

**GRANT REHABILITATION AND CARE CENTER  
27 EARLY AVENUE  
PETERSBURG, WV 26847**

**ADMISSION AGREEMENT**

AGREEMENT made and entered this \_\_\_\_\_ day of, \_\_\_\_\_  
20 \_\_\_\_\_, by and between \_\_\_\_\_  
(hereinafter referred to as "facility") and \_\_\_\_\_  
\_\_\_\_\_ (or guardian, next of kin, sponsoring agency, representative payor, or  
responsible party hereinafter referred to as "Responsible Party"), who agree to the following terms, conditions  
and arrangements to provide for the medical, nursing and personal care of \_\_\_\_\_  
\_\_\_\_\_ (hereinafter referred to as "Patient/Resident").

**WITNESSETH**

1. Facility agrees to furnish room, board, bedding, and laundered linens, nursing care, and such other personal services as may be required for the health, safety, welfare, good grooming, and well-being of Patient/Resident.
2. Facility agrees to permit the services of a licensed physician of Patient's/Resident's choice as necessary, or the services of another licensed physician if a personal physician has not been designated or is not available. This requirement is to ensure that medications and treatments are prescribed by his/her physician on a timely basis.
  - a. If Patient/Resident is found to be mentally disturbed and cannot be managed after admission, immediate arrangements will be made via the attending physician for transfer of Patient/Resident to an appropriate facility at the earliest practical time.
  - b. If a change occurs in Patient's/Resident's physical condition which necessitates a change in care which Facility is not prepared to provide, immediate arrangements will be made to have Patient/Resident transferred to another appropriate facility which can care for Patient/Resident.
  - c. Except in an emergency, Patient/Resident will not be transferred or discharged from Facility without prior notification of Patient/Resident and his/her Responsible Party. Suitable clinical notes, a list of orders, and all medications as directed by an attending physician shall accompany Patient/Resident when transferred to another medical facility.
3. Facility agrees to attempt to: (1) arrange for transfer of Patient/Resident to a hospital when such transfer is ordered by the attending physician and (2) immediately notify Patient's/Resident's Responsible Party.
4. Facility agrees to permit Patient/Resident to request to upgrade or change the room assigned to Patient/Resident at any time, for any reason, provided the room requested is readily available and Patient/Resident is financially able to pay for the requested room. The Facility reserves the right to make room changes for roommate compatibility or to admit new residents to the Facility.
5. Facility agrees to comply with the provisions of the Federal Civil Rights Act of 1964 and the appropriate State Human Relations Act, and all requirements imposed pursuant thereto, to the end that no person shall, on grounds of race, color, national origin, ancestry, age, sex, or religious creed be excluded from participation in, be denied benefits of, or otherwise be subject to discrimination in the provision of any care or service. The non-discrimination policy of Facility applies to Patient's/Resident's physicians, and all employees. Under no

circumstances will the application of this policy result in the segregation or resegregation of buildings, wings, floors, and rooms for reasons of race, color, national origin, ancestry, age, sex, or religious creed.

6. Facility prefers not to manage Patient's/Resident's personal financial affairs. Facility may elect under specific conditions to manage Patient's/Resident's personal financial affairs when the Patient/Resident or Responsible Party cannot manage those financial affairs and designates the transfer of such responsibility in writing to the Facility. Prior consideration and negotiation of this transaction must be done with the Facility. If such transfer of responsibility is done, Facility will provide Patient/Resident and/or Responsible Party with a quarterly accounting of all financial transactions made on Patient's/Resident's behalf.
7. Patient/Resident or Responsible Party agrees to provide such personal clothing and effects as needed or desired by Patient/Resident (as space permits). Restrictions would apply to items that would infringe upon rights of other Patients/Residents or that are contradicted as documented by Patient's/Resident's physician in the medical record.
8. The Facility shall be responsible for providing each Patient/Resident with a locked space if requested by the Patient/Resident. The use of said locked space, and the placement or storage of any items therein, is recognized as being at the sole risk and liability of Patients/Residents and Responsible Party, and no liability or responsibility whatever with respect to any such items is assumed by Facility. The Facility will investigate losses and damages reported by the Patient/Resident or Responsible Party, and agrees to aid Patients/Residents by recommending legal counsel when prosecution of any individual/individuals is desired. The Facility accepts no liability to replace or be responsible for stolen, damaged, lost, or misplaced personal property. The Facility will not accept responsibility for personal valuables and Facility strongly recommends that no jewelry or other valuables be brought to or maintained at the premises. The only exception is for valuables locked in the Facility's safe.
9. Patient/Resident or Responsible Party agrees to provide personal funds required by Patient/Resident.
10. If the Patient/Resident feels he/she is eligible for any governmental assistance in which the facility participates, Patient/Resident or Responsible Party shall notify social services which will assist in applying for that assistance. The Facility will process this application on behalf of the Patient/Resident when requested. Eligibility, with refusal to apply for any governmental assistance available, will void this agreement. When the Facility receives approval, on the basis of established criteria, that the Patient's/Resident's care may be reimbursed wholly or in part, the Facility will submit a claim for payment to the fiscal intermediary. The fact that Facility submits a claim for payment, indicating that care may be reimbursed, does not relieve Patient/Resident or Responsible Party from liability to Facility if it is determined by the fiscal intermediary that Patient/Resident does not qualify for reimbursement. The Facility agrees to continue to provide services of the same quality and type of care regardless of the source of payment.
11. Patient/Resident or Responsible Party hereby acknowledges that no representation, statement, or claim has been made by anyone connected with Facility that the services to be provided to Patient/Resident are or will be covered by or under Public Law 89-97 (Medicare, Part A or Part B), or any other governmental assistance program. Facility makes no guarantee of any kind that services will be covered by Medicare.
12. Patient/Resident or Responsible Party hereby releases Facility, its agents and employees, from any liability or responsibility in connection with Patient's/Resident's potential claim for coverage under Part A or Part B of the Medicare Program or any other governmental assistance program.

13. The financial agreement and understanding of the parties hereto is as follow:

a. On a monthly basis, the Patient/Resident and/or Responsible Party agrees to pay the Facility for care and services rendered, based upon the following:

1) Room, board and nursing care, (either a or b):

- a) computed daily upon attending physicians' "level of care" certification and Facility's current "schedule of rates and charges." \*
- b) the amount determined by the appropriate funding source as payable by the Patient/Resident.

2) Charges for special services and supplies (see posted copy of fee schedule\*) not included in the Facility per diem rate when 1-a is used, or benefits of the governmental assistance program when 1-b is used. Explanations of these will be given upon request and presentation of statement being questioned.

3) The cost of co-insurance is provided by Public Law 89-97 (Medicare) for 1-a. Where 1-b applies, the cost of co-insurance will be billed to the Medicaid program.

4) Physician and medication charges will be billed directly to the Patient/Resident by the physician/pharmacist, unless such provider agreements exist which place the burden of deductibles and co-insurance on the Facility. In this circumstance, Patient/Resident will be billed for the amounts due.

\*All charges are based upon current expenses and are subject to change with 30 days written notice. Also, if a discharge occurs and the Patient/Resident has already paid for that entire month, a refund will be made to the Responsible Party.

14. Patient/Resident and/or Responsible Party agrees to be responsible for the payment of all charges incurred by or on behalf of Patient/Resident. All notices shall be considered delivered to the Responsible Party if they are sent by regular mail to that address, unless a newer address has been furnished in writing.

15. Either party may terminate this Agreement on 30 days written notice. This Agreement will remain in effect until a different or subsequent Agreement is executed. Notification of adjustment in charges for room, board, nursing car, etc., shall be considered an amendment to this agreement, but at the time of such adjustment, execution of a different or subsequent agreement shall not be necessary to effect such change of rates. However, this in no way shall be construed to mean that Patient/Resident will be forced to remain in Facility against his/her will for any period of time.

16. This contract may be terminated immediately by either party upon showing of negligence, lack of due diligence, intemperance, immorality, incompetency, cruelty, mental derangement, willful violation of laws, or governmental regulation or willful violation of explicit rules and regulations of Facility. From the viewpoint of point of the Facility, the term "negligence" includes non-payment of charges due. The account will be considered past due when it is not paid by the 15<sup>th</sup> of the month following the calendar month of presentation of itemized billings. A service charge of 1¼% per month will be added to all past due accounts. Non-payment of all charges by due date may result in notification to the Patient/Resident to vacate the premises.

17. If a Patient/Resident receives notification of transfer or discharge for other than medical reasons, those reasons shall be documented. An impartial hearing may be requested by the Patient/Resident or Responsible Party within 14 days of receipt of notification. The request must be in writing, addressed to the administrator of the Facility and must offer suggestions and assume responsibility in the resolution of the documented reason(s) for discharge. The Administrator will give a decision, in writing, within 10 working days. The Facility excludes the right to any hearing if the transfer or discharge is because of non-payment. A condition to any hearing requires up-to-date status of an account.
18. The Patient/Resident and/or Responsible Party, by virtue of their signing this Agreement, declares that said Agreement has been fully explained and understood.
19. This Facility does not require: 1) patients or families to pay private rates for a specified period before converting to Medical Assistance; 2) patients or families to supplement Medical Assistance or to make contributions as a precondition of admission or continued stay.
20. Our facility is a SMOKE FREE facility. This means no resident will be permitted to smoke.
21. The Patient/Resident and/or Responsible Party agree to pay the Facility daily rates;  
Semi-private Room: \_\_\_\_\_ & Private Room: \_\_\_\_\_. If Patient/Resident is eligible for Third party assistance (i.e. Medicaid) the West Virginia Department of Human Services will inform both the Facility and the Patient/Resident and/or Responsible Party of any payment due the Facility from resources of the Patient/Resident.

\_\_\_\_\_  
Facility Representative and Title

\_\_\_\_\_  
Patient/Resident

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party

\_\_\_\_\_  
Address

\_\_\_\_\_

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Relationship to Patient/Resident