

Enriched Housing Admission Agreement

I. General Provisions

This is the Admission Agreement between the operator(s) of Judson Meadows/ Baptist Health Enriched Housing Program, Inc. and _____ (Name of Resident) and _____ (Resident's Representative) stating the terms and conditions of the resident's admission and living arrangements at the Judson Meadows/ Baptist Health Enriched Housing Program, Inc. located at ___ Swaggertown Road, Scotia, New York 12302.

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 Enriched Housing Program 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 Health.

II. Enriched Housing Program Services

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

- a. Housing (describe living arrangement).
- b. One prepared, hot congregate meal per day, plus food assistance with shopping for and preparation of food for other meals and snacks.
- c. Personal care services as necessary.
- d. Case Management.
- e. Housekeeping services.
- f. Linen services.
- g. Laundry of resident's personal washable clothing.
- h. Assistance in arranging transportation for purposes of obtaining medical and dental care and other essential services.
- i. A coordinated activities program.
- j. Provision of 24-hour emergency coverage by a responsible person(s).

III. Resident Responsibilities

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

- a. Payment of the required rate.
- b. Supply of personal clothing and effects.
- c. Payment of all medical expenses including transportation for medical purposes, except where payment is available under Medicare, Medicaid or third party coverage.
- d. 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 one every twelve (12) months or more frequently if a change in condition warrants.
- e. Informing the operator of change in health status, change in physician or change in medications.
- f. In addition, the resident agrees to obey all reasonable rules of the facility and to respect the rights and property of 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 _____
Weekly Rate	\$ _____ *	Payment due by _____
Daily Rate	\$ _____ *	Payment due by _____

* Must include payments 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 received Supplemental Security Income (SSI) or Safety Net Assistance (SNA), formerly Home Relief (HR), payments at a charge that is reasonable 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 affect the resident, additional chares 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 _____. (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 _____. 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 Protections

The operator agrees to provide the resident with a copy of the Resident Rights and Protections 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 Safety Net Assistance (SNA), formerly 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 Safety Net Assistance (SNA), formerly Home Relief (HR), funds.

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

I receive SSI funds or I have applied for SSI funds _____
I receive SNA funds or I have applied for SNA funds _____
I do not receive either SSI or SNA _____
(CHECK ONE OF THE ABOVE)

VII. Termination

This admission agreement and residency in the Enriched Housing Program may be terminated in the following ways:

- a. By mutual agreement of the resident and operation;
- b. Upon _____ days written notice from the resident to the operator of the resident's intention to terminate the agreement and leave the Enriched Housing Program;
- c. Upon thirty (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:

- a. The resident requires continual medical or nursing care which the Enriched Housing Program cannot provide;
- b. The resident's behavior poses imminent risk of death or imminent risk of serious physical harm to himself or anyone else;
- c. 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 service 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 thirty (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;

- d. 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 Enriched Housing Program;
- e. The operator has had its operating certificate limited, revoked, temporarily suspended or the operator has voluntarily surrendered the operating certificate of the Enriched Housing Program to the New York State Department of Health; or
- f. 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 Enriched Housing Program to other facilities or is making other provisions for the resident's 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 Health. Such notice will include the date of termination and discharge, which must be at least thirty (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 New York State Department of Health. Copies will be sent to the resident's next-of-kin, legally responsible relatives, and to the appropriate regional office of the New York State Department of Health.

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.

In the event the lease for the dwelling unit in which the resident resides is between the resident and the landlord directly, termination of the Enriched Housing Admission Agreement will not in and of itself terminate the lease and corresponding occupancy in the dwelling unit.

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 thirty (30) days notice or court review, for the following reasons:

- a. 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 Enriched Housing Program, he shall be readmitted.
- b. In the event that a resident's behavior poses an imminent risk of death or serious physical injury to himself or others.
- c. When a receiver has been appointed under the provisions of New York State Social Services Law and is providing for the orderly transfer of all residents in the Enriched Housing Program to other facilities or is making other provisions for the resident's continued safety and care.

After transfer, if return to the Enriched Housing Program 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 Enriched Housing Program. In addition, the operator shall return, within three (3) 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 Enriched Housing Program 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 Regulation of the State Department of Health 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.

DATED: _____

(Signature of Resident)

DATED: _____

(Signature of Resident's Representative)

DATED: _____

(Signature of Operator or His Designee)

Judson Meadows Resident "Closing" ALP Checklist

Name: _____, Apt: _____ Date: _____

- ✓ Food Preferences
- ✓ Consumer Information Guide
- ✓ Privacy Notice
- ✓ Medication (DOH Regulations)
- ✓ Agreement When Resident/Family Is Responsible for Supply Medication
- ✓ Medical Leave of Absence
- ✓ Direct Deposit Information
- ✓ Rent Receipt Waiver Form
- ✓ Check
- ✓ Meal Certificate
- ✓ Voluntarily to Participate
- ✓ Medicaid Services/Billing
- ✓ Shared Common space agreement
- ✓ Inventory for shared apartments
- ✓ Personal/Compassionate Caregiving Designation Form

Remember to...

Enter resident into PCC/ create invoice- ND

Update Diet Roster- NS (one copy for each MAR, Food Service, Wendy, disaster)

Update QA Roster- MH (copy in Emergency Folder)

Dining Room seating- FLIK

Shower/Bedding Schedule (copy on back of door and task binder) -DW

Email everyone of move in and plans- DW, ND

Admission Agreement Addendum For The Assisted Living Program

I. General Provisions

This is the Admission Agreement Addendum between the operator(s) of Judson Meadows/ Baptist Health Enriched Housing Program, Inc. and _____ (Name of Resident) and _____ (Resident's Representative) stating the terms and conditions of the resident's admission and living arrangements at the Judson Meadows/ Baptist Health Enriched Housing Program, Inc. located at ___ Swaggertown Road, Scotia, New York 12302.

This addendum pertains to the Admission Agreement approved by the Department for the above named adult care facility and amends only the sections contained herein; all other provisions of the Admission Agreement remain in effect, unless otherwise amended.

This addendum must be attached to the Admission Agreement of the adult care facility. The parties to this addendum understand that this program is an Assisted Living Program (ALP) providing long-term residential care and providing or arranging for home care services to the resident in accordance with New York State Social Services Law and New York State Public Health Law and the regulations of New York State Department of Health.

II. Assisted Living Program Services

The ALP operator must be responsible for providing an organized, 24-hour a day program of supervision, care and services including:

- a. The services listed in the Admission Agreement; and
- b. The provision of, or arrangement for, the following home care services:
 - i. personal care services which are reimbursable under Title XIX of the Federal Social Security Act;
 - ii. home health aid services;
 - iii. personal emergency response services;
 - iv. nursing services;
 - v. physical therapy;
 - vi. occupational therapy;
 - vii. speech therapy;
 - viii. medical supplies and equipment not requiring prior approval; and
 - ix. adult day health care in a program approved by the Commissioner of Health.

III. Resident Responsibilities

The resident responsibilities section of the Admission Agreement remains in effect except for the following modification regarding medical evaluation:

At the time of admission, the resident agrees to cooperate with the completion of the assessment process which includes obtaining a dated and signed medical evaluation on a form conforming to department regulations. The resident agrees to cooperate with the reassessment process which includes obtaining an approved medical evaluation form every six months, or as frequently as required, to respond to changes in the resident's condition and to ensure immediate access to necessary and appropriate services by the resident.

IV. Financial Arrangements

RATE: The following supersedes the financial arrangement section of the Admission Agreement except for the supplemental services section:

The resident and the resident's representative, if any, agree to pay and the operator agrees to accept the following payment in full satisfaction of the basic rate for services, material, equipment and food as specified in the Admission Agreement and in Section II of this addendum which the operator must provide according to law and regulation (select one schedule of payment):

Monthly Rate \$	_____	Due Date	_____
Weekly Rate \$	_____	Due Date	_____
Daily Rate \$	_____	Due Date	_____

The resident agrees to apply for and maintain all applicable income entitlements and public benefits necessary to support payment for services provided by the operator.

V. Agreement Addendum Authorization

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

DATED: _____

(Signature of Resident)

DATED: _____

(Signature of Resident's Representative)

DATED: _____

(Signature of Operator or His Designee)

RESIDENT RIGHTS IN ASSISTED LIVING PROGRAMS

The Social Services Law and the Public Health law give you certain rights as a resident in an Assisted Living Program. AT A MINIMUM A RESIDENT HAS A RIGHT THE RIGHT:

- (i) To receive courteous, fair and respectful care and treatment, and not be physically, mentally, or emotionally abused or neglected in any manner.
- (ii) To exercise his or her civil rights and religious liberties, and to make personal decisions, including the choice of a physician, and to have the assistance and encouragement of the operator in exercising these rights and liberties.
- (iii) To have private written and verbal communications or visits with anyone of his or her choice, or to deny or end such communication and visits.
- (iv) To send and receive mail or any correspondence unopened and without interception or interference.
- (v) To present grievances and complaints including those related to care and services including lack of respect for property by anyone furnishing service and recommend changes in policies and services on his or her behalf, or the behalf of other residents, to the administrator, facility staff, the Department of Health, other government officials or any other parties without fear of interference, coercion, discrimination or reprisal. This extends to the resident's designee as well. If not satisfied with the results of the complaint investigation, the resident or his or her designee shall have the right to appeal the outcome to the Department of Health.
- (vi) To join other residents or individuals inside or outside the facility to work for improvement in resident care.
- (vii) To confidential treatment of personal, social, financial, and health records.
- (viii) To participate in the planning of his or her care and be advised in advance of any changes to the plan of care.
- (ix) To have privacy in treatment and caring for personal needs.
- (x) To receive a written statement (admission agreement) of the services regularly provided by the facility operator, those additional services which will be provided if the resident needs or asks for them and the charges (if any) for these additional services.
- (xi) To manage his or her own financial affairs.
- (xii) To not be coerced or required to perform the work of staff members or contractual work; and if the resident works, to receive fair compensation from the operator of the facility.
- (xiii) To have security for any personal possessions if stored by the operator.
- (xiv) To have recorded on the facility's accident or incident report the resident's version of the events leading up to the accident or incident.
- (xv) To object if the operator terminates the admission agreement against the resident's will.
- (xvi) To refuse treatment after being fully informed of and understanding the consequences of such actions, unless such refusal causes, or is likely to cause, in the judgment of a physician, life threatening danger to the resident or others and
- (xvii) To authorize those family members and other adults who will be given priority to visit consistent with the resident's ability to receive visitors.

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RESIDENT RIGHTS

As a resident of this agency, the New York State Department of Health requires that this information be shared with you both orally and in writing:

- Be informed of these rights in writing prior to initiation of care. Written documentation of the receipt of this information will be contained in your record.
- Receive a statement for the services available from the Licensed Home Care Agency and related charges.
- To be advised before care is initiated of the extent to which payment for agency services may be expected from the third party payors and the extent to which payment may be required from you.
- Participate in the development of the plan of care and discharge plan, and be informed of all treatments the agency is to provide, when, and how services will be provided, and the name and functions of any person and affiliated agency providing care and services.
- Be advised in advance of any changes to the plan of care.
- Refuse treatment and being fully informed of and understanding the consequences of such action.
- Be informed of the procedure for submitting suggestions, grievances or complaints.
- Voice suggestions, grievances or complaints and recommend changes in policies and services to agency staff, the NYS Department of Health, or any outside representative that you choose. The expression of such complaints by the resident or his/her designee shall be free from interference, coercion, discrimination, or reprisal.
- Be treated with consideration, respect and full recognition of your dignity and individuality.
- Privacy, including confidential treatment of resident records, and the right to refuse the release of records to any individual outside the agency, except in the case of your transfer to a health care facility, or as required by law or third party payment.
- Have the agency advise you of any changes in information regarding your care as soon as possible, but no later than 30 day calendar days from the date of the agency becomes aware of the change.
- You may make complaint to the Executive Director. All written complaints will receive a written response from the Executive Director. All written complaints will receive a written response from the Executive Director on the outcome of the investigation. Oral complaints will receive a written response by the individual making the complaint. The response time will not exceed 15 days in either case.
- If you do not agree with the decision rendered you have the right to appeal the outcome. The appeals process with the review by a member or committee of the governing authority will occur within 30 days of the appeal.
- All personnel providing care will be made aware of the rights of the resident and to protect and promote the exercise of such rights.

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- If you do not agree with the decision rendered you have the right to appeal the outcome. The appeals process with the review by a member or committee of the governing authority will occur within 30 days of the appeal.
- You have the right to submit resident complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing services on behalf of the agency, to be informed of the procedure for filing such complaints, and to have the agency investigate such complaints. The agency is also responsible for notifying the resident of his/her designee that if the patient is not satisfied by the response, the resident may complain to the appropriate area office of the New York State Department of Health's Office of Health System.
- 1-866-893-6772.

The above rights have been explained to me, and a copy has been provided.

RESIDENT

Date: _____

DESIGNATED REPRESENTATIVE

Date: _____

FACILITY REPRESENTATIVE/TITLE

Date: _____

READ TO RESIDENT WITH VISUAL IMPAIRMENT' ____YES ____NO ____N/A

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COMPLAINT AND GRIEVANCE PROCEDURE

As a resident or designated representative of the resident you have the right to make a complaint. The LHCSA (licensed home health care agency-Judson Meadows) has established to make the process flow smoothly.

- ~ Any staff member may receive a complaint, or it may be submitted confidentially in the grievance/suggestion box located in the sun room. It will then be referred to Administration for investigation.
- ~ All complaints will be investigated completely, and you will be notified of our findings.
- ~ If your complaint is in writing, we will give you a written reply in 15 working days.
- ~ If your complaint was verbal, we will give you a written reply in 15 working days.
- ~ If you are not satisfied with the investigation you have to write an appeal. Please contact the Executive Director at Judson Meadows (39 Swaggertown Road, Glenville, New York 12302). Phone Number: 518-831-2400.
- ~ If you remain dissatisfied the Resident Council or a subcommittee thereof will review the complaint, and a response will be given to you in writing within 30 days of the receipt of a request for an appeal.
- ~ If you are still not satisfied by the response you may contact the Department of Health at 1 800-628-5972 or 518-408-1638 during business hours (9 AM-5 PM) Monday through Friday, excluding legal holidays.

I have read and understand the complaint and grievance procedure.

RESIDENT SIGNATURE

Date: _____

DESIGNATED REPRESENTATIVE

Date: _____

FACILITY REPRESENTATIVE

Date: _____

Internal Grievance/Suggestion/Concern Form

Date: _____ Name of Resident: _____ Room/Apartment: _____

Resident telephone # _____ Time Complaint Filed: _____

Please note that you do not have to include your name or room number. If this is submitted confidentially, the response will be given to the resident council president to be read at the next meeting. The Administrator will respond to all correspondence within 15 days.

We welcome your suggestions, complaints and concerns about this facility and your care or treatment. We are committed to your health and safety. We want you to feel comfortable and at home.

Please check one Suggestion Complaint Concern

Name of Family Member or Representative (optional) making the grievance, concern, or suggestion on behalf of the

Resident. Name: _____ Contact number: _____

Your Suggestion/Complaint/Concern:

Would you like this to be read at Resident Council? Yes _____ No _____

Investigation and Action taken/Resolution:

Return Completed Form to the Resident or Resident's Representative or promptly (within 15 business days).

Staff Signature: _____ Date: _____

I am satisfied with the response. I am not satisfied with the response.
You have the right to make a complaint to the local ombudsman. The Ombudsman poster listing your contact at the local office is posted in the glass case across from the Café, and/or the DOH website www.state.health.ny.us and phone numbers.

Comments:

(Signature of Resident or Representative)

(Date Received)

IF YOU FEEL THAT ANY OF THESE RIGHTS HAVE BEEN OR ARE
BEING VIOLATED YOU MAY CONTACT:

THE NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT
ADULT HOME COMPLAINT UNIT
875 CENTRAL AVENUE
ALBANY, NY 12206
1 (866) 893-6772

THE NEW YORK STATE DEPARTMENT OF HEALTH
HOME HEALTH CARE AND HOSPICE
CAPITAL DISTRICT REGIONAL OFFICE
875 CENTRAL AVENUE
ALBANY NY 12206
(518) 408-5287

OFFICE OF THE STATE
NYS LONG TERM CARE OMBUDSMAN PROGRAM
2 EMPIRE STATE PLAZA
ALBANY NY 12223
1 (855) 582-6769
518-372-5667

New York State Department Of Health
Licensed Home Care Services Agencies (LHCSA)
99 Washington Ave
One Commerce
Albany, N.Y. 12231
1(800) 628-5972
518-408-1638