NEW YORK STATE | Department of Health
Helen Hayes Hospital

51-55 N Route 9W, West Haverstraw, NY 10993

Skilled Nursing Facility and Transitional Care Unit
Basic Service Admissions Agreement

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I. Definition of Terms

A. Resident:

The person admitted to the facility for skilled nursing care/transitional care.

B. Facility:

Helen Hayes Hospital

C. Designated Representative:

An individual responsible for meeting the financial obligations of the resident under this Agreement from the resident's income and resources or third party payers and ensuring continuity of payment to the facility from such sources.

D. Responsible Party:

The individual, such as a power-of-attorney, guardian, conservator, joint tenant, or representative payee, who has legal access to and authority to handle the resident's as sets and who agrees to assist the resident in meeting his/her financial obligations under this Agreement as more fully described in Addendum 3.

E. Third Party Payers:

Medicaid, Medicare, other government programs, or private insurance.

II. Highlights of Admission Agreement

You are being admitted to the Skilled Nursing Facility or Transitional Care Unit at Helen Hayes Hospital for short-term rehabilitation. In compliance with Federal and New York State regulations, you are being asked to sign an Admission Agreement to the facility. You may review the entire Admission Agreement; for your convenience, we have highlighted the sections most relevant to short-term rehabilitation residents.

A. Financial Considerations

Under Medicare you are entitled to skilled nursing care or transitional care unit benefits. We believe based on our pre-admission screen and review of your medical record that you qualify for skilled nursing care or transitional care unit benefits.

We want you to be aware of the following:

- Entitlement of Medicare services and payment to the facility for providing the services are not guaranteed.
- You acknowledge financial responsibility for payment of services provided.
- Helen Hayes Hospital follows New York State and Medicare regulations with the collection and submittal of clinical information, which supports the facility in receiving payment.

The facility will bill all secondary and third party payers for services that are not covered under Medicare. We need your assistance in making sure that we have the correct payer and billing information and that you will be responsible in timely follow up with all required information to ensure uninterrupted payment to the facility. This may include private pay, co-payments, deductibles, and/or cooperation in obtaining Medicaid coverage if appropriate.

B. Services

Helen Hayes Hospital is committed to providing you with the best rehabilitation therapy and nursing care. Our short-term rehabilitation program is targeted to individuals who are motivated to participate in therapy and have a realistic discharge plan in place to return home. It is not the intention of the facility to provide long-term maintenance care. If long-term care services are recommended or required, you will be referred to facilities that provide this type of service. Our social work staff will assist you and your family members as needed with securing post-care services.

Skilled Nursing Facility and Transitional Care Unit at Helen Hayes Hospital

BASIC SERVICE ADMISSIONS AGREEMENT

Between the

Skilled Nursing Facility and Transitional Care Unit, referred to as [Facility]
Helen Hayes Hospital
51-55 North Route 9W
West Haverstraw, NY 10993

And

Resident

_____

And

Resident's Designated Representative and/or Responsible Party

_____

Whereas, it is the purpose of Helen Hayes Hospital to provide for the health, safety and general welfare of the short-term rehabilitation residents admitted for care according to the provisions of all Federal and New York State laws and regulations governing the Skilled Nursing Facility and Transitional Care Unit at Helen Hayes Hospital; this Agreement shall specify the rights and obligations of the residents and the facility which shall apply to the period of admission of such residents and will set forth the procedures for payment to be made by the resident, Medicare and/or Medicaid programs, or third party payers.

III. Services Provided by the Facility

A. Basic Services: The following services are provided under the daily basic

1. Lodging, including a clean, properly outfitted, healthful sheltered environment, and board, including therapeutic or modified diets as prescribed by a physician.
2. Twenty-four (24) hour per day nursing care.
3. Use of all customarily stocked equipment, medical supplies, and modalities, notwithstanding the quantity, usually used in the everyday care of facility residents.
4. Fresh bed linen, as required, changed at least twice weekly, including sufficient quantities of necessary bed linen or appropriate substitutes changed as often as required for incontinent residents.
5. Hospital gowns required by the clinical condition of the resident unless the resident or another person on the resident's behalf elects to furnish them. Laundry services as needed for these and other launderable personal clothing items.
6. General household medicine cabinet supplies, including, but not limited to, non-prescription medications, materials for routine skin care, oral hygiene, and care of hair except when specific items are medically indicated and prescribed for exceptional use for a specific resident.
7. Assistance and/or supervision, as required, with activities of daily living including, but not limited to, toilet, bathing, feeding, and ambulation assistance.
8. Services in the daily performance of their assigned duties by the appropriate members of the facility staff concerned with resident care.
9. Use of customarily stocked equipment including, but not limited to, crutches, walkers, wheelchairs, or other supportive equipment, including training in their use as necessary unless such item is prescribed by a physician for regular and sole use by the resident.
10. Activity programs including, but not limited to, a planned schedule of recreational, motivational, social, and other activities, together with the necessary material and supplies associated with activities programs.
11. Social services and pastoral care as needed.
12. Dental assessment provided by a dentist if requested.
13. Maintenance therapy (physical, occupational, and speech, if needed) to maintain optimal level of function as prescribed by a physician and provided by qualified personnel.
14. Kosher food or food products prepared in accordance with Orthodox Jewish dietary laws shall be provided when a resident, based on sincerely held religious beliefs, chooses to observe those dietary requirements.

B. Physician and Ancillary Services

Except as may be prohibited by third party payers or otherwise provided by a contract with a third party payer, charges for physician visits and certain physician ordered ancillary services **are not** included in the daily basic rate.

Examples of the ancillary services are as follows:

1. Ambulance.
2. Physician services and consultation fees.
3. Prescription medication and pharmaceutical supplies (except for limited amounts noted above in Section III.A.6. of Basic Services).
4. Restorative physical, restorative occupational, and speech therapy services.
5. Podiatry, ophthalmology, and dental services.
6. Electrocardiograph, x-ray, laboratory tests, or professional fees for the same.
7. Dentures, eyeglasses, contact lens, hearing aids, or similar personal items.
8. Special nursing or personal care supplies not considered routine.
9. Supportive equipment such as walkers, canes, and wheelchairs when these are prescribed by a physician for regular and sole use by a specific resident.
10. Enteral feedings.
11. Respiratory and inhalation therapy.

In addition, the services listed below are not included in the facility's charges, nor are they generally covered by third party benefits:

1. Outgoing toll telephone calls.
2. Television, radio, or newspaper for personal use.
3. Social events and entertainment offered off of the premises and outside the scope of the facility's activities program.
4. Dry cleaning and special laundering services.
5. Any other items or services required by the resident or representative that are not covered by Medicare, Medicaid, insurance, or any other third party payer.
6. Private duty nurses, aides, and/or companions.

C. Additional Charges

The facility will not assess additional charges in excess of the daily basic rate except:

1. Upon express written approval of the resident, designated representative, or responsible party.
2. Upon express written orders of the resident's physician stipulating specific services and supplies not included in the basic rate.
3. Thirty (30) days written notice to the resident, designated representative, or responsible party of additional charges due to the increased cost of maintenance and/or operation of the facility or in the event of a health emergency, which requires immediate special services or supplies.

IV. Payment and Related Obligations

A. Basic Payment Obligation

The resident, designated representative, and/or responsible party agree to pay for, or arrange to have paid for by Medicare, Medicaid, or other insurers or third party payers, all items and services included in the daily basic rate and all additional items and services that are charged separately to the resident.

In addition, the resident agrees to pay the facility charges for physician and ancillary services outlined in Section III.B. At the time of admission, the resident is required to pay the basic rate for thirty (30) days in advance and thereafter for thirty (30) days regularly by the first of each month, except for residents covered by Medicare Part A, Medicaid, or managed care payers.

The resident, designated representative, and/or responsible party agree to pay the daily basic payment obligation as a private pay resident until he/she is assigned a Medicaid number. The resident agrees to pay this basic payment obligation after any Medicare Part A coverage has been applied or exhausted. The resident understands and agrees that he/she will pay the daily basic obligation if the application is denied. The resident agrees to pay any third party payer deductible and co-insurance to the facility. The facility will bill amounts due at discharge or monthly.

B. Duty to Assure Third Party Payment

The resident guarantees the continuity of payment of all charges incurred at the facility, which includes the duty to arrange for timely coverage, and payment from third party payers. The resident agrees to provide timely and complete information to the facility pertaining to all potential third party payers and to either 1) provide proof to the facility hat a claim for coverage has been made or 2) provide necessary information and authorization to the facility to submit the claim.

C. Duty to Arrange for Timely Medicaid Application and Coverage

The resident, designated representative, and/or responsible party guarantee of continuity of payment includes the duty to monitor his/her resources to ensure uninterrupted payment to the facility by making a timely and complete application to the county Department of Social Services (DSS) for Medicaid coverage. The resident agrees to notify the facility in writing:

(i.) three months prior to the anticipated time when the resident will have spent his/her resources down to the Medicaid eligibility level;

(ii.) when the Medicaid application will be filed and is filed; and

(iii.) of the status of the Medicaid application for re-certification at all times.

The resident authorizes the facility to have access to the resident's Medicaid application and re-certification files and any supporting documentation required by the DSS and to represent the resident in the Medicaid application and re-certification process, if necessary. The resident will sign Addendum 1 to provide such authority.

D. Duty to Pay Monthly Income Under Medicaid

The resident understands that if he/she receives monthly income, and obtains Medicaid coverage, the DSS will require the monthly income (the net available monthly income or NAMI) minus $50.00 personal needs allowance. The resident agrees to pay the facility such income on or before the 10th day of the month in which such income was received or to arrange for such payment to be sent directly to the facility from the payer pursuant to the arrangement outlined in Addendum 2. If the amount is in dispute, it may be paid into an escrow account in accordance with the law.

E. Truthfulness of Information Provided

The resident, designated representative, and/or responsible party each separately represent that the financial information submitted to the facility is true, accurate, and complete in all material respects and that there are no material omissions and that it is understood that the facility will rely on such information as submitted.

F. No Guarantee of Third Party Payment

The resident, the designated representative, and/or the responsible party hereby acknowledge that no representation, statement, or claim has been made by anyone connected with the facility that the services or items to be provided to the resident are or will be covered under Medicare Part A or Part B, Medicaid, or any other insurer or third-party payer.

G. Managed Care Payers

If the resident is covered by a managed care payer with whom the facility has an agreement, the facility will provide the level and type of covered services defined in the agreement with the managed care payer in exchange for the rate negotiated with the managed care payer. The covered services provided to the resident pursuant to an agreement with a managed care payer must include the basic services listed in Section III.A. of this Agreement. The resident, designated representative, and/or responsible party agree to pay, or have Medicare, Medicaid,or other third-party payer pay, the facility for any applicable co-payments, co-insurance amounts, or deductibles required by the managed care payer and any additional services or items furnished to the resident that are not covered by the managed care payer.

H. Private Pay Rate

The resident, designated representative, and/or responsible party agree to pay the private pay rate for the basic services listed in Section III.A. of this Agreement and the facility's charges for additional services and items listed in Section 1.B. of this Agreement.

The private pay rate may be increased on thirty (30) day's advanced written notice to the resident, designated representative, and/or responsible party.

V. Late and Non-Payment, Transfer and Discharge

A. The resident may be discharged or transferred for medical reasons, for his/her welfare, and for non-payment of any sums due under this Agreement, except as prohibited by third-party payers. Notice of transfer or discharge will be provided at least thirty (30) days before the resident is transferred or discharged unless:

1. The resident's needs can no longer by met on the unit and the discharge/ transfer is necessary for their welfare.
2. There has been significant improvement of the resident's medical or rehabilitative status so that they: a) can benefit from more intensive acute rehabilitation services or b) no longer require skilled nursing or transitional care unit services.
3. The health or safety of other residents would be endangered.
4. The resident no longer meets the criteria for the Helen Hayes Hospital Skilled Nursing Facility or Transitional Care Unit rehabilitation program.
5. The resident has failed, after reasonable and appropriate notice, to pay for the stay on the unit.
6. The unit ceases to operate.
7. Discharge or transfer is being made in compliance with the resident's request. In such cases, the notice shall be given as soon as practicable before transfer or discharge.

B. In the case of non-payment of any sum due under this Agreement, the resident, designated representative, and/or responsible party agree to pay reasonable collection fees, attorney's fees, and damages incurred by the facility for breach of their obligation set forth in this Agreement.

C. All past due balances shall be delinquent if not paid within the month following the date that services were rendered. A service charge of 1.5% (18% per year) may be charged monthly on all rates and charges for which payment is not received by the 15th of the month. A service charge of $35.00 will be charged for all checks returned for "insufficient funds" except to the extent prohibited by law and third-party payers.

D. A refund will be made within a reasonable amount of time after discharge for any amount paid by, or on behalf of, the resident in excess of amounts due for services rendered if the resident leaves the facility prior to the end of the pre-payment period for reasons beyond the control of the resident, designated representative, and/or responsible party. The resident agrees to provide the facility with a 14-day notice of discharge.

E. The facility shall have the right, upon thirty (30) days prior written notice to the resident, his/her designated representative, responsible party, or where appropriate, health care agent, consultation to make an administrative room transfer with the facility.

Such thirty (30) day notice and consultation will not be required under the following circumstances:

1. The resident has requested or agreed to the change;
2. The medical condition of the resident requires a more immediate change; or
3. An emergency situation develops.

Under such circumstances, the facility will endeavor to give the resident and designated representative prior notice of such room change. In the event of a change in roommate assignment, the facility will provide prompt notice to the residents involved and/or their designated representative.

F. In the event the resident dies, the facility will endeavor to notify a member or members of his/her family, designated representative and/or responsible party. It is expected that the family will promptly provide for and bear the expenses of the resident's end of life arrangements. In the event of the resident's death, all funds and personal property shall be returned in accordance with appropriate county regulations. If the facility is not notified within thirty (30) day of the resident's death of the appointment of a personal representative of the resident's estate, the facility shall transfer all funds and personal property of the resident to the Chief Fiscal Officer of the resident's county of residence prior to admission or to an appropriate Public Administrator, whichever is applicable.

V. Bed Holds

In the event that a resident is absent from the Helen Hayes Hospital Skilled Nursing Facility or Transitional Care Unit for a period of time by reason of illness of other cause, the resident's accommodations will be held available provided the resident continues to pay the scheduled private pay rate for said accommodations. If the resident is receiving Medicaid, said resident's room will be held in accordance with State and Federal laws and regulations. If a Medicaid resident's hospitalizations or therapeutic leave

exceed the bed hold period prescribed by State and Federal law, Helen Hayes Hospital shall readmit the resident to the short-term rehabilitation unit immediately upon the first availability of a bed in a semi-private room if the resident:

1. Requires the services provided by Helen Hayes Hospital short-term rehabilitation unit, and
2. Is eligible for Medicaid services.

VII. Resident's Property

A. Each resident is informed prior to and/or upon admission to limit valuables brought to the facility. The resident has the right to manage his/her personal valuables and money.

The retention of property by a resident in his/her room is at the risk of the resident and is the responsibility of the resident, and insurance coverage is strongly recommended in such cases. In addition, the resident, designated representative, and/or responsible party may utilize the on-site banking services located on the Hospital premises for direct access of personal 24-hour banking services. See Section X, Paragraph E.

B. The resident, designated representative, and/or responsible party must arrange or disposition of the resident's property upon discharge. The facility may dispose of property remaining thirty (30) days after discharge.

VIII. Authorization

A. For physician visits, the resident, designated representative, and/or responsible party agree that an assigned credentialed physician at the Skilled Nursing Facility or Transitional Care Unit short-term rehabilitation unit at Helen Hayes Hospital may visit the resident in the facility every thirty (30) days for the first ninety (90) days and every sixty (60) days thereafter, or as often as necessary to address the resident's medical needs. The facility may arrange for another credentialed physician to see the resident if the resident's staff physician is delinquent in visitation or is unable to see the resident when medically necessary.

B. The resident, designated representative, and/or responsible party authorize the facility to bill third party payers and to receive payment directly for credit to the resident's account. The resident, designated representative, and/or responsible party consent to the release of any medical record maintained by the facility to third party payers for the purpose of utilizing review and obtaining payment. The resident, designated representative, and/or responsible party also authorize

the facility's Social Service staff and Accounting Department to open and handle correspondence pertaining to Medicare, Medicaid, Social Security, and other related billing matters. Medical information may also be shared with the Hospital and/or Skilled Nursing Facility or Transitional Care Unit consultants and agents as may be appropriate. Personal mail, however, is not included in this authorization.

IX. Resident's Rights

A. The resident, designated representative, and/or responsible party will be provided with a copy of "Your Rights as a Nursing Home Resident in New York State and Facility Responsibilities." Upon admission to the facility, all residents will receive a package of information about the Hospital, services, and policies. The resident agrees to adhere to the rules and regulations, as well as all policies and procedures established by the facility throughout the resident's stay.

B. The Skilled Nursing Facility and Transitional Care Unit at Helen Hayes Hospital have a grievance complaint procedure in the event that a resident, family member, or designated representative wishes to file a complaint about the services provided by the facility or its staff. This procedure has been developed in order to help the residents, family members, and/or designated representative bring a problem to the attention of the staff so that the grievance can be resolved in an appropriate manner.

X. Miscellaneous Provisions

A. The facility has the responsibility to electronically transmit the Minimum Data Set 3.0 (MDS 3.0) information to the State and in turn to the Federal Health Care Financing Administration. This information is subject to the Federal Privacy Minimum Data Set System of Records System. Addendum IV describes this Privacy Act.

B. The facility assumes no financial obligations arising as a result of the death of a resident. All expenses for end of life arrangements are to be paid from the estate of the resident, by legally responsible persons, or by funds made available by law, unless the resident has made specific prior arrangements with the facility.

C. The resident authorizes funeral arrangements to be made by the facility on his/her behalf if the resident does not have family or next of kin, or if funeral arrangements are not made within twenty-four (24) hours of death. The expenses for the same shall be paid by the estate of the resident or from funds made available by law for that purpose, without any liability by the facility for the exercise of such authority.

D. The facility will not be liable for the loss of any personal property by the resident during the term of his/her stay at the facility unless said loss is caused by the negligence of the facility or violation of the Public Health Law by the facility.

E. When so requested in writing, the facility shall provide a service to hold moneys for incidental expenses. Residents may obtain these funds from the business office of the facility during designated hours. The resident may also establish a personal fund account through the direct banking services located on-site in the main atrium of the Hospital. See Section V, Paragraph A.

F. The facility shall not be liable or responsible for injuries to the resident or damage to the resident's personal property unless the negligence of the facility or a violation of the Public Health Law causes such injury or damage.

G. In the event the facility is required to engage legal counsel to collect from the resident the basic daily charge, NAMI moneys, or other charges, the resident agrees to pay the facility's attorney fees together with any and all costs incurred with respect to any legal action undertaken to collect such charges.

H. The Skilled Nursing Facility and Transitional Care Unit at Helen Hayes Hospital provide short-term rehabilitation care. It is not the intention of the facility to provide ongoing, long-term maintenance care. If long-term services are required or recommended, you understand and agree to be referred and transferred to a facility that does provide this type of service.

We, the undersigned, have read, been advised of, and understand this Agreement and agree to be legally bound to its terms. We have had an opportunity to discuss it with the representative of the facility who is also signing this Agreement.

Admission Agreement Summary

Acceptance and Signatures

In compliance with State and Federal regulations, the Skilled Nursing Facility and Transitional Care Unit at Helen Hayes Hospital does not discriminate during admission, retention, and care in any form on the basis of age, color, creed, disability, blindness, handicap, marital status, national origin, race, religion, sex, sexual preference, source of payment, and/or sponsor.

Date	**Signature/Mark of Resident Party**
Date	**Signature of Designated Representative or Responsible Party**
Date	**Printed Name of Designated Representative or Responsible Party**
Date	**Signature of Helen Hayes Hospital Representative**
Date	**Printed Name of Helen Hayes Hospital Representative**

ADDENDUM 1

Authorization for Release of Resident Medicaid Information to the Facility

I, _____, hereby authorize the _____ _____ County Department of Social Services, ("the Department") to release information about _____ _____ Medicaid case to Helen Hayes Hospital.

Authorization for the Facility to Represent the Resident in the Medicaid Process

I, _____, also authorize Helen Hayes Hospital to act on behalf of I, _____, in the Medicaid application and recertification process. This authorization includes representation in the appeal of a denial of Medicaid eligibility or benefits should such representation become necessary because the resident, designated representative, and/or responsible party is unable or unwilling to make such appeal and provided the facility deems such appeal advisable. The facility shall be authorized, but not obligated, to file on its own initiative a Medicaid application or perform a Medicaid re-certification application on behalf of the resident in the event that the resident or his/her representatives are unable or unwilling to do so. I understand that by signing this authorization, the facility does not undertake any obligation to file any such application to appeal a denial of Medicaid benefits on behalf of the resident unless the facility deems its action is necessary and prudent. These authorizations will continue without expiration unless otherwise indicated below:

_____
Expiration of Authorization Date

I retain the right to rescind this authorization at any time with written notice.

_____ _____
Date **Signature/Mark of Resident Party**

_____ _____
Date **Signature of Designated Representative or Responsible Party**

_____ _____
Date **Printed Name of Designated Representative or Responsible Party**

ADDENDUM 2

Agreement to Arrange Direct Payment of NAMI to the Facility

I agree to arrange for direct payment of the resident's monthly income checks to Helen Hayes Hospital with the understanding that the facility will apply the amount from such income owed to the facility as the NAMI and will deposit the remainder in a personal fund account.

_____	_____
Date	**Signature/Mark of Resident Party**
_____	_____
Date	**Signature of Designated Representative or Responsible Party**
_____	_____
Date	**Printed Name of Designated Representative or Responsible Party**

ADDENDUM 3

Responsible Party's Personal Agreement for the Benefit of the Resident

Agreement between Helen Hayes Hospital, located at 51-55 North Route 9W, West Haverstraw, New York and _____, (Responsible Party) residing at _____, for the benefit of and concerning the admission of _____, (the Resident) pursuant to the attached Admission Agreement between Helen Hayes Hospital and the resident and the responsible party and/or the designated representative.

Whereas, the responsible party understands that he/she is a financial agent for the resident because the responsible party has access to some or all of the resident assets; and

Whereas the responsible party understand the resident obligations to the facility as set forth in the facility's admission agreement and acknowledges that the resident wishes the responsible party to comply with the attached admission agreement; and

Whereas the responsible party wishes to assist the resident and to facilitate the resident admission to the facility; and

Whereas the responsible party agrees and acknowledges that the facility will be relying on the responsible party's agreement herein;

Now, wherefore, in consideration of the foregoing and for other and further valuable consideration, the parties hereby agree as follows:

A. The responsible party agrees to provide the following assistance to the facility in the event such assistance is both needed and required.

B. Without incurring the obligation to pay for the cost of the resident's care from the responsible party's own funds, and in recognition that the agent is not currently the designated representative for the resident, the responsible party personally agrees to use his/her access to the resident's funds to aid the resident in meeting his/her obligations under the admission agreement if such assistance is necessary to enable the resident to comply with the terms of such agreement.

C. More specifically, the agent personally agrees that, to the extent of his/her authority, the responsible party will use his/her access to the resident's assets to ensure continued satisfaction of the resident payment obligations to the facility and agrees not to use the resident's assets in such a way as to place the facility in a position where it cannot receive payment from either the resident funds or Medicaid.

D. If the resident becomes Medicaid eligible and if the responsible party has access to the resident's income the responsible party personally agrees to assure that the facility is paid that portion of the monthly Medicaid rate which the Medicaid agency may direct the resident to pay towards the cost of his/her care.

E. The responsible party personally agrees to assist in meeting the insurance obligations under this Agreement if necessary and if requested by providing timely financial formation and/or documentation of the resident's assets to which the responsible party has access, and

F. The responsible party agrees to pay damages to the facility for any breach of his/her personal obligation as set forth in this Agreement.

In witness whereof, the responsible party hereby executes this Agreement for the benefit of the resident as of the date indicated.

Date	**Signature of Designated Representative or Responsible Party**
Date	**Printed Name of Designated Representative or Responsible Party**

ADDENDUM 4

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU

WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

For Nursing Home residents residing in a certified Medicare/Medicaid nursing facility, the requested information is mandatory because of the need to assess the effectiveness and quality of care given in certified facilities and to assess the appropriateness of providing services. If the requested information is not furnished, the determination of beneficiary services and resultant reimbursement may not be possible.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

Date	**Signature/Mark of Resident Party**
Date	**Signature of Designated Representative or Responsible Party**
Date	**Printed Name of Designated Representative or Responsible Party**