GrandeVille
ASSISTED LIVING
555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 621-8002

GRANDEVILLE SENIOR LIVING COMMUNITY RESIDENCY AGREEMENT

A. This Agreement is made between GrandeVille Senior Living Community LLC. the "Operator", _____ (the "Resident" or "You" or "Your") _____ (the "Resident's Representative", if any) and _____ (the "Resident's Legal Representative", if any).

RECITALS

A. **The Operator** is licensed by the New York State Department of Health to operate at 555 Maiden Lane Rochester New York 14616, an Assisted Living Residence (The "Residence") and an Adult Home, commonly known as GrandeVille Senior Living Community. The Operator is also certified to operate, at this same location, an Enhanced Assisted Living Residence, and Special Needs Assisted Living Residence.

B. You have requested to become a Resident at The Residence and the Operator has accepted your request.

AGREEMENTS

I. Housing Accommodations and Services. Beginning on _____, the Operator shall provide the following housing accommodations and services to You, subject to the other terms, limitations and conditions contained in this Agreement. This Agreement will remain in effect until amended or terminated by the parties in accordance with the provisions of this Agreement.

A. Housing Accommodations and Services:

1. Your Apartment/Room. You may occupy and use a private ( ) or semiprivate ( ) unit identified on Exhibit I.A.1, subject to the terms of this Agreement.

2. Common areas. You will be provided with the opportunity to use the general- purpose rooms at the Residence.

3. Furnishings/Appliances Provided By The Operator. Attached as Exhibit 1.A.3. and made a part of this Agreement is an Inventory of furnishings, appliances and other items supplied by the Operator in Your room.

4. Furnishings/Appliances Provided by You. Attached as Exhibit I.A.4. and made a part of this agreement is an Inventory of furnishings, appliances and other items supplied by

You in Your room. Such Exhibit also contains any limitations or conditions concerning what type of appliances may not be permitted.

B. Basic Services

The following services ("Basic Services") will be provided to You, in accordance with Your Individualized Services Plan.

1. **Meals and Snacks.** Three nutritionally well-balanced meals per day and three snacks per day are included in Your Basic Rate. The following modified diets will be available to You if ordered by Your physician and included in Your Individualized Service Plan:

_____ HOUSE - approximately 2000 calories, no salt in cooking, seconds available.

_____ NO FREE SALT - House diet except NFS, NAS, no salt on table.

_____ LIMITED CARBOHYDRATE - House diet except diet desserts, skim milk and sugar substitutes. Regular desserts available 3 times weekly.

2. **Activities.** The Operator will provide a program of planned activities; opportunities for community participation and services designed to meet Your physical, social and spiritual needs, and will post a monthly schedule of activities in a readily visible common area of the Residence.

3. **Housekeeping.** Weekly housekeeping included in rate.

4. **Linen Service.** Towels and washcloths; pillow, pillowcase, blanket, bed sheets, bedspread; all clean and in good condition.

5. **Laundry of Your personal Washable clothing.** You are required to clearly mark your clothing for identification purposes. GrandeVille is not responsible for shrinkage.

6. **Supervision on a 24-hour basis.** The Operator will provide appropriate staff on site to provide supervision services in accordance with law. Supervision will include monitoring (a response to urgent or emergency needs or requests for assistance on a 24-hour a day, seven days a week basis) as well as the other components of supervision as specified in law.

7. **Case Management.** The Operator will provide appropriate staff to provide case management services in accordance with law. Such case management services will include identification and assessment of Your needs and interests, information and referral, and coordination with available resources to best address Your identified needs and interests.

8. **Personal Care.** Includes some assistance with bathing, grooming, dressing, toileting *(if applicable),* ambulation *(if applicable),* transferring *(if applicable),* feeding, medication acquisition, storage and disposal, assistance with self-administration of medication.

9. **Development of Individualized Service Plan.**

C. Additional Services. Exhibit I.C., attached to and made a part of this Agreement, describes in detail, any additional services or amenities available for an additional, supplemental or other fee from the Operator directly or through arrangements with the Operator. Such exhibit states who would provide such services or amenities, if other than the Operator.

D. Licensure/Certification Status. A listing of all providers offering home care or personal care services under an arrangement with the Operator, and a description of the licensure or certification status of each provider is set forth in Exhibit I.D. of this Agreement. Such Exhibit will be updated as frequently as necessary.

II. Disclosure Statement. The Operator is disclosing information as required under Public Health Law Section 4658(3). Such disclosures are contained in Exhibit II., which is attached to and made part of this Agreement.

III. Fees

A.1. Basic Rate. Flat Fee Arrangements. The Resident, Resident's Representative and/or Resident's Legal Representative agree to pay, and the Operator agrees to accept, the following payment in full satisfaction of the Basic Services described in Section I. B. of this Agreement. The Basic Rate at the date of this agreement is $_____ per month or $_____ per day. GrandeVille does not charge based upon a tiered fee arrangement and does not charge a community fee.

A.2. Full Short-Term Rate. This rate applies only to planned stays of sixty (60) days or less. Such stays are commonly referred to as respite stays. The Operator, the Resident and/or the Resident Representative may agree in advance to the provision of room and care services for a specific period of time. The fee for that period will be $_____, beginning _____, 20____ and ending _____, 20____.

B. Supplemental or Additional Fees. A Supplemental or Additional fee is a fee for service, care or amenities that is in addition to those fees included in the Basic Rate. A Supplemental fee must be at Residents option. In some cases, the law permits the Operator to charge an Additional fee without the express written approval of the Resident. Any charges by the Operator, whether a part of the Basic Rate or Supplemental or Additional fees, shall be made only for services and supplies that are actually supplied to the Resident. Exhibit I.C. describes these fees.

C. Billing and Payment Terms. Payment is due by the 10th day of each month and shall be delivered to the Bookkeeper's Office. Rates will be pro-rated upon admission, for the balance of the entry month. Payments remaining unpaid after the due date shall incur a monthly flat rate service charge of Thirty Dollars ($30.00). A Ten Dollar ($10.00) deposit is required for room keys, refundable when residency is terminated, and original keys returned. IMPORTANT:
The intent of this Agreement is to provide appropriate, long-term care for the Resident. GrandeVille does not charge an application or admission fee. The rate quoted is based upon a long-term relationship. Therefore, in the event that the resident or resident's legal representative terminates this Agreement, without the written approval of the Operator, within sixty (60) days of the admission date, or the length of residency is less than sixty (60) days, unless otherwise expressly agreed to in writing or provided for by law, or the resident was admitted under the "Full Short-Term Rate", the Operator reserves the right to charge an additional sum of $ _____ per day. The Resident and his/her Legal Representative jointly and severally agree to pay the rate as stated in this section or any addendum attached hereto unless otherwise agreed to in writing by the parties to this Agreement provided that the same is not prohibited by law. If a dispute arises between us and you or between us and your Responsible Person, if any, about this Residency Agreement, the prevailing party may collect from the losing party all reasonable attorney's fees incurred by the prevailing party in resolving the dispute which the court has expressly ordered the losing party to pay; provided however, that nothing in the agreement shall be deemed to limit the ability of any party to avail themselves of any legal action to contest or appeal the proposed imposition of such attorney's fees. The Resident and Responsible Party further: (i) consent to the personal jurisdiction of any State or Federal court located in Monroe County, New York, (ii) waives objection to the laying of venue. The Resident Representative waives personal service of process and subpoenas and consents to service of process and subpoenas by registered mail directed to such Resident Representative at the last address shown in the records relating to this Agreement, with such service deemed completed five (5) days after mailing or as otherwise provided by the laws of the State of New York or the United States.

D. Adjustments to Basic Rate or Additional or Supplemental Fees. (1) You have the right to written notice of any proposed increase of the Basic Rate or any Additional or Supplemental fees not less than forty-five (45) days prior to the effective date of the rate or fee increase, subject to the exceptions stated in paragraphs 3, 4 and 5 below. (2) If You, or Your Resident Representative or Legal Representative agrees in writing to a specific Rate or Fee increase, through an amendment of this Agreement, due to Your need for additional care, services or supplies, the Operator may

increase such Rate or Fee upon less than forty-five (45) days written notice. (3) If the Operator provides additional care, services or supplies upon the express written order of Your primary physician, the Operator may, through an amendment to this Agreement, increase the Basic Rate or an Additional or Supplementary fee upon less than forty-five (45) days written Notice. (4) In the event of any emergency which affects You, the Operator may assess additional charges for Your benefit as are reasonable and necessary for services, material, equipment and food supplied during such emergency.

E. Bed Reservation. The Operator agrees to reserve a residential space *as* specified in Section III. A. 1 above in the event of Your temporary absence. The charge for this reservation is the same as the rate agreed to Section III. A. 1. The Operator, at his option, may offer a discount for meals. No fees in excess of the agreed Basic Rate will be charged. A provision to reserve a residential space does not supercede the requirements for termination as set forth in Section XIII of this agreement. You may choose to terminate this agreement rather than reserve such space, but must provide the Operator with any required notice.

IV. Refund/Return of Resident Monies and Property. Upon termination of this agreement or at the time of Your discharge, but in no case more than three business days after You leave the Residence, the Operator must provide You, Your Resident or Legal Representative or any person designated by You with a final written statement of Your payment and personal allowance accounts at the Residence. The Operator must also return at the time of Your discharge, but in no case more than three business days, any of your money or property that comes into the possession of the Operator after Your discharge. The Operator must refund on the basis or a per diem prorating any advance payment(s) that you have made. If you die, the Operator must turn over your property to the legally authorized representative of your estate. If you die without a will and the whereabouts of your next-of-kin is unknown, the Operator shall contact the Surrogate's Court of the County wherein the Residence is located in order to determine what should be done with property of Your estate.

V. Transfer of Funds or Property to Operator. If you wish to voluntarily transfer money, property or things of value to the Operator upon admission or at any time, the Operator must enumerate the items given or promised to be given and attach to this agreement a listing of the items given or transferred. Such listing is attached as Exhibit V. and is made a part of this Agreement. Such listing shall include any agreements made by third parties for Your benefit.

VI. Property or items of value held in the Operator's custody for You. If, upon admission or any other time, you wish to place property or things of value in the Operator's custody and the Operator agrees to accept the responsibility of such custody, the Operator must enumerate the

items so placed and attach to this agreement a listing of such items. Such listing is attached as Exhibit VI. of this Agreement.

VII. Fiduciary Responsibility. If the Operator assumes management responsibility over Your funds, the Operator shall maintain such funds in a fiduciary capacity to You. Any interest on money received and held for You by the Operator shall be Your property.

VIII. Tipping. The Operator must not accept, nor allow Residence staff or agents to accept, any tip or gratuity in any form for any services provided or arranged for as specified by statute, regulation or agreement.

IX. 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) payments by executing a Statement of Offering (DSS-2853) with You or Your Representative. You agree to inform the Operator if you receive or have applied for Supplemental Security Income (SSI) or Safety Net Assistance (SNA) funds.

You must 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 funds

If you have a signatory to this agreement besides Yourself and if that signatory does not choose to place Your personal allowance funds in a Residence maintained account, then that signatory hereby agrees that he/she will comply with the Supplemental Security Income (SSI) or Safety Net Assistance (SNA) personal allowance requirements.

X. Admission and Retention Criteria for an Assisted Living Residence:

1. Under the law which governs Assisted Living Residences (Public Health Law Article 46-b), the Operator shall not admit any Resident if the Operator is not able to meet the care needs of the Resident, within the scope of services authorized under such law, and within the scope of services determined necessary within the Resident's Individualized Services Plan. The Operator shall not admit any Resident in need of 24-hour skilled nursing care.
2. The Operator shall conduct an initial pre-admission evaluation of a prospective Resident to determine whether or not the individual is appropriate for admission.
3. The Operator has conducted such evaluation of Yourself and has determined that You are appropriate for admission to this Residence, and that the Operator is able to meet Your care needs within the scope of services authorized under the law and within the scope of services determined necessary for You under Your Individualized Services Plan.

4. If You are being admitted to a duly certified Enhanced Assisted Living Residence, the additional terms of the "Enhanced Assisted Living Residence Addendum" will apply.

5. If You are being admitted to a Special Needs Assisted Living Residence, the "Special Needs Assisted Living Residence Addendum" will apply.

6. If You are residing in a "Basic" Assisted Living Residence and Your care needs subsequently change in the future to the point that You require either Enhanced Assisted Living Care or 24-hour skilled nursing care, You will no longer be appropriate for residency in this Basic Residence. If this occurs, the Operator will take the appropriate action to terminate this Agreement, pursuant to Section XIII of the Agreement. However, if the Operator also has an approved Enhanced Assisted Living Certificate, has a unit available, and is able and willing to meet Your needs in such unit, You may be eligible for residency in such Enhanced Assisted Living unit.

7. Enhanced Assisted Living Care is provided to persons who desire to continue to age in place in an Assisted Living Residence and who:

(a) are chronically chair fast and unable to transfer, or chronically require the physical assistance of another person to transfer; or

(b) chronically require the physical assistance of another person in order to walk; or

(c) chronically required the physical assistance of another person to climb or descend stairs; or

(d) are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; or

(e) have chronic unmanaged urinary or bowel incontinence.

8. Enhanced Assisted Living Care may also be provided to certain persons who desire to continue to age in place in an Assisted Living Residence and who are assessed as requiring 24 hour skilled nursing care or medical care and who meet the conditions stated in the Enhanced Assisted Living Residence Addendum.

XI. Rules of the Residence. Attached hereto made a part of this Agreement is GrandeVille's Welcome Manual that includes the Rules of the Residence. By signing this agreement, You and Your representatives agree to obey all reasonable Rules of the Residence.

XII. Responsibilities of Resident, Resident's Representatives:

A. You, or Your Resident or Legal Representative to the extent specified in this Agreement, are responsible for the following:

1. Payment of the Basic Rate and any authorized Additional and agreed to Supplemental or Community Fees as detailed in this Agreement.

2. Supply of properly marked and identifiable personal clothing and effects.

3. Payment of all medical expenses including transportation for medical purposes, except when payment is available under Medicare, Medicaid or other third party coverage.

4. At the time of admission and at least once every twelve (12) months, or more frequently if a change in condition warrants, providing the Operator with a dated and signed medical evaluation that conforms to regulations of the New York State Department of Health.

5. Informing the Operator promptly of change in health status, change in physician, change in medications, or change in financial status.

6. Informing the Operator promptly of any change of name, address and/or phone number.

7. To cooperate with management in the event that it may become necessary to change room assignments. GrandeVille shall endeavor to maintain the resident in the room originally assigned, but reserves the right to make changes as conditions warrant.

8. To hold harmless GrandeVille Senior Living Community, or its agents, or employees from any and all damages to either the person or the property of the Resident, or from the loss of or any damage to any property of the Resident by theft or from any other cause whatsoever, unless caused by, or due to the negligence of GrandeVille of its agents, employees or contractors. Neither GrandeVille nor its agents/employees shall be liable for any injury or damage to the person or property or loss of residential facilities resulting from fire, explosion, falling plaster, steam, gas, electricity, water, rain or snow, leaks from pipes, appliances, plumbing works or roof, street or subsurface, or from *any* other place or by any other cause whatsoever in nature unless caused by or due to the negligence of GrandeVille or its agents/employees, or be liable for any damages caused by other Residents or persons in said building of GrandeVille Senior Living Community, or caused by operations, construction of any private, public or quasi-public works, unless caused by or due to the negligence of GrandeVille or its agents, servants and employees, nor shall GrandeVille or its agents/employees be liable for any latent defects in the facility. GrandeVille is not responsible for any circumstances beyond its control, such as those commonly referred to as Acts of God.

9. To authorize GrandeVille to call the Resident's physician, or if not available another physician to otherwise cope with the situation, using its best judgment for the Resident whenever GrandeVille reasonably believes that the Resident is in need of medical attention and to arrange emergency transportation of the resident if GrandeVille reasonably believes conditions warrant same.

B. The Resident's Representative and/or Legal Representative shall, in the event that the Resident may become eligible for specific benefits or other entitlements; or, in the event that the Resident may require a level of care that cannot be legally provided by the Operator, make promptly available to the Operator and/or other appropriate parties, such assistance, information or documentation, to the extent available to said Resident Representative or Legal Representative.

XIII. Termination and Discharge. This Residency Agreement and residency in the Residence may be terminated in any of the following ways:

1. By mutual agreement between You and the Operator;
2. Upon 30 days written notice from You or Your Representative to the Operator of Your intention to terminate the agreement and leave the facility;
3. Upon 30 days written notice from the Operator to You, Your Representative, Your next of kin, the person designated in this agreement as the responsible party and any person designated by You. Involuntary termination of a Residency Agreement is permitted only for the reasons listed below, and then only if the Operator initiates a court proceeding and the court rules in favor of the Operator.

The grounds upon which involuntary termination may occur are:

1. You require continual medical or nursing care that the Residence is not permitted by law or regulation to provide;
2. If Your behavior poses imminent risk of death or imminent risk of serious physical harm to You or anyone else;
3. You fail 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 You have agreed to pay under this Agreement. If Your failure to make timely payment resulted from an interruption in Your receipt of any public benefit to which You are entitled, no involuntary termination of this Agreement can take place unless the Operator, during the thirty-day period of notice of termination assists

You in obtaining such public benefits or other available supplemental public benefits. You agree that You will cooperate fully with such efforts by the Operator to obtain such benefits.

4. You repeatedly behave in a manner that directly impairs the well being, care or safety of Yourself or any other Resident, or which substantially interferes with the orderly operation of the Residence;

5. The Operator has had his/her operating certificate limited, revoked, temporarily suspended or the Operator has voluntarily surrendered the operation of the facility;

6. A receiver has been appointed pursuant to Section 461-f of the NYS Social Services Law and is providing for the orderly transfer of all residents in the Residence to other residences or is making other provisions for the Residents' continued safety and care.

If the Operator decides to terminate the Residency Agreement for any of the reasons stated above, the Operator will give You a notice of termination and discharge, which must be at least 30 days after delivery of notice, the reason for termination, a statement of Your right to object and a list of free legal advocacy resources approved by the State Department of Health. You may object to the Operator about the proposed termination and may be represented by an attorney or advocate. If You challenge the termination, the Operator, in order to terminate, must institute a special proceeding in court. You will not be discharged against Your will unless the court rules in favor of the Operator. While legal action is in progress, the Operator must not seek to amend the Residency Agreement in effect as of the date of the notice of termination, fail to provide any of the care and services required by Department regulations and the Residency Agreement, or engage in any action to intimidate or harass You. Both You and the Operator are free to seek any other judicial relief to which they may be entitled. The Operator must assist You if the Operator proposes to transfer or discharge You to the extent necessary to assure, whenever practicable, Your placement in a care setting which is adequate, appropriate and consistent with Your wishes.

XIV. <u>Transfer</u>. Notwithstanding the above, an Operator may seek appropriate evaluation and assistance and may arrange for Your transfer to an appropriate and safe location, prior to termination of a Residency Agreement and without 30 days notice or court review, for the following reasons:

1. When You develop a communicable disease, medical or mental condition, or sustain an injury such that continual skilled medical or nursing services are required;

2. In the event that Your behavior poses an imminent risk of death or serious physical injury to him/herself of others; or

3. 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 Residence to other residences or is making other provisions for the Residents' continued safety and care.

If You are transferred, in order to terminate Your Residency Agreement, the Operator must proceed with the termination requirements as set forth in Section XIII of this Agreement, except that the written notice of termination must be hand delivered to You at the location to which You have been removed. If such hand delivery is not possible, then the notice must be given by any of the methods provided by law for personal service upon a natural person. If the basis for the transfer permitted under parts 1 and 2 above of this Section no longer exists, You are deemed appropriate for placement in this Residence and if the Residency Agreement is still in effect, You must be readmitted.

XV. Resident Rights and Responsibilities. Attached as Exhibit XV and made a part of this Agreement is a Statement of Resident Rights and Responsibilities. This Statement will be posted in a readily visible common area in the Residence. The Operator agrees to treat You in accordance with such Statement of Resident Rights and Responsibilities.

XVI. Complaint Resolution. The Operator's procedures for receiving and responding to resident grievances and recommendations for change or improvement in the Residence's operations and program are attached as Exhibit XVI. and made a part of this Agreement. In addition, such procedures will be posted in a readily visible common area of the Residence. The Operator agrees that the Residents of the Residence may organize and maintain councils or such other self-governing body as the Residents may choose. The Operator agrees to address any complaints, problems, issues or suggestions reported by the Residents' Organization and to provide a written report to the Residents' organization that addresses the same. Complaint handling is a direct service of the Long Term Care Ombudsman Program. The Long Term Care Ombudsman is available to identify, investigate and resolve Your complaints in order to assist in the protection and exercise of Your rights.

XVII. Miscellaneous Provisions.

1. This Agreement constitutes the entire Agreement of the parties.
2. This Agreement may be amended upon the written agreement of the parties; provided however, that any amendment or provision of this Agreement not consistent with the statute and regulation shall be null and void.

3. The parties agree that assisted living residency agreements and related documents executed by the parties shall be maintained by the Operator in files of the Residence from the date of execution until three years after the Agreement is terminated. The parties further agree that such agreements and related document shall be made available for inspection by the New York State Department of Health upon request at any time.

4. Waiver by the parties of any provision in this Agreement that is required by statute or regulation shall be null and void.

XVIII. 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 Resident's Legal Representative)

Dated: _____ _____

(Signature of Operator or the Operator's Representative)

(Optional), **Personal Guarantee of Payment**: _____ personally guarantees payment of charges for Your Basic Rate.

_____ personally guarantees payment of charges for the following services, materials or equipment, provided to You, that are not covered by the Basic Rate: _____

_____

Date _____ _____

(Guarantor's Signature)

_____

(Guarantor's Name in Print)

(Optional) **Guarantor of Payment of Public Funds.** If You have a signatory to this Agreement besides Yourself and that signatory controls all or a portion of Your public funds (SSI, Safety Net, Social Security, Other), and if that signatory does not choose to have such public funds delivered directly to the Operator, then the signatory hereby agrees that he/she will personally guarantee continuity of payment of the Basic Rate and any agreed upon charges above and beyond the Basic Rate from either Your Personal Funds (other than Your Personal Needs Allowance), or SSI, Safety Net, Social Security or other public benefits, to meet Your obligations under this Agreement.

Date: _____ _____

(Guarantor's Signature)

_____

(Guarantor's Name in Print)

GrandeVille
ASSISTED LIVING
555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 621-8002

RESIDENT ROOM CHECK DECLINATION

GrandeVille Senior Living Community offers late night room checks to all residents of this facility. The reason for the check is to verify the health and safety of the resident. The method of the check is to have a Resident Care Aide physically come into your room and make a cursory, visual examination. Generally, a flashlight is used to make the observation. Staff is instructed to conduct this procedure as quickly and quietly as humanly possible.

The facility checks all residents unless instructed otherwise. Residents wishing to be checked need to do nothing. Residents (or their representatives) who decline this check must do so by signing this form. Your decision may be altered at any later date.

I DECLINE THE FACILITY'S OFFER TO CONDUCT A LATE NIGHT ROOM CHECK TO MONITOR MY PERSONAL HEALTH AND SAFETY.

_____ _____

Date Resident

_____ _____

Date Legal Representative

Confidential/Protected Information- **CHART COPY**

***Resident Personal Identifiable Information**

Resident Name: _____ Date: _____

Resident's Preferred Name: _____

Resident's Preferred Pronoun: He/Him: ___ She/Her: ___ They/Them: ___

Gender Identity: Male: _____ Female: _____ Other: _____

Other: _____

Notes: _____

_____

***This form is to be completed upon admission by Case Manager or designee and placed in resident's chart and duplicate copy in business file.**

Confidential/Protected Information-**BUSINESS OFFICE COPY**

***Resident Personal Identifiable Information**

Resident Name: _____ Date: _____

Resident's Preferred Name: _____

Resident's Preferred Pronoun: He/Him: ___ She/Her: ___ They/Them: ___

Gender Identity: Male: _____ Female: _____ Other: _____

Other: _____

Notes: _____

_____

***This form is to be completed upon admission by Case Manager or designee and placed in resident's chart and duplicate copy in business file.**

Saved as: "Resident Sexual Orientation Form"

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ACKNOWLEDGEMENTS

I (we) have received a copy of GrandeVille Senior Living Community Notice of Privacy Practices, which I (we) have read and understand. I (we) have received a copy of GrandeVille's Welcome Booklet that includes: Policies & Procedures of GrandeVille Senior Living Community; The Rights of Residents & Clients; and, Resident Protections. I (we) understand that the provision of this material is required by the Department of Health and Human Services and the NYS Department of Health. I (we) also understand, that as except defined by law, all correspondence, conversations and issues raised pursuant to these Rights and Protections will be held confidential unless authorized in writing, to the contrary by myself or my representative.

IMPORTANT INFORMATION REGARDING YOUR ROOM AND CARE RATE

Helping you understand how your room and care rate is charged is important to you and to us. Our traditional care rates are computed on a per month basis, regardless of the number of days in any given month. The remainder* of our services are charged on a daily fee basis.

Regarding our monthly rates, admissions and discharges are pro-rated in the month they occur and are calculated based on a thirty (30) day month.

Our fee schedule, both monthly and daily, begin on the day of your admission and continues through and includes your day of discharge, provided that you comply with the Terms and Conditions of your Admission and Financial Agreement.

It is our policy to charge for any portion of your first and last day, therefore, we cordially invite you to arrive early and stay as late as you wish.

*except Home Health Care which is charged hourly; and Adult Day Care which is charged as either half day, full day or hourly, depending on your choice of program.

_____ _____
(Resident) (Date)

_____ _____
(Resident Representative) (Date)

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ADDITIONAL SERVICES, SUPPLIES OR AMENITIES

The following is a list of services, supplies and/or amenities either provided by or through the Operator:

ITEM:	ADDITIONAL CHARGE:	PROVIDED BY:
Professional Dry Cleaning	As Charged by Provider	Resident's Choice
Professional Hair Grooming	As Charged by Provider	Resident's Choice
Personal Toilet Articles	As Charged by Provider	Resident's Choice
Commissary Goods	As Charged by Provider	Resident's Choice
Medical Transportation	As Charged by Provider	Available Contractor
Medical/Personal Transportation	Exhibit I. C. 1	Available Contractor
Cultural/Activity Transportation	No Charge	GrandeVille
Local/Long Distance Phone Services	As Charged by Provider	Frontier/Others
Cable Television	As Charged by Provider	Spectrum
Other (specify):		

Date: _____

_____ _____

(Resident) (Resident Representative

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EXHIBIT: I. C. 1

ADDITIONAL SERVICES, SUPPLIES OR AMENITIES

The following is a list of services, supplies and/or amenities fees as charged by the operator:

Medical/Personal Transportation: Private transportation to medical or personal appointments can be arranged through independent transportation providers at an additional fee.

A complete list of vendors and fees is available in the GrandeVille Marketing Office.

* Please note: if you require assistance arranging transportation, please contact us at least 1 week in advance.

NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Adult Care Facility Statement
Offering Personal Allowance Account

FACILITY NAME: _____ **OPERATING CERTIFICATE NUMBER:** _____

For Supplemental Security Income (SSI) and Safety Net Assistance (SNA) Recipients

I understand that New York State Department of Health (NYS DOH) Regulations provide me, as an SSI or SNA recipient, with a personal allowance which may be used as I wish for clothing, personal hygiene items, and other supplies, services, entertainment, or transportation for my personal use.

I understand that the operator cannot accept my personal allowance to pay for supplies and services that the operator is required to provide by law, regulation, or admission agreement. In addition, my personal allowance may not be used to pay the operator for any services for which payment is available under Medicare, Medicaid, or third party coverage.

I understand that the operator must offer me or my representative a facility maintained personal allowance account to safeguard my personal allowance funds.

I understand that if I or my representative choose a facility maintained personal allowance account, the NYS DOH Regulations require the operator to: make these funds available to me for my own use; tell me the business hours when I may deposit or withdraw my funds or review my personal allowance records; pay me interest (if my funds are in an interest bearing account); show or give me upon request, or at least every three months, a summary of my account which includes my current balance and informs me of any other important facts about my account.

I understand that I do not have to put my funds in a facility maintained account.

I understand that I may close my facility maintained account at any time and have my funds returned to me.

I understand there are legal protections for my funds and account.

I understand that I may ask the NYS DOH or legal/advocacy agencies to help me if I do not receive my personal allowance or have access to money in my personal allowance account.

Check one of the following boxes:

☐ I authorize the operator to establish a facility maintained personal allowance account.

☐ I do not authorize the operator to establish a facility maintained personal allowance account.

☐ As representative for _____, I agree to comply with the personal allowance requirements set forth above.
☐ **I do** ☐ **I do not** authorize the operator to establish a facility maintained personal allowance account.

☐ I am not an SSI or SNA recipient. However, the operator has offered to maintain a personal fund account for me. I hereby authorize such an account.

Signature of Resident _____ Date _____

Signature of Resident Representative _____ Date _____

Signature of Operator or Designee _____ Date _____

GrandeVille
ASSISTED LIVING
555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 621-6841

ADVANCED DIRECTIVES/POA
INSURANCE INFORMATION

Name of Resident: _____

I. MOLST/Advanced Directives/POA

A copy of any ***MOLST**/Advanced Directives/DNR/POA, Living Will, Health Care Proxy is required and must be provided to GrandeVille prior to admission.

I have a current: (check all that apply)

_____ Advance Directive
_____ DNR (Do Not Resuscitate Order)
_____ Health Care Proxy
_____ Living Will
_____ MOLST
_____ Power of Attorney

A copy of any Advanced Directives/DNR/POA, Living Will, Health Care Proxy is required and must be provided to GrandeVille prior to admission and whenever changed or updated.

_____ _____
(Date) (Signature)

_____ _____
(Date) (Witness)

II. Insurance Information

A copy of all insurance cards (including prescription and Medicare D) is required and must be provided to GrandeVille prior to admission.

_____ _____
(Date) (Signature)

*The Medical Orders for Life-Sustaining Treatment (MOLST) form can be used for individuals with advanced illness who require long-term care services. A MOLST form allows an individual to document their decision to withhold life-sustaining treatment at the end of life, when extending the duration of the individual's life is more likely to result in a quality of life characterized by burden or suffering.

**The facility strongly encourages residents to discuss and complete a MOLST with their physician and provide a copy to GrandeVille.

***In accordance with NYSDOH regulations, our community is not required to provide CPR (Cardio Pulmonary Resuscitation) to residents. In the event of a resident/registrant emergency, our staff will contact 911 for medical/emergency response.

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AUTHORIZATIONS

INSTRUCTIONS: Strike out any section or terms unacceptable.

I authorize GrandeVille Senior Living Community:

1.To release necessary and specific Protected Health Information (PHI) about me, in accordance with applicable laws, to any of the following: NYS Department of Health; Social Security Administration; Veteran's Administration; LIFESPAN; pharmacy; certified health care screeners/assessors; or, other as deemed necessary.

2. For the term of my residency, to receive personal or medical information from physicians, hospitals, certified healthcare screeners/assessors, Veterans Administration, mental health providers and/or any residential care facility.

3. To establish and maintain a personal allowance fund on my behalf, pursuant to section 487.6 (d) (1-5) of the NYSDOH Rules and Regulations. I understand that the sufficient funds in my account will be available to me Monday-Friday, 8:00 AM – 12:00 PM and 1:00 PM – 3:30 PM except holidays at the Reception Desk. I may request receipt of full monthly allowance within 2 banking days and I have the right to examine and/or terminate this account at my request during my residency. I further understand that my funds will be held in a non-interest bearing account at the bank of GrandeVille's choice and that I will be personally responsible and liable for any insufficient or returned check charges, charged to the account by reason of any draft created by me or my representative. I understand that account reconciliations will be performed and quarterly statements will be issued.

4. To withhold the receipt for funds paid by check for: room, care or supplemental services.

_____ _____
(Resident) (Date)

_____ _____
(Resident Representative) (Date)

GrandeVille
ASSISTED LIVING
555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 381-0680

AUTHORIZATION TO OBTAIN MEDICATIONS FROM IN-HOUSE PHARMACY

I have informed GrandeVille Senior Living Community that I will be obtaining any needed medications for myself/my family member from an outside pharmaceutical source.

My signature below indicates that I am aware of the responsibility for refilling the medication in a timely fashion, prior to the current supply being depleted. I further understand that the facility will only call me in the event a dosage has been changed, and will not be calling for routine refills.

If I do not supply the medication before it is needed, I understand that an emergency supply (quantity to be determined based on dosage) will be ordered by the facility staff from the in-house pharmacy, and that I will be responsible for any cost incurred for such supply.

I have read and understand this release form.

Resident	Date
Representative	Date
GrandeVille Senior Living Community	Date

Grande Ville
ASSISTED LIVING

Collections of Veterans Information (CVI Form)

To: Resident and Resident Representative

Re: Veteran Status

Resident Name: _____ Res. Rep: _____

Date: _____

In compliance with NYSDOH, it is required for assisted living facilities to **collect and transmit** veteran status information to the New York State Division of Veterans' Services.

Please read and complete the steps below as directed.

Step #1: Collection of Veterans Information:

Have you or your spouse ever served in the United States military?

Choose one: YES NO

If you answered NO, do not proceed any further

If you answered YES, proceed to step #2 and step #3

Step #2: This is the contact Information for the NYS Division of Veterans' Services:

NYS Division or Veterans' Services Help Line: 1-888-838-7697 (VETSNYS)

Or contact: Fong Mattice- Service Officer, Pension Benefits, Veterans Service Agency

125 Westfall Road, Rochester, NY 14620

Ph: 585-753-6040 or 6644

Step #3: Please complete the requested information below and it will be submitted to datasharing@veterans.ny.gov .

Resident Name: _____

Mailing Address: _____

Email Address: _____ phone: _____

COPY OF THIS FORM GIVEN TO RESIDENT/RESIDENT REPRESENTATIVE

3/2022

GrandeVille
ASSISTED LIVING
555 Maiden Lane, Rochester New York 14616-4199 (585) 621-6160 FAX (585) 621-8002

E-Mail Information

In an effort to reduce the use of paper we are asking for the email address of the Resident Representative so we are able to send electronic communications. This will provide us an efficient way to keep you informed of upcoming events as well as any other important news at GrandeVille.

Thank you for your cooperation.

_____ _____

Resident Representative Email Address

Important Note:

Resident rooms are provided with a lockable cabinet to secure all valuables and residents are highly encouraged to use this.

Residents wishing to have cash on-hand, are urged to make use of the PERSONAL ALLOWANCE ACCOUNT, which can be set up with the receptionist Monday-Fridays, 8am-3pm.

Residents should not keep cash in their room.

Resident or Representative Initials: _____ **Date:** _____

as of 9/07/22

Grande Ville
ASSISTED LIVING
555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 621-8002

EXHIBIT I. A. 3

FURNISHINGS/APPLIANCES PROVIDED BY GRANDEVILLE

The following are provided as standard items. Cross out any that are not applicable.

Single Bed
Mattress & Box Spring
Pillow
Bedspread
Bed Sheets
Towels
Wardrobe or Closet
Dresser
Night Stand
Table Lamp
Floor Lamp
Chair
Room key(s)
Medicine Cabinet
Window Treatment
Shower Curtain
Heat &Air Conditioning Unit
Wall-to-Wall Carpeting or laminate flooring
Other: _____
_____
_____

With the exception of normal wear and tear, it is your responsibility to maintain the above items in the condition they were provided to you. The Operator reserves the right to charge the fair market replacement value for lost or intentionally damaged articles. You should note any irregular conditions below:

_____
_____
_____
_____

Date: _____

_____ (Resident)

_____ (Resident Representative)

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ASSISTED LIVING
555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 621-8002

EXHIBIT: I. A. 4

FURNISHINGS/APPLIANCES PROVIDED BY YOU

The following furnishings/appliances are provided by you: *(check all that apply)*

_____ Bed	_____ Blanket
_____ Mattress & Box Spring	_____ Pillow
_____ Night Stand	_____ Bedspread
_____ Dresser	_____ Window Treatment
_____ Chair	_____ Shower Curtain
_____ Table Lamp	_____ Small Refrigerator (cube type)
_____ Floor Lamp	_____ Additional Chair
_____ Desk & Chair	_____ Dining Table & Chairs
_____ Television	_____ Radio or Media Player
_____ Telephone	_____ Computer

_____ Other Items: *(describe)* _____

The Operator must approve any item supplied by you. Chairs must be soil resistant. Textile goods, including mattresses and box springs must be fire resistant. State and local safety codes restrict the use of certain electrical appliances and extension cords. No other electrical device or extension cord may be brought into the facility without the express written approval of the Operator.

It is your responsibility to maintain the items in a good and sanitary condition at all times. The Operator reserves the right to require the removal of any of the items at any time.

Date: _____

_____ _____

(Resident) (Resident Representative)

Grande Ville
ASSISTED LIVING
555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 621-8002

EXHIBIT: I. D

LICENSURE/CERTIFICATION STATUS OF PROVIDERS

The following is a list of current providers offering home care or personal care services under an arrangement with the Operator.

RRHC (Rochester Regional Home Care)	Certified Health Care Agency
HCR (Home Care of Rochester)	Certified Health Care Agency
Lifetime Care	Certified Health Care Agency
UR Medicine Home Care	Certified Health Care Agency

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Home Health Care Services

In the event that _____ requires home health care
(Resident)

services, the home care preference is: *(Please check one)*

_____ OPTION 1: RRHC – Rochester Regional Home Care is affiliated with GrandeVille Senior Living Community.

_____ OPTION 2: HCR – Home Care of Rochester

_____ OPTION 3: Lifetime Care

_____ OPTION 4: UR Medicine Home Care

_____ _____
Resident/Resident Representative GrandeVille Senior Living Representative

GrandeVille Resident COVID-19 Health and Vaccine Certification

Name_____

Please read each question and section.

I CERTIFY THAT I HAVE NOT EXPERIENCED THE FOLLOWING SYMPTOMS IN THE LAST 2 WEEKS; Fever of 100 degrees or higher or chills, cough, nausea or vomiting, loss of taste or smell, sore throat, shortness of breath, congestion, runny nose, fatigue, body aches or upset stomach.

I ALSO CERTIFY THAT I HAVE NOT; Come in contact with someone who has had COVID – 19 symptoms or tested positive, or traveled outside of the country in the past 2 weeks.

FOR VACCINATED RESIDENTS:

I have / will (circle one) complete my COVID – 19 vaccination on _____(date) and will provide a copy of my vaccination information or vaccination card to GrandeVille.

FOR UNVACCINATED RESIDENTS:

I have not received my COVID – 19 vaccination due to (circle one):

Personal Choice OR Medically Ineligible as determined by a physician

I understand that the facility can assist in arranging for a COVID – 19 vaccination and I:

Accept / Decline.

I further understand that if I decide later to be vaccinated for COVID – 19, I will contact GrandeVille management for assistance.

Regarding COVID – 19 Boosters:

I have / have not (circle one) received a COVID – 19 booster.

If I indicated no, I understand that the facility can assist in arranging for a COVID – 19 booster and I: Accept / Decline.

I further understand that if I decide later to receive the COVID – 19 booster, I will contact GrandeVille management for assistance.

By signing below, I am certifying that the information I have provided is accurate.

Resident Signature:_____ Date:_____

Resident Representative (if applicable):_____Date:_____

Revised 8/2025

GrandeVille
ASSISTED LIVING
555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 697-2934

RESIDENT NAME:_____

Loan Equipment and Deposit Agreement

The following item(s) are not part of the Residency Agreement or any Amendments thereof and are thereby considered loaned equipment.

Item	Item Description	Date Loaned	Date Returned	Deposit (if required)
1				
2				
3				
4				

Item number _____ requires a monthly equipment use fee of $_____

Item number _____ requires a monthly equipment use fee of $_____

Item number _____ requires a monthly equipment use fee of $_____

Item number _____ requires a monthly equipment use fee of $_____

By your signature below you agree that: upon termination of your Residency Agreement; or, if no longer required for use, you will return the above described item(s) in good working order. You agree that if you damage the item(s) or otherwise fail to return the item(s) or any components thereof, you will bear the full cost of replacement and may forfeit all or a portion of your deposit.

- Deposits are held in a non-interest bearing federally insured bank account

Date_____ Resident: _____

Date _____ Resident Representative: _____

Check this box if you are declining to receive a room key ☐

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NYSDOH FINANCIAL DISCLOSURE

The New York State Department of Health (NYSDOH) has changed their method regarding licensing fees charged to Assisted Living Residences (ALR). The NYSDOH now charges the ALR a fee for every resident whose annual income is greater than 4 times the Federal Poverty Level. This would currently equal $_____ per year.

Income is defined as the total of any/all of the following:

- Social Security
- IRA Distributions
- Dividends
- Interest Income
- Deferred Compensation Payments
- Rent or Royalty Payments
- Capital Gains on Sales of Investments
- Alimony

We are required by law to ask all residents the following question: "Is your yearly income more than or less than $ _____".

Answer: _____ more than _____ less than

Resident: _____

Resident Representative: _____

Date: _____

GrandeVille
ASSISTED LIVING

Personal Caregiving Visitors and Compassionate Caregiving Visitors Designation Form

Date: _____

Resident Name: _____

Resident Representative (if resident is unable to designate): _____

I hereby designate the following person(s) as my personal caregiving visitors:

1. _____
2. _____

_____ *I choose to NOT designate anyone as my personal caregiving visitors*

I hereby designate the following person(s) as my compassionate caregiving visitors:

1. _____
2. _____

_____ *I choose to NOT designate anyone as my compassionate caregiving visitors*

I understand that I may change my designations at any time, and that the community will reach out to me once every six months, and upon change of condition, to see if there are updates to my designated persons

X _____

Resident or Resident Representative Signature

GrandeVille
ASSISTED LIVING

Photo Release Form

I _____,

(Circle One) DO DO NOT

Give my permission for GrandeVille Senior Living Community to use my photo in print and/or promotional materials.

Signature: _____ Date: _____

Grande Ville
ASSISTED LIVING
555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 621-8002

RECEIPT OF DOCUMENTS ACKNOWLEDGED

The undersigned acknowledges receipt of the following documents:

- "IMPORTANT INFORMATION REGARDING GRANDEVILLE SENIOR LIVING COMMUNITY'S PRIVATE PAY POLICY";
- Dear Resident, Resident Representative and Family Members letter dated March 2010 regarding NYS Department of Health safety interpretations;
- "IMPORTANT SAFETY INFORMATION":
- Security/Surveillance Equipment Policy and Procedure

I have read and understand each document and I have been given the opportunity to ask questions about each.

Date: _____ Resident: _____

Date: _____ Res. Representative: _____

GRANDEVILLE SENIOR LIVING COMMUNITY
555 Maiden Lane, Rochester, NY 14616
Phone: 585-621-6160

SPECIAL NEEDS ASSISTED LIVING RESIDENCE ADDENDUM TO RESIDENCY AGREEMENT

This is an Addendum to a Residency Agreement made between Grandeville Senior Living Community, LLC ("the Operator"), and _____ (the "Resident"),and_____(the"Resident's Representative"), and _____ (the "Resident's Legal Representative"). Such Residency Agreement is dated _____.

This Addendum adds new sections and amends, if any, only the sections specified in this Addendum. All other provisions of the Residency Agreement shall remain in effect, unless otherwise amended in accordance with this Addendum. This Addendum must be attached to the Residency Agreement between the parties.

I. Special Needs Assisted Living Certificates

The Operator is currently certified by the New York State Department of Health to provide Special Needs Assisted Living at Grandeville Senior Living Community located at 555 Maiden Lane, Rochester, NY 146.

II. Request for and Acceptance of Admission

You have requested to become a Resident at this Special Needs Assisted Living Residence ("the Residence"), and the Operator has accepted Your request.

III. Specialized Programs, Staff Qualifications, and Environmental Modifications

APPROVED BY
DIVISION OF ADULT CARE FACILITY & ASSISTED LIVING SURVEILLANCE
NYSDOH REGIONAL OFFICE
INITIALS STW DATE 1/28/2026

GRANDEVILLE SENIOR LIVING COMMUNITY
555 Maiden Lane, Rochester, NY 14616
Phone: 585-621-6160

SPECIAL NEEDS ASSISTED LIVING RESIDENCE ADDENDUM TO RESIDENCY AGREEMENT

Specialized services to be provided in the Residence include daily activities tailored to challenge Residents with dementia. The activities program is supervised by the facility Activities Director.

Staffing levels will be maintained in compliance with all applicable laws and regulations appropriate for the level of care needed to perform and carryout the tasks that Residents require. The Residence will be staffed with direct care personnel, a program director, a qualified activities director and case manager. Other staff not specifically assigned to the Residence are available to attend to needs of Residents that arise. The staffing plan will be adjusted to meet the needs of the Residents.

Each of our personal care aides, home health aides, and nurses receive comprehensive training on effectively and respectfully meeting the needs of persons with dementia. The training includes methods on successfully cuing such individuals to independently perform personal care tasks, coordinating care with the Resident and their family, and wandering prevention.

The Residence is organized as a secured unit that is equipped with delayed egress doors to prevent wandering. Window openings are limited to prevent accidents and elopement. The entire facility is equipped with a sprinkler system throughout, emergency call bells in all resident rooms and bathrooms, smoke corridors, and supervised smoke detection systems for Resident safety. Secured outdoor recreational areas are also available for Residents to safely enjoy the outdoors. The Residence has

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NYSDOH REGIONAL OFFICE
INITIALS SJW DATE 1/28/2026

its own dining room to allow for staff to accommodate Resident's needs and dining schedule preferences and variations.

IV. Addendum Authorization

We, the undersigned, have read this 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 Resident's Legal Representative)

Dated:_____ _____
(Signature of Operator/Operator's Representative)

APPROVED BY
DIVISION OF ADULT CARE FACILITY & ASSISTED LIVING SURVEILLANCE
NYSDOH REGIONAL OFFICE
INITIALS STW DATE 1/28/2026

555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 621-8002

GRANDEVILLE SENIOR LIVING COMMUNITY

ENHANCED ASSISTED LIVING RESIDENCE

ADDENDUM TO RESIDENCY AGREEMENT

This is an addendum to a Residency Agreement made between GrandeVille Senior Living Community (the "Operator"),_____, (the "Resident" or "You"), _____, (the "Resident's Representative"), _____, (the "Resident's Legal Representative"). Such Residency Agreement is dated_____.

This addendum adds new sections and amends, if any, only the sections specified in this addendum. All other provisions of the Residency Agreement shall remain in effect, unless otherwise amended in accordance with this Agreement. This addendum must be attached to the Residency Agreement between the parties.

I. Enhanced Assisted Living Certification.

The operator is currently certified by the New York State Department of Health to provide Enhanced Assisted Living at GrandeVille Senior Living Community, located at 555 Maiden Lane, Rochester, New York, 14616.

II. Physician Report.

You have submitted to the Operator a written report from your physician, which report states that:

a. Your physician has physically examined you within the last month prior to your admission into this Enhanced Assisted Living Residence; and,
b. You are not in need of 24 – hour skilled nursing care or medical care, which would require placement in a hospital or nursing home.

III. Request for and Acceptance of Admission.

You have requested that you become a Resident at this Enhanced Assisted Living Residence (the "Residence") and the Operator has accepted such request.

IV. Specialized Programs, Staff Qualifications and Environmental Modifications.

Attached as EALR Appendix 1 and made part of the agreement is a written description of:

- Services to be provided in the Enhanced Assisted Living Residence;
- Staffing Levels;
- Staff education and training and work experience, and professional affiliations or special characteristics relevant to serving persons in the Enhanced Assisted Living Residence; and
- Any environmental modifications that have been made to protect the health, safety and welfare of residents.

APPROVED BY

DIVISION OF ADULT CARE FACILITY & ASSISTED LIVING SURVEILLANCE

NYSDOH REGIONAL OFFICE

INITIALS SW DATE 10/24/2025

V. Aging in Place.

The Operator has notified you that, while the Operator will make reasonable efforts to facilitate your ability to age in place according to your Individualized Service Plan, there may be a point reached where your needs cannot be safely or appropriately met at the residence. If this occurs, the Operator will communicate with you regarding the need to relocate to a more appropriate setting, in accordance with law.

VI. If 24 – Hour Skilled Nursing or Medical Care is Needed.

If you reach a point where you are in need of 24 – Hour skilled nursing care or medical care that is required to be provided by a hospital, nursing home, or facility licensed under the Mental Hygiene Law, the Operator will initiate proceedings for the termination of this agreement and to discharge you from residency UNLESS each of the following conditions are met:

a. You hire appropriate nursing, medical or hospice staff to care for your increased needs; AND
b. Your physician and a home care services agency both determine and document that with the provision of such additional nursing, medical or hospice care, you can be safely cared for in the residence and would not require placement in a hospital, nursing home, or other facility licensed under Public Health Law Article 28 or Mental Hygiene Law Articles 19, 31 or 32; AND,
c. The Operator agrees to retain you as a resident and to coordinate the care provided by the Operator and the additional nursing, medical or hospice staff; AND,
d. You are otherwise eligible to reside at the Residence.

VII. Addendum Agreement Authorization.

We, the undersigned have read this Addendum 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 Resident's Legal Representative)

Dated:_____ _____

GrandeVille Senior Living Community

EALR Appendix 1

APPROVED BY
DIVISION OF ADULT CARE FACILITY & ASSISTED LIVING SURVEILLANCE
NYSDOH REGIONAL OFFICE
INITIALS SW DATE 10/24/2025

I. **Services to be provided**-The following services will be available to the Enhanced Assisted Living Residents:

- Physical Assistance with ambulation (1 person assist)
- Physical Assistance with ambulation (2 person assist)
- Physical Assistance of 1 person for transfers
- Physical Assistance of 2 persons for transfers
- Incontinence Management
- Physical Assistance to manage oxygen equipment
- Transfer/escort resident in wheelchair

II. Staffing Levels:

Staffing levels will be maintained in compliance with all applicable laws and regulations appropriate for the level of care needed to provide required supervision and perform all the tasks necessary to meet the resident's needs. The Enhanced program will be staffed with resident care aides and nurses to provide supervision and meet the needs of residents at all times. The staffing schedule will be adjusted to meet the needs and census of residents enrolled in the Enhanced Assisted Living Residence (EALR).

III. Staff education and training:

- All applicable staff are provided with training related to serving persons in an Enhanced Assisted Living Residence. This training includes methods of assisting with mobility impairments, oxygen equipment as well as personal care assistance. Resident Care staff are assessed annually to ensure skill levels are maintained.

IV. Environmental Modifications:

- The Enhanced Assisted Living Residence residents will reside throughout the facility.
- The facility is equipped with a fire & sprinkler system, emergency call system (call bells in the resident bedrooms and bathrooms as well as a pendant alarm system which works in all areas of the facility). Smoke barrier doors and a supervised smoke detection system throughout the building is provided for increased resident safety.

Revised 6-25-25

APPROVED BY
DIVISION OF ADULT CARE FACILITY & ASSISTED LIVING SURVEILLANCE
NYSDOH REGIONAL OFFICE
INITIALS SW DATE 10/24/2025

Grande Ville
ASSISTED LIVING
555 MAIDEN LANE, ROCHESTER, NEW YORK 14616-4199 (585) 621-6160 FAX (585) 697-2934

TEMPORARY RESIDENTIAL CARE
ADDENDUM TO ADMISSION/RESIDENCY AGREEMENT

_____ ("You" or "Resident") have requested to stay at Grande Ville Assisted Living ("the Community") until _____ {date} (the "Respite Stay"). This Respite Stay is limited to up to one-hundred twenty days (120) in any twelve-month period. In connection with the Respite Stay, you and the Community have entered into the Community's Adult Care Facility Admission/Residency Agreement, a copy of which is attached to this addendum. The Community holds the following licenses and certifications:

*Enhanced Assisted Living Residence
*Special Needs Assisted Living Residence
*Assisted Living Residence

The purpose of this Addendum is to amend certain provisions of the Admission/Residency Agreement to reflect your Respite Stay.

1. During your Respite Stay, the rate you will be charged for each day of the Respite Stay will be $_____ ("Daily Rate"), inclusive of all services that the Community may provide you.
2. During your Respite Stay, you may terminate your Respite Stay, this Addendum, and the Admission/Residency Agreement early by delivering to the Community notice of termination at least three days prior to the date you intend to vacate your Apartment/Room. If you paid for the Respite Stay in advance and you elect under this Section to shorten the Respite Stay, the Community will refund to you an amount equal to the amount you prepaid minus the product of the number of days you actually stayed multiplied by your Daily Rate.
3. The Community may also terminate your Respite Stay upon three days' written notice on the grounds set forth in the Termination procedure provided in the Admission/Residency Agreement.
4. After your Respite Stay expires, this Addendum shall expire and be of no further force and effect. If you have not terminated this addendum, pursuant to Paragraph 3, you will continue to be bound by the terms of the Admission/Residency Agreement, including any payments that need to be made by the terms of that Agreement and which have not been made during the term of your Respite Stay.
5. Within 30 days prior to admission, you must provide a dated signed medical examination report which conforms to Department Regulations (DSS-3122 or an

approved substitute). Thereafter, you must have a physical examination at least once every six (6) months (or more frequently if a change in a condition warrants) and additional examinations considered necessary by your physician.

6. During the Term of your Respite Stay, the provision of this Addendum supersedes any provisions of the Admission/Residency Agreement that are inconsistent with this Addendum. All other terms in your Admission/Residency Agreement remain in full force and effect.
7. All Residents admitted under this Temporary Residential Care Addendum to the Admission/Residency Agreement shall receive the same emergency evacuation training as all other Residents.
8. Only Residents appropriate for the level of care for which the Community is licensed by the Department of Health to provide will be admitted to the Temporary Residential Care Program.
9. In the event that you wish to become a permanent resident at the Community upon expiration of your Respite Stay, you must notify the Community at least one week prior to the expiration of your Respite Stay, and you will continue to be bound by the terms of the Residency Agreement, including and payments that need to be made by the terms of that Agreement and which have not been made during the term of your Respite Stay.

Having read this Addendum, the undersigned acknowledge that they understand that rights and obligations created by this Addendum and the Original Agreement, and by signing below agree to all the terms and conditions contained therein.

_____ _____

Signature of Community Representative/Title Date

_____ _____

Signature of Resident Date

Having read and understood this Addendum, the Original Agreement, and the obligations created by such documents, the Responsible Person(s) signs this Addendum to undertake to guarantee the obligations of Resident, including the payment of all fees that the Resident may owe the Community under this Addendum and the Original Agreement.

_____ _____

Signature of Responsible Person Date

NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Adult Care Facility Statement Offering Personal Allowance Account

FACILITY NAME: _____ **OPERATING CERTIFICATE NUMBER:** _____

For Supplemental Security Income (SSI) and Safety Net Assistance (SNA) Recipients

I understand that New York State Department of Health (NYS DOH) Regulations provide me, as an SSI or SNA recipient, with a personal allowance which may be used as I wish for clothing, personal hygiene items, and other supplies, services, entertainment, or transportation for my personal use.

I understand that the operator cannot accept my personal allowance to pay for supplies and services that the operator is required to provide by law, regulation, or admission agreement. In addition, my personal allowance may not be used to pay the operator for any services for which payment is available under Medicare, Medicaid, or third party coverage.

I understand that the operator must offer me or my representative a facility maintained personal allowance account to safeguard my personal allowance funds.

I understand that if I or my representative choose a facility maintained personal allowance account, the NYS DOH Regulations require the operator to: make these funds available to me for my own use; tell me the business hours when I may deposit or withdraw my funds or review my personal allowance records; pay me interest (if my funds are in an interest bearing account); show or give me upon request, or at least every three months, a summary of my account which includes my current balance and informs me of any other important facts about my account.

I understand that I do not have to put my funds in a facility maintained account.

I understand that I may close my facility maintained account at any time and have my funds returned to me.

I understand there are legal protections for my funds and account.

I understand that I may ask the NYS DOH or legal/advocacy agencies to help me if I do not receive my personal allowance or have access to money in my personal allowance account.

Check one of the following boxes:

☐ I authorize the operator to establish a facility maintained personal allowance account.

☐ I do not authorize the operator to establish a facility maintained personal allowance account.

☐ As representative for _____ , I agree to comply with the personal allowance requirements set forth above.
☐ **I do** ☐ **I do not** authorize the operator to establish a facility maintained personal allowance account.

☐ I am not an SSI or SNA recipient. However, the operator has offered to maintain a personal fund account for me. I hereby authorize such an account.

Signature of Resident _____ Date _____

Signature of Resident Representative _____ Date _____

Signature of Operator or Designee _____ Date _____

GRANDEVILLE SENIOR LIVING COMMUNITY
ADULT DAY SERVICES PROGRAM
555 MAIDEN LANE
ROCHESTER, NEW YORK 14616
(585) 621-6160

TRADITIONAL PROGRAM, ALZHEIMER'S AND DEMENTIA CARE

ADMISSION AND FINANCIAL AGREEMENT

I. General Provisions:

This Agreement is between GrandeVille Adult Day Services Program (GrandeVille) and _____, the Client, and _____, his/her Legal Representative, stating the terms and conditions of the Client's admission into GrandeVille Adult Day Services Program.

This Agreement is effective as of _____, 20__, and will remain in effect unless otherwise amended or modified 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 the Agreement understand that GrandeVille is authorized to provide Adult Day Services in accordance with the New York Social Services Law and the Rules & Regulations of the New York State Department of Health.

II. Facility Services:

GrandeVille shall be responsible for the provision of the following:

A. An organized full ____ time and/or part ____ time non-residents program;
B. Appropriate daily Meal(s) and nutritious snack(s) per plan chosen;
C. Personal Care services as required;
D. An organized and diversified program of individual and group activities;
E. The following diet as ordered by the Client's primary care physician:
   a. _____ House – approx. 2000 calories, no salt in cooking, seconds available
   b. _____ No Free Salt- House diet except NFS, NAS, no salt on table
   c. _____ Limited Carbohydrate- House diet except diet desserts, skim milk and sugar substitutes. (Regular desserts available up to 3 times per week).
F. Case Management services as required;
G. Medication management services for full and part-time clients. See §III. (J).

III. Client/Legal Representative Responsibilities:

The Client and his/her Legal Representative shall be responsible for and/or agree to the following:

A. Payment of the required rate;
B. Supply of personal clothing and effects as needed by the Client;

C. Payment of all medical expenses including transportation for medical purposes, except where payment is available under Medicare, Medicaid or third party coverage;
D. To furnish a dated and signed Medical Evaluation which conforms to NYSDOH regulations, at the time of admissions and thereafter at least once every twelve months or more frequently if conditions warrant;
E. To inform the Operator, in writing, of any change in health status, change of physician or medication and/or change in financial status;
F. To obey all reasonable rules of the facility and to respect the rights and property of other clients, residents and staff;
G. To hold harmless GrandeVille, its agents and employees, from any and all damages to the person or the property of the Client, or from the loss of or any damage to the property of the Client by theft or from any other cause whatsoever. Neither GrandeVille nor its agents/employees shall be liable for any injury or damages to the persons or property or loss of residential facilities resulting from fire, explosion, falling plaster, steam, gas, electricity, water, rain or snow; leaks from pipes, appliances, plumbing works or roof, street or subsurface or from any other place or any other cause whatsoever in nature unless caused by or due to the negligence of GrandeVille, its agents, servants or employees; nor shall GrandeVille, its agents/employees be liable for any damage caused by other clients, residents or persons in said building, or caused by operations, constructions of private, public or quasi-public works, unless caused by or due to the negligence of GrandeVille or its agents, servants or employees, nor shall GrandeVille or its agents/employees be liable for any latent defects in the facility. GrandeVille is not responsible for any circumstances beyond its control, such as those commonly referred to as Acts of God;
H. To authorize GrandeVille to call the Client's Physician, or if not available, another physician or to otherwise cope with the situation, using its best judgment for the Client, whenever GrandeVille reasonably believes that the Client is in need of medical attention;
I. Except as is otherwise provided by statue, temporary removal of the Client from GrandeVille shall terminate any and all responsibility and/or liability to the Client or Client Representative on the part of GrandeVille, until the Client has officially returned to the premises and has again been placed under the supervision of staff. Permanent removal of the Client shall terminate any further liability and/or responsibility on that part of GrandeVille or on behalf of said Client or Client Representative, except as provided by statute;
J. Client and/or Legal Representative agree to provide GrandeVille with a statement regarding the Client's current medication regiment; all current medication in their original packaging and an entry and exit count of all medication performed with a GrandeVille staff person. If the Client's medication regiment has changed since the last
K. Client visit, the Client and Legal Representative agree to provide GrandeVille with current Physician Orders.
L. All parties agree to execute any or all modifications to this Agreement not in the original terms thereof insofar as the same neither violates the rights of the Client nor any laws or regulations governing the operation of this program.

IV. Financial Agreements:

A. **Rate.** The Client and the Client's Legal Representative, jointly and severally agree to pay, and GrandeVille agrees to accept the following payment in full satisfaction of the services which GrandeVille must provide according to law and regulation:

- Full day rate* of $_____ per day; and/or,
- Part day rate* of $_____ per day

The full day rate is based on more than 4 hours but less than 8 hours of service. The part day rate is based on no more than 4 hours of service.

All payments are due in full within 10 days of billing, unless other written arrangements are made with management. Payments not received within 30 days of due date are subject to a $30.00 late charge. The Client and his/her Legal Representative jointly and severally agree to pay the rates as listed in this section or any addendum attached hereto unless otherwise agreed to in writing by the parties to this Agreement provided that same is not prohibited by law. The Client and his/her Legal Representative jointly and severally agree to pay all reasonable costs and expenses, including reasonable attorney's fees incurred by GrandeVille in enforcing this Agreement.

B. Supplemental Services. GrandeVille agrees to provide services and supplies beyond those required by law and regulation as is more particularly set forth in the section titled "Supplemental Services and Supplies". Those services and supplies, chargeable to the Client shall only be made at the Client's or client's Legal Representative request or as otherwise provided in Section IV, paragraph C and shall only include charges for services and supplies actually received by the Client.

C. Adjustment to Rate/Supplemental Service Charges. GrandeVille 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 Client or client's Legal Representative; or,
2. To provide additional care, services or supplies upon the orders of the Client's Physician; or,
3. Upon 45 days written notice to the Client and client's Legal Representative of additional charges and expenses due to increased costs of maintenance and operation.
4. In the event of an emergency, which affects the Client, additional charges may be assessed for the benefit of the Client as are reasonable and necessary for services, materials, equipment and food supplied during such an emergency.

D. Reservation. GrandeVille agrees to reserve space for the Client in the Adult Day Services Program as defined in Paragraph A of this section. The Client and client's Legal Representative agree to pay for such space whether used or not, unless written notice of the Client's absence is provided to the Program Coordinator in excess of 24 hours before the program start time. Client/Representative agree to reserve their days of attendance with GrandeVille, one week in advance.

E. Tipping. The Operator and the Operator's staff, employees, agents, and servants shall not accept any tip or gratuity from any Client or Client Representative, for any services or act performed, in any form whatsoever.

V. Client's Rights and Protections.

GrandeVille agrees to provide a copy of the "Clients Rights and Protections" and to treat each Client in accordance with the principals stated therein.

VI. Personal Allowance Accounts.

GrandeVille agrees to establish a Personal Allowance Account at the request of any Client who receives Supplemental Security Income or Home Relief payments by executing a Statement of Offering (DSS-2853).

VII. Termination.

This Agreement may be terminated in any of the following ways:

A. By mutual agreement between the Operator and the Client.
B. Upon 10 days written notice from the Client to GrandeVille of the Client's intention to terminate the Agreement and to leave the Program. Clients and Client Representatives failing to provide the required notice or leaving the Program prior to the termination of the 10 days written notice will be responsible for payment of equivalent fees for the 10 days or balance of the 10 days.
C. Upon 72 hours written notice to the Client and Client's Representative of the facility's intention to terminate the Agreement. The notice must be dated and must state the date of termination and the reason(s) for same. Those reasons may include:
    1. The Client requires continual medical or nursing care which the program cannot provide;
    2. The Client's behavior poses an imminent risk of death or serious physical harm to himself/herself or others;
    3. The Client fails to make timely payments for all authorized charges, expenses and assessments, if any, for services including use of the premises, materials, equipment and food which the Client has agreed to pay pursuant to this Agreement. If failure to make timely payments resulted from an interruption in the receipt of public funds to which the Client was entitled, no involuntary termination may take place unless GrandeVille, during the notice period, assists the Client in obtaining the benefits or any other available supplemental public benefits. The Client must cooperate with such efforts made by GrandeVille.
    4. The Client behaves in a manner that directly impairs the well-being, care or safety of others, or which substantially interferes with the orderly operation of the Program and the facility;
    5. The Operator has had its operations certificate limited, revoked or temporarily suspended or has surrendered the certificate to the New York State Department of Health; or

6. A receiver has been appointed pursuant to Section 461-F of the NY Social Services Law and is providing for the orderly transfer of all clients to other Programs or is making other provisions for the Client's continued safety and care.

The Operator may immediately terminate the Agreement should the Client develop a serious physical or mental dysfunction which constitutes an immediate and present danger to him/her or others.

VIII. Refund/Return of Client's Money and/or Property.

Upon termination of this Agreement, GrandeVille shall provide the Client within 3 business days, a final written statement of the Client's payment and personal allowance account, if applicable. In addition and at the same time, GrandeVille will return any money and release any property or things of value, held in safekeeping or owed to the Client. The refund shall be based upon unused, prepaid days or part days, provided that the Client has complied with Section VII of this Agreement.

If the Client Dies, GrandeVille will turn over the money or property of the individual in its possession, to the legally authorized representative of the Client's estate. If the Client dies without a will and the whereabouts of the next-of-kin of the individual is unknown, the Operator shall contact the Surrogate Court of the County of Monroe in order to determine what should be done with the property.

IX. Waiver.

Any modification or provision of the Agreement not consistent with the Social Services Law and the Regulations of the State Department of Health shall be null and void. Waiver by the Client or any provision in this Agreement which is required by law or regulation shall be deemed null and void and of no force and effect. The failure of either party to require strict performance of any of the items of this Agreement or the Waiver by either party of any breach under this Agreement shall not prevent a subsequent enforcement of such terms, nor be deemed a waiver of any subsequent breach. In the event any provisions of this Agreement shall be held invalid or unenforceable by any court of competent jurisdiction, such holdings shall not invalidate or render unenforceable any other provisions hereof.

X. 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:

Date	**Client**
Date	**Legal Representative**
Date	**(for) GrandeVille Adult Day Services Program**

11/17/16

CLIENT/LEGAL REPRESENTATIVE'S
CERTIFICATION REGARDING CLIENT'S
MEDICATION REGIMENT AND/OR PHYSICAL CONDITION

Name of Client: _____

I, _____ HEREBY CERTIFY THAT SINCE OUR LAST PARTICIPATION IN GRANDEVILLE'S ADULT DAY CARE PROGRAM THERE HAS BEEN NO CHANGE OF MEDICATION OR PHYSICAL CONDITION FOR THE ABOVE NAMED CLIENT.

I HAVE BEEN APPROPRIATELY INFORMED THAT, IF THERE HAS BEEN ANY MEDICAL CHANGE OR IF OUR LAST PARTICIPATION HAS BEEN MORE THAN 30 DAYS PREVIOUS TO THIS PARTICIPATION WE WOULD HAVE TO PROVIDE A CURRENT MEDICAL EVALUATION (NYSDOH FORM 3122) AND/OR PHYSICIAN'S ORDERS.

DATE:_____ _____

(Signature of Client or Legal Representative)