Eddy SeniorCare
St Peter's Health Partners

ENROLLMENT AGREEMENT

DEMOGRAPHICS

_____
Participant's Name Printed (First Middle Last)

_____
Participant's Address City State Zip

____ ____ - ____ ____ - ____ ____ ____ ____ ____ ____ ____ - ____ ____ - ____ ____ ____ ____
Date of Birth Social Security Number

_____ _____
Home Telephone Mobile / Cell Phone

_____ ____Female ____ Male
Email Address Gender

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Primary Language: _____

Race: ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian
☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

GUARDIAN/REPRESENTATIVE (if applicable)

_____
Guardian/Representative Name Printed (First Middle Last)

_____
Guardian/Representative Address City State Zip

_____ _____
Guardian/Representative Home Telephone Guardian/Representative Mobile / Cell Phone

_____
Guardian/Representative Email Address

Legal representative exercising patient's rights per court order (____) copy received

ENROLLMENT INFORMATION

____ ____ - ____ ____ - ____ ____ ____ ____
Effective Date of Enrollment

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Your Eddy SeniorCare Member Identification Number

Eddy SeniorCare
St Peter's Health Partners

ENROLLMENT AGREEMENT

I have received, read and understand the Eddy SeniorCare:

- **Enrollment Handbook**
- **Provider Network List**
- **Enrollment Agreement**
- **Notice of Privacy Practices**
- **Advance Directives Booklet**.

Copies of the Handbook and Provider Network List were given to you at our Intake Visit. If you no longer had a copy of those, another copy was provided to you today.

The conditions of Enrollment, services covered and my Rights and Responsibilities as described in the Enrollment Handbook have been explained to me. I have been given the opportunity to ask questions, and my questions have been answered to my satisfaction.

I agree to participate in Eddy SeniorCare according to the terms and conditions described in the Enrollment Handbook and this Enrollment Agreement.

As a participant, I understand Eddy SeniorCare is the sole service provider who guarantees access to services, but not to a specific provider, and I agree to receive all services through Eddy SeniorCare and, when referred, to the providers listed in our Provider Network.

I understand that my enrollment is voluntary and my Enrollment date is:_____.

Important Notice: The benefits under this agreement are made possible through a special agreement that Eddy SeniorCare has with the Centers for Medicare and Medicaid Services and the New York State Department of Health. When you sign this Enrollment Agreement, you are agreeing to accept benefits exclusively through Eddy SeniorCare in place of the usual Medicare and Medicaid benefits.

____ I have been informed of my right to appoint a Health Care Proxy and to document any Advanced Directives regarding my health care. I understand that Eddy SeniorCare staff will assist me in this area if I need help.

____ I will allow Eddy SeniorCare to act as my representative for the purpose of reviewing Medicaid eligibility and recertification.

____ I understand that enrollment in PACE results in disenrollment from any other Medicare or Medicaid prepayment or optional benefit. Electing enrollment in any other Medicare or Medicaid prepayment or optional benefit, including hospice benefit, after enrolling as a PACE participant is considered a voluntary disenrollment from PACE.

____ I have been informed that if I have an employer group health plan, enrollment into PACE may result in disenrollment from my employer group health plan.

____ I understand that Eddy SeniorCare's Program Agreement with the Centers for Medicare and Medicaid Services and the New York State Department of Health is subject to renewal, and if the agreement is not renewed, the program will be terminated.

____ I understand that I may disenroll from Eddy SeniorCare's plan by contacting Eddy SeniorCare. Until the effective day of disenrollment, I must continue to receive health care from the Eddy SeniorCare plan. I may not disenroll at a Social Security Office.

____ I have been informed of my rights and responsibilities as a participant of Eddy SeniorCare

____ I understand that the Centers for Medicare and Medicaid Services, and New York State Department of Health, and Eddy SeniorCare have access to my medical records, and I authorize consent to disclose and exchange information.

____ If I am or become a resident in a nursing home, I agree to a referral to New York State's contractor for *Money Follows the Person/Open Doors*, a program that can work with Eddy SeniorCare to help me return to community living.

____ I understand and accept my financial responsibility as outlined in the Enrollment Agreement.

____ I understand that if my payor source is Medicaid-only or private pay and I become eligible for Medicare after enrollment in Eddy SeniorCare, I will be voluntarily disenrolled from Eddy SeniorCare if I elect to obtain Medicare coverage other than from Eddy SeniorCare/PACE.

____ I agree to be photographed for the purposes of medical care or identification.

____ I agree to participate in Eddy SeniorCare according to the terms and conditions in this Enrollment Agreement. As a participant, I agree to receive and/or have coordinated my health and health-related services from Eddy SeniorCare. I also agree to allow disclosure and information exchange about my participation with Eddy SeniorCare between the federal and state government, the local Department of Social Services and Eddy SeniorCare.

____ I have received, read and agree to abide by the Participant Responsibilities.

If you are not interested in enrolling in Eddy SeniorCare, you may return the agreement without signing it.

Participant's Name Printed (First, Middle, Last)	Participant's Signature	Date
Guardian/Representative Printed (If applicable)	Guardian/Representative Signature	Date
Witness Name Printed	Witness Signature	Date
Eddy SeniorCare Representative Name Printed	Eddy SeniorCare Representative Signature	Date

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ADVANCE DIRECTIVES

I acknowledge receipt of the Advance Directives booklet about my right to make healthcare decisions for myself. I understand that I may express my wishes in a document called an Advance Directive (Living Will, Durable Power of Attorney for Healthcare, MOLST Medical Orders for Life Sustaining Treatment, Do Not Resuscitate Order) so that my wishes may be known when I am unable to speak for myself.

My Health Care Proxy Is: _____ (____copy provided)
First Name, Last Name

_____
Health Care Proxy's Address City State Zip

_____ _____
Health Care Proxy's Home Telephone Mobile / Cell Phone

_____
Email Address

Living Will _____ No _____ Yes (____copy provided)

Community DNR _____No _____ Yes (____copy provided)

Medical Orders for Life Sustaining Treatment MOLST ___No ___Yes (___copy provided)

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PAYOR SOURCE

1. Are you paying privately? _____ Yes _____ No
2. Do you have New York State Medicaid? _____ Yes _____ No _____ Pending

   _____ _____ _____ _____ _____ _____ _____ _____
   New York State Medicaid ID #
3. Do you have Medicare _____ Yes _____ No _____ Pending

   ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ Part A ____ Part B _____
   Medicare ID #
4. Do you have any other health insurance/payor source? _____Yes _____ No

   _____ _____
   Name of Insurance Policy #

MONTHLY PREMIUM & PAYMENT AGREEMENT

I understand that as part of my participation in the Eddy SeniorCare program, I am required to pay monthly premiums as they relate to my continuing eligibility for Medicaid Medical Assistance, Medicare and/or private pay services. I understand that the monthly fees may vary as my eligibility for these programs may change in the future, and may be adjusted annually. I may be required to pay monthly fees directly to Eddy SeniorCare.

I understand that all required payments to Eddy SeniorCare are due on the first of the month.

My payment to Eddy SeniorCare will be: $_____

Effective date: ___ ___ - ___ ___ - ___ ___ ___ ___

I agree to make the payment as indicated above:

Participant Signature	Participant Printed Name	Date
Representative Signature	Representative Printed Name	Date
Eddy SeniorCare Staff Signature	ESC Staff Printed Name & Title	Date

cc: Schenectady, Albany, Rensselaer County Department of Social Services

Eddy SeniorCare
St Peter's Health Partners

METHOD OF PAYMENT

******Due to confidential nature of this document, please do not make any photocopies once filled out ******

Debit/Credit Card or Automatic Checking Authorization

_____
Today's Date

Participant Last Name _____ First Name _____

ESC ID Number: _____(MRN-program-DOS)

Amount to Charge $_____ **Credit Card Holders Zip Code _____**

One Time Only? ☐ For _____ Date _____
Recurring? ☐ Start Date _____ Amount $_____

Transaction Notes: _____

If receipt is needed please circle ---> YES

For File Only Pending Trust? ☐ No ☐ YES (IF YES, DO NOT PROCESS ANY PAYMENTS)

_____ _____
Name (as it appears on Credit Card) **Phone Number** (of card holder if not patient)

_____ _____
Signature **Date**

- ✂✂✂✂✂✂✂✂✂ -

(FINANCE TO DESTROY THIS LOWER SECTION ONCE PROCESSED)

Checking account info:

Routing Number:_____

Account Number:_____
(Note: Please attach blank check)

Credit Card info:
Credit Card #_____Expiration Date: _____ month ____ year

3 Digit Security Code _____ (Found on back of card in signature area)

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CONSENT FOR TREATMENT – PRIMARY CARE PROVIDER

While enrolled in Eddy SeniorCare, I will receive primary care services from Eddy SeniorCare. I hereby request and consent to medical and/or diagnostic treatment by Eddy SeniorCare, and hereby authorize their physicians, nurse practitioners and physician assistants, to treat myself in ways providers determine to be therapeutically necessary and as ordered by my primary care provider. I understand that this treatment may include tests (lab/diagnostics), examinations, administration of medications, medical or surgical procedures and appropriate counseling and health maintenance services. I also understand that it is customary, absent emergency or extraordinary circumstances, that no substantial procedures are performed upon a patient unless and until he or she has an opportunity to discuss them with the physician or other health professional to the patient's satisfaction and that each patient has the right to refuse to consent to any proposed procedure or treatment. I acknowledge that no guarantees have been made concerning any medical care. This form has been fully explained to me and I am satisfied that I fully understand its consents and significance.

CONSENT TO TREATMENT – LICENSED HOME CARE AGENCY AND OUTPATIENT REHAB CLINIC

From time to time, as ordered by my Eddy SeniorCare primary care provider, I may receive services from Eddy SeniorCare's licensed home care services agency and/or outpatient rehab clinic. I hereby authorize and give my consent to Eddy SeniorCare, including its employed and contracted nurses, therapists and other health care professionals to provide me with outpatient rehab and/or home health care services and to perform all necessary procedures and treatments as prescribed by my physician/nurse practitioner. I understand that the home health care services to which I am consenting include those nursing, physical/occupational/speech therapy, social work, telehomecare/remote patient monitoring, aide and housekeeping services as ordered by my Eddy SeniorCare primary care provider. I understand that I can withdraw my consent for any treatment at any time prior to the treatment or terminate services at any time. I understand that no guarantees or assurances have been made to me as to the results or the effects of such outpatient rehab or home health care services.

PRIVACY AND RELEASE OF INFORMATION

I have received the Notice of Privacy Practices. Eddy SeniorCare may release my protected health information for treatment, payment and healthcare operations purposes. I authorize Eddy SeniorCare to release my protected health information to the following family members/caregivers:

1. _____
2. _____
3. _____

Participant Signature	Participant Printed Name	Date
Representative Signature	Representative Printed Name	Date
Eddy SeniorCare Staff Signature	ESC Staff Printed Name & Title	Date