resident, the Facility, and the Resident's Representative. References to the "Resident's Representative" are references to: _____, the person who will sign on your behalf to admit you to this Facility, and/or who is authorized to make decisions for you in the event that you are unable to. To the extent permitted by law, you may designate a person as your Representative at any time.

Note: the person indicated as your "**Resident's Representative**" may be a family member, or by law, any of the following: a conservator, a person designated under the Resident's Advance Health Care Directive or Power of Attorney for Health Care, the Resident's next of kin, any other person designated by the Resident consistent with State law, a person authorized by a court, or, if the Resident is a minor, a person authorized by law to represent the minor.

Signing this Agreement as a Resident's Representative does not, in and of itself, make the Resident's Representative liable for the Resident's debts. However, a Resident's Representative acting as the Resident's financial conservator or otherwise responsible for distribution of the Resident's monies shall provide reimbursements from the Resident's assets to the Facility in compliance with Section V. of the agreement.

IF OUR FACILITY PARTICIPATES IN THE MEDI-CAL OR MEDICARE PROGRAM, OUR FACILITY DOES NOT REQUIRE THAT YOU HAVE ANYONE GUARANTEE PAYMENT FOR YOUR CARE BY SIGNING OR COSIGNING THIS ADMISSION AGREEMENT AS A CONDITION OF ADMISSION.

The Parties to this Agreement are:

Resident: _____
(Type or Print Resident's Name Here)

Resident's Representative: _____
(Type or Print Representative's Name Here)

Relationship: _____

Facility: Home for Jewish Parents
(Type or Print the Facility's Name as it appears on the License)

III. Consent to Treatment

The Resident hereby consents to routine nursing care provided by this Facility, as well as emergency care that may be required.

However, you have the right, to the extent permitted by law, to refuse any treatment and the right to be informed of potential medical consequences should you refuse treatment. We will keep you informed about the routine nursing and emergency care we provide to you, and we will answer your questions about the care and services we provide you.

If you are, or become, incapable of making your own medical decisions, we will follow the direction of a person with legal authority to make medical treatment decisions on your behalf, such as a guardian, conservator, next of kin, or a person designated in an Advance Health Care Directive or Power of Attorney for Health Care.

Following admission, we encourage you to provide us with an Advance Health Care Directive specifying your wishes as to the care and services you want to receive in certain circumstances. However, you are not required to prepare one, or to provide us a copy of one, as a condition of admission to our Facility. If you already have an Advance Health Care Directive, it is important that you provide us with a copy so that we may inform our staff.

If you do not know how to prepare an Advance Health Care Directive and wish to prepare one, we will help you find someone to assist you in doing so.

IV. Your Rights as a Resident

Residents of this Facility keep all their basic rights and liberties as a citizen or resident of the United States when, and after, they are admitted. Because these rights are so important, both federal and state laws and regulations describe them in detail, and state law requires that a comprehensive Resident Bill of Rights be attached to this Agreement.

Attachment F, entitled "Resident Bill of Rights," lists your rights, as set forth in State and Federal law. For your information, the attachment also provides the location of your rights in statute.

Violations of state laws and regulations identified above may subject our Facility and our staff to civil or criminal proceedings. You have the right to voice grievances to us without fear of any reprisal, and you may submit complaints or any questions or concerns you may have about our services or your rights to the local office of the California Department of Public Health, Licensing and Certification District Office _____, or to the State Long-Term Care Ombudsman (see page 1 for contact information).

You should review the attached "Resident Bill of Rights" very carefully. To acknowledge that you have been informed of the "Resident Bill of Rights," please sign here:

_____

V. Financial Arrangements

Beginning on _____(date), we will provide routine nursing and emergency care and other services to you in exchange for payment.

Our Facility has been approved to receive payment from the following government insurance programs: _____**Medi-Cal** _____**Medicare**

At the time of admission, payment for the care we provide to you will be made by:

_____**Resident (Private Pay)**
_____**Medi-Cal**
_____**Medicare Part A** **Medicare Part B:** _____
_____ **Private Insurance:** _____
(Enter Insurance Company Name and Policy Number)

_____**Managed Care Organization:** _____
_____ **Other:** _____

Resident's Share of Cost. Medi-Cal, Medicare, or a private payor may require that the Resident pay a co-payment, co-insurance, or a deductible, all of which the Facility considers to be the Resident's share of cost. Failure by the Resident to pay his or her share of cost is grounds for involuntary discharge of the Resident.

If you do not know whether your care in our Facility can be covered by Medi-Cal or Medicare, we will help you get the information you need. You should note that, if our Facility does not participate in Medi-Cal or Medicare and you later want these programs to cover the cost of your care, you may be required to leave our Facility.

[APPLICABLE ONLY IF DATE IS ENTERED:] On _____(date) our Facility notified the California Department of Health Care Services of our intent to withdraw from the Medi-Cal Program. If you are admitted after that date, we cannot accept Medi-Cal reimbursement on your behalf, and we will not be required to retain you as a Resident if you convert to Medi-Cal reimbursement during your stay here. If, on the other hand, you were a Resident here on that date, we are required to accept Medi-Cal reimbursement on your behalf, even if you become eligible for Medi-Cal reimbursement after that date.

YOU SHOULD BE AWARE THAT NO FACILITY THAT PARTICIPATES IN THE MEDI-CAL PROGRAM MAY REQUIRE ANY RESIDENT TO REMAIN IN PRIVATE PAY STATUS FOR ANY PERIOD OF TIME BEFORE CONVERTING TO MEDI-CAL COVERAGE. NOR, AS A CONDITION OF ADMISSION OR CONTINUED STAY IN SUCH A FACILITY, MAY THE FACILITY REQUIRE ORAL OR WRITTEN ASSURANCE FROM A RESIDENT THAT HE OR SHE IS NOT ELIGIBLE FOR, OR WILL NOT APPLY FOR, MEDICARE OR MEDI-CAL BENEFITS.

A. Charges for Private Pay Residents

Our Facility charges the following basic daily rates:

$ 352 for a private, single bed room

$ 272 for a room with two beds

$ 243 for a room with three beds

$ _____ for _____
(Specify any other accommodation here)

The basic daily rate for private pay and privately insured Residents includes payment for the services and supplies described in **Attachment B-1.**

The basic daily rate will be charged for the day of admission, but not for any day beyond the day of discharge or death. However, if you are voluntarily discharged from the Facility less than 3 days after the date of admission, we may charge you for a maximum of 3 days at the basic daily rate.

We will provide you with a 30-day written notice before increasing the basic daily rate, unless the increase is required because the State increases the Medi-Cal rate to a level higher than our regular rate. In this case, state law waives the 30-day notification.

Attachment B-2 lists for private pay and privately insured Residents optional supplies and services not included in our basic daily rate, and our charges for those supplies and services. We will only charge you for optional supplies and services that you specifically request, unless the supply or service was required in an emergency. We will provide you a 30-day written notice before any increase in charges for optional supplies and services.

If you become eligible for Medi-Cal at any time after your admission, the services and supplies included in the daily rate may change, and also the list of optional supplies and services. At the time Medi-Cal confirms it will pay for your stay in this Facility, we will review and explain any changes in coverage.

B. Security Deposits

If you are a private pay or privately insured Resident, we require a security deposit of $ one month rent.

We will return the security deposit to you, with no deduction for administration or handling charges, within 14 days after you close your private account or we receive payment from Medi-Cal, whichever is later.

If your care in our Facility is covered by Medi-Cal or Medicare, no security deposit is required.

C. Charges for Medi-Cal, Medicare, or Insured Residents

IF YOU ARE APPROVED FOR MEDI-CAL COVERAGE AFTER YOU ARE ADMITTED TO OUR FACILITY, YOU MAY BE ENTITLED TO A REFUND. WE WILL REFUND TO YOU ANY PAYMENTS YOU MADE FOR SERVICES AND SUPPLIES THAT ARE LATER PAID FOR BY MEDI-CAL, LESS ANY DEDUCTIBLE OR SHARE OF COST. WHEN OUR FACILITY RECEIVES PAYMENT FROM THE MEDI-CAL PROGRAM, WE WILL ISSUE A REFUND TO YOU.

If you are entitled to benefits under Medi-Cal, Medicare, or private insurance, and if we are a participating Provider, we agree to accept payment from them for our basic daily rate. **NEITHER YOU NOR YOUR REPRESENTATIVE SHALL BE REQUIRED TO PAY PRIVATELY FOR ANY MEDI-CAL COVERED SERVICES PROVIDED TO YOU DURING THE TIME YOUR STAY HAS BEEN APPROVED FOR PAYMENT BY MEDI-CAL. UPON PRESENTATION OF THE MEDI-CAL CARD OR OTHER PROOF OF ELIGIBILITY, THE FACILITY SHALL SUBMIT A MEDI-CAL CLAIM FOR REIMBURSEMENT.** However, you are still responsible for paying all deductibles, copayments, coinsurance, and charges for services and supplies that are not covered by Medi-Cal, Medicare, or your insurance. Please note that our Facility does not determine the amount of any deductible, copayment, or coinsurance you may be required to pay: rather, Medi-Cal, Medicare, or your insurance carrier determines these amounts.

Attachments C-1, C-2, and C-3 describe the services covered by the Medi-Cal daily rate, services that are covered by Medi-Cal but are not included in the daily rate, and services that are not covered by Medi-Cal but are available if you wish to pay for them.

Attachments D-1 and D-2 describe the services covered by Medicare, and services that are not covered by Medicare but are available if you wish to pay for them.

You should note that Medi-Cal will only pay for covered supplies and services if they are medically necessary. If Medi-Cal determines that a supply or service is not medically necessary, we will ask whether you still want that supply or service and if you are willing to pay for it yourself.

We will only charge you for optional supplies and services that you specifically request, unless the supply or service was required in an emergency. We will provide you a 30-day written notice before any increase in charges for optional supplies and services.

D. Billing and Payment

We will provide to you an itemized statement of charges that you must pay every month. You agree to pay the account monthly on the 1st of each month (enter day of month).

Payment is overdue 10 days after the due date. A late charge at an interest rate of 12 % is charged on past due accounts and is calculated as follows:
Annually if account is more than 30 days past due

E. Payment of Other Refunds Due To You

As indicated in **Section C.** above, refunds may be due to you as a result of Medi-Cal paying for services and supplies you had purchased before your eligibility for Medi-Cal was approved or for any security deposit you may have made. At the time of your discharge, you may also be due other refunds, such as unused advance payments you may have made for optional services not covered by the daily rate. We will refund any money due to you within 14 days of your leaving our Facility. We will not deduct any administration or handling charges from any refund due to you.

VI. Transfers and Discharges

We will help arrange for your voluntary discharge or transfer to another facility.

Except in an emergency, we will not transfer you to another room within our Facility against your wishes, unless we give prior reasonable written notice to you, determined on a case by case basis, in accord with applicable state and federal requirements. For example, you have a right to refuse the transfer if the purpose of the transfer is to move you to or from a Medicare-certified bed.

Our written notice of transfer to another facility or discharge against your wishes will be provided 30 days in advance. However, we may provide less than 30 days notice if the reason for the transfer or discharge is to protect your health and safety or the health and safety of other individuals, if your improved health allows for a shorter notice, or if you have been in our Facility for less than 30 days. Our written notice will include the effective date, the location to which you will be transferred or discharged, and the reason the action is necessary.

The only reasons that we can transfer you to another facility or discharge you against your wishes are:

1) It is required to protect your well-being, because your needs cannot be met in our Facility;

2) It is appropriate because your health has improved enough that you no longer need the services of our Facility;

3) Your presence in our Facility endangers the health and safety of other individuals;

4) You have not paid for your stay in our Facility or have not arranged to have payment made under Medicare, Medi-Cal, or private insurance;

5) Our Facility ceases to operate.

6) Material or fraudulent misrepresentation of your finances to us.

If we participate in Medi-Cal or Medicare, we will not transfer you from the Facility or discharge you solely because you change from private pay or Medicare to Medi-Cal payment.

In our written notice, we will advise you that you have the right to appeal the transfer or discharge to the California Department of Health Care Services and we will also provide the name, address, and telephone number of the State Long-Term Care Ombudsman.

If you are transferred or discharged against your wishes, we will provide transfer and discharge planning as required by law.

VII. Bed Holds and Readmission

If you must be transferred to an acute hospital for seven days or less, we will notify you or your representative that we are willing to hold your bed. You or your representative have 24 hours after receiving this notice to let us know whether you want us to hold your bed for you.

If Medi-Cal is paying for your care, then Medi-Cal will pay for up to seven days for us to hold the bed for you. If you are not eligible for Medi-Cal and the daily rate is not covered by your insurance, then you are responsible for paying $ 212.00 for each day we hold the bed for you. You should be aware that Medicare does not cover costs related to holding a bed for you in these situations.

If we do not follow the notification procedure described above, we are required by law (Title 22 California Code of Regulations Sections 72520(c) and 73504(c)) to offer you the next available appropriate bed in our Facility.

You should also note that, if our Facility participates in Medi-Cal and you are eligible for Medi-Cal, if you are away from our Facility for more than seven days due to hospitalization or other medical treatment, we will readmit you to the first available bed in a semi-private room if you need the care provided by our Facility and wish to be readmitted.

VIII. Personal Property and Funds

Our Facility has a theft and loss prevention program as required by state law. At the time you are admitted, we will give you a copy of our policies and procedures regarding protection of your personal property, as well as copies of the state laws that require us to have these policies and procedures.

If our Facility participates in Medi-Cal or Medicare and you give us your written authorization, we will agree to hold personal funds for you in a manner consistent with all federal and state laws and regulations. If we are not certified for Medi-Cal or Medicare, we may offer these services but are not required to. You are not required to allow us to hold your personal funds for you as a condition of admission to our Facility. At your request, we will provide you with our policies, procedures, and authorization forms related to our holding your personal funds for you.

IX. Photographs

You agree that we may take photographs of you for identification and health care purposes. We will not take a photograph of you for any other purpose, unless you give us your prior written permission to do so.

X. Confidentiality of Your Medical Information

You have a right to confidential treatment of your medical information.
You may authorize us to disclose medical information about you to a family member or other person by completing the "Authorization for Disclosure of Medical Information" form in **Attachment E**.

XI. Facility Rules and Grievance Procedure

You agree to comply with reasonable rules, policies and procedures that we establish. When you are admitted, we will give you a copy of those rules, policies, and procedures, including a procedure for you to suggest changes to them.

A copy of the Facility grievance procedure, for resolution of resident complaints about Facility practices, is available; we will also give you a copy of our grievance procedure for resolution of any complaints you may have about our Facility. You may also contact the following agencies about any grievance or complaint you may have:

California Department of Public Health
_____ Licensing and Certification District Office

Phone number: 510-620-3900

(OR)

State Long-Term Care Ombudsman Program

Phone number: 510-685-2070

XII. Entire Agreement

This Agreement and the Attachments to it constitute the entire Agreement between you and us for the purposes of your admission to our Facility. There are no other agreements, understandings, restrictions, warranties, or representations between you and us as a condition of your admission to our Facility. This Agreement supersedes any prior agreements or understandings regarding your admission to our Facility.

All captions and headings are for convenience purposes only, and have no independent meaning.

If any provision of this Agreement becomes invalid, the remaining provisions shall remain in full force and effect.

The Facility's acceptance of a partial payment on any occasion does not constitute a continuing waiver of the payment requirements of the Agreement, or otherwise limit the Facility's rights under the Agreement.

This Agreement shall be construed according to the laws of the State of California.

Other than as noted for a duly authorized Resident's Representative, the Resident may not assign or otherwise transfer his or her interests in this Agreement.

Upon your request, we shall provide you or your legal representative with a copy of the signed agreement, all attachments and any other documents you sign at admission and shall provide you with a receipt for any payments you make at admission.

Attachment A
Facility Owner and Licensee Identification

The owner and licensee of Home for Jewish Parents is:
(Name of Facility)

Jewish Welfare Federation.
(Name of Owner/Licensee)

If you have any questions concerning any aspect of patient care in this facility, or about the operation of this facility, you may contact:

Serenity Management Services
(Name of Individual/Entity Responsible for Patient Care and Facility Operation)

Address: 2440 Camino Ramon
Suite 120
San Ramon, CA 94583

Telephone: 925-284-5544

ATTACHMENT B-1

Supplies and Services Included in the Basic Daily Rate for Private Pay and Privately Insured Residents

Equipment including, but not necessarily limited to, beds and mattresses, wheelchairs, walkers and canes, footboards and cradles, trapeze bars and lifts.

Personal hygiene items including, but not necessarily limited to, toothbrushes, floss and toothpaste, denture cleaners and adhesives, hair combs and brushes, tissue wipes for individual use, soap and specialized cleansing agents (when indicated to treat special skin problems or to fight infection), shampoos, shavers, bedside utensils (bed pans and basins), nail files, moisturizing lotion, cotton balls and swabs, deodorant, towels, washcloths, and hospital gowns.

Services including, but not necessarily limited to, 24 hour skilled nursing care, dietary (meals and snacks), laundry, recreational activities, medical and social services, housekeeping, maintenance and repairs, and billing (as appropriate and necessary).

ATTACHMENT B-2
Optional Supplies and Services Not Included in the Basic Daily Rate for Private Pay and Privately Insured Residents

Description of Supply or Service	Price
Beautician/Barber Services	See provider list
Guest Meal Trays	$5.00 per Child/$10.00 per Adult
Laboratory Service	Facility's invoiced charge
Medical Supplies	Facility's invoiced charge
Occupational Therapy	$140.00/hour
Physical Therapy	$140.00/hour
Speech Therapy	$140.00/hour
Resident Personal Needs	Facility's invoiced charge
Pharmacy	Billed directly by provider
Podiatry	See provider list
Respiratory	Facility's invoiced charge
Telephone Long Distance	$2.00/month
X-Ray Services	Facility's invoiced charge
Optometry	See provider list

ATTACHMENT C-1

Supplies and Services Included in the Basic Daily Rate for Medi-Cal Residents

Room and board
Nursing services
Respiratory therapy
Emergency oxygen and other equipment
Personal hygiene items and services, such as: Denture cleaners Denture adhesives Dental floss Oral cleansing swabs Hair combs and brushes Lotions Shaving soaps/creams Toothbrushes and toothpaste Laundry Tissue wipes Shaves Shampoos Periodic hair trim Periodic nail trim
Commonly used items of equipment, supplies and services used for medical and nursing care, such as: Standard wheelchair (not exclusively for individual patient use) Incontinence supplies
Maintenance therapies Range of motion Getting patients out of bed Providing activities Changing position in bed Assisting with self-care and activities of daily living Maintenance of proper body alignment and joint movement
Non-legend drugs, such as: Aspirin Acetaminophen Cough Syrup

ATTACHMENT C-2

Supplies and Services NOT Included in the Medi-Cal Basic Daily Rate That Medi-Cal Will Pay the Dispensing Provider For Separately

Physician services
Optometry services
Dental services
Audiology services
Durable medical equipment, other than as listed in Attachment C-1 Specialty anti-decubitus beds Oxygen concentrators and accessories Intermittent Positive Pressure Breathing (IPPB) equipment Oxygen, except emergency, including administration sets and tanks Custom equipment for individual patient use (cane, crutches, wheelchair), including parts and repairs MacLaren or Pogon Buggy Osteogenesis stimulator device Precontoured structures (VASCO-PASS, cut out foam) Variable height beds
Therapy services provided by a licensed therapist, identified in the Minimum Data Set (MDS) and included in the patient's plan of care Physical therapy Occupational therapy Speech therapy
Chiropractic services
Laboratory services
Outpatient heroin detoxification services
Organized outpatient clinic services
Home health agency services
Radioisotope services
Prayer or spiritual healing
Rehabilitation center outpatient services
Prosthetic and orthotic appliances

(continued on next page)

ATTACHMENT C-2
(continued)

Supplies and Services NOT Included in the Medi-Cal Basic Daily Rate That Medi-Cal Will Pay the Dispensing Provider For Separately

Hospital outpatient department services
Chronic hemodialysis
Podiatry services
Psychology
Radiology (x-rays)
Early and periodic screening services
Hearing aids
Blood and blood derivatives
Nurse anesthetist services
Inpatient hospital services
Eyeglasses, prosthetic eyes, and other eye appliances
Pharmaceutical services and prescribed drugs Insulin Legend drugs
Medical supplies, other than those listed in Attachment C-1 IV trays IV tubing Blood infusion sets Nasal cannula Reagent testing sets (urine testing)
Other equipment and supplies for which prior authorization has been granted to another provider
Short-Doyle Medi-Cal provider services (mental health)
Traction equipment and accessories
Transportation

ATTACHMENT C-3

Optional Supplies and Services Not Covered By Medi-Cal That May Be Purchased By Medi-Cal Residents

Description of Supply or Service	Price
Beautician/Barber Services *	See Provider List
Guest Meal Trays	$5.00 per Child/$10.00 per Adult
Occupational Therapy **	$140.00/hour
Physical Therapy **	$140.00/hour
Speech Therapy **	$140.00
Resident Personal Needs ***	Facility's invoiced Charge
Telephone Long Distance	$2.00/month
*Beauty Shop services are provided under Medi-Cal	
every 6 weeks. Any special services or increased frequency	
Provided by the beautician are optional.	
**Therapy services that are not deemed necessary and	
Appropriate by a physician may be provided as an	
optional service.	
***Resident personal items including, but not necessarily	
limited to, novelties, confections, tobacco products, dry	
cleaning, and cosmetics	

ATTACHMENT D-1

Supplies and Services Covered By the Medicare Program For Medicare Residents

The Medicare Program is administered by the federal government, and the federal government defines what supplies and services are covered under the basic daily rate and what additional supplies and services may be available to the Resident that Medicare will pay the dispensing provider for.

The following two pages were excerpted from the brochure entitled **"Your Medicare Benefits", which is published by the federal Centers for Medicare and Medicaid Services** and describe Medicare Skilled Nursing Facility coverage. You can call toll free 1-800-MEDICARE to order a copy of this publication or to get additional information. You can also find this publication and other useful information at the Medicare Internet site at www.medicare.gov

Medicare covers skilled care in a skilled nursing facility (SNF) under certain conditions for a limited time. Skilled care is health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Examples of skilled care include changing sterile dressings and physical therapy. It is given in a Medicare-certified SNF. Care that can be given by non-professional staff is not considered skilled care. Medicare covers certain skilled care services that are needed daily on a short-term basis (up to 100 days).

Medicare will cover skilled care only if **all** these conditions are met:

1. You have Medicare **Part A** (Hospital Insurance) and have days left in your benefit period to use.
2. You have a qualifying hospital stay. This means an inpatient hospital stay of three consecutive days or more, not including the day you leave the hospital. You must enter the SNF within a short time (generally 30 days) of leaving the hospital. After you leave the SNF, if you re-enter the same or another SNF within 30 days, you don't need another 3-day qualifying hospital stay to get additional SNF benefits. This is also true if you stop getting skilled care while in the SNF and then start getting skilled care again within 30 days.
3. Your doctor has decided that you need daily skilled care. It must be given by, or under the direct supervision of, skilled nursing or rehabilitation staff. If you are in the SNF for skilled rehabilitation services only, your care is considered daily care even if these therapy services are offered just 5 or 6 days a week.
4. You get these skilled services in a SNF that has been certified by Medicare.

(continued on next page)

ATTACHMENT D-1
(continued)

Supplies and Services Covered By the Medicare Program For Medicare Residents

5. You need these skilled services for a medical condition that: a) was treated during a qualifying 3-day hospital stay, or b) started while you were getting Medicare-covered SNF care. (For example, if you are in the SNF because you had a stroke and you fall and sprain your wrist.)

Medicare **Part A** covered services include a semiprivate room, meals, skilled nursing and rehabilitative services, and other hospital services and supplies, such as anesthesia, limited ambulance service, blood, chemotherapy, clinical trials, kidney dialysis, durable medical equipment, mental health care, hospice care, some types of transplants, and physician-prescribed pharmaceutical and medical equipment. Physical therapy, occupational therapy, speech therapy, and other allied health services as physician-prescribed may be included.

This does not include private duty nursing or a television or telephone in your room. It also does not include a private room, unless medically necessary.

In addition, you may be eligible for Medicare **Part B** program. **Contact the Business Office in your facility for further information.**

ATTACHMENT D-2

Optional Supplies and Services Not Covered By Medicare That May Be Purchased By Medicare Residents

Description of Supply or Service	Price
Beautician/Barber Services *	See Provider List
Guest Meal Trays	$5.00 per Child/$10.00 per Adult
Resident Personal Needs **	Facility's Invoiced Charge
Telephone Long Distance	
A Private Room ***	
*Beauty Shop services are provided under Medi-Cal	
every 6 weeks. Any special services or increased frequency	
Provided by the beautician are optional.	
**Resident personal items including, but not necessarily	
limited to, novelties, confections, tobacco products, dry	
cleaning, and cosmetics	
***Unless medically necessary and requested by the	
Resident's physician	
The daily rate for Medicare does not include the following:	
1. A private room unless therapeutically required	
2. Barber or beautician services other than a hair trim every	
6 weeks by the beautician, or shaves or shampoos	
performed by staff as part of resident care.	
3. A private duty nurse	
4. Newspaper service	
5. Non-basic personal laundry services	
For a complete list of non-covered items see 42 CFR 483.10((c))(8)	

Co-Insurance and Medi-Cal Pending Billing Process

The Reutlinger will bill secondary insurance as a courtesy. Should the insurance be denied for any reason the resident or family will be responsible 100 percent of the payment.

Responsible Party Signature _____

Reutlinger Representative Signature_____

If a resident is being admitted the Medi-Cal application is in process the resident or family member will be 100 percent responsible for the bill privately until the medical application is approved. Once we have received payment from Medi-Cal all private funds will be refunded.

Responsible Party Initial _____

Reutlinger Representative Initial _____

ATTACHMENT E

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I, _____, hereby
(Resident's Name)

authorize the Facility, RCJL _____,
(Name of Facility)

to provide information regarding my medical history, mental or physical condition, care, or treatment as specified below:

This authorization is limited to disclosure to the following persons:

_____
_____
_____
_____
_____

This authorization is limited to the following types of medical information:

_____
_____
_____
_____
_____

The persons to whom records and information are disclosed pursuant to this authorization may use those records and information only for the following purposes:

_____
_____
_____
_____
_____

This authorization shall become effective immediately and shall remain in effect until _____.
(Date)

I understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. However, if I authorize the disclosure of my medical information to person(s) and/or organization(s) who are not health care providers or other people who not are subject to laws governing the disclosure of medical information, they may be permitted to re-disclose the information without my prior permission. Re-disclosure in such cases may not be limited by state or federal law.

I further understand that the Facility will give me a copy of this signed authorization.

I understand that I have the right to revoke this authorization, in writing, at any time before it ends. I also understand that my written revocation will not affect any disclosures of my information that the person(s) and/or organization(s) listed on the first page of this authorization have already made, in reliance on this authorization, before the time I revoke it.

I further understand that I am under no obligation to sign this authorization, and may refuse to do so. Except as permitted under applicable law, the Facility may not refuse to provide treatment or other health care services because of my refusal to sign.

Resident Signature:_____ Date:_____

Resident's Representative*
Signature:_____ Date:_____

* The Resident's Representative is authorized to sign for the resident because _____

ATTACHMENT J

ACKNOWLEDGEMENT OF ADVANCE DIRECTIVE, DO NOT RESUSCITATE, WITHHOLDING TREATMENT

I have been provided with written information regarding my right to formulate an Advance Directive.

I do possess an Advance Directive
Copy obtained _____
Copy provided by _____

I do not possess an Advance Directive
I do / do not wish to formulate an Advance Directive (circle one)
I am unsure at this time if I want to formulate and Advance Directive

_____ _____
Resident, Agent, or Responsible Party Date

_____ _____
Facility Representative Date

*A copy of this signed acknowledgement must be provided to the Social Services Department.

GENERAL CONSENT

Please read the statements below and **circle** the appropriate answer next to the statements that apply to you or your family member.

Yes No I/my family member may be photographed by the facility for facility activity purposes..

Yes No I/my family member herby give(s) consent to receive a PPD* test (per facility's policy) as part of the admission for TB screening and to receive it annually thereafter unless contraindicated.

Yes No I/my family member consent to an eye health evaluation and treatment of resident as necessary. *Please be advised that these services may or may not be covered by Medicare or Medi-Cal.*

Yes No I/my family member consent to podiatric services for evaluation and treatment of resident as necessary. *Please be advised that these services may or may not be covered by Medicare or Medi-Cal.*

Yes No I/my family member consent to dental services for evaluation and treatment of resident as necessary. *Please be advised that these services may or may not be covered by Medicare or Medi-Cal.*

*NOTE: PPD is a skin test for T.B. and is required by law for all residents. The facility's policy on PPD is 2 steps, which means the PPD will be given again 14 days after the first PPD in order to assure accuracy.

For any further information on the above listed services, please see the facility's Business Office Manager or Social Services Designee.

_____ _____

Resident, Agent, or Responsible Party Date