IN THE COURT OF COMMON PLEAS
CRAWFORD COUNTY, OHIO

Calvin Loyer, as the Personal Representative of the Estate of Edeltrud Loyer (deceased),	)	Case No. 15-CV-0148
	)	Judge Sean E. Leuthold
Plaintiff,	)	Plaintiff's Brief in Opposition to Defendants' Motion to Stay Proceedings.
vs.	)	
Signature Healthcare of Galion, et al.,	)	
Defendants.	)	

Now comes Plaintiff Calvin Loyer, as the Personal Representative of the Estate of Edeltrud Loyer (Deceased), by and through her attorneys, Blake A. Dickson, and Daniel Z. Inscore of The Dickson Firm, L.L.C., and, for her Brief in Opposition to Defendants' Motion to Stay Proceedings Pending Binding Arbitration, states as follows.

I. INTRODUCTION.

The Defendants have filed a Motion to Stay Proceedings Pending Binding Arbitration, asking this court to permanently stay this case, and to forever deny the Loyer family their day in court relative to the death of Edeltrud Loyer. The alleged basis for this motion is an arbitration clause, a copy of which is attached hereto as Exhibit "A".

None of the Defendants are parties to this arbitration clause.

As the court will see from reading the arbitration clause, the arbitration clause states that it is in agreement between the two (2) signatories to the arbitration clause. The two people who signed the arbitration clause are Calvin Loyer, Edeltrud Loyer's husband (who had no authority to sign on her behalf as will be demonstrated below), and Becky King, a nurse employed by Signature Healthcare Payroll Services, which is not a Defendant in this case.

None of the Defendants are named or listed in the arbitration clause.

The Defendants in this case are simply are not parties to the arbitration clause.

"Signature HealthCARE of Galion, LLC" is identified as the "facility" in the arbitration clause. Signature HealthCARE of Galion, LLC is not a party to this case.

Pursuant to the express language of the Arbitration Clause - which is a contract of adhesion, written by the nursing home and provided to Calvin Loyer on a take it or leave it basis - Signature HealthCARE of Galion, LLC is not a party to the arbitration clause.

Signature HealthCARE of Galion, LLC is not a legal entity. "Signature HealthCARE of Galion," is a fictitious name registered to LP Galion, LLC. But Signature HealthCARE of Galion, LLC is not a limited liability company registered to operate in Ohio.

As a result, this arbitration clause is clearly invalid. The Defendants have no basis to seek to enforce this clause as none of them are a party to it.

Accordingly, Plaintiff respectfully requests that this Honorable Court not only deny the Defendants' Motion to Stay, but that this Court specifically find that none of the Defendants are parties to the subject arbitration clause. Defendants have clearly filed their Motion to Stay to delay this case. After this baseless Motion to Stay is inevitably denied, Defendants will likely seek a frivolous appeal to delay this case further. Such appeals have been a trend among nursing homes when they have been sued in the State of Ohio. Nursing homes frequently file frivolous Motions to Stay, for the sole purpose of delaying the case. Once the baseless Motion is denied, the nursing homes attempts to delay the case further, by filing an appeal. If this Honorable Court finds, as a finding of fact, that none of the Defendants are parties to the arbitration clause, this may enable Plaintiff's counsel to prevent the Defendants from pursing a frivolous appeal pursuant to Ohio

Revised Code § 2711.02.

Not only are none of the Defendants parties to the arbitration clause, Edeltrud Loyer is also not a party to the arbitration clause.

As stated above, the language of the arbitration clause indicates that it is between the signatories, Calvin Loyer and Becky King.

Edeltrud Loyer never signed the arbitration clause.

Calvin Loyer had no authority to bind Edeltrud Loyer to anything. See Affidavit of Calvin Loyer, attached hereto as Exhibit "B". He did not have power of attorney over her. *Id.* He did not have a guardianship over her. *Id.* And no such documents are being offered by the Defendants. [1]

Edeltrud Loyer is not even listed on the arbitration clause as the resident. "Edeltrude Loyer" is listed as the resident on the arbitration clause. *See* Arbitration Clause, Exhibit "A".

Therefore, pursuant to the express language of the arbitration clause, the parties to the clause are Becky King and Calvin Loyer.

None of the Defendants are parties to the arbitration clause.

Edeltrud Loyer is not a party to the arbitration clause.

Edeltrud Loyer's next of kin are not parties to the arbitration clause nor bound by it. As the Ohio Supreme Court definitively ruled in the controlling case of *Peters v. Columbus Steel Castings, Co.*, 115 Ohio St.3d 134, 2007-Ohio-4784, 873 N.E.2d 1258 (2007), an arbitration clause, even if valid, would not act to stay the wrongful death portion of this case. The Ohio Supreme Court in *Peters* made it very clear that an individual, does not have the authority to bind his or her next of kin

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[1] Becky King did testify at her deposition that she thought she remembered Calvin Loyer bringing in an Power of Attorney for his wife. However, Calvin Loyer attests in his affidavit that no such document ever existed and the Defendants have never produced any such document.

to arbitration with respect to their wrongful death claims.

Defendants' arbitration clause is both procedurally and substantively unconscionable and is therefore unenforceable as a matter of law.

The arbitration clause in this case violates Ohio Revised Code § 2711.23's minimum requirements for healthcare arbitration contracts in at least five (5) different ways and is therefore unenforceable as a matter of law.

It is clear that the Defendants' sole purpose in filing this completely baseless Motion to Stay is to delay this case. Delays benefit the party who does not have the burden of proof. The Plaintiff in this case has the burden of proof and as this case is continuously delayed, witnesses' memories fade, witnesses move away, and Plaintiff's case becomes harder and harder to prove. This case will involve the testimony of multiple employees of the nursing home, including nurses, aides, and other employees. As more time elapses, it may become very difficult to find various witnesses, and certainly the memories of all of the witnesses will fade, all of which benefit the Defendants, who do not have the burden of proof in this case. Further, delays challenge the resolve of the Loyer family, increase the time spent on this case, and increase the cost of this case. And every delay postpones the time when the Defendants have to pay a settlement or judgment.

Accordingly, as fully articulated below, Plaintiff respectfully requests that this Honorable Court promptly deny Defendants' Motion to Stay. Further, Plaintiff respectfully requests that this Honorable Court specifically find that none of the Defendants are proper parties to the arbitration clause, that Edeltrud Loyer was not a party to the arbitration clause, and that therefore there is no valid arbitration clause in this case. The purpose of this request is to potentially prevent the Defendants from pursuing a frivolous appeal and delaying this case further.

II. STATEMENT OF FACTS.

On April 14, 2014, Edeltrud Loyer went to the Galion Hospital for a urinary tract infection. She was found to be mildly dehydrated.

On April 15, 2014 Edeltrud Loyer was admitted to the Signature HealthCARE of Galion nursing home.

On April 21, 2014, the nursing home staff noted a "facility acquired", Stage II, pressure ulcer on Edeltrud Loyer's coccyx measuring 2.3 c.m. x 1.7 c.m. x 0.1 c.m. Wound cleansing and dressing was ordered for every three (3) days and as needed. The cleansing and dressing order was not added to Edeltrud Loyer's care plan. The nursing home did not notify Edeltrud Loyer's husband, Calvin Loyer, about the wound, until the next day when he happened to be in the facility visiting his wife.

On April 22, 2014, an air mattress was ordered for Edeltrud Loyer. The air mattress was not added to Ms. Loyer's care plan.

On April 29, 2014, Edeltrud Loyer's **facility acquired** coccyx pressure ulcer had grown to 2.5 c.m. x 2.0 c.m. x 0.1 c.m. It had developed slough, a moist yellow or gray necrotic tissue. Ms. Loyer had also begun to experience pain as the result of her pressure ulcer. The wound bed had become white. Edeltrud Loyer's care plan was not updated. The nursing home did not notify her husband, Calvin Loyer of her worsening wound.

On April 30, 2014, Dr. Wood ordered santyl treatment to the wound. This order was not added to Edeltrud Loyer's care plan.

On May 2, 2014, at the MedCentral outpatient Wound Care Clinic, Edeltrud Loyer's coccyx pressure ulcer is noted to be 2.5 c.m. x 1.5 c.m. with white necrotic tissue obscuring the wound bed, making the wound unstageable. The physician ordered Dakins solution, quarter strength, on a 2 in.

x 2 in. dressing, for the wound to be covered with a dry sterile dressing, and for the dressing to be changed daily. She is also ordered to return to the wound clinic on May 8, 2015 to have her wound debrided. Edeltrud Loyer's care plan at the nursing home was not updated to reflect the orders from the wound care clinic.

On May 3, 2014, the dressing to Edeltrud Loyer's coccyx is ordered to be changed to santyl rather than Dakins. Edeltrud Loyer's care plan never contained the santyl dressing order nor any other and was not updated to include Dakins solution.

On May 6, 2014, Edeltrud Loyer's facility acquired coccyx pressure ulcer was noted to have become unstageable, it had grown to 6.1 c.m. x 2.3 c.m. x 0.3 c.m. It had developed "grey/green" purulent foul smelling exudate. The wound bed was now "grey/green" and the wound edges were "very dark". Still, the nursing home did not notify her husband, Calvin Loyer.

On May 8, 2014, Edeltrud Loyer returned to the MedCentral Wound Care Clinic. Her wound measured 6.4 c.m. x 3.2 c.m. and was 75-100% necrotic. The necrotic tissue in the wound consisted of gray and tan fibrin slough. The wound had a moderate amount of foul smelling serosanguinous exudate. The physician at the wound clinic debrided the wound, cutting out the dead necrotic tissue, which went all of the way down to Edeltrud Loyer's muscle fascia. The physician ordered a dietician consult, turning and repositioning every two hours, padding to pressure areas, tight diabetic control, washing of the wounds prior to dressing changes, wet to dry dressings using Dakins solution three times per day. The wound clinic physician also ordered a wound culture.

On May 12, 2014, Edeltrud Loyer is sent to the Galion Hospital emergency room due to a fever and decrease in responsiveness. There she is diagnosed with a fever, dehydration, and an infected decubitus ulcer.

Later that day, Edeltrud Loyer was transferred to the Bucyrus Community Hospital, where her wound was found to be infected with proteus mirabilis, a bacteria typically found in the urine. She was put on several antibiotics and underwent another surgical debridement. Ms. Loyer had several electrolyte abnormalities and a low prealbumin level, indicating a nutritional deficiency that required PEG tube placement. However, by this time the medical staff was recommending comfort care for Ms. Loyer.

On May 20, 2014, Edeltrud Loyer was re-admitted to the Signature Healthcare of Galion nursing home. Her wound was noted to be 7.9 c.m. x 5.7 c.m. x 3.8 c.m. with serous exudate, slough, and significant undermining. The wound was noted to cause her to moan and grimace with pain. Over the next several days her pressure ulcer only worsened.

On May 28, 2014, Edeltrud Loyer was found unresponsive. She was rushed to the hospital where she was declared deceased. Her white blood cell count was highly elevated indicating a severe infection.

Not a single individualized intervention appears in any of Edeltrud Loyer's care plans. The interventions in her care plans were never changed or updated. Edeltrud Loyer was not turned and repositioned to prevent pressure ulcers. Defendants did almost no nutritional monitoring nor evaluation until it was too late. There is no indication that the Defendants monitored Edeltrud Loyer's liquid intake before or after she was sent to the hospital severely dehydrated.

III. PROCEDURAL HISTORY.

On July 28, 2015, Plaintiff Calvin Loyer, as the Personal Representative of the Estate of Edeltrud Loyer (deceased) filed the Complaint in this case against the owners and operators of the Signature HealthCARE of Galion nursing home.

On August 4, 2015, Plaintiff propounded his First Set of Interrogatories and his First Requests for Production of Documents on Defendants.

On August 7, 2015, Defendants filed an Answer to Plaintiff's Complaint in which they demanded a jury trial.

Also on August 7, 2015, Defendants filed a Motion to Stay Proceedings Pending Arbitration under R.C. 2711.02.

On August 24, 2015, Plaintiff moved for an extension of time to respond to Defendants' Motion to stay in order to investigate arbitration.

On September 8, 2015, Defendants' moved for a protective order to prevent Plaintiff from conducting discovery.

On December 14, 2015, the Court scheduled a settlement conference for January 6, 2016. Apparently, a new insurance adjustor had been assigned to this case and Plaintiff's counsel agreed to reschedule the settlement conference for January 27, 2016 in order to allow the new adjustor to become familiar with the case.

On January 27, 2016, a settlement conference was held, but was not attended by any insurance adjustor nor anyone with meaningful authority to negotiate a settlement. The settlement conference was rescheduled for February 9, 2015 and Defendants' Motion for Protective Order was denied.

On February 9, 2015, a second settlement conference was held. The insurance adjustor attended. Defendants made no meaningful effort to settle the case.

On February 25, 2016, Plaintiff's counsel deposed Becky King, LPN, both individually and as the Civ.R. 30(B)(5) representative of Defendants, relative to the arbitration clause.

IV. LAW AND ARGUMENT.

A. None of the Defendants in this case are parties to the arbitration clause.

As indicated above, the arbitration clause in this case only purports to bind its signatories: Becky King and Calvin Loyer. Edeltrud Loyer, the nursing home resident is not a party to the arbitration clause. None of the Defendants are parties to the arbitration clause. Therefore, there is no basis to stay this case.

The Defendants drafted the arbitration clause. Deposition of Becky King, 54:14. A contract must be strictly construed against the party that drafted it. *King v. Nationwide Ins. Co.*, 35 Ohio St. 3d 208, 211 (1988), citing *Faruque v.. Provident Life & Acc. Ins. Co.* (1987), 31 Ohio St. 3d 34, 31 OBR 83, 508 N.E. 2d 949, syllabus and *Thompson v.. Preferred Risk Mut. Ins. Co.* (1987), 32 Ohio St. 3d 340, 342, 513 N.E. 2d 733, 736. The nursing home drafted the arbitration clause. They could have drafted it to say anything they chose. It was presented to Calvin Loyer on a take it or leave it basis. It is a classic contract of adhesion. The nursing home drafted this contract in such a way that the only people who are parties to this contract are Becky King and Calvin Loyer. Exhibit "A". On the first page of the arbitration clause, the clause indicates at numbered paragraph 1., "1. If a dispute, or legal claim of any kind (including a class claim or representative action), arises or occurs between anyone signing this agreement (a "dispute"):" So the arbitration clause applies to "anyone signing this agreement". The only two people who signed the agreement are Becky King and Calvin Loyer. Becky King is employed by Signature Payroll Services, which is not one of the Defendants. Deposition of Becky King, 53:8. Calvin Loyer had no authority to bind Edeltrud Loyer to anything. As a result, none of the Defendants are entitled to a stay of this case pending binding arbitration.

Signature HealthCARE of Galion, LLC is the entity identified as the facility. *See* Exhibit

"A". Signature HealthCARE of Galion, LLC is not identified as a party to the arbitration clause. The clause is "between anyone signing his agreement". Signature HealthCARE of Galion is not one of the Defendants in this case. Signature HealthCARE of Galion, LLC is also not an entity that is registered in Ohio. Signature HealthCARE of Galion, LLC would be the abbreviation for Signature HealthCARE of Galion Limited Liability Company. There is no limited liability company known as Signature HealthCARE of Galion, LLC registered to do business in Ohio.

"Signature HealthCARE of Galion" is a registered trade name, but that is different than "Signature HealthCARE of Galion, LLC." Signature HealthCARE of Galion is a trade name that is registered to LP Galion, L.L.C. LP Galion, L.L.C. is one of the named Defendants. However, LP Galion, L.L.C. appears nowhere on the arbitration clause nor anywhere throughout the entire Admission Agreement. No Defendant in this case appears anywhere on the arbitration clause. Defendant Signature HealthCARE of Galion is not a party to the arbitration clause. Exhibit, "A". Defendant SHC LP Holdings, LLC is not a party to the arbitration clause. *Id.* Defendant Signature HealthCARE, LLC is not a party to the arbitration clause. *Id.* Defendant Signature HealthCARE Clinical Consulting Services, LLC is not a party to the arbitration clause. *Id.* Defendant Egwulo Rawlins is not a party to the arbitration clause. *Id.* Defendant SHC of Galion is not a party to the arbitration clause. *Id.* And Defendant LP Galion LLC d/b/a Signature HealthCARE of Galion is not a party to the arbitration clause. *Id.*

R.C. § 2711.01(A) defines a valid arbitration clause, in pertinent part, as "any agreement in writing between two or more persons to submit to arbitration any controversy existing between them". R.C. § 2711.22(A)(emphasis added) provides that an arbitration clause becomes "enforceable once the contract is **signed by all parties**." No one signed the arbitration clause on behalf of any

of the Defendants. Therefore, none of the Defendants are parties to the arbitration clause.

By its very terms, the arbitration clause in this case applies to disputes that arise between its signatories, Calvin Loyer and Becky King, LPN an employee of Signature HealthCARE Payroll Services. The subject arbitration clause is irrelevant to this litigation.

Accordingly, Plaintiff asks that this Court find that none of the Defendants are parties to the arbitration clause, so there is no basis to stay the case against any of the Defendants. Defendants' Motion to Stay must be denied.

B. The Arbitration Clause is not enforceable against Edeltrud Loyer because it was never signed by Edeltrud Loyer nor anyone with authority to sign on her behalf.

Edeltrud Loyer never signed the arbitration clause.

Calvin Loyer, Edeltrud Loyer's husband, did sign the arbitration clause. Calvin Loyer had no authority to anything on behalf of his wife. *See* Affidavit of Calvin Loyer, Exhibit "B". He did not have power of attorney. *Id.* He was not her guardian. *Id.* He did not tell anyone at the nursing home that he had authority to sign any paperwork on Edeltrud Loyer's behalf. *Id.* He did not tell anyone that Edeltrud Loyer told him to sign any paperwork on Edeltrud Loyer's behalf. *Id.* He had no authority to bind Edeltrud Loyer to anything. Edeltrud Loyer is not a party to this arbitration clause. She did not sign the arbitration clause. Her name does not even appear properly on the clause as the resident.

In *Council of Smaller Enters. v. Gates, McDonald & Co.*, 80 Ohio St.3d 661, 1998-Ohio-172, 687 N.E.2d 1352 (1998), the Supreme Court of Ohio reaffirmed the first principle to be analyzed when considering the applicability of any arbitration clause or agreement. The Court stated that "'arbitration is a matter of contract and a party cannot be required to submit to arbitration any dispute

which he has not agreed so to submit.' * * * This axiom recognizes the fact that arbitrators derive their authority to resolve disputes only because the parties have agreed to submit such grievances to arbitration." *Council of Smaller Enters.*, 80 Ohio St.3d, at 665, quoting *AT&T Technologies, Inc. v. Communications Workers of Am.*, 475 U.S. 643, 648-49, 106 S. Ct. 1415, 89 L. Ed. 2d 648 (1986), quoting *Steelworkers v. Warrior & Gulf Navigation Co.*, 363 U.S. 574, 582, 80 S. Ct. 1347, 4 L. Ed. 2d 1409 (1960). The Court went on to hold that there is a **presumption <u>against</u> arbitrability** when "there is serious doubt that the party resisting arbitration has empowered the arbitrator to decide anything." *Id.* at 667-68, citing *First Options of Chicago, Inc. v. Kaplan*, 514 U.S. 938, 115 S. Ct. 1920, 131 L. Ed. 2d 985 (1995). In *First Options*, the United States Supreme Court held that since the Kaplans had not personally signed the document containing the alleged arbitration clause, they were not required to arbitrate the underlying dispute.

In *Doe v. Vineyard Columbus*, 2014-Ohio-2617, ¶¶ 15-16 (10th Dist. 2015) (emphasis added), the Tenth District Court of Appeals held:

> **The court must first determine whether the parties agreed to submit a matter to arbitration**, a question typically raising a question of law for the court to decide. Id. Arbitration is a matter of contract and a party cannot be required to submit a dispute to arbitration when it has not agreed to do so. *Academy of Med. of Cincinnati v. Aetna Health, Inc.*, 108 Ohio St.3d 185, 2006-Ohio-657, ¶ 11. Thus, a court must " 'look first to whether the parties agreed to arbitrate a dispute, not to general policy goals, to determine the scope of the agreement.' " *Columbus Steel Castings v. Real Time Staffing Servs.*, 10th Dist. No. 10AP-1127, 2011-Ohio-3708, ¶ 13, quoting *White v. Equity, Inc.*, 191 Ohio App.3d 141, 2010-Ohio-4743, (10th Dist.) ¶ 19, quoting *E.E.O.C. v. Waffle House, Inc.*, 534 U.S. 279, 294 (2002).
>
> A valid and enforceable contract requires an offer by one party and an acceptance of the offer by another party. *Huffman v. Kazak Bros., Inc.*, 11th Dist. No. 2000-L-15, 2002-Ohio-1683, citing *Camastro v. Motel 6 Operating, L.P.*, 11th Dist. No. 2000-T-0053 (Apr. 27, 2001). There must be a meeting of the minds to create a proper offer and acceptance. Id. "In order for a meeting of the minds to occur, both parties to an agreement must mutually assent to the substance of the exchange."

> *Miller v. Lindsay-Green, Inc.*, 10th Dist. No. 04AP-848, 2005-Ohio-6366, ¶ 63. Thus, the parties must have a "'distinct and common intention which is communicated by each party to the other.'" *Huffman* quoting *McCarthy, Lebit, Crystal & Haiman Co., L.PA. v. First Union Mgt., Inc.*, 87 Ohio App.3d 613 (8th Dist.1993). Therefore, " '[i]f the minds of the parties have not met, no contract is formed.' " Id.

In *Koch v. Keystone Pointe Health & Rehab.*, 2012-Ohio-5817, at ¶ 19 (9th Dist. 2012), the Ninth District Court of Appeals recently held that "no contract existed which bound the parties to arbitrate any disputes or claims" where a nursing home resident's daughter-in-law, who did not hold a power of attorney, signed nursing home admission paperwork on behalf of her father-in-law. As a result, the arbitration agreement that she signed during the admission process was not enforceable against the father-in-law nor his estate.

In this case, Edeltrud Loyer did not sign the arbitration clause. *See* Arbitration Clause, Exhibit "A".

The arbitration clause was signed by Edeltrud Loyer's husband, Calvin Loyer, on a line entitled "Resident Representative Signature". However, Calvin Loyer was not Edeltrud Loyer's legal representative in any way. Calvin Loyer did not have a power of attorney nor a guardianship for Edeltrud Loyer, nor did he have any authority to bind Edeltrud Loyer to an arbitration clause nor sign any document on her behalf. *See* Affidavit of Calvin Loyer, Exhibit "B".

Becky King testified that she remembers receiving a power of attorney document from Calvin Loyer. However, she testified that she did not have any Power of Attorney document when Calvin Loyer signed the arbitration clause. She claims remembering receiving a Power of Attorney from Calvin Loyer some time later. Deposition of Becky King 37:23-24. The Defendants have never produced any power of attorney document. Calvin Loyer attests in his affidavit that he had never

had power of attorney for his wife.

Becky King also testified that she participates in up to100 admissions a year and she has the entire time she has worked at the subject nursing home. *Id.* at 25:4. That means that to date, since December 1, 2013 when the Defendants bought the facility, she's participated in upwards of 200 admissions. The notion that she has a specific memory of Calvin Loyer dropping off a specific document is unlikely. Calvin Loyer has never had power of attorney over his wife. Exhibit "B". Defendants have not produced any such power of attorney document.

Becky King testified that Calvin Loyer told her he had a power of attorney agreement for his wife. Deposition Becky King, 35:25. **However, she did not place a check mark next to that line on the arbitration clause that indicated that Calvin Loyer had a Power of Attorney for his wife.** *See* Exhibit "A". If Calvin Loyer actually had told Becky King he had a power of attorney for his wife she would have checked that line. She did not. Exhibit "A". Calvin Loyer did not have a power of attorney for his wife.

Becky King testified the Calvin Loyer had a "durable power of attorney" for his wife. Deposition of Becky King, 42:7. However, Ohio Revised Code §§ 1337.12 and 1337.13, clearly requires a healthcare power of attorney in order to empower an agent to sign a healthcare arbitration clause. *Templeman v. Kindred Healthcare, Inc.*, 2013-Ohio-3738, ¶ 24 (8th Dist. 2013). Becky King did not testify that a durable power of attorney for health care for Edeltrud Loyer exists nor that she has ever seen one. Therefore, even if this power of attorney document, which Calvin Loyer swears does not exist, and which the facility cannot produce, did in fact exist at one time, it would be insufficient as a durable power of attorney and NOT a power of attorney for health care too enable Calvin Loyer to sign the arbitration clause and bind his wife. Becky King was not trained to know

that Calvin Loyer needed a durable power of attorney for health care in order for Calvin Loyer to have authority to bind his wife to an arbitration clause.

It is not in dispute that the Defendants in this case drafted this arbitration clause, and provided it to Calvin Loyer on a take it or leave it basis. Deposition of Becky King, 54:14. Calvin Loyer did not alter one word of the arbitration clause. He made no changes whatsoever. *Id.* at 28:12. Calvin Loyer signed the arbitration clause because it was his belief that that is what he had to do to get his wife admitted to the nursing home. Affidavit of Calvin Loyer, Exhibit "B". Edeltrud Loyer had just come from the hospital. She needed nursing home care and so he signed this clause. However, he had no authority to sign on behalf of his wife. He was not her guardian. *Id.* He did not have power of attorney to sign on her behalf. *Id.*

The third page of the arbitration clause is intended to show whether the person signing the clause has authority to sign on behalf of the resident. Becky King testified that she filled out this page by going down the list and asking Calving Loyer which items apply. Deposition of Becky King, 31:15. Calvin Loyer denies this and states they she merely told him where to sign. Exhibit "B".

Becky King testified that Calvin Loyer told her his wife gave him oral authority to sign his admission paperwork and so she placed a check mark next to that line. *Id.* at 38:6. Calvin Loyer denies this. Exhibit "B". Becky King also testified that the reason why Edeltrud Loyer was not signing her own admission paper was because of her "cognitive deficits". Deposition of Becky King, 27:6. Thus, even if Edeltrud Loyer had given Calvin Loyer oral authority, which she did not, and even if he had told Becky King that his wife had given him oral authority, which he did not, if Edeltrud Loyer was incompetent to sign her paperwork she was incompetent to give Calvin Loyer

oral authority to sign her paperwork.

Becky King also testified that he told her he was recognized as his wife's "healthcare decision maker" because she placed a check mark next to that line. Deposition of Becky King 39:25. Calvin Loyer denies that this was true and denies and that he said this. Exhibit "B".

The third page also requires that the signor must provide proof of his authority to sign on behalf of a resident in order to sign. Exhibit "A". As a result, the Defendants were aware that Calvin Loyer had to have some **proof** before he could sign on his wife's behalf. However, they did not train Becky King, the person in charge of admissions that proof was necessary. Her testimony was that just because he was the spouse, he could sign. *Id.* at 39:12. Her testimony was that her understanding was that if the resident was incompetent, her spouse could sign. *Id.* Obviously, that is not the law so the Defendants in this case failed to train their admissions person properly.

Decedent Edeltrud Loyer did not sign any agreement requiring her to arbitrate any claims that may arise against the Defendants in this case. *See* Exhibit "A". Calvin Loyer signed the arbitration clause but he had no authority to sign a document for his wife. *See* Exhibit "B". The arbitration clause in this case not enforceable.

Calvin Loyer also did not have any apparent authority to sign an arbitration clause on Edeltrud Loyer's behalf.

Becky King testified that Calvin Loyer told her that he had authority to sign on her behalf. While he disputes this, it is irrelevant to any apparent authority analysis. Only the acts of the principal, Edeltrud Loyer, can create apparent authority. Becky King clearly testified that during the signing of the arbitration clause in this case Edeltrud Loyer was on the nursing home's memory care unit and not present in the lobby where Calvin Loyer signed the arbitration clause. Deposition of

Becky King, 27:3. Therefore she could not have done anything to create apparent authority in Calvin Loyer. Further, Becky King testified that she thought that Edeltrud Loyer was incompetent to sign her own paperwork, which would also make her incompetent to create apparent authority for Calvin Loyer. *Id.* at 26:7.

In *Lang v. Beachwood Pointe Care Center*, 2014-Ohio-1238 (8th Dist. 2014), the nursing home resident's husband's adult daughter signed an arbitration clause for the resident. However, the resident's husband's adult daughter did not have any power of attorney agreement relative to her father's wife. The defendants in that case argued that the resident's husband's adult daughter had "apparent authority" to sign on behalf of the resident. The Eighth District Court of Appeals articulated the two-part, conjunctive test for apparent authority:

> Apparent authority for an agent's act will be found when (1) the **principal** held the agent out to the public as possessing sufficient authority to embrace the particular act in question, or knowingly permitted the agent to act as having such authority, and (2) the person dealing with the agent knew of those facts and acting in good faith had reason to believe and did believe that the agent possessed the necessary authority. *Master Consol. Corp. v. BancOhio Natl. Bank*, 61 Ohio St.3d 570, 575 N.E.2d 817

Id. at ¶ 4 (emphasis added). In this case the nursing home had no reason whatsoever to believe that Calvin Loyer had the necessary authority. They have no power of attorney document. Becky King admits that she had no such document when Calvin Loyer signed the arbitration clause. That is why the arbitration clause does not indicate that Calvin Loyer had power of attorney. An apparent authority analysis requires the party attempting to prove apparent authority to demonstrate **both** objective acts by the principal creating authority **and** a subjective actual belief that those acts did create such authority. *Id.* Edeltrud Loyer did nothing to indicate that Calvin Loyer had the authority to sign the clause on her behalf. In the *Lang* case the Eighth District Court of Appeals found no

evidence that the principal, the nursing home resident, held out her husband's adult daughter as possessing authority to act on her behalf or that the nursing home had any good faith reason to believe that she had such authority. *Id.* at ¶¶ 5-7. As in *Lang*, Edeltrud Loyer did not do anything to indicate that her husband had authority to act on her behalf. Edeltrud Loyer was not even present during the signing of his admission paperwork. Affidavit of Calvin Loyer, Exhibit "B". Becky King did not and could not point to any objective acts by Edeltrud Loyer which could create apparent authority. Further, Becky King testified that she did not believe that Edeltrud Loyer was mentally competent to sign her own admission paperwork. Deposition of Becky King, 27:6.

Inn this case Defendants fail on both prongs of the apparent authority test. Edeltrud Loyer did not do anything to authorize her husband to sign on her behalf. Exhibit "B". And Becky King had no reason to believe that Calvin Loyer had authority to sign on his wife's behalf.

In case the Defendants cite *Brown v. Extendicare, Inc.*, 2015-Ohio-3059 (2nd Dist. 2015) in support of their motion, in the *Brown* case the nursing home resident was present during the admission process, was not advanced in age, and was not physically and mentally impaired. *Id.* at ¶ 49. The resident-principal in *Brown*, later signed a subsequent admission agreement that indicated that the agent was considered her legal representative. *Id.* None of these facts are consistent with the facts in this case. In this case Defendants concede that Edeltrud Loyer was not present when the arbitration clause was signed. Becky King testified that Edeltrud Loyer was not competent when the arbitration clause was signed. Edeltrud Loyer never signed a subsequent admission agreement that indicated that her husband was her legal representative. *Brown* is inapplicable to this case.

Ohio's Statute of Frauds, R.C. §1335.05 provides in part (emphasis added):

> No action shall be brought whereby to charge the defendant, upon a special

promise, to answer for the debt, default, or miscarriage of another person; nor to charge an executor or administrator upon a special promise to answer damages out of his own estate; nor to charge a person upon an agreement made upon consideration of marriage, or upon a contract for sale of lands, tenements, or hereditaments, or interest in or concerning them, **or upon an agreement that is not to be performed within one year from the making thereof; unless the agreement upon which such action is brought, or some memorandum or note thereof, is in writing and signed by the party to be charged therewith or some other person thereunto by him or her lawfully authorized.**

R.C. § 2711.01(A) defines a valid arbitration agreement, in pertinent part, as "any agreement in writing between two or more persons to submit to arbitration any controversy existing between them". *See also* R.C. § 2711.22(A). In this case, there is no agreement between Edeltrud Loyer and anyone. Edeltrud Loyer did not sign any agreement nor did anyone sign on her behalf who had authority to sign on her behalf. And none of the Defendants are parties to the arbitration clause. As a result, there is no agreement between the Estate of Edeltrud Loyer and the Defendants. Defendants' Motion to Stay must be denied.

C. Pursuant to the Ohio Supreme Court's decision in *Peters v. Columbus Steel Castings, Co.*, 115 Ohio St.3d 134, 2007-Ohio-4787, 873 N.E.2d 1258 (2007), no one had the authority to bind Edeltrud Loyer's next of kin to arbitrate their wrongful death claims.

In *Peters v. Columbus Steel Castings Co.*, 115 Ohio St.3d 134, 2007-Ohio-4787, 873 N.E.2d 1258 (2007), the Ohio Supreme Court considered the issue of "whether the personal representative of a decedent's estate is required to arbitrate a wrongful-death claim when the decedent had agreed to arbitrate all claims against the alleged tortfeasor." *Peters*, 115 Ohio St.3d at 135. In considering this issue, the Court reviewed the separate nature of survival claims and wrongful death claims. The Court stated that "when an individual is killed by the wrongful act of another, the personal representative of the decedent's estate may bring a survival action *for the decedent's own injuries*

leading to his or her death as well as a wrongful-death action *for the injuries suffered by the beneficiaries of the decedent* as a result of the death." *Peters*, 115 Ohio St.3d at 137 (emphasis in original); *See also* R.C. §§ 2125.02 and 2305.21, which provide separate causes of action for wrongful death claims and survival claims respectively. The Ohio Supreme Court recognized that although survival claims and wrongful death claims both relate to the same allegedly negligent acts of a defendant, and such claims are both pursued by the same nominal party (i.e., the personal representative of the estate) in the same case, they are distinct claims that are brought for different parties in interest. *Peters*, 115 Ohio St.3d at 137, citing *Mahoning Valley Ry. Co. v. Van Alstine*, 77 Ohio St. 395, 414, 83 N.E. 601 (1908). As a result of the different nature of wrongful death claims from survival claims, the Court held that "a decedent cannot bind his or her beneficiaries to arbitrate their wrongful-death claims. The beneficiaries can agree to arbitrate these claims themselves, but they are not required to do so. Because Peter's beneficiaries did not sign the plan nor any other dispute-resolution agreement, they cannot be forced into arbitration." *Peters*, 115 Ohio St.3d at 138, citing *Thompson v. Wing*, 70 Ohio St.3d 176, 182-83, 637 N.E.2d 917 (1994). Simply put, the Court concluded that "[a]lthough we have long favored arbitration and encourage it as a cost-effective proceeding that permits parties to achieve permanent resolution of their disputes in an expedient manner, it may not be imposed on the unwilling." *Peters*, 115 Ohio St.3d at 138. The Court went on to state that "[r]equiring Peters's beneficiaries to arbitrate their wrongful-death claims without a signed arbitration agreement would be unconstitutional, inequitable, and in violation of nearly a century's worth of established precedent." *Peters*, 115 Ohio St.3d at 138-39.

The holding and reasoning in *Peters* applies to the wrongful death claims which have been brought by Plaintiff Calvin Loyer on behalf of Decedent Edeltrud Loyer's next-of-kin. The wrongful

death claims in this case are not subject to arbitration pursuant to the *Peters* case. As a result, there is absolutely no basis for this Court to stay the wrongful death claims in this case. None of Edeltrud Loyer's next-of-kin were ever a party to the arbitration clause, so they are not bound by it. Calvin Loyer signed the arbitration clause to get his wife admitted to the nursing home. He clearly never entered into an arbitration agreement on his own behalf relative to his potential wrongful death claims relative to his wife's death. It is clear that the arbitration clause, in no way, binds Edeltrud Loyer nor any of her next-of-kin.

In this case, there is no question that Plaintiff's wrongful death claims are not stayed by the arbitration clause.

Accordingly, this Court should promptly deny Defendants' Motion to Stay Proceedings Pending Arbitration.

D. The Arbitration Clause is void under Ohio law.

Pursuant to R.C. § 2711.23, an arbitration agreement involving a medical claim is only valid and enforceable if it meets several minimum requirements. Since the arbitration clause in this case completely fails to meet the minimum requirements of the Ohio Revised code in five (5) different respects, it is invalid and unenforceable as a matter of law.

R.C. § 2711.23 states, in pertinent part (emphasis added):

> **To be valid and enforceable** any arbitration agreements pursuant to sections 2711.01 and 2711.22 of the Revised Code for controversies involving a medical, dental, chiropractic, or optometric claim that is entered into prior to a patient receiving any care, diagnosis, or treatment shall include and be subject to the following conditions:
>
> (B) The agreement shall provide that the patient, or the patient's spouse, or the personal representative of the patient's estate in the event of the patient's death or incapacity, shall have a right to withdraw the patient's consent to arbitrate the

> patient's claim by notifying the healthcare provider or hospital in writing within thirty days after the patient's signing of the agreement. Nothing in this division shall be construed to mean that the spouse of a competent patient can withdraw over the objection of the patient the consent of the patient to arbitrate;
>
> (C) The agreement shall provide that the decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence;
>
> * * *
>
> (F) Any arbitration panel shall consist of three persons, no more than one of whom shall be a physician or the representative of a hospital;
>
> (G) The arbitration agreement shall be separate from any other agreement, consent, or document;
>
> * * *
>
> (J) The agreement shall contain a separately stated notice that clearly informs the patient of the patient's rights under division (B) of this section.

The arbitration clause violates R.C. § 2711.23(B) because the arbitration clause does not correctly state rights articulated in paragraph B and only provided that the *resident* could revoke the agreement. Exhibit "A".

The arbitration clause violates R.C. § 2711.23(C), because the arbitration clause did not provide that "the decision whether or not to sign the agreement is solely a matter of for the patient's determination without any influence." Exhibit "A".

The arbitration clause violates R.C. § 2711.23(F), because the arbitration clause provides for one (1) arbitrator unless the parties do not agree. Exhibit "A". The clause only provides for a panel if the parties do not agree. *Id.*

The arbitration clause violates R.C. § 2711.23(G), because it is not separate from any other agreement, consent, or document. Attached, as Exhibit "C", is the Admission Packet as it was Presented to Calvin Loyer as reassembled by Becky King during her deposition. Deposition of Becky Page, 11:3. The arbitration clause was four (4) pages of a 28-page admission packet that was

presented to Calvin Loyer. Exhibit "C". Defendants also produced a checklist of everything that is *supposed* to be part of the admission packet. *See* Exhibit "D".

Items on the checklist, but not produced to Plaintiff's counsel include:

- Full life conference notification form
- Sex Offender Registry Check
- Insurance Verification/Financial Assessment Form
- HMO Authorization
- Copies of Medicare and/or Insurance card(s), Social Security Card, and driver's license

The arbitration clause in this case was merely four (4) pages at the bottom of a stack of at least twenty-eight (28) pages of admission paperwork that were indistinguishable to Calvin Loyer. *See* Exhibit "C".

The Admission agreement and all of its attachments, including the subject arbitration clause, comprise one document. They were presented to Calvin Loyer as one document. The arbitration clause is not a separate agreement, but is simply an attachment to the Admission Packet.

The arbitration clause also violates R.C. § 2711.23(J), because it does not contain a separately stated notice that clearly informs the patient of the patient's rights under R.C. § 2711.13(B). Exhibit "A".

Since the arbitration clause violates R.C. § 2711.23 in at least five (5) different ways, it is invalid and unenforceable as a matter of law.

E. The arbitration clause contained within Defendant's Admission Agreement is both procedurally and substantively unconscionable and, therefore, it is unenforceable.

Defendants' arbitration clause is not enforceable because it is both procedurally

unconscionable and substantively unconscionable.

"[A]n arbitration agreement is enforceable unless grounds exist at law or in equity for revoking the agreement." *Hayes v. Oakridge Home*, 122 Ohio St.3d 63, 67, 2009-Ohio-2054, 908 N.E.2d 408 (2009), citing R.C. § 2711.01(A). "Unconscionability is a ground for revocation of an arbitration agreement." *Id.*, citing *Taylor Bldg. Corp. of Am. v. Benfield*, 117 Ohio St.3d 352, 2008-Ohio-938, 884 N.E.2d 12 (2008). "Unconscionability includes both 'an absence of meaningful choice on the part of one of the parties together with contract terms which are unreasonably favorable to the other party." *Id.*, quoting *Lake Ridge Academy v. Carney*, 66 Ohio St.3d 376, 383, 613 N.E.2d 183 (1993). *Arnold v. Burger King*, 2015-Ohio-4485, ¶ 69 (8th Dist. 2015) provides:

> Unconscionability embodies two separate concepts: (1) unfair and unreasonable contract terms, i.e., substantive unconscionability; and (2) an absence of meaningful choice on the part of one of the parties, i.e., procedural unconscionability. *Taylor Bldg.*, 117 Ohio St.3d 352, 2008-Ohio-938, 884 N.E.2d 12, at ¶ 34.

1. Procedural Unconscionability.

Procedural unconscionability is about power. Did the parties negotiate the terms of the contract from a position of equal footing or was it a classic contract of adhesion? "[N]o single factor alone determines whether a contract is procedurally unconscionable; a court must consider the totality of the circumstances." *Arnold* at ¶79.

"Procedural unconscionability involves those factors bearing on the relative bargaining position of the contracting parties, e.g., 'age, education, intelligence, business acumen and experience, relative bargaining power, who drafted the contract, whether the terms were explained to the weaker party, whether alterations in the printed terms were possible, whether there were alternative sources of supply for the goods in question.'" *Small v. HCF of Perrysburg*, 159 Ohio

App.3d 66, 2004-Ohio-5757, 823 N.E.2d 19 (6th Dist. 2004), quoting *Johnson v. Mobil Oil Corp.*, 415 F.Supp. 264, 268 (E.D. Mich. 1976).

"Additional factors that may contribute to a finding of procedural unconscionability include the following: 'belief by the stronger party that there is no reasonable probability that the weaker party will fully perform the contract; knowledge of the stronger party that the weaker party will be unable to receive substantial benefits from the contract; knowledge of the stronger party that the weaker party is unable reasonably to protect his interests by reason of physical or mental infirmities, ignorance, illiteracy or inability to understand the language of the agreement, or similar factors.'" *Hayes*, 122 Ohio St.3d at 68, citing *Taylor Bldg. Corp. of Am.*, 117 Ohio St.3d at 362.

"Comprehension of the terms of the agreement is an element of both procedural and substantive unconscionability, the latter of which is addressed in greater detail below." *Arnold* at ¶80.

In *Manley v. Personacare of Ohio*, 2007-Ohio-343, ¶ 31 (11th Dist. 2007), the Eleventh District Court of Appeals held that an arbitration agreement, signed by a nursing home resident during admission, was procedurally unconscionable. In *Manley*, the resident signed a "resident admission agreement" as well as an "alternative dispute resolution agreement between resident and facility". *Id.* at ¶ 3. The Eleventh District Court of Appeals held that the arbitration agreement was procedurally unconscionable. *Id.* at ¶ 31. The Eleventh District Court of Appeals noted that the resident, Patricia Manley, had left the hospital a week prior to her admission, went directly from the hospital to the nursing home, she did not have a friend or family member with her during her admission, she was sixty-six (66) years old, she was college educated but had no legal experience, and she did not have an attorney present when she entered into the arbitration agreement. *Id.* at ¶¶

21-23. The Eleventh District Court of Appeals also considered Patricia Manley's cognitive impairments when finding the arbitration clause procedurally unconscionable. The Court noted that Patricia Manley was competent, however, she suffered from a "very mild cognitive impairment." *Id.* at ¶ 24. It was also noted that she had two different medical conditions, either of which could cause her confusion. *Id.* Patricia Manley also had numerous physical ailments. *Id.* at ¶ 25. After considering these factors, the Eleventh District Court of Appeals stated:

> The fact that a resident is signing an arbitration agreement contemporaneously with being admitted into a nursing home is troubling. By definition, an individual being admitted into a nursing home has a physical or mental detriment that requires them to need the assistance of a nursing home. Further, the reality is that, for many individuals, their admission to a nursing home is the final step in the road of life. As such, this is an extremely stressful time for elderly persons of diminished health. In most circumstances, it will be difficult to conclude that such an individual has equal bargaining power with a corporation that, through corporate counsel, drafted the form contract at issue.

Id. at ¶ 29. Accordingly, the Eleventh District Court of Appeals held that the arbitration clause entered into between the resident and the nursing home was procedurally unconscionable.

In *Small v. HCF of Perrysburg*, 159 Ohio App.3d 66, 71-73, 2004-Ohio-5757, 823 N.E.2d 19 (6th Dist. 2004), the Sixth District Court of Appeals held that an arbitration clause that provided for the arbitration of a nursing home resident's negligence claims was both procedurally and substantively unconscionable. The Court determined that the arbitration clause was procedurally unconscionable because "[w]hen Mrs. Small signed the agreement she was under a great amount of stress. The agreement was not explained to her; she did not have an attorney present. Mrs. Small did not have any particularized legal expertise and was 69 years old on the date the agreement was signed." *Small*, 159 Ohio App.3d at 73.

The Eleventh District Court of Appeals affirmed the trial court's finding of unconscionability

when the nursing home resident had similar diagnoses to Edeltrud Loyer's.

> The trial court possessed sufficient factual evidence to make a finding of procedural unconscionability. The affidavit of appellee, decedent's sister, described decedent's diminished mental abilities. Even though he possessed the ability to sign his own name, he was unable to read or write. He was diagnosed with MRDD and paranoid schizophrenia. He participated in special education classes throughout the entirety of his education. Decedent never held a job that required him to read or write. His family or assisted-living employees handled his personal matters including finances, scheduling appointments, and transportation to and from those appointments. Decedent was unable to conduct commercial transactions on his own because he could not properly count money, read, or write. Additionally, the deposition of Darlene Stincic, the admissions coordinator, demonstrates that although she read the agreement to decedent, she had difficulty explaining what arbitration is, how it works, and what rights he was relinquishing by signing the arbitration agreement. Under the circumstances, we conclude the trial court did not err in finding the agreement was procedurally unconscionable.

Pearson v. ManorCare Health Servs., 2015-Ohio-5460, ¶ 40 (11th Dist. 2015).

Edeltrud Loyer suffered from lewy body dementia. She was 63 years old and had just been discharged from the hospital. It was an extremely stressful time for her and her husband, Calvin Loyer. Exhibit "B".

It is clear that Becky King does not understand the difference between litigation and arbitration, so she could not possibly have explained it to Calvin Loyer and she did not speak with Edeltrud Loyer at all. Therefore, there is clearly procedural unconscionability in this case.

The facility provides their residents or their resident's family members with documentation that clearly indicates that arbitration is cheaper than litigation. *See* Resident's Handbook, Exhibit "E". However, Becky King was unable to explain that in any way. *Id.* at 46:25. One of the reasons she thinks arbitration is cheaper than litigation is because she thinks you have to pay for the judge's time in litigation. Deposition of Becky King, 48:23. One of the things that was never discussed with Calvin Loyer is the fact that under the alternative dispute resolution process first there has to be a

mediation then there has to be an arbitration. *See* Exhibit "B". The mediation involves a mediator who has to be paid and the arbitration involves a panel of up to three arbitrators all whom have to be paid presumably to rule on any issues and then to preside over the arbitration. All of this could add up to tens of thousands of dollars. Obviously, these are not costs that are associated with litigation.

In no place was there any discussion about the fact that most cases like this case, including this case, are handled by the lawyers on a contingent fee basis. *See* Exhibit "B". If there is no recovery, it does not cost the family anything at all, not a single penny, not for attorney fees, and not for litigation expenses. Therefore, the notion that arbitration is less expensive than litigation is simply false. The fact that the Defendants told Calvin Loyer that is further proof of procedural unconscionability.

The arbitration clause states that the Rules of Civil Procedure and the Rules of Evidence will apply to the arbitration. Exhibit "A". Becky King has no idea what Rules of Civil Procedure would be applied in arbitration. *Id.* at 44:3-6. She has no idea what Rules of Evidence would be applied in an arbitration. She has no idea what Ohio laws would be applied in an arbitration. *Id.* at 44:9-11. She did not know whether an arbitrator could issue a subpoena to compel the testimony of a witness. Becky King clearly has no idea what the difference is between litigation and arbitration and therefore was completely unable to explain that to Calvin Loyer further leading to the conclusion that there's clearly procedural unconscionability in this case.

"Signature HealthCARE is a long-term health care and rehabilitation company with 145 locations in 11 states and nearly 24,000 employees." Signature HealthCARE website, http://ltcrevolution.com/about-shc, accessed February 28, 2016. Becky King testified that she

participated in 60 to 100 admissions per year at this one facility . Deposition of Becky King, 25:4. The Defendants owned 145 facilities and as a result, are involved in thousands of admissions. They are certainly sophisticated with respect to admissions. They are certainly sophisticated with respect to contracts.

The circumstances surrounding the signing of the arbitration clause could not have been more procedurally unconscionable.

It is clear that the Defendants had all of the relevant experience and business acumen.

In terms of relative bargaining power, Defendants are powerful and sophisticated:

It is clear that Defendant had all of the bargaining power.

Defendants drafted the arbitration clause.

In terms of whether alterations to the printed terms were possible, it is clear that Calvin Loyer did not alter one word of the arbitration clause. The arbitration clause in this case is a boilerplate contract of adhesion that was presented on a take it or leave it basis.

The arbitration clause is procedurally unconscionable.

2. Substantive Unconscionability.

"Substantive unconscionability involves those factors which relate to the contract terms themselves and whether they are commercially reasonable. Because the determination of commercial reasonableness varies with the content of the contract terms at issue in any given case, no generally accepted list of factors has been developed for this category of unconscionability. However, courts examining whether a particular limitations clause is substantively unconscionable have considered the following factors: the fairness of the terms, the charge for the service rendered, the standard in the industry, and the ability to accurately predict the extent of future liability." *Small*,

159 Ohio App.3d at 71.

The Eleventh District Court of Appeals "determined 'the burden is on the nursing home to produce something that reflects it was dealing with an individual who, at a minimum had the capacity to contract. Lacking such information in the record, **any substantive deficiency would be fatal.**'" *Pearson v. ManorCare Health Servs.*, 2015-Ohio-5460, P41 (11th Dist. 2015) (emphasis added), quoting *Wascovich v. Personacare*, 190 Ohio App.3d 619, 2010-Ohio-4563, 943 N.E.2d 1030 (11th Dist. 2010).

In *Arnold v. Burger King*, 2015-Ohio-4485, ¶ 85 (8th Dist. 2015), the Eighth District Court of Appeals analyzed an arbitration clause in the employment context. There, the clause claimed that "arbitration is 'quicker and less expensive for both sides."". However, in *Arnold* the Eighth District Court of Appeals recognized that arbitration does not necessarily save money for a plaintiff:

> That is not always the case, particularly for the employee. For example, employment attorneys typically represent plaintiffs on a contingency basis so there is often no cost to the employee until success or settlement. Court filing fees are usually lower than the fees to initiate arbitration. Arbitration is generally beneficial for employers because it is, as opposed to litigation, less expensive due to brevity and lack of appeal rights. It is also advantageous to the employer where, as in this case, the agreement limits the worker's recovery of damages otherwise available via litigation, "[i]n the event you prevail, [the arbitrator] will limit your relief to compensation for demonstrated and actual injury to the extent consistent with the Procedural Standards [that are not attached to the MAA]."

In *Arnold* the Court scoffed at the hoops that the arbitration clause required a party to jump through in order to invoke arbitration:

> To file a request for arbitration, an employee must send the request to the listed JAMS New York City office with a copy to the Legal Department in Syracuse, New York address with an explanation of the issue. The request must be sent via "U.S. mail or a reputable overnight delivery service." There is no mention of registered or certified mail to verify timeliness.

Id. at ¶¶ 85-86.

In *Small*, the Sixth District Court of Appeals held that an arbitration clause was substantively unconscionable where the resident or representative was given no means by which to reject the arbitration clause in an admissions agreement, despite the presence of a sentence in the agreement stating that admission is not conditioned on agreement to the arbitration clause. The Court stated that "we believe that the resident or representative is, by signing the agreement that is required for admission, for all practical purposes being required to agree to the arbitration clause." *Small*, 159 Ohio App.3d at 72.

Additionally, in *Fortune v. Castle Nursing Homes, Inc.*, 164 Ohio App.3d 689, 696, 2005-Ohio-6195, 843 N.E. 2d 1216 (5th Dist. 2005), the Fifth District Court of Appeals held that an arbitration agreement entered into between a resident and a nursing home was substantively unconscionable. In this case, the Fifth District Court of Appeals noted that the arbitration agreement required the patient to waive his or her right to a jury trial. *Id.* at 692. The Court also noted that the arbitration clause was written in the same size font as the rest of the agreement. *Id.* The Fifth District Court of Appeals also provided an example of a non-oppressive, conscionable arbitration agreement in a medical setting. *Id.* at 696. The Court's example included that it be a stand-alone, one-page contract containing an explanation of its purpose that encouraged the patient to ask questions. *Id.*

In *Manley*, 2007-Ohio-343 at ¶ 53, Judge Mary Colleen O'Toole discussed the substantive unconscionability of nursing home arbitration clauses in her dissenting opinion. In her opinion, Judge Mary Colleen O'Toole stated that:

The location is non-neutral. The arbitration provisions are buried near the end of the

> extremely long admission contract, and are presented to the resident at the time of admission. Thus a resident is required to make his or her decision regarding this vital issue at a time when, typically, they are sick and in need of care.
>
> * * *
>
> This contract gives potential residents a choice between being out on the street with no medical care, or accepting the first available bed.
>
> * * *
>
> The arbitration provision is not in compliance with industry standards. Contract provisions of the type at issue are disfavored by the American Arbitration Association, the American Bar Association, and the American Medical Association. Binding arbitration should not be used between patients and commercial healthcare providers unless the parties agree to it *after* the dispute arises. This is the only way a consumer/patient entering a nursing or healthcare facility in an ailing and diminished capacity can stand on equal footing with a large corporate entity. This would promote meaningful dispute resolution and allow both sides to enter into this agreement voluntarily and knowingly. The law favors arbitration: it abhors contracts of adhesion.
>
> The third factor of substantive unconscionability deals with the ability to properly determine future liability. It is clear that neither party to this contract could accurately predict the extent of future liability. The negligence had not occurred at the time of the signing of the contract. It was impossible to determine if Ms. Manley, at the time of admission, could be waiving her right to a wrongful death lawsuit. Certainly when she went into the nursing home she was anticipating her release.
> *Id.* at ¶¶ 59-62.

The arbitration clause in this case is a classic contract of adhesion. The Defendants are in complete control of the process from beginning to end. There is nothing in the arbitration clause that says that sometimes nursing home residents are neglected and abused. *See* Exhibit "A". There is nothing in the clause about the benefits of a jury trial. *Id.*

Like in *Arnold*, the Resident Handbook would lead a resident to believe that arbitration is cheaper for them, even though that is clearly not the case. Exhibit "D".

Like in *Small*, Calvin did not have an opportunity to reject the arbitration clause. Exhibit "B". For example, there is nowhere on the arbitration clause where a resident could check a box to

indicate that they are opting out of arbitration. Exhibit "A".

Like in *Arnold*, the clause in this case requires the parties to jump through hoops to initiate arbitration. In order to initiate arbitration it requires a party to send a request in writing including "a detailed account of the dispute, a proposed resolution, and what process is being requested (informal resolution, mediation, or arbitration)." Exhibit "A". This clause does not explain where to send the request. Mediation, arbitration and informal resolution are not defined or explained in any way. The clause also provides for a single arbitrator, which as discussed above is contrary to Ohio Revised Code § R.C. 2711.23. *Id.*

Like in *Manley* and *Fortune*, the clause was buried amid a confusing admission packet that was presented as a single document. Exhibit "C".

There is no question that the arbitration clause is substantively unconscionable, as well as procedurally unconscionable. Since both prongs for the test for unconscionability have been met, Plaintiff respectfully requests that this Honorable Court deny Defendant's Motion to Stay Proceedings Pending Arbitration.

As noted in Judge Colleen O'Toole's opinion in *Manley*, the AMA, the ABA, and the AAA have unanimously come out against pre-dispute arbitration clauses involving nursing home residents.

As the Court reviews the unconscionability of the arbitration clause at issue in this case, Plaintiff urges the Court to also consider that the American Medical Association, the leading national organization of doctors and other health care providers, the American Bar Association, the leading national organization of attorneys, and the American Arbitration Association, the leading national organization of arbitrators, have all come out against arbitration clauses like the one at issue in this case.

In 1997, the American Arbitration Association, the American Bar Association and the American Medical Association, the leading associations involved in alternative dispute resolution, law, and medicine, collaborated to form a Commission on Health Care Dispute Resolution ("the Commission"). The Commission's goal was to issue, by the Summer of 1998, a Final Report on the appropriate use of alternative dispute resolution (ADR) in resolving disputes in the private managed health care environment. Their Final Report discusses the activities of the Commission from its formation in September 1997 through the date of its report, and sets forth its unanimous recommendations. The Commission issued its Final Report on July 27, 1998, a copy of which is attached hereto as Exhibit "F". That report concluded on Page 15, in Principle 3 of a section entitled, "C. A Due Process Protocol for Resolution of Health Care Disputes." that: "**The agreement to use ADR should be knowing and voluntary. Consent to use an ADR process should not be a requirement for receiving emergency care or treatment. In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises**." (Emphasis added.)

The arbitration clause at issue in the within case clearly violates the guidelines set forth above. It should not be enforced. It cannot be over-emphasized that the American Arbitration Association, the American Bar Association and the American Medical Association, the leading associations involved in alternative dispute resolution, law, and medicine, have come together and issued a joint report which argues against the enforcement of arbitration clauses like the one at issue in this case.

The arbitration clause in this case was signed just after Edeltrud Loyer's admission and before she or her family had a claim and could evaluate how to pursue that claim. The arbitration

clause was not entered into knowingly, nor was it entered into voluntarily. According to the Commission's Final Report, the arbitration clause is unconscionable and should not be enforced.

F. Defendant has waived any alleged right to arbitration by acting inconsistently with the right to arbitrate.

Once a party litigates a case they waive their right to arbitrate it. In *Hogan v. Cincinnati Fin. Corp.*, 2004-Ohio-3331, at ¶¶ 22-25 (11th Dist. 2004), the Eleventh District Court of Appeals held:

> It is well-established that the right to arbitration can be waived. See, e.g., *Griffith v. Linton (1998), 130 Ohio App. 3d 746, 751, 721 N.E.2d 146*; *Siam Feather & Forest Products Co., Inc. v. Midwest Feather Co., Inc. (S.D. Ohio 1980), 503 F. Supp. 239,*

According to the Tenth District Court of Appeals in *Gordon v. OM Financial Life Ins. Co.*, 2009-Ohio-814, 08AP-480 , ¶14 (10th Dist. 2009) (emphasis added) there is a two-prong test:

> **A party asserting waiver of arbitration must demonstrate that the party waiving the right knew of the existing right of arbitration, and that it acted inconsistently with that right.** *Blackburn*, at ¶17, citing *Griffith v. Linton* (1998), 130 Ohio App.3d 746.

For the first prong, Defendants clearly knew of their alleged right to arbitration. They have been in possession of the arbitration clause since April 23, 2014. Further, they raised the right to arbitrate as an affirmative defense in their Answer to Plaintiff's Complaint.

For the second prong, Defendants have clearly acted inconsistently with the right to arbitrate. Defendants Answer to Plaintiffs complaint also contained a jury demand. Defendants in this case have taken advantage of the hospitality of the Court. Defendants have participated in two (2) separate settlement conferences that were facilitated by the Court. Defendants cannot both argue that this case should be decided by an arbitrator and also have the benefits of litigation, such as having a duly elected Judge working to facilitate the resolution of your case. Defendants have acted inconsistently with any right to arbitrate and have thereby waived any such right.

V. CONCLUSION.

Edeltrud Loyer never signed the arbitration clause, nor did anyone with authority to do so on her behalf.

None of the Defendants are parties to the arbitration clause nor did anyone sign the arbitration clause on behalf of any of the Defendants.

There is no justification for enforcing the arbitration clause against Edeltrud Loyer's next of kin nor for staying the claims of Edeltrud Loyer's next-of-kin.

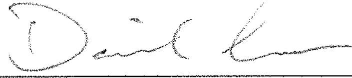
The arbitration clause in this case is also void and unenforceable according to the Ohio Revised Code.

The arbitration clause in this case is unenforceable because it is both procedurally and substantively unconscionable.

Defendants have waived any right to arbitration.

Accordingly, this Court should deny Defendants' Motion to Stay Proceedings Pending Arbitration.

Respectfully submitted,
THE DICKSON FIRM, L.L.C.

By: 

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Telephone (216) 595-6500
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E-mail Dinscore@TheDicksonFirm.com

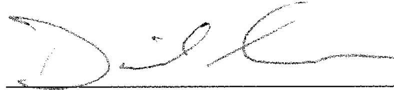
Attorneys for Plaintiff Calvin Loyer, as the Personal Representative of the Estate of Edeltrud Loyer (deceased).

CERTIFICATE OF SERVICE

I hereby certify that a true and accurate copy of the foregoing, Plaintiff's Brief in Opposition to Defendants' Motion to Stay Proceedings, was sent electronically this **29th day of February 2016**, to the following:

Mark D. Meeks, Esq.
ANSPACH MEEKS ELLENBERGER, LLP
300 Madison Avenue
Suite 1600
Toledo, Ohio 43604
Mmeeks@AnspachLaw.com

Attorney for Defendants Signature Healthcare of Galion, SHC LP Holdings, LLC, Signature Healthcare LLC, Signature Healthcare Clinical Consulting Services LLC, Signature Healthcare Consulting Services LLC, Ugwulo Rawlins, SHC of Galion, and LP Galion LLC d.b.a. Signature Healthcare of Galion.

By: 

Blake A. Dickson (0059329)
Daniel Z. Inscore (0092586)

Attorneys for Plaintiff Calvin Loyer, as the Personal Representative of the Estate of Edeltrud Loyer (deceased).

AGREEMENT TO INFORMALLY RESOLVE AND ARBITRATE ALL DISPUTES

Thank you for choosing our Facility!
We hope you will be pleased with your experience here.
Please read this document carefully.

Edeltrude Loyer
RESIDENT NAME

and

Signature HealthCARE of Galion, LLC (and all affiliates, parents, officers, owners, members, agents, successors and assigns)
FACILITY NAME

RESIDENT, FACILITY, AND ANY OTHER PERSON SIGNING THIS, UNDERSTAND AND AGREE THAT:

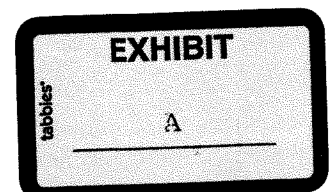
1. If a dispute, or legal claim of any kind (including a class claim or representative action), arises or occurs between anyone signing this agreement (a "dispute"):
   - We will first try and resolve the dispute between ourselves.
   - If we do not succeed, we will mediate the dispute.
   - If mediation is not successful, we will arbitrate the dispute with an arbitrator.

2. The arbitrator is a neutral person who will decide our dispute, and who we agree:
   - Can award any one of us the same damages as a court or jury could;
   - Will apply the Federal Arbitration Act and the **OHIO** law and Rules of Civil Procedure and Rules of Evidence;
   - Will decide all questions about this agreement, including whether the person(s) signing it has proper authority and whether it is enforceable;
   - His/her decision(s) will be FINAL.

   THIS MEANS THAT WE WILL NOT FILE A LAWSUIT AGAINST EACH OTHER, INCLUDING AS PART OF A CLASS CLAIM OR REPRESENTATIVE ACTION, AND THAT EACH PARTY IS GIVING UP, OR WAIVING, THE RIGHT TO FILE A LAWSUIT AND HAVE A JUDGE OR A JURY DECIDE THE DISPUTE AND/OR ANY ISSUES ABOUT THIS AGREEMENT. We can still talk about our dispute, however, to any federal or state agency.

3. The mediation and/or arbitration will take place in **OHIO**, in the county where the Facility is located. We can have an attorney represent us.

4. This agreement involves interstate commerce, and the Federal Arbitration Act will govern and control it.



5. **TO START THE INFORMAL DISPUTE , MEDIATION, OR ARBITRATION PROCESS**, one of us must:
   - Send the other a request in writing, and include a detailed account of the dispute, a proposed resolution, and what process is being requested (informal resolution, mediation, or arbitration).

   - If informal resolution is requested, the parties will schedule a mutually convenient time to discuss the dispute and possible resolution(s).

   - If mediation or arbitration is requested, the parties will discuss and agree upon the person who will mediate or arbitrate the dispute, and when mediation or arbitration will occur. We agree that the arbitrator will be an independent, disinterested, and qualified attorney with at least 7 years' experience in nursing home care. If we cannot agree on an arbitrator, then each of us will nominate our own arbitrator candidate, and together, the candidates will agree upon and select another independent, disinterested, and qualified attorney with at least 7 years' experience in nursing home care.

6. We understand that this agreement will bind any person or entity that is later appointed to act on my/our behalf. It will also remain valid and in effect if one of us later becomes disabled or incompetent. This means it will be upheld and enforced against our heirs, beneficiaries, estates, estate representatives, successors, statutory wrongful death beneficiaries, and assigns.

7. This agreement will also remain valid, and of full force and effect, even if the Resident is discharged and then later re-admitted to the Facility. It will also apply to all of the Resident's prior and subsequent admissions there.

8. As well, if any part or term of this agreement is determined to be legally invalid, we understand and agree that the rest of its terms will still remain in full force and effect.

9. We represent to each other that we have the proper authority to sign this agreement, and rely upon this. This means that each of us has told the other that we have the proper authority to sign this agreement, and that each of us is relying upon the other's statement about this.

10. Each of us understands that we do not have to sign this agreement, and that if we do, it is voluntarily. And any of us can cancel it, by writing the other party, within 30 days after signing. If the Resident cancels, the writing must be sent to the Facility Administrator.

[COMPLETE NUMBER 11 ONLY IF YOU ARE NOT THE RESIDENT]

11. ***If I am not the Resident and am signing on the Resident's behalf***, I have shown the Facility evidence of my authority to sign for the Resident, and represent:

    a. I have legal authority to sign this agreement:

    (Check all that apply)

    - The Resident, while able, gave me oral authority to make decisions for him/her ✓
    - I have handled the Resident's legal and business affairs for _______ (years / months) ____
    - The Resident signed a written document allowing me to make decisions for him/her (e.g., POA, health care surrogate, living will), **COPY PROVIDED** ____
    - I am recognized as the health care decision maker or surrogate ✓
    - A court has given me written authority to act and make decisions for the Resident (e.g., conservator or guardian) ____

    b. By allowing the Facility's care and treatment for the Resident, I ratify this agreement; *and* ✓

    c. I understand that the Resident and/or the Resident's agents, heirs, beneficiaries, estate, and assigns are intended beneficiaries of, and will be bound by, this agreement. ✓

I HAVE READ THIS AGREEMENT TO INFORMALLY RESOLVE AND ARBITRATE ALL DISPUTES, UNDERSTAND IT, HAVE HAD THE CHANCE TO ASK QUESTIONS, ACKNOWLEDGE MY RIGHT TO SPEAK WITH AN ATTORNEY ABOUT THIS, AND SIGN IT VOLUNTARILY.

Date: 4-23-14

Edeltrude Loyer
Resident Name

RESIDENT SIGNATURE

Calvin Loyer Spouse
Resident's Authorized Representative/ Name and Relationship

Calvin Loyer
RESIDENT REPRESENTATIVE SIGNATURE

Becky King LPN
Facility Representative

Becky King Lpn
Facility Representative Signature

Additional Signatory/Relationship to Resident

Additional Signatory/Relationship to Resident

STATE OF OHIO)
) SS:
COUNTY OF CRAWFORD)

Now comes Calvin Loyer, and for his Affidavit, states as follows:

1. I am Edeltrud Loyer's husband.

2. I am at least 18 years old and competent to execute this affidavit.

3. My wife was admitted to the Signature Healthcare of Galion nursing home on April 15, 2014. Her admission was very stressful. She had just been discharged from the hospital. Two (2) days prior she was at home with me. My wife suffered from Lewy body dementia.

4. On April 23, 2014, I signed my wife's admission paperwork. My wife Edeltrud Loyer, was not present when I signed her admission paperwork.

5. The whole process of signing the admission paperwork took between ten (10) and fifteen (15) minutes, including the time I spent meeting with Becky King and the time I spent signing all of the documents.

6. I never read the admission paperwork. I just signed my name. My only concern was getting my wife admitted into the facility to get the care she needed. I was never told that I could hire an attorney. I was never told that signing any part of the admission packet was optional. I thought that I had to sign all of the admission paperwork to get my wife admitted to the nursing home.

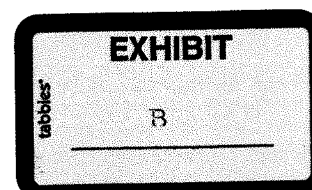
7. I do not know what arbitration is. I do not know the difference between arbitration and litigation. The nursing home did not explain arbitration to me. They did not explain litigation to me. They did not explain the affect of signing or not signing any particular admission document. No one ever explained that if they neglected my wife and allowed her to suffer injury that I would be precluded from bringing a lawsuit.

8. I never had any authority to sign any document on Edeltrud Loyer's behalf. I have never had power of attorney for my wife nor have I ever been my wife's guardian.

9. I was simply told that I had to sign the documents because my wife was unable to, and I did so for the sole purpose of getting her admitted to the nursing home.

10. I never had any intention of waiving any of Edeltrud Loyer's rights, including her right to pursue litigation if she was ever the victim of substandard care, neglect, or abuse.

11. Edeltrud Loyer never gave me oral authority to make decisions for her.



12. I have never been recognized as the health care decision maker nor surrogate for my wife.

13. I never saw my wife read any of the admission documents.

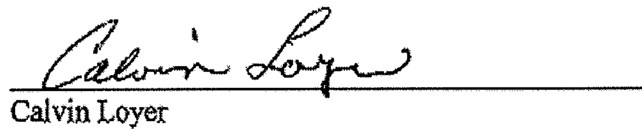
14. I never saw anyone explain any of the admission documents to my wife.

15. My wife did not authorize me to sign any document on her behalf at any time.

16. I never told anyone at the nursing home that I had any authority to sign anything on behalf of my wife, Edeltrud Loyer.

17. I never saw or heard my wife tell anyone at the nursing home that I had any authority to sign anything on her behalf.

Affiant further sayeth naught.



Calvin Loyer

Sworn to and subscribed before me in my presence this 28 day of February, 2016, in Galion, Ohio.

NOTARY PUBLIC

SARAH CRAWFORD
NOTARY PUBLIC, STATE OF OHIO
My Commission Expires 10/2/2018

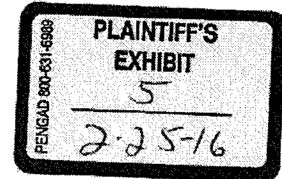
Consent & Authorizations

INSTRUCTIONS: Each section of this form must be reviewed with, initialed, and signed at the bottom by the resident -- or the appropriate resident's.representative, but only if the resident is considered to be mentally incompetent or otherwise unable to sign. If signed by the resident's representative, complete the following information and attach copies of all relevant documents evidencing the legal authority to act on the resident's behalf (e.g., a power of attorney, guardianship order, designation of health care surrogate, etc.):

Resident: Edeltrude Loyer

Resident Representative: Calvin Loyer

Relationship: Spouse



Consent to Treatment
The Resident and/or Responsible Party consent to the facility's administration of care, treatment services, and medical or nursing procedures to the Resident, as the Facility and the Resident's attending physician or nurse practitioner deem appropriate. The Resident has the right to change this consent or to refuse treatment.

Initials CL

Assignment of Benefits
The Resident or Responsible Party hereby request(s) that payments of any Authorized benefits (including Medicare, Medicaid and/or private medical Insurance benefits, including Medigap) be made on the Resident's behalf to Facility for any services provided to the Resident by the Facility, for physician services for which the Facility is authorized to bill, and for any other physician or nurse practitioner services furnished in the Facility, as applicable.

Initials CL

Mail
I request that the business office at the Facility assist in the opening and/or reading of my personal and/or financially related mail (such as checks, medical bills or statements, Medicare and Medicaid correspondence). I understand that I may revoke this request at any time.

Initials CL

Yes	No	
☐	☒	Opening of personal mail requested.
☐	☒	Opening of financial mail requested.
☐	☒	I authorize the facility to handle financial mail on my behalf.

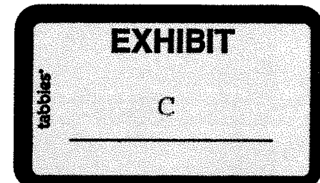
As indicated by my initials on the foregoing items, I have read and understand each consent or authorization agreement.

[signature] — Resident/Resident's Representative

Calvin Loyer — Print Name

4-23-14 — Date

OH Rev. 12/13



SHC 00023

Advance Directives / Informed Consent

Facility: Signature HealthCARE of Galion

Resident Name: Edeltrude Loyer

Attending Physician: Dr. Mark Wood

This is to acknowledge that I have been informed, in writing and in a language that I understand, of my rights and all rules and regulations regarding decisions concerning medical care, including:

- The right to accept or refuse medical or surgical treatment
- The right to formulate and to issue Advance Directives to be followed should I become incapacitated

☐ I have chosen to formulate and issue the following Advance Directives. I understand it is my responsibility to provide to the facility copies of all pertinent documentation which verify those Advance Directives specified below for placement in my medical record.

	Date Issued		Date Issued
☐ Living Will		☐ Medication Restrictions	
☐ Durable POA		Types:	
☐ Do not Resuscitate		☐ Other Treatment Restrictions	
☐ Do Not Hospitalize		Types:	
☒ Organ Donation		☒ Other Advance Directives	
☐ Autopsy Request		Type: Full Code	
☐ Designation of Health Care Surrogate		☐ Feeding Restrictions	
		Type:	

☐ I do not choose to formulate or issue any Advance Directives at this time. I want efforts made to prolong my life and warrant life sustaining treatment to be provided.

Acknowledgement Signatures

Resident / Patient: ______________________ **Date:** __________

Attorney-in-Fact, Guardian, Surrogate, Legal Representative:

Calvin Loyer **Date:** 4-23-14

If Legal Representative signed, complete the following:

Calvin Loyer	Spouse	
Print Name	Relationship to Resident/Patient	Type of Legal Appointment

If Resident / Patient is unable to sign name, state medical reason:

Physician Signature : ______________________ **Date:** __________

Witness : ______________________ **Date:** __________

Witness : ______________________ **Date:** __________

(Second Witness Signature Required If Acknowledged by Resident / Patient "Mark")

Advance Directives Informed Consent, 1.1, January 2003

OH Rev. 12/13

Handbook Acknowledgement

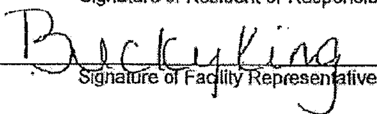
I acknowledge the receipt of the *Resident Handbook & Admission Information* and agree that the following items were reviewed by me:

- Facility Services
  - Care & Treatment
  - Therapeutic, Business Office, Nutrition, Physician, Pharmacy, Laundry, & Barber/Beautician Services
  - Volunteers
- Facility Rules & Regulations
  - Abuse
  - Alcoholic Beverages
  - Bed Hold Policy
  - Cameras, Videotaping & Recording
  - Illegal Drugs
  - Electrical Appliances
  - Environment
  - Family Council
  - Federal & State Survey Inspections
  - Fire Drills
  - Resident Funds
  - Gratuities
  - Grievances
  - Home Visits
  - Internet / Computers
  - Mail
  - Married Couples
  - Medications
  - Personal Items
  - Pets
  - Phone
  - Posted Information
  - Private Room Charge
  - Resident Council
  - Restraints
  - Room Change
  - Solicitation
  - Smoking
  - Transfer/Discharge
  - Transportation
  - Visitors
  - Weapons
  - Work Opportunities
- Advance Directives
- Medicare & Medicaid Information
- Notice of Privacy Practices
- Privacy Act Statement – Health Care Records
- Federal Resident Rights
- Ancillary Charges (Items and Services Not Covered by Medicare and Medicaid)

Resident Name: Edeltrude Loyer

Resident Representative: Calvin Loyer Relationship: Spouse

Signature of Resident or Responsible Party 4-23-14 Date



Signature of Facility Representative 4-23-14 Date

OH Rev. 12/13

New Admission Payment Information (Review all that apply.)

Name of Resident: Edeltrude Loyer

Private Pay Resident

1. 30 day advance payment is due prior to admission $ 175.00 per day.
2. Statements are mailed by the 3rd business day of each month.
3. The bill includes room and board, ancillaries, and 20% of Part B therapies.
4. An additional daily fee is charged for a private room.
5. A SNF Determination Letter is issued upon admission.

Medicaid Resident

1. Advance payment of estimated patient liability of $______ is due at the time of admission unless other arrangements have been made with ~~the Business Office~~ Manager.
2. Patient liability is due for days 21 – 30 for Medicare residents.
3. A Medicaid application must be completed in 2 weeks.
4. Patient liability is due no later than the 10th of each month.
5. Resident staying less than 30 days will be billed the private rate. Amount due will be for the number of days in the facility at $ 175.00 per day.
6. A SNF Determination Letter is issued upon admission.

Medicare Resident

1. Medicare Part A requires a 3-day hospital stay and the diagnosis must meet Medicare criteria.
2. The 3-day hospital stay must be within the last 30 days.
3. Medicare pays 100% of the first 20 days.
4. Medicare pays all but $ 152.00 per day for days 21 – 100.
5. The maximum allowable days on Medicare is 100 days.
6. If the resident fails to meet the medical criteria prior to the 100th day, the facility will issue a SNF Determination Letter 3 days prior to being changed from Medicare to either Private Pay or Medicaid.
7. Medicaid applicants will pay $ 152.00 per day if the financial application to Medicaid is not approved.
8. Medicare Secondary Payer (MSP) Screening is completed.

Insurance (and Co-insurance) Resident

1. Verification of insurance and co-insurance presented on or before admission.
2. Prior authorization obtained if required by insurance company.
3. Resident is liable for expenses if the insurance denies the claim.
4. Assignment of benefits form must be signed upon admission.
5. Expenses include: room & board at $ 175.00 per day, ancillary charges, pharmacy charges, and 20% co-pay for Medicare Part B charges.
6. Insurance ____________________ states that when you are admitted for an inpatient stay in a Skilled Nursing Facility, you are required to pay to the Facility a co-payment of $__________ per day, beginning on __________ and continuing through __________.
7. Co-payments required by Medicare A, Medicare B, or insurance will be paid by ____________________ insurance or privately paid.
8. A SNF Determination Letter is issued upon admission if insurance is primary.

[signature] 4-23-14

Signature of Resident or Responsible Party — Date

Becky King 4-23-14

Signature of Facility Representative — Date

OH Rev. 12/13

Admission & Financial Agreement

Signature HealthCARE of Galion

(the "Facility" or "we" or "us")

and Edeltrude Loyer

(the "Resident" or "you")

Hereby agree to the following:

Facility agrees to do the following:

Health Care Services

A. We will provide you with general nursing care and nursing treatments such as administration of medication, preventive skin care, and assistance with bathing, toileting, feeding, dressing and mobility. (Throughout this Agreement is information about which services are covered in the Facility's daily rate and which are available for an additional charge.)

B. Any representations made by Facility staff members in anticipation of the Resident's admission as a resident of this Facility were based on historical data but are not a promise that care will be provided in any particular way, or that specific results will be obtained as a result of the care administered. The undersigned agrees and accepts that the Facility will use its best efforts to care for the Resident, but that it cannot guarantee any particular result.

C. When your doctor orders health care services which we do not have the capability to provide, with your approval, we will arrange for the services to be provided by an outside provider, or we will arrange for your transfer to the hospital or other health care providers.

D. We admit and treat all patients/residents without regard to race, religion, color, national origin, sexual preference, handicap, or age.

Personal Services

E. We will provide the Resident with room and board, housekeeping services, recreational and social programs, and personal care.

F. We will provide you with a reasonable amount of storage space for your personal belongings.

G. At your request, we will maintain your personal funds in compliance with the laws and regulations relating to our management of your funds. (See *Facility Services / Business Office Services* section of this handbook on page 1.)

Resident/responsible party agrees to do the following:

Paying for the Resident's Care

A. In order to bill properly, a copy of the Resident's Medicare card, Social Security card and any insurance cards are needed at the time of admission. If a copy is not provided by the Resident or the Responsible Party, the Resident will be charged as a private pay Resident.

B. Who Can be Required to Pay for Your Care: Only you and your insurers can be required to pay for your care. No other person – e.g. a family member, friend, neighbor, legal agent or guardian – can be required to pay for your care from their own funds, although he or she may knowingly and voluntarily agree to pay for the cost of your care. However, a person with access and/or control over your funds may be required to pay all amounts due from you from your funds and, if any such person has improperly used your funds, they may be liable.

We require you to pay for your care under the terms of this contract in a timely manner. If you or anyone else with authority to pay for your care on your behalf fails to pay a Facility bill, we may request a court to order such payment.

You agree to provide all information requested by us about your health and financial status and to update this information while you are a resident here. You understand that if we later find that you knowingly or willfully provided us with incomplete or inaccurate information, we will consider that as a breach of this Agreement, which gives us the right to pursue all legal remedies against you.

It is anticipated that the Resident's care will be paid for as stated on the New Admission Payment Information form. It is understood that Medicare and Medicaid will make the determination concerning your medical and financial eligibility for payment by those programs.

You agree to pay either directly or through a third party payer for all items and services provided to the Resident by the Facility. You request that the Facility send the bills to:______________________
____.

C. Private Pay Residents: The items and services included in our semi private daily rate of $175.00 include basic room, board and general nursing care as required by your medical condition (including the day of discharge). Payment for items and services that are included in the daily rate is payable one month in advance and due on the first of each month, and you agree to make timely payments. When a personal check is received we will electronically scan the check and place a "same day hold" on the check amount.

You will be charged separately for additional items and services which you or your physician, with your approval, request and which are not included in our daily rates such as ancillary medical supplies (incontinence supplies, wound dressings, etc.), special nursing care, special equipment, pharmacy charges, laboratory charges and additional services such as telephone expenses, clothing, beauty and barber services, and newspapers. An explanation of items and services for which you may be charged is available from the Business Office Manager. If you (or your physician with your approval) request items or services other than those listed, you will be notified of the cost. Payment for these additional items and services are due within 30 days after you (or your physician with your approval) have requested them, and you have received and have been billed for them. Within 90 days of receiving an item or service, or within 30 days of payment, you have the right to ask us for an itemized statement that briefly but clearly describes each item and service, the amount charged for it, and the identity of the payer billed for the service.

You understand and agree that you are responsible for paying the Facility for items and services provided to you during any period of time in which you are or were a resident of the Facility and during which you have not been determined eligible for Medicaid coverage. If you do not pay the amount you owe us after receiving Facility bills, and we hire a collection agency or attorney, you agree to pay their fees, expenses, and costs.

If you do not pay what is owed the Facility, you agree to apply to Medicaid for a determination of your income and assets available to pay the cost of your care. Once Medicaid determines the income and assets available to pay for your care, you agree to use such income and assets to pay the Facility's bills.[1]

You agree to notify the Facility promptly if you have insufficient income, funds, or assets to meet your financial obligations to the Facility and you agree to apply for Medicaid benefits. You agree to cooperate fully in the Medicaid eligibility determination process. If you do not apply or cooperate fully in the process, the Facility may ask the court to order you to do so.

If you are no longer able to pay for your care at the Facility and you are ineligible for Medicaid, you will be notified of the Facility's intention to discharge you for non-payment. You agree to continue to pay the Facility's prevailing day charges until the date of your departure.

If there is any dispute about whether you should be discharged, the notice, and other requirements in Section 483.12(a) of the Federal Resident Rights (see page 25 of this handbook) applies. If transfer or discharge becomes necessary because you or someone else misappropriated or abused your funds, the Facility will request that the appropriate state agency investigate, which may result in prosecution.

---

[1] If you do not request a determination by Medicaid, or if payment is not made with the income and assets determined to be available for your care, the Facility may ask the court to order you to obtain the determination or to make payment.

D. Medicare Residents: We participate in the Medicare Program. Medicare may pay for some or all of your nursing home care. For information on Medicare, see page 11 of this handbook. If you are eligible for Medicare, you have the right to have claims for your nursing home care submitted to Medicare. If Medicare agrees to pay for your care, you understand that Medicare has a co-payment (for most covered services) and you agree to make the required co-payment, currently $ 152.00 per day, which Medicare changes yearly. You also understand that Medicare does not cover some items and services offered by the Facility and if you want any of these items or services, you agree to pay for them. (A list of the items and services not covered by Medicare are on page 12 of this handbook. If you also participate in Medicare Part B for physical, occupational, or speech therapy or other billable charges (which are not covered by Medicare Part A), you agree to pay any required deductible, and any applicable co-payments.

E. Insurance Residents: If you have managed care or other insurance, our Business Office can assist in answering your questions about coverage and billing.

F. Medicaid Residents: We participate in the Medicaid Program. For information on Medicaid, see page 11 of this handbook. You are not required to give up any of your rights to Medicaid benefits to be admitted or to stay here. If your funds are used up during your stay here and you are eligible for Medicaid, we will accept Medicaid payments.

You acknowledge that you are responsible for applying for and obtaining Medicaid benefits and we will assist you by promptly providing all required information in our possession. We may not charge, ask for, accept or receive any gift, money, donation or consideration other than Medicaid reimbursement as a condition of your admission or continued stay here.

If you receive Medicaid, most of your nursing home charges such as room, board and general nursing care are covered, although Medicaid may require you to pay some amount from your monthly income. The local Ohio Dept. of Jobs and Family Services (ODJFS) will tell you whether you have to pay part of the charges for your care and, if so, how much. You understand and agree to pay on a timely basis this contribution amount as determined and periodically adjusted by the local Dept. of Jobs and Family Services (ODJFS). If you (or anyone else with authority to pay) fail to pay this amount, we may request a court to order such payment.

A list of items and services covered by Medicaid may be obtained from the Business Office Manager.

Medicaid does not cover some of the items and services that we offer. If you want any items or services that are not covered by Medicaid, you will have to pay for them. A list of the items and services not covered by Medicaid is on page 12 of this handbook. Payment for items and services that are not covered by Medicaid is due after you (or your physician with your approval) have requested them and you have received them and have been billed for them. Within 90 days of receiving an item or service, or within 30 days of payment, you have the right to ask us for an itemized statement that briefly but clearly describes each item and the amount charged for it, and the identity of the payer billed for the service.

You understand that non-payment of items and services not covered by Medicaid may result in a discharge action for non-payment of bills. If all of your personal needs have been met, you understand that money in your personal funds account may be needed to pay for items and services not covered by Medicaid, which were requested by you (or your physician, with your approval) and are provided by the Facility.

G. Increases in Charges and Fees: Any time we increase a fee or charge for an item or service or add a new item or service, we will provide you with 30 days advance written notice.

H. Interest Penalties: We may not charge you a penalty if you pay the Resident's itemized statement on time. Payment is on time if it is made within 10 days after the end of the billing period. The interest penalty we charge is 1.5% of the amount due, calculated on a monthly basis. For any bill delinquent over one month, penalties will be calculated at 18% per year.[2]

I. Private Duty Nurses/Geriatric Aides: If you want a private duty nurse or a private duty geriatric aide, you are responsible for selecting a person that is licensed and/or certified according to state

[2] The Facility may not charge interest on a Medicaid contribution to cost of care for covered services.

laws and regulations. You are also responsible for paying him or her, and for letting us know that you hired one. The person you hire is not an employee or agent of the Facility, but he or she must meet our standards and follow our policies and procedures. Employees of the Facility may not serve as private duty nurses or private duty geriatric aides.

J. Limitations of Liability: The Facility is obligated to take reasonable precautions to provide you and your personal belongings with security, including providing a reasonable amount of secured space for the Resident's belongings. The Facility, however, cannot be responsible for any loss or damage to your valuables or money that is not delivered into the custody of the Facility Administrator or his/her designee, unless that loss or damage is caused by the negligent or willful action of the Facility staff.

You, and not the Facility, shall be responsible for the provision of personal comfort items, including footwear, clothing and petty cash to be utilized for your incidental expenses. All clothing and personal items should be marked to indicate your ownership. The Facility strongly discourages the keeping with the Facility of valuable jewelry, papers, electronic equipment, large sums of money or other items considered of value. The Facility shall not be responsible for loss, theft or destruction of your personal property.

If, in spite of the Facility's best efforts, there is loss or damage to property, or injury or death of persons, which is mutually agreed to be or determined by an appropriate third party to be caused solely by you, you agree to be responsible for the damage, injury, or death. This responsibility includes payment for damages and all costs including reasonable attorney's fees required to defend a claim resulting from such damage.

In addition, although you have the right to make your own health care decisions, including the right to refuse treatment, you accept responsibility for any consequences resulting from your refusal to accept nursing or medical treatment or services considered by your physicians to be necessary for your care.

K. Patient Refunds: It is the policy of the company to issue refunds for any services overpaid in a timely manner. If a resident, responsible party, or insurance company, including Medicare or Medicaid, has paid in excess of the amount due, a Refund Request will be submitted to the Accounts Payable Department. Requests for refunds are submitted within 30 days of discharge unless there is another payer type that may require payment from the resident.

Consent to Treatment

The Resident and Responsible Party consent to the administration of such care, treatment services, and medical or nursing procedures to the Resident, as the Facility and Resident's attending physician or nurse practitioner deem appropriate. The Resident has the right to change this consent or to refuse treatment.

Photographs

The Resident agrees to allow the Facility to photograph the Resident as a means of identification or in case of emergency. Photographs may be taken and displayed as part of ongoing activity programs, special events, and community outreach materials. The Resident has the right to request that photos not be displayed.

Resident Rights

As a Resident of this Facility, you have many rights under Federal and State Law. A written description of all of your rights is located in the Reference Materials section of this handbook.

Right to End this Contract

If you decide to end this contract and leave the Facility, the bill becomes due and payable on the day you leave.

In the event you expire while a resident of the Facility, please designate whom we should contact:

Relative or Friend: Jason Loyer - Son Funeral Home: PIA

Unless you have instructed us otherwise, we will immediately contact the individual(s) listed above to make funeral arrangements. If we are unable to reach the individual(s), we will contact the funeral home directly.

Additional Documents

This Agreement, together with the information and documents in the *Resident Handbook & Admission Information*, executed by both parties, represents the entire understanding between the parties, and supersedes all previous representations, understandings or agreements, oral or written, between the parties.

You and/or your Responsible Party acknowledge being informed, orally and in writing, of:

- Resident's Rights under Federal law as included in this packet. You and/or your Responsible Party acknowledge they have had the opportunity to ask questions and those questions have been answered satisfactorily.
- The Facility's private pay rate and the opportunity to ask questions about additional charges.
- The Facility's policy on advance directives and medical treatment decisions.
- The Facility's bed hold policy.
- This agreement, which you understand and agree to; that the terms have been explained to you by a representative of the Facility; and that you have had an opportunity to ask questions about this Agreement.

Changes in Law

Any provision of this Agreement that is found to be invalid or unenforceable as a result of change in State or Federal law will not invalidate the remaining provisions of this Agreement and, it is agreed that to the extent possible, the Resident and the Facility will continue to fulfill their respective obligations under this Agreement consistent with the law.

In the event it is necessary to take legal action to enforce the terms of this Agreement, you agree to pay all reasonable legal fees and costs, including counsel that are employees of the Facility or its affiliates, to the extent permitted by law.

THE UNDERSIGNED HEREBY CERTIFY AND ACKNOWLEDGE THAT THEY HAVE EACH READ AND UNDERSTOOD THE FOREGOING AGREEMENT, AND THAT THEY HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND THAT ANY SUCH QUESTIONS HAVE BEEN ANSWERED TO THEIR SATISFACTION.

Signature of Resident: ____________________ Date: __________

Signature of Responsible Party: Calvin Loyer Date: 4-23-14

Print Name of Responsible Party: Calvin Loyer Relationship: Spouse

Facility Representative: Becky King Date: 4-23-14

Notice of Privacy Practices & Record of Acknowledgements

Name of Facility: Signature HealthCARE of Galion

Name of Resident: Edeltrude Loyer Date: ____________

The Facility is committed to preserving the privacy and confidentiality of your health information, whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are required by state and federal regulations to abide by the privacy practices described in the notice provided to you including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Effective Date of this Privacy Notice

The effective date of this *Privacy Notice* is: 4/23/03

Changes or Revisions to our Privacy Notice

We reserve the right to change our *Privacy Notice* at any time and to make the revised or changed notice effective for health information we already have about you, as well as any information we receive in the future about you. Should we revise or change our *Privacy Notice*, we will post a copy of the new or revised notice in our main lobby. You may obtain a copy of the new revised *Privacy Notice* from the business office or download a copy from our website (as applicable).

[X] Our *Privacy Notice* was revised on 9/23/13 [ ] No changes since the effective date listed above.

Privacy Notices, Information Restrictions, Record Amendments/Corrections, Disclosures of Information, Revoking an Authorization, Inspection and Copying of Records, Confidential Communications, Filing Complaints, Etc.

Should you have any questions concerning our facility's privacy practices, obtaining copies of our privacy notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your health information, obtaining a listing of the information we disclosed concerning your health information, requests to inspect or copy your medical information, requests to communicate information about your health matters in a certain way, denial of access to your health information, filing complaints, or any other concerns you may have relative to our facility's privacy practices, please contact:

Jean Stiles, HIPAA Privacy Officer
Name of Person to Contact
1200 Bluegrass Pkwy, Louisville, KY 40299
Address
(502) 568-7706
Telephone Number
(502) 568-7160
Fax Number
www.signaturehealthcarellc.com
Website Address (as applicable)

YOU MAY ALSO FILE COMPLAINTS WITH:

U.S. Department of Health and Human Services
2001 Independence Avenue S.W.
Washington, DC 20201
(202) 619-0257
Toll Free 1-877-696-6775

Acknowledgement

I certify that I received a copy of the Facility's *Privacy Notice*, that I have had an opportunity to review and ask questions about it to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the Facility is committed to protecting my health information.

Date: ____________ My Signature: ____________

My Printed Name: Edeltrude Loyer

Date: ____________ Signature of Witness: ____________

I certify that I am the authorized representative of Edeltrude Loyer (Resident Name), that I have received the *Privacy Notice* on behalf of this individual, and that the Facility provided me with an opportunity to review this document and ask questions to assist me in understanding his/her privacy rights. I am satisfied with the explanations provided to me and I am confident that the Facility is committed to protecting health information.

Date: 4-23-14 Signature of Representative: Calvin Loyer

Printed Name: Calvin Loyer

Date: ____________ Relationship to Individual: Spouse

Signature of Witness: ____________

**A copy of this document must be given to the person to whom the *Privacy Notice* was provided and also filed in the Resident's medical record.

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Medicare Secondary Payer Questionnaire

Resident Name ____Edeltrude Loyer____

The following questionnaire contains questions that can be used to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers may use this as a guide to help identify other payers that may be primary to Medicare. This questionnaire was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct you to the next appropriate question to determine Medicare Secondary Payer (MSP) situations.

PART I

1. Are you receiving Black Lung (BL) Benefits?
___ Yes; Date benefits began:__________ BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.
_X_ No.

2. Are the services to be paid by a government program such as a research grant?
___ Yes; GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR SERVICES.
_X_ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
___ Yes. DVA IS PRIMARY FOR THESE SERVICES.
_X_ No.

4. Was the illness/injury due to a work related accident/condition?
___ Yes; Date of injury/illness: ____________ Policy or identification number: ________________

Name and address of WC plan: ____________________ Name and address of your employer: ____________________

WC (Worker's Comp.) IS PRIMARY PAYER ONLY FOR CLAIMS RELATED FOR WORK RELATED INJURIES OR ILLNESS, GO TO PART III.
_X_ No. GO TO PART II.

PART II

1. Was illness/injury due to a non-work related accident?
___ Yes; Date of accident: ____________________ _X_ No. GO TO PART III

2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)
___ Yes. Name and address of no-fault insurer(s) and no-fault insurance policy owner: ________________
Insurance claim number: ____________________
___ No.

3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)
___ Yes. Name and address of liability insurer(s) and responsibility party: ____________________
Insurance claim number: ____________________
___ No.

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT. LIABILITY INSURANCE IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE LIABILITY SETTLEMENT, JUDGEMENT, OR AWARD. GO TO PART III.

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PART III

1. Are you entitled to Medicare based on:

___ Age. GO TO PART IV.

___ Disability. GO TO PART V.

___ End-Stage Renal Disease (ESRD). GO TO PART VI.

Please note that both "Age" and "ESRD" OR "Disability" and "ESRD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "PARTS" associated with the patient's selections.

PART IV- Age

1. Are you currently employed?

___ Yes. Name and address of your employer: ___________________________

___ No. If applicable, date of retirement: ______________

___ No. Never Employed

2. Do you have a spouse who is currently employed?

___ Yes. Name and address of your spouse's employer: ___________________________

___ No. If applicable, date of retirement: ______________

___ No. Never Employed

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

___ Yes, both. ___ Yes, self. ___ Yes, spouse

___ No. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

4. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?

___ Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFO:

Name and address of GHP: ___________________________

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): ______________ Group identification number: ______________

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient): ______________

Name of policyholder/named insured: ______________ Relationship to patient: ________

___ No.

5. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 20 or more employees?

___ Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFO:

Name and address of GHP: ___________________________

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): ______________ Group identification number: ______________

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient): ______________

Name of policyholder/named insured: ______________ Relationship to patient: ________

___ No

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 4 AND 5, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART V - Disability

1. Are you currently employed?
___ Yes. Name and address of your employer: ______________________________
___ No. If applicable, date of retirement: ______________ ___ No. Never Employed.

2. Do you have a spouse who is currently employed?
___ Yes. Name and address of spouse's employer: ______________________________
___ No. If applicable, date of retirement: ______________ ___ No. Never Employed.

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?
___ Yes, both. ___ Yes, self. ___ Yes, spouse. ___ No.

4. Are you covered under the GHP of a family member other than your spouse?
___ Yes. Name and address of your family member's employer: ______________________________
___ No

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1, 2, 3 AND 4, STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

5. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 100 or more employees?
___ Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.
Name and address of GHP: ______________________________
Policy identification number (this number is sometimes referred to as the health insurance benefit package number): ______________ Group identification number: ______________
Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): ______________
Name of policyholder/named insured: ______________ Relationship to patient: ______________
___ No.

6. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 100 or more employees?
___ Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.
Name and address of GHP: ______________________________
Policy identification number (this number is sometimes referred to as the health insurance benefit package number): ______________ Group identification number: ______________
Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): ______________
Name of policyholder/named insured: ______________ Relationship to patient: ______________
___ No.

7. If you have GHP coverage based on a family member's current employment, does your family member's employer, that sponsors or contributes to the GHP, employ 100 or more employees?
___ Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.
Name and address of GHP: ______________________________ Policy identification number (this number is sometimes referred to as the health insurance benefit package number): ______________ Group identification number: ______________
Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): ______________
Name of policyholder/named insured: ______________ Relationship to patient: ______________
___ No.

IF THE PATIENT ANSWERED "NO" TO QUESTIONS 5, 6, AND 7, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART VI - ESRD

1. Do you have group health plan (GHP) coverage?
___ Yes. IF APPLICABLE, YOUR GHP INFORMATION:
Name and address of GHP: ___
Policy identification number *(this number is sometimes referred to as the health insurance benefit package number)*: ___ Group identification number: ___

Membership number *(prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient)*: ___

Name of policyholder/named insured: ___ Relationship to patient: ___
Name and address of employer, if any, from which you receive GHP coverage:
___

IF APPLICABLE, YOUR SPOUSE'S GHP INFORMATION:
Name and address of GHP: ___
Policy identification number *(this number is sometimes referred to as the health insurance benefit package number)*: ___ Group identification number: ___

Membership number *(prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient)*: ___

Name of policyholder/named insured: ___ Relationship to patient: ___
Name and address of employer, if any, from which you receive GHP coverage:
___

IF APPLICABLE, YOUR FAMILY MEMBER'S GHP INFORMATION:
Name and address of GHP: ___
Policy identification number *(this number is sometimes referred to as the health insurance benefit package number)*: ___ Group identification number: ___

Membership number *(prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient)*: ___

Name of policyholder/named insured: ___ Relationship to patient: ___
Name and address of employer, if any, from which you receive GHP coverage:
___

___ No. STOP. MEDICARE IS PRIMARY.

2. Have you received a kidney transplant?
___ Yes. Date of transplant: ___
___ No.

3. Have you received maintenance dialysis treatments?
___ Yes. Date dialysis began: ___
If you participated in a self-dialysis training program, provide date training started: ___
___ No.

4. Are you within the 30-month coordination period that starts ___? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis). If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)
___ Yes
___ No. STOP. MEDICARE IS PRIMARY.

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
___ Yes.
___ No.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?
___ Yes. STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MO. COORDINATION PERIOD.
___ No. INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.

7. Does the working aged or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement)?
___ Yes. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.

___ No. MEDICARE CONTINUES TO PAY PRIMARY.

If no MSP data are found in the Common Working File (CWF) for the beneficiary, the provider still asks the types of questions above and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.

Signature of Responsible Party/Resident

4-23-14
Date

N/A
Resident Medicare #

(MSP Form revised 2/06 per CMS guidelines.)

Skilled Nursing Facility Determination on Admission

Date of Notice: ______________________

Resident's Name: Edeltrude Loyer

Medicare Number: ______________________

We reviewed your medical information available at the time of, or prior to your admission, and we believe that the services the above-named resident needed did not meet the requirements for coverage under Medicare for the following reason:

- ☐ No qualifying 3-day inpatient hospital stay
- ☐ No days left in this benefit period
- ☐ Care not ordered or certified by a physician
- ☐ Daily skilled care not needed
- ☐ SNF transfer requirement not met
- ☐ Facility/Bed not certified by Medicare
- ☐ Care not given by, nor supervised by, skilled nursing or rehabilitation staff
- ☐ Items or services not furnished under arrangements by the skilled nursing facility
- ☐ Resident is enrolled in a managed Medicare plan
- ☒ Other: NO medicare

This decision has not been made by Medicare. It represents our judgment that the services you needed did not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request that a bill be submitted. If you request that a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination you may file an appeal.

Under the provision of the Medicare law, you do not have to pay for non-covered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were non-covered. You are considered to know that these services were non-covered effective with the date of this notice.

If you have questions concerning your liability for payment for services you received prior to the date of this notice, you must request a bill be submitted to Medicare.

Please check on the boxes attached to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

____

Signature of Administrative Officer

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Skilled Nursing Facility Determination on Admission – Page 2

☐ A. I do want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact:

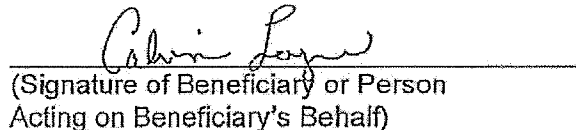
Mutual of Omaha - Medicare
P.O. Box 1602
Omaha NE 68101
(877) 647-6528

☐ B. I do not want my bill submitted to the intermediary for a Medicare decision. I understand that I do not have Medicare appeal rights if no bill is submitted.

NOTE: Beginning October 1, 1989, you are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

Verification of Receipt of Notice

☑ C. This acknowledges that I received the notice of non-coverage of services under Medicare on 4-23-14.



(Signature of Beneficiary or Person Acting on Beneficiary's Behalf)

☐ D. This is to confirm that you were advised of the non-coverage of the services under Medicare by telephone on ____________________

____
Name of Beneficiary or Representative Contacted

____
Signature of Contacting Administrative Officer

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Ohio Department of Job and Family Services

Medicaid Resource Assessment Notice

Facility Name: Signature HealthCARE of Galion		
Address: 935 Rosewood Drive		
City: Galion	State: OH	Zip: 44833
County: Crawford		

- Federal regulations provide that, at the request of an institutionalized spouse or a community spouse, the State shall promptly assess and document the total value of the couple's resources that exist as of the beginning of the first continuous period of institutionalization.
- A resource assessment is a determination of the amount of countable resources a married couple owns as of the date of institutionalization of one of the spouses. This assessment allocates a portion of the resources to each spouse.
- All married persons who enter a medical institution and intend to remain for 30 days or longer are entitled to have a resource assessment completed by their local Department of Job and Family Services (CDJFS).
- If you request a resource assessment and you do not apply for Medicaid, you will be charged $50. If you request a resource assessment at the same time you apply for Medicaid, you will not be charged for the assessment. There is no charge to apply for Medicaid at any time.
- If you want a resource assessment, or if you want to apply for Medicaid, you may request that someone in your facility's social service department contact your local Department of Job and Family Services (CDJFS) on your behalf. You may also apply by contacting the CDJFS yourself or have someone else, such as a relative, friend, or attorney, apply for you. A resource assessment may be requested by you, your spouse, or a representative acting on behalf of you or your spouse.

☐ *Yes, I want the county Department of Job and Family Services (CDJFS) to complete a resource assessment.*

☒ *No, I am not requesting a resource assessment at this time.*

Resident Name (please print): Edeltrude Loyer	
Signature (resident or authorized representative): Calvin Loyer	Date: 4-23-14

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Ohio Department of Job and Family Services

DESIGNATION OF AUTHORIZED REPRESENTATIVE

First Name of Applicant/Recipient	MI	Last Name		Medicaid billing # or SSN
Edeltrude		Loyer		270-56-1503
Street Address, including Apt. #		City	Zip	County
7326 St. Rt. 19 Unit 2004		Mt. Gilead	43338	Morrow

I hereby authorize the following person or company to act as my representative:

First Name	MI	Last Name		Home Phone
Tracy		Pigg		
Title	Company			Work Phone
B.O.M.	SHC of Galion			419-468-7544
Mailing Address		City	State	Zip
935 Rosewood Drive		Galion	OH	44833

I authorize this person or company to represent me regarding:

☐ Food Assistance ☐ Cash Assistance ☒ Medicaid ☐ Child Care

This authority lasts until:

☐ My application has been approved
☐ I rescind this authority, or appoint a new representative
☐ Other (please specify a date or action) ____________________

I authorize this person or company to do the following on my behalf:

☐ Take any action that may be needed to ensure that I receive or continue to receive the benefits indicated above

OR only the specific actions selected below

☐ Present my application for benefits
☐ Represent me at a state hearing
☐ Provide verifications to the CDJFS on my behalf
☐ Collect my medical records
☐ Receive and respond to copies of all correspondence regarding my application
☐ Other (please specify) ____________________

While this authorization is in effect, all notices sent by the County Department of Job & Family Services or the Ohio Department of Job & Family Services will also be sent to your authorized representative.

Signatures. This form has no effect unless signed by the person granting authority and by the authorized representative or an employee of the company appointed to be the authorized representative.

Signature of Person Granting Authority		Date
[signature]		4-23-14
Signature of Authorized Representative	Title (if employee of authorized company)	Date

Resident: Edeltrude Loyer [Print Resident Name] Facility: Signature HealthCARE of Galion [Print Facility Name]

CONSENT AND RELEASE FORM FOR COMMON ACTIVITIES

I, the undersigned, am the resident or legal representative of Edeltrude Loyer, (name of the "Resident"). I grant permission for Resident to leave the Facility's premises and to participate in the following Common Activity outings with the Facility (collectively, the "**Common Activities**"):

- Ball parks
- Community centers/clubs
- Fairs
- Fishing trips
- Libraries
- Other: ______
- Movies/theaters
- Museums
- Parks
- Picnics
- Restaurants
- Other: ______
- Scenic rides
- Schools
- Shopping trips
- Sight-seeing
- Stadiums

I have been educated on the Common Activities fully, and have reviewed all information the Facility has provided about them. I have had the opportunity to ask questions. I fully understand the inherent, actual, and associated risks related to the Common Activities, and any involved physical exercise or recreational activity that it may require. Such risks may include, but are not limited to; physical and mental injury of Resident, up to and including death. I am participating in the Common Activities, or give my permission to do so, ***voluntarily***. I fully release the Facility, Signature Healthcare, LLC, and its owners, managers, directors, affiliates, subsidiaries, agents, officers, and employees (collectively the "Released Parties") from any and all liability, claims, causes of action, damages, or losses of any kind whatsoever that is related to, or arises from, the Common Activities.

This Consent and Release shall be binding upon the Resident's heirs, executors, administrators and personal representatives. A facsimile signature shall have the same force and effect as an original signature.

By signing below, I represent and warrant that I am either: 1) the Resident, who is an adult and mentally competent of making my own decisions; or 2) legally authorized to sign this Consent and Release for the Resident.

Please ask any questions ***BEFORE*** you give consent and sign this release. We will gladly answer them and want to make sure you understand the fun and inherent risks associated with these activities!

By: Calvin Loyer WITNESS: Becky King

Print Name: Calvin Loyer Date: 4-23-14

Relationship to Resident: ☐ Self ☐ Guardian ☐ Attorney-in-Fact [Mark Appropriate Box]

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Resident MEDIA Release Agreement

Instructions: Each section of this form must be reviewed and signed by the resident or the resident's legal representative. If signed by the resident's legal representative, attach a copy of the document evidencing the authority to act on the resident's behalf (e.g., power of attorney, guardianship order, health care surrogate, etc.).

Resident: Edeltrude Loyer

Resident Representative: Calvin Loyer Relationship: Spouse

I understand and acknowledge that a representative of Signature HealthCARE of Galion, LLC (and any of its parent and affiliated companies (collectively, the "Facility")) may take or use photograph(s), a verbal or written testimonial, or print a story – of or about the above named resident – for identification purposes of the resident, as well as for use in media and other Facility marketing events, and other possible uses as indicated below. In accordance with the Health Insurance Portability and Affordability Act of 1996 (HIPAA), the photographs, names or written/verbal testimonials given by the above named resident or on behalf of resident's family members will not be used in a manner that would disclose protected health information, except for the fact that the resident resides at the Facility, unless I agree otherwise.

Yes ☒ No ☐ The Facility may take and use said photo(s) as part of ongoing activity programs, marketing and/or special Facility events.

Yes ☒ No ☐ The photo(s), story, name of the above named resident, and/or written or verbal testimonials can be displayed on Facility bulletin boards, in Facility newsletters, email or other internal or external communication systems, on Facility and/or Company websites, in Facility and/or Company blogs, and in all other marketing or advertising mediums the Facility chooses, such as brochures, Facility DVD, etc.; they may also be used for community outreach programs, and/or internal company birthday announcements.

Yes ☒ No ☐ The photo(s) of the above named resident can only be used for the purposes indicated below.

- ☐ Bulletin Boards
- ☐ Newsletters
- ☐ Facility Website
- ☐ Facility Advertising
- ☐ Company Website
- ☐ Facility Blogs
- ☐ Company Blogs
- ☐ Marketing Mediums
- ☐ Fundraising
- ☐ Community Outreach Programs
- ☐ Birthday Announcements
- ☐ Other: ______________________

Yes ☒ No ☐ The Facility has permission to use said photo, name, written or verbal testimonial, and/or story about the above named resident without paying me or the resident any compensation and until the end of time. I understand and agree that all photos (including all digital files), stories, and testimonials are the Facility's property, solely and completely.

Yes ☐ No ☒ My name or my family member's name can also be listed in the Facility Directory.

Resident/Representative Signature: Calvin Loyer

Resident/Representative (Print): Calvin Loyer

Date: 4-23-14

OH Rev. 12/13

Resident Trust Fund Authorization

Resident Name ____ Edeltrude Loyer ____

Resident # ____ 201418 ____

X I choose not to have the facility handle my resident trust funds.

OR

____ I authorize the administrator of this facility or any other person authorized by the administrator to handle my resident trust funds as follows:

- Endorse all Social Security or other checks made payable to me and deposit them into this nursing facility's resident trust bank account. I understand that the facility will provide me with a statement of my account and all transactions within the period at least quarterly.
- Disburse my resident trust funds according to my verbal or written instructions. If I provide verbal instructions I will confirm my directions in writing.
- Apply my resident trust funds to charges which I owe for services and supplies provided during my stay. The nursing facility will only deduct trust funds to cover my outstanding balance, and to pay for any charges as they become due.
- I designate as beneficiary of my account at my death:

  Name ____________________

  Address ____________________

Resident / Legal Guardian ____________________ Date ________

Power of Attorney ____________________ Date ________

Responsible Party Calvin Loyer Date 4-23-14

Witness** ____________________ Date ________

** Only required if resident signs with a mark (X)

OH Rev. 12/13

ACCOUNT NO.

Resident Fund Management Service

AUTHORIZATION AND AGREEMENT TO HANDLE RESIDENT FUNDS ** PLEASE TYPE OR PRINT **

Resident Name Edeltrude Loyer (First / Last) Taxpayer ID NO. 270-56-1503 (Resident's own Social Security No.)

Facility Name Signature HealthCARE of Galion Facility Resident ID 201418 (Optional Data - Max 12 Characters)

Statement Address ______ (Only if different than Facility address.)

CHECK ACCOUNT TYPE

1. RESIDENT FUND ACCOUNT

_____ NON-TRANSFERRING ACCOUNT (No automatic transfer of deposits to pay for care cost.)

_____ TRANSFERRING ACCOUNT (Automatic transfer of care cost payments due the facility.) with $_________ MONTHLY ALLOWANCE AMOUNT.

2. BURIAL ACCOUNT (Deposit only account - monies to be used for burial expenses only.)

_____ Revocable (May be closed prior to death.)

_____ Irrevocable (To be closed after death or if resident transfers from facility or if transferred to another burial account.)

_____ Non-interest bearing burial account (Interest will be paid if this item is NOT checked.)

DIRECT DEPOSIT – Please enroll my indicated recurring benefit payments for direct deposit.

_____ Social Security _____ Supplemental Security Income _____ ____________

_____ Veterans Administration _____ Civil Service _____ ____________

_____ Railroad Retirement _____ Miners Benefit/Black Lung _____ ____________

*** Note – Enter the direct deposit information in the RFMS software, or complete the appropriate direct deposit form (Direct Deposit Enrollment Form or other pension form).***

By my signature below, I hereby authorize the facility named above to establish and manage an FDIC insured interest bearing resident fund or burial account with the options as specified above. I understand, I may have my recurring checks direct deposited to my resident fund account, I may make deposits to and withdrawals from my resident fund account at the facility, and I will receive a statement of any account I have at least quarterly.

In the event that I elect to have a resident fund transferring account, I direct that the amount stipulated by me or required or permitted under federal, state or local law from time to time in effect, be withheld monthly for my personal use and that the remainder be transferred to the facility for the payment of my care costs. I hereby authorize the facility administrator and/or his/her designated staff, to from time to time adjust my personal allowance amount to comply with governing laws as they apply to me.

In the event of my death, I direct that any funds owed or advanced to me by the facility prior to my death are to be paid to the facility with any remaining balance in my resident fund account to become part of my estate.

By signing this form, I under penalties of perjury, certify that (1) the number shown on this form is my correct taxpayer identification number, and (2) I am not subject to backup withholding because (a) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (b) the Internal Revenue Service (IRS) has notified me that I am no longer subject to backup withholding. [If the signer has been notified by the IRS that he/she is subject to backup withholding, cross out the language in (2) above.]

** RESIDENT'S ILLEGIBLE SIGNATURE OR MARK (X) REQUIRES TWO WITNESS SIGNATURES **

Witness: ______________________ RESIDENT * ______________________
Signature or Mark (X)

Witness: ______________________ Date: ______________________

* ANYONE SIGNING FOR THE RESIDENT MUST SIGN THE CERTIFICATION BELOW

I, the undersigned, certify that I am the legal representative as stated below for the above named resident and agree to all the terms stated above and will provide valid legal supporting documentation of my legal capacity and authority upon the facility's request.

Calvin Loyer
PRINTED NAME OF REPRESENTATIVE

____
SIGNATURE OF LEGAL REPRESENTATIVE

____
DATE

LEGAL TITLE: ______________________
REP PAYEE; GUARDIAN; CONSERVATOR; TRUSTEE; POA

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AGREEMENT TO INFORMALLY RESOLVE AND ARBITRATE ALL DISPUTES

Thank you for choosing our Facility!
We hope you will be pleased with your experience here.
Please read this document carefully.

Edeltrude Loyer
RESIDENT NAME

and

Signature HealthCARE of Galion, LLC (and all affiliates, parents, officers, owners, members, agents, successors and assigns)
FACILITY NAME

RESIDENT, FACILITY, AND ANY OTHER PERSON SIGNING THIS, UNDERSTAND AND AGREE THAT:

1. If a dispute, or legal claim of any kind (including a class claim or representative action), arises or occurs between anyone signing this agreement (a "dispute"):
   - We will first try and resolve the dispute between ourselves.
   - If we do not succeed, we will mediate the dispute.
   - If mediation is not successful, we will arbitrate the dispute with an arbitrator.

2. The arbitrator is a neutral person who will decide our dispute, and who we agree:
   - Can award any one of us the same damages as a court or jury could;
   - Will apply the Federal Arbitration Act and the OHIO law and Rules of Civil Procedure and Rules of Evidence;
   - Will decide all questions about this agreement, including whether the person(s) signing it has proper authority and whether it is enforceable;
   - His/her decision(s) will be FINAL.

   THIS MEANS THAT WE WILL NOT FILE A LAWSUIT AGAINST EACH OTHER, INCLUDING AS PART OF A CLASS CLAIM OR REPRESENTATIVE ACTION, AND THAT EACH PARTY IS GIVING UP, OR WAIVING, THE RIGHT TO FILE A LAWSUIT AND HAVE A JUDGE OR A JURY DECIDE THE DISPUTE AND/OR ANY ISSUES ABOUT THIS AGREEMENT. We can still talk about our dispute, however, to any federal or state agency.

3. The mediation and/or arbitration will take place in OHIO, in the county where the Facility is located. We can have an attorney represent us.

4. This agreement involves interstate commerce, and the Federal Arbitration Act will govern and control it.

5. TO START THE INFORMAL DISPUTE , MEDIATION, OR ARBITRATION PROCESS, one of us must:
   - Send the other a request in writing, and include a detailed account of the dispute, a proposed resolution, and what process is being requested (informal resolution, mediation, or arbitration).
   - If informal resolution is requested, the parties will schedule a mutually convenient time to discuss the dispute and possible resolution(s).
   - If mediation or arbitration is requested, the parties will discuss and agree upon the person who will mediate or arbitrate the dispute, and when mediation or arbitration will occur. We agree that the arbitrator will be an independent, disinterested, and qualified attorney with at least 7 years' experience in nursing home care. If we cannot agree on an arbitrator, then each of us will nominate our own arbitrator candidate, and together, the candidates will agree upon and select another independent, disinterested, and qualified attorney with at least 7 years' experience in nursing home care.

6. We understand that this agreement will bind any person or entity that is later appointed to act on my/our behalf. It will also remain valid and in effect if one of us later becomes disabled or incompetent. This means it will be upheld and enforced against our heirs, beneficiaries, estates, estate representatives, successors, statutory wrongful death beneficiaries, and assigns.

7. This agreement will also remain valid, and of full force and effect, even if the Resident is discharged and then later re-admitted to the Facility. It will also apply to all of the Resident's prior and subsequent admissions there.

8. As well, if any part or term of this agreement is determined to be legally invalid, we understand and agree that the rest of its terms will still remain in full force and effect.

9. We represent to each other that we have the proper authority to sign this agreement, and rely upon this. This means that each of us has told the other that we have the proper authority to sign this agreement, and that each of us is relying upon the other's statement about this.

10. Each of us understands that we do not have to sign this agreement, and that if we do, it is voluntarily. And any of us can cancel it, by writing the other party, within 30 days after signing. If the Resident cancels, the writing must be sent to the Facility Administrator.

[COMPLETE NUMBER 11 ONLY IF YOU ARE NOT THE RESIDENT]

11. *If I am not the Resident and am signing on the Resident's behalf*, I have shown the Facility evidence of my authority to sign for the Resident, and represent:

a. I have legal authority to sign this agreement:

(Check all that apply)

- The Resident, while able, gave me oral authority to make decisions for him/her ✓
- I have handled the Resident's legal and business affairs for _______ (years / months) ____
- The Resident signed a written document allowing me to make decisions for him/her (e.g., POA, health care surrogate, living will), COPY PROVIDED ____
- I am recognized as the health care decision maker or surrogate ✓
- A court has given me written authority to act and make decisions for the Resident (e.g., conservator or guardian) ____

b. By allowing the Facility's care and treatment for the Resident, I ratify this agreement; and ✓

c. I understand that the Resident and/or the Resident's agents, heirs, beneficiaries, estate, and assigns are intended beneficiaries of, and will be bound by, this agreement. ✓

I HAVE READ THIS AGREEMENT TO INFORMALLY RESOLVE AND ARBITRATE ALL DISPUTES, UNDERSTAND IT, HAVE HAD THE CHANCE TO ASK QUESTIONS, ACKNOWLEDGE MY RIGHT TO SPEAK WITH AN ATTORNEY ABOUT THIS, AND SIGN IT VOLUNTARILY.

Date: 4-23-14

Edeltrude Loyer
Resident Name

RESIDENT SIGNATURE

Calvin Loyer Spouse
Resident's Authorized Representative/ Name and Relationship

Calvin Loyer
RESIDENT REPRESENTATIVE SIGNATURE

Becky King LPN
Facility Representative

Becky King Lpn
Facility Representative Signature

Additional Signatory/Relationship to Resident

Additional Signatory/Relationship to Resident

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Admission Packet Checklist

(* = copy to patient chart)

Resident Name: Edeltrude Loyer

✓ Consent & Authorizations (completed & signed)*
Advance Directives / Informed Consent*
Handbook Acknowledgement
New Admission Payment Information (completed & signed)
Admission & Financial Agreement (completed & signed)
Notice of Privacy Practices (completed & signed)
Medicare Secondary Payer (MSP) Form (for Medicare patients)
SNF Determination Upon Admission (for all but MC-A)
ODJFS Medicaid Resource Assessment Notice
ODJFS Designation of Authorized Representative
Activities Consent & Release Form*
Resident Media Release Agreement*
Full Life Conference Notification Form (completed & signed)
Resident Trust Fund Authorization
Resident Fund Management Service (RFMS) Authorization
Facility and Resident Agreement to Resolve Disputes (Arbitration)
Sex Offender Registry Checked (site checked & resident not listed)
PASSR (Pre-Admission Screening & Resident Review)*
Insurance Verification/Financial Assessment Form
HMO Authorization (Auth #, level of care, days approved)
Copies (front & back) of Medicare and/or Insurance card(s), Social Security card, and driver's license
✓ Check for 30 days or respite stay days (if private pay) or patient liability

Becky King 4-23-14
Admissions Sign-Off / Date | **B.O.M. Signature / Date** | **Administrator Signature / Date**

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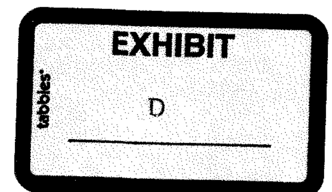

Resident Handbook & Admission Information

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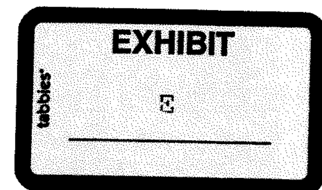

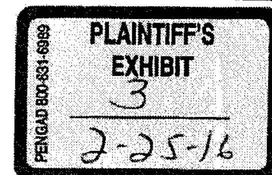

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    - ☐ Resident Trust Fund Authorization
    - ☐ Resident Fund Management Service (RFMS) Authorization
    - ☐ Facility and Resident Agreement to Resolve Disputes

Facility Services

Welcome to our Facility! We are honored you chose us.

We provide a variety of care and services to assist you in meeting your identified health needs, and strive to provide them in a manner and environment that is respectful of who you are as an individual and your dignity.

Please review the following information about our care and services.

Care & Treatment

We will provide you with general nursing care and treatments, such as the administration of medication, skin care, and assistance with bathing, toileting, feeding, dressing, and mobility, as needed. Together with you and your attending physician, an interdisciplinary team will develop a care plan that will guide the care, support and services determined necessary to meet your identified health needs and goals. The interdisciplinary team will review your care plan with you on a regular basis. If a significant change in your condition or treatment plan is needed, we will discuss those changes with you, your physician and/or your legal representative. We will also inform your physician and/or legal representative if you decide to refuse treatment or medication. You may freely contact any member of the interdisciplinary team, at any time, if you have questions regarding your care plan.

For your protection and safety, as well as those of your family members or visitors, we ask that you, or anyone with you, please contact a facility staff member for assistance when moving around the facility. For example, when you, the resident, needs to get in or out of bed, transfer to a wheelchair, or use the restroom, please ask a staff member for assistance.

If your doctor orders health care services that we do not provide, with your approval, we will arrange for these care services to be provided to you in the facility by another service provider, or we will arrange for your transfer to the hospital or another provider who will provide you the service.

Please know that we admit and treat all patients/residents in a non-discriminatory manner as required by federal and state law, without regard to race, gender, religion, national origin, veteran status, sexual preference, disability, age, or any other legally protected status.

Therapeutic Services

Our goal is to assist you in attaining and maintaining the highest quality of life possible. For that reason, the facility offers a variety of services, including social services, planned recreational activities, and other therapeutic and rehabilitative services, that will be consistent with your care plan. If the need for physical, occupational or speech therapy services is identified for you, the attending physician will order these special services.

Business Office Services

The facility Business Office Manager (BOM) is responsible for all Medicare and Medicaid billing and claim submissions, as well as insurance company and private pay billing.

The BOM also manages all resident personal funds, but only as requested in writing by a resident. The facility is not responsible for the safekeeping of your personal funds, unless you deposit them in the facility business office. We recommend that you take advantage of this, and will give you a receipt for all funds deposited there.

You also may choose to have your personal funds deposited in a special facility resident trust fund account. Any funds deposited with the facility will be kept in an interest bearing account called the Resident Trust Account (RTA). Generally accepted accounting principles will be followed in safeguarding these funds. Deposits and withdrawals to the RTA can be made by contacting the BOM, who serves as the on-site accountant of the RTA program.

Deposits into the RTA may be made in person or by mail, and you will receive a receipt for each deposit. Your Social Security, Supplemental Security Income, Veteran's Administration checks or any of your other third party checks may be deposited in the RTAs and accounted for in the individual resident ledger.

You will be required to sign the Resident Trust Disbursement Log for all withdrawals. We may issue you a check for larger amounts of money withdrawals.

You may approve charges for certain services to be paid from your Resident Trust Account, including bed hold charges, barber/beautician services, and resident shopping purchases, as applicable.

On a quarterly basis, we will send you, or your legal representative, a copy of your RTA ledger. You also may request to view this ledger at any time during regular business office hours.

Nutrition Services

A dietician and qualified nutrition services manager are available to assist with your nutritional needs. Please know that if you are on a special diet ordered by your physician, we must follow that diet. As well, for your safety and health concerns, please notify the nurse before consuming any food or drink that may be brought to you from outside of the facility. If your diet permits, and you choose to keep food in your room, it must be stored in an airtight container. We encourage you to eat in the dining room with our other residents. Your family members and friends are welcome to dine with you; we ask that you please give us advance notice. There may be a nominal charge for a guest meal.

Physician Services

As a resident in our facility, you must be under the care of a physician who is authorized to admit and care for residents here and meets applicable federal and state guidelines. If you are in need of a physician, the facility can provide you a list of approved physicians who regularly see residents here. In the event your physician cannot be contacted during a medical emergency, the facility's "on-call" physician or Medical Director will be responsible for and temporarily assume your care.

Pharmacy Services

A pharmacy designated by the facility will provide your needed medications, through a uniform medication distribution system. This system complies with the facility's established policies and procedures for medication therapy, distribution, and control. Unless brand name medications are specifically requested by the physician or resident, the pharmacy will supply generic medications for you. Generic medications offer the equivalent quality of name brands medications at a reduced cost. Most medications and supplies are included in the Medicare or Medicaid daily room rate. The pharmacy may be able to bill some insurance plans (excluding Medicare supplements) for other certain items. You will be responsible to pay the cost of any medications and supplies not covered or partially covered by Medicare, Medicaid or an insurance plan.

Please know that you have the right to select an alternate pharmacy instead of using the one chosen by the facility. If you decide to use another pharmacy, please be aware that it must be one that complies with the facility's uniform medication distribution system and procedures, and all applicable laws.

Barber/Beautician Services

We provide routine washing and drying of hair at no cost to you. A barber/beautician can also be available to provide additional services (e.g., haircuts, hair sets, permanents, etc.), at the resident's expense. Please contact a facility representative for additional information about these services and related costs.

Laundry Services

We also provide personal laundry services. If you are currently receiving Medicare or Medicaid, laundry service fees are included, and there is no extra charge for this service. If you are not currently receiving Medicare or Medicaid, we may charge a fee for laundry service. Please contact a facility representative for more information.

If you do not wish to use our laundry service, you will need a clothes hamper with a lid and your laundry must be picked up at least twice a week.

To ensure we can identify your laundry and clothing, please discreetly mark all of your clothing items with your name using a label or permanent marker. From time to time, and at admission, we may ask you to

complete an inventory of clothing and other personal items. Please notify the Social Services Director of any new items to be recorded on the inventory.

Volunteers

Our facility encourages volunteer participation. Volunteers may provide services on a routine, consistent basis or may visit the facility for special events. There are many opportunities for volunteering. If you have family or friends interested in volunteering, please have them contact the Quality of Life Activities Director or Coordinator.

Rules & Regulations

This facility has established the following rules, in accordance with state and federal regulations, to provide dignified, safe and appropriate care to all residents. From time to time and in its sole discretion, the facility may change these rules, as needed. We will notify you of these changes when they occur. This information is provided in accordance with Federal and State regulations, which are available for you to review in the "Reference Materials" section of this handbook.

As a resident of this facility, you have the right to a dignified existence and to communicate with individuals and representatives of your choice. The facility will act accordingly, to help protect and promote the rights of each resident.

Abuse

The facility has policies and procedures that prohibit the mistreatment, neglect and abuse of a resident or misappropriation of a resident's property. Upon hiring and at least once every year, all staff are trained and educated about resident abuse and neglect and the proper handling of resident property. Please notify facility leadership immediately if you have questions or concerns related to this procedure, or if you suspect or have knowledge of any resident mistreatment, neglect, abuse or property misappropriation.

Alcoholic Beverages

If prescribed by your physician, you may have alcoholic beverages while a resident. These beverages will be administered to you by a facility staff member, in accordance with your physician's order.

Bed Hold Policy

If you are transferred out of the facility to the hospital or for an overnight therapeutic leave, we will provide written information about our "bed hold" policy to you. This means that under certain circumstances, including receipt of a written request from you for a bed hold, the facility will "hold" or not assign a resident's bed to another person. The facility's policy on bed holds is as follows:

Private Pay – The Facility will hold the bed of a private pay resident, only if authorized to do so by either the Resident or their legal representative. At the time of Resident transfer, the Facility will notify the Resident/Responsible Party and ask whether they wish to hold the bed. If the Resident/Responsible Party wishes to have the bed held (or the hold discontinued), they must send the Facility a written notification about this. Once written notice is received, the Resident/Responsible party will be charged the posted room rate for each day the bed is held. If the Resident elects not to hold the bed, the Resident will be considered discharged from the Facility and readmitted only if there is a private pay bed available.

Medicare – A Medicare Resident will NOT have their bed-hold paid by the Medicare Program. As with Private Pay, a Medicare Resident will be given the opportunity to make a written request for a bed-hold, and if elected, will be charged privately to the Resident at the current posted room rate for each day the bed is held. If the Resident elects not to hold the bed, the Resident will be considered discharged from the Facility and readmitted only if there is a Medicare bed available.

Medicaid – Ohio Medicaid pays for up to 30 bed-hold days on a per calendar year per resident basis. Bed hold days will be requested under the Medicaid State Plan at the time of transfer. When the Resident's hospitalization or therapeutic leave exceeds the bed hold period under the State Plan, the Resident will be readmitted to the facility immediately upon the first availability of a bed, if the Resident chooses to be readmitted and is still eligible for Institutional Medicaid funding. The maximum number of days for which the Medicaid program will pay to hold the resident's bed for hospitalization or leave of absence may be increased or decreased upon changes in the law or the regulations established under the appropriate State Medical Assistance Program.

Other Payer Sources – A bed-hold may or may not be within the Resident's insurance contract. Please refer to your insurance company policy for further information and clarification.

Cameras / Videotaping / Recording

It is not permissible to photograph, videotape, or use any device of any kind that records audio or pictures, at any time or anywhere in the facility, without the Facility's and Resident's or Responsible party's express

written permission. Please be aware that the Facility may have surveillance cameras installed in certain common or public areas for safety and quality assurance purposes.

Contact Information

We will ask you for the name, address and phone number of your legal representative and/or family members with whom you may want information shared. This information will be updated periodically. Please let us know if there is a change in who we may contact, or their address or phone number.

Drugs

Illegal or street drugs of any kind are strictly prohibited in the facility or on its grounds.

Electrical Appliances

For the safety of all residents, we request that you limit the use of electrical appliances in resident rooms. All electrical appliances (i.e., television, radios, etc.) must be inspected by our maintenance supervisor before use. We apologize, but some appliances may not meet the facility's safety requirements and thus, cannot be used.

Environment

The facility strives to provide a safe, clean, comfortable and homelike environment, allowing you to use your personal belongings to the extent possible. Please refer to the *Personal Items* section of this handbook for more information.

Family Council

Families of residents may establish and participate in a Family Council to provide support to each other and to assist residents and facility staff in improving resident care. Please contact the Social Services Director for more information.

Federal & State Survey Inspections

The facility is regulated by numerous federal and state laws, and accordingly, is routinely subject to visits by federal, state and other regulatory officials. These government representatives may review medical records and other written information while here, for survey and/or continued certification and licensure purposes. The results of the most recent federal and state surveys are available in the facility for your review. Please contact the Administrator about any questions you may have regarding survey results.

Fire Drills

The facility periodically conducts fire drills to ensure the safety of our residents and staff. We appreciate your patience and cooperation when these fire drills occur. Based on the facility's geographic location, other drills may be conducted as well, for example, hurricane and tornado.

Funds

Please refer to the *Facility Services / Business Office Services* section of this handbook for information regarding resident funds.

Gratuities

Our staff is not allowed to accept gratuities of any kind from a resident, family member, or friend. Instead, we ask that you please share a kind word or comment, whether in person or by letter, email, or on the facility website. We welcome your positive feedback!

Grievances

We welcome you to share concerns about your care in the Facility at any time. We also encourage you to make suggestions for change about any of our policies or services. Please know that you will not suffer harassment or discrimination for making a complaint or suggesting change. If we are unable to resolve your concern, the appropriate state agency may be notified.

Home Visits

While a Resident, visits to your home may be arranged for therapeutic purposes. Please understand that certain federal and state regulations may apply to overnight home stays. Before leaving the facility, you must tell a nursing supervisor. If you are interested in learning more about home visits or arranging for a home visit, please contact the Social Services Director.

Internet Services / Computer Use

Feel free to bring your computer with you to our facility. WiFi is available to you free of charge. WiFi is banned for illegal use. If it is determined that you are using the internet for unlawful reasons you will be forbidden from use and reported to the appropriate agency if necessary.

Mail

Mail received at the facility, addressed to you, will be delivered to you unopened as soon as possible. Outgoing mail will be sent as soon as possible, within 24 hours, except when there is no regularly scheduled postal delivery and pick-up service. We will gladly provide you access to stationery, postage and writing instruments, at your expense. If you wish, facility staff may assist you in opening your mail; we just need you to request this service in writing.

Married Couples

Married couples may, and are encouraged to, share a room. Please understand that even though married, the facility is responsible for providing for the health and safety of each individual resident. Therefore, some married couples may not be able to room together.

Medications

All medications you receive and take must be ordered by your physician. We do not allow medication of any kind (including over-the-counter medication, creams, ointments, medicated powders, etc.) to be kept in your room without a physician's order and an appropriate label. If your care plan permits, you may self-administer your medications.

Personal Items

We want your room to be "home like" and thus, encourage you to personalize your room. Please remember that others reside in the facility, too, and that you may have a roommate. Accordingly, please mark all personal items with your name. As well, we may ask you to remove some furnishings and clothing if it infringes upon the rights or health and safety of others. From time to time and upon admission, facility staff may ask you to complete an inventory of your personal items, which will be kept in your record. Please let us know about any new items that need to be added to your personal property inventory list. We recommend that valuable items not be kept in the facility.

Pets

Pet visitation is allowed according to facility policy and should be arranged in advance with staff. Before any animal may enter the facility, we will need to see proof of immunization. Also, due to the nature of our business, animals exhibiting poor health cannot be allowed in the facility.

Phone

A phone is available for your private use. There will be a charge, however, for long distance calls. If you would like a phone installed in your room and are willing to pay for same, you or your responsible party may make arrangements with the phone company to have a phone installed in your room. Please be aware that, at times, room changes are unavoidable. If you request a room change and already have a private phone, you will be responsible for all phone disconnection and relocation costs.

Posted Information

Certain information will be posted in the facility for your access. This will include, but is not limited to, the names, addresses and telephone numbers of pertinent State client advocacy groups, State survey and certification agency, State licensure office, State ombudsman program, Notice of Privacy Practices, protection & advocacy network, and the Medicaid fraud control unit.

In addition, we will also post information on how to file a complaint with the State survey and certification agency concerning resident abuse, neglect, misappropriation of resident property and non-compliance with advance directives information.

We will also provide you information on how to contact your physician and how to apply for and use Medicare and Medicaid benefits.

Privacy

Please refer to the *Notice of Privacy Practices* in this handbook for more information.

Private Room Charge

If Medicare, Medicaid, or your insurance plan does not pay for a private room, but you request a private room and one is available, the Facility may charge you the difference between its customary charge for a private room and its most prevalent charge for a semi-private room. The current additional amount will be provided at the time the request is made.

Resident Council

Residents have the opportunity to meet together monthly in an organized group setting to discuss current issues and topics of their choice. Please contact the Quality of Life Activities Director or Activity Coordinator for more information about Resident Council.

Restraints

The Facility strives to limit the use of any physical restraints by providing individualized care and services that promote the highest practicable level of function for each resident.

The interdisciplinary team works with the resident and family to develop a care plan that maintains the resident's dignity, improves level of function, and promotes safety. The use of a restraint may be indicated if the resident has medical symptoms that would benefit from the short term use of a restraint, or if a resident is experiencing behaviors that threaten their safety or the safety of others, or when alternative measures have been determined to be ineffective.

Pease contact the Director of Nursing or the Social Services Director if you have further questions regarding the facility's policy on restraint use.

Room Change

Facility staff will make every effort to allow you to retain your assigned room or bed. Please know, however, that the facility may have to transfer you to another facility room or bed for your care and safety needs. You and your legal representative or interested family member will be notified promptly if a room or bed change is required, or if your roommate will be reassigned.

Smoking

This is a smoke-free facility, unless otherwise noted. If smoking is allowed, it is permitted only in designated smoking areas and/or at designated times. Facility staff may evaluate your ability to safely smoke independently. Please contact the Social Services Director for further information.

Solicitation

Solicitation of any kind is prohibited in the facility or on facility grounds.

Transfer / Discharge

Federal and/or state law gives you the right to remain at the facility once admitted, and not be transferred or discharged against your will, except for the following reasons: (a) your condition has improved so that you no longer need the services we provide; (b) the transfer or discharge is necessary for your welfare and your needs cannot be met by the Facility; (c) the health or safety of you or other individuals in the facility is endangered; (d) you, after reasonable and appropriate notice, have failed to pay (or your insurers have failed to pay) for a stay at the Facility; or (e) the Facility ceases to operate.

If you qualify for one of these reasons for transfer or discharge, we will notify you by letter at least 30 days in advance of the transfer or discharge date. We will also notify the appropriate state agency. If you are

transferred because of an emergency situation, we will provide the required notice as soon as reasonable. The notice or "involuntary discharge" letter will contain the qualifying reason(s) for the transfer or discharge and its effective date, as well as explain your rights regarding the discharge or transfer. The letter will also tell you how you can appeal our decision to transfer or discharge you, by requesting a hearing, and will tell you what state agencies you can call for assistance.

Your cooperation and assistance with your discharge planning is required (if appropriate), including with other facilities that are considering admitting you and with applicable governmental agencies. If you or the Facility believes that any abuse or misappropriation of your funds contributed to or caused transfer or discharge for non-payment, you may, or the Facility will, ask the appropriate state agency to investigate the situation and make referrals to other appropriate government agencies.

Transportation

Your responsible party and/or family members may be asked to provide or assist with your transportation needs from and back to the facility. Depending on the circumstances, facility staff may be available to assist with transportation needs, if needed. Please contact the Social Services Director for more information, including about transportation costs.

Visitors

We welcome visitors to our facility! Your immediate family members and relatives do not have visiting hour limitations, unless imposed by you or as the facility may otherwise require to protect the health or safety of others. Other visitors must comply with the facility's visiting hour policy. Children under the age of 16 must always be accompanied by an adult. The facility reserves the right to ask any visitor who is abusive or disruptive toward residents, family members or staff, or under the influence of alcohol or drugs, to leave or be removed from the premises.

All persons must sign the facility's guest register upon entering and leaving. This includes, but is not limited to: visitors, family members, volunteers, contractors and vendors. Please contact the Administrator for more information regarding visitation policies, including after-hours entry to the facility.

Weapons

Weapons are not allowed in the facility at any time. Examples of weapons include, but are not limited to: guns, knives, swords, stun guns, etc.

Work Opportunities

You have the right to perform facility identified services, if you choose, based on your need or desire to work and consistent with your care plan. If you have the opportunity, and choose to work, any Medicaid benefits you receive may be affected.

Health Care Advance Directives

Information for residents and their families about advance directives for medical care

Make your wishes known
You alone have the right to make basic decisions about the medical and health care services you receive from your physician or other health care providers. You have the right to accept, refuse or take away any treatment. You also have the right to be informed and give informed consent before diagnosis or treatment.

Those who provide your health care are responsible for following your wishes. However, there may be times when you may not be able to decide or make health care decisions for yourself. Or you may not be able to tell others what your health care wishes are. Many people want to decide ahead of time what kinds of medical treatment they want to keep them alive. An ***Advance directive*** is a written document that lets people make their wishes known to others.

Self-determination
The federal Patient Self-Determination Act of 1990 requires health care providers and some insurance plans to tell you about your specific rights to issue an ***advance directive*** as allowed in your state.

The Act requires all health care providers that accept Medicare or Medicaid payments to ask all adult inpatients if they have an ***advance directive***. They must document your answers and give you information about state laws. They also must tell you about their own policies on ***advance directives***.

The information listed below tells you about these rights. It is not legal advice. Only your lawyer can give you legal advice or answer legal questions. Your doctor can give you medical advice or answer medical questions.

Right to Natural Death
The Right to Natural Death Act recognizes your rights as a competent adult to make decisions about your medical care. This law says that every person has the basic and natural right to die with as much dignity as possible. It also says that every person can accept, refuse and stop treatment. A person can control decisions about the care he or she receives.

Medical care means any procedure for diagnosis or treatment. This may be surgery, drugs, transfusions, mechanical breathing, dialysis, cardiopulmonary resuscitation (CPR), artificial or forced feeding, and radiation therapy. The statute **does not** permit the withholding of normal food or fluids.

This law gives you a way to control heroic measures and treatment that keep you alive when you are terminally ill. You may not be able to tell your doctor about your wishes at the time that a decision regarding your treatment must be made.

Advance directives
An ***advance directive*** is a document written before a disabling illness. It states a resident's choice about treatment. It may name someone to make choices if the resident cannot. With ***advance directives***, residents can legally decide about their future medical treatment.

There are two types of ***advance directives***. They are the ***living will*** and the ***durable power of attorney for health care***. Through these documents, you can make sure your wishes are followed in the event you cannot speak or decide for yourself. If you do not have an ***advance directive***, your wishes may not be known.

Living Wills
A ***living will*** is a legal document that allows a competent person to state his or her wishes regarding accepting, refusing, stopping, or otherwise deciding about medical care, especially treatment that keeps him/her alive. The directives contained in the ***living will*** are followed when the person's condition is terminal or the person is in a persistent vegetative state and he/she cannot decide about his/her own medical care.

A ***living will*** document goes into effect only when you no longer can decide. It remains in effect only as long as you cannot tell your doctor about your wishes. You may revoke your ***living will*** any time. You may do this in writing with at least one witness or notary. You also may tell your doctor that you want to revoke your ***living will***.

A ***living will*** must be signed in the presence of two witnesses who know you. One of these two people cannot be your spouse or a blood relative. The witnesses should not be health care providers taking care of you.

The ***living will*** form included in the law has a place for a notary to sign. The law does not say you must use a notary, but using a notary is a good idea.

You, or someone acting for you, are responsible for giving your doctor or other provider a copy of your ***living will***. The ***living will*** then must be documented in your medical record. If you change doctors, make sure your new doctor has a copy. It is a good idea to talk to your family and caregivers about your ***living will***. You should give them a copy as well.

Keep the signed original of your ***living will*** at home with your important papers. Tell family and friends where to find it. DO NOT KEEP your ***living will*** in a safe deposit box. KEEP it in a place where it will be easy to find. If your doctor or other provider cannot follow your ***living will***, he/she must tell you or your next of kin or agent. If you want to be transferred to another doctor or other health care provider who will follow your ***living will***, your doctor or provider must help transfer you.

Withholding or taking away medical care from a patient as requested by a properly executed ***living will*** is legal. No doctor or health care provider taking part in withholding or taking away treatment that keeps someone alive as requested by a ***living will*** shall be subject to civil or criminal responsibility. He/she will not be guilty of unprofessional conduct if all actions otherwise conform to reasonable medical standards. This law does not allow anyone to withhold normal food or fluids.

If you wish artificial food and fluids to be withheld or taken away, you may specify this in your *living will*. You may do so by checking the proper space on the *living will* form.

Having a ***living will*** cannot affect getting or continuing your insurance. No insurance plan or policy can allow or not allow you to receive care because you have a ***living will***. They cannot require you to sign a ***living will*** to get insurance.

You may decide to use both a ***living will*** and a ***designation of Health Care Surrogate***. Make sure that the instructions are the same on both documents.

Organ and Tissue Donor Certification
You may state your wishes about donating your organs and tissues when you die. If you are a donor, your doctor must keep you on artificial life support long enough to remove the donated organs and tissues. You may donate all of your organs or tissues. You can also state which organs and tissues you want to donate. You may state that you do not wish to be an organ or tissue donor.

Designation of Health Care Surrogate
A ***designation of health care surrogate*** is a special document. It lets you have someone else make health care choices for you if you cannot. This is different from a general power of attorney. It does not allow someone else to control and dispose of your assets and execute legal documents.

The individual you give the power to decide about your health care if you cannot is your ***health care surrogate***. The person appointed in a ***designation health care surrogate*** does not have to be a lawyer. You should tell the person before you name him or her as your agent.

The ***health care surrogate*** is your agent. He or she must follow the directions you state in your ***designation of health care surrogate***. The ***health care surrogate*** also must follow the wishes in your ***living will***. If you do not have a ***living will***, the ***health care surrogate*** makes choices for you.

The ***designation of health care surrogate*** allows your agent to consent, refuse or take away any care, treatment, service or procedure. This power is limited by what you write in this document. You may state any types of treatment that you do not want.

You have the right to take away your agent's authority. To do this, tell or write your agent or health care provider.

A court can take away the power of your agent to make health care choices for you. This can happen if he/she authorizes anything that is illegal or acts against your desires as stated in this document.

If your ***health care surrogate*** cannot serve as your agent, you may name someone else to serve as your ***health care surrogate***.

Your ***health care surrogate*** has the right to look at your medical records. He or she can allow your providers to release your records to others unless you limit this right.

This document also may give your ***health care surrogate*** other powers after you die unless you say otherwise. Your ***health care surrogate*** may allow an autopsy. He/she may donate your body, organs or tissues for certain uses. He/she also may decide what will be done with your bodily remains.

Your ***health care surrogate*** can make important choices for you. Even with a ***designation of health care surrogate***, you have the right to make choices for yourself while able. No treatment may be given to you if you do not want it.

You must sign your ***designation of health care surrogate*** in front of two witnesses, none of which can be the designated ***health care surrogate***. One of the witnesses must not be your spouse or a blood relative. A notary must certify the signatures of the witnesses.

Witnesses must know you personally and certify that you are of sound mind and under no duress, fraud or undue influence. Friends, non-relatives and other independent people are good choices for witnesses.

Witnesses may not be your health care provider, operator of a health care facility or service, nor an employee of a health care provider.

Your Questions

Questions about setting up ***advance directives*** should be discussed with your doctor, family members, close friends or spiritual advisor. A lawyer can answer your legal questions and help execute documents.

You should prepare ***advance directives*** before you actually need them. You should tell your doctor, family, friends and other health care providers that you have a ***living will*** or ***designation of health care surrogate***. Give your doctor a copy. These directives must be documented in your personal medical record. You should tell hospitals, nursing homes, hospices and home health care agencies that you have these documents when you are admitted.

Once signed, you do not have to renew a ***living will*** or ***designation of health care surrogate***. You should review them periodically because laws may change. You also may change your mind.

Medicare & Medicaid Information

The information provided below is general in nature. Medicare and Medicaid programs are subject to change. Please contact the Business Office Manager or Social Services Director for further information.

Medicare

Medicare is a Federal health insurance program for people who are 65 years old and older, or who have been disabled for at least two consecutive years. Medicare provides payment for skilled nursing services under two parts of the program.

Medicare Part A / Hospital Insurance

Part A assists in paying for an inpatient stay in a skilled nursing facility. Part A has deductibles and co-insurance requirements. Most beneficiaries do not have to pay premiums for Medicare Part A.

Medicare Part A will only pay for skilled nursing care in a long term care facility. Skilled care is considered rendered if your condition requires:

1. Daily skilled nursing or skilled rehabilitation services which can only be provided in a skilled nursing facility (SNF); and
2. You have been in the hospital for at least three consecutive days and nights; and
3. You are admitted to a SNF within 30 days following your hospital discharge or last covered SNF stay; and
4. Your care in the SNF is for a related condition that was treated in the hospital and a physician certifies that you need skilled nursing or rehabilitation services.
5. A 60 day wellness period is required by Medicare to begin a new 100 day skilled benefit period.

Medicare Part B / Supplemental Medical Insurance

Part B assists in paying for services such as rehabilitation, physician services and medical supplies received in a SNF. Medicare part B has premium deductibles and co-insurance amounts that you must pay yourself or through coverage by another insurance plan. Premiums, deductibles and co-insurance amounts are set each year based on formulas established by Federal law.

Supplies and Services Covered

Please contact the Social Services Director or Business Office Manager for the most current information regarding covered supplies and services.

Supplies & Services Not Covered

Please contact the Social Services Director, Business Office Manager or your local Social Security office for further information regarding Medicare coverage. A list of items not covered is provided at the end of this section (*Medicare & Medicaid Information*).

Medicaid

You may be eligible for Medicaid benefits if you have already depleted, or are about to exhaust, your savings or other assets, and if your income in not enough to pay for the costs of care in the nursing facility. The Medicaid program helps individuals pay for medical costs such as doctor's care, hospitalization, drugs and nursing home care.

Individuals are currently allowed to have cash reserves or other assets totaling up to $2000, plus a non-revocable prepaid burial contract, subject to limitations by the Medicaid Agency (Ohio Dept. of Jobs and Family Services aka ODJFS). If you have a spouse living at home, he or she may be able to keep a portion of your income and your savings to meet his or her living expenses and needs. Further, your spouse can request an assessment to determine the extent of non-exempt resources at the time of your admission. This Determination attributes to your spouse an equitable share of resources that may not be considered available of payment toward the costs of your medical care at the facility or his or her process of spending down to Medicaid eligibility levels.

A representative from the Ohio Dept.of Jobs and Family Services (ODJFS) can review your financial information and explain if you are eligible for Medicaid benefits. An application for Medicaid must be made at the ODJFS office. If you are unable to submit this application on your own, a family member, legal representative or another person who knows about your circumstances may assist you. Medicaid applications should be made as soon as possible to allow time for processing.

The state Medicaid program will determine the date you qualify for benefits. This facility cannot refuse to admit you, nor may we discharge you solely because you receive Medicaid to help pay for the cost of your care.

Please let our Business Office Manager know if you have applied for Medicaid or if you decide later to apply. Once your Medicaid application has been approved, the Business Office Manager will work with you to refund any overpayments made during the approval process.

Items and Services Not Covered By Medicare and Medicaid

You may be charged for these items and services if you or your legal representative (or the Resident's physician with the Resident's or your approval) ask for and receive them. You will be notified of those charges at the time the services and/or supplies are ordered.

Barber/Beautician services (Includes those services not routinely covered by facility staff)
Flowers and Plants
Newspapers and other reading materials
Physical, Occupational & Speech Therapy Services (unless they are part of a specialized rehabilitative therapy services program as ordered by your physician, meeting certain regulatory requirements)
Personal Clothing & Comfort Items (including smoking materials)
Private Room, unless deemed medically necessary
Privately Hired Nurses and Nursing Assistants
Telephone Service- billed direct
Cable Television Service - billed direct
Transportation by Ambulance to a Physician's Office (unless as a part of your plan of care under the Medicare program)

Applying for Medicaid

Medicaid applications may be made by visiting the Department for Medicaid Services. Following this process, it may take up to 45 days for your Medicaid eligibility to be determined. The process will go more quickly if you are prepared prior to your meeting. Following is a list of items that the caseworker will request from you. Please bring all items, or as many as you have, to your meeting with the caseworker.

1. Social Security card
2. Medicare card
3. Birth certificate or other record of birth
4. Bank statements for the last 3 months for your checking account
5. Bank statements for the last 3 months for your savings account
6. All life insurance policies that cover you, your spouse, and your children. If you are paying for insurance that covers another family member (for example, you grandchildren), also bring those policies
7. Insurance premium books which list the policy numbers of all policies for which you pay premiums
8. All hospital, cancer or accident policies and their identification cards as well as proof that you pay the premiums for these policies (such as cancelled checks or receipts)
9. Tax records and deeds to property

10. Motor vehicle titles or registration cards for any vehicles listed in your name

11. Proof of the amount you owe on any vehicle in your name, such as monthly statements or the payment book

12. Original documents for stocks, bonds or trust funds

13. Benefit award letters for Social security, VA, retirement pensions or supplemental security income (SSI)

14. Wage stubs for employment for the last 8 weeks. If you are applying for retroactive coverage (regular Medicaid only), you will need the stubs for all of the checks that you received during the months of the medical expense

15. All medical bills and receipts for medical expenses incurred during the last 3 months, paid or unpaid. IF you have been in the hospital, bring the itemized bill that you received

16. If you have recently become disabled and you have not applied for social security benefits or SSI, you must visit the social security office and fill out an application. Proof that you have applied for those benefits will need to be provided

17. Power-of-attorney document if someone will conduct your business for you

Notice of Privacy Practices

Signature HealthCARE, LLC
Signature Holdings II, LLC and all of their affiliated facilities and entities

Signature HealthCARE Corporate Office
12201 Bluegrass Pkwy, Louisville, KY 40299
www.signaturehealthcarellc.com
HIPAA Privacy Officer: Jean Stiles
P: 502-568-7706 E-mail: jstiles@shccs.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2** for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3** for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4** for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of Notice: 9/23/13

This Notice of Privacy Practices applies to the following organizations:

Signature HealthCARE, LLC
Signature Holdings II, LLC
All of the above's affiliated health care facilities and related entities

Privacy Act Statement – Health Care Records

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974 (5 U.S.C.A. 552A). THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. **AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.** *Authority for maintenance of the system is given under* Sections *1102(a), 1819(b) (3)(A), 1819(f) and 1864 of the Social Security Act.*

The system contains information on all residents of long-term care (LTC) facilities that are Medicare and/or Medicaid certified, including private pay individuals and not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer data containing other party liability insurance information necessary for appropriate Medicare claim payment.

Medicare and Medicaid participating *LTC* facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information *is also* used by the Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. *42 CFR §483.20, requires LTC facilities* to establish a database, *the Minimum Data Set (MDS),* of resident assessment information. *The MDS data are required to be* electronically transmitted to the CMS *National Repository.*

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures. These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS LTC System of Records.

2. **PRINCIPAL PURPOSES OF THE SYSTEM FOR WHICH INFORMATION IS INTENDED TO BE USED.** *The primary purpose of the system is to aid in the administration of the survey and certification, and payment of Medicare/Medicaid LTC services which include skilled nursing facilities (SNFs), nursing facilities (NFS) and non-critical access hospitals with a swing bed agreement.*

Information in this system is also used to study and improve the effectiveness and quality of care given in these facilities. This system will only collect the minimum amount of personal data necessary to achieve the purposes of the MDS, reimbursement, policy and research functions.

3. **ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM.** The information collected will be entered into the LTC MDS System of Records, System No. 09-70-0528. *This system will only disclose the minimum amount of personal data necessary to accomplish the purposes of the disclosure.* Information from this system may be disclosed to the following entities under specific circumstances (routine uses), which include:

   (1) To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS;

   (2) To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent for purposes of contributing to the accuracy of CMS' proper payment of Medicare benefits and to enable such agencies to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds and for the purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State, and determine Medicare and/or Medicaid eligibility;

   (3) To assist Quality Improvement Organizations (QIOs) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Title XI or Title XVIII of the Social Security Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans;

(4) To assist insurers and other entities or organizations that process individual insurance claims or oversees administration of health care services for coordination of benefits with the Medicare program and for evaluating and monitoring Medicare claims information of beneficiaries including proper reimbursement for services provided;

(5) To support an individual or organization to facilitate research, evaluation, or epidemiological projects related to effectiveness, quality of care, prevention of disease or disability, the restoration or maintenance of health, or payment related projects;

(6) To support litigation involving the agency, this information may be disclosed to The Department of Justice, courts or adjudicatory bodies;

(7) To support a national accrediting organization whose accredited facilities meet certain Medicare requirements for inpatient hospital (including swing beds) services;

(8) To assist a CMS contractor (including but not limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program to combat fraud, waste and abuse in certain health benefit programs; and

(9) To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste and abuse in a health benefits program funded in whole or in part by federal funds.

4. **EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION.** The information contained in the *LTC MDS System of Records* is generally necessary for the facility to provide appropriate and effective care to each resident.

   If a resident fails to provide such information, *e.g.* a thorough and accurate medical history, potentially inappropriate and inaccurate care may result. Moreover, payment for services by Medicare, Medicaid and third parties may not be available unless the facility has sufficient information to identify the individual and to support a claim for payment on services rendered.

   NOTE: *Residents or their representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions, or distributed in other ways to residents or their representative(s). Although signature of receipt is NOT required,* providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided and merely acknowledges that they have been provided with this information.

Reference Materials

Includes:

- ☐ Federal Resident Rights
- ☐ Frequently Asked Questions about Mediation and Arbitration
- ☐ Ancillary Charges

Federal Resident/Patient Rights

Every facility resident has a right to a dignified existence, self-determination and communication with, and access to, persons and services inside and outside the facility. In accordance with the Omnibus Budget Reconciliation Act ("OBRA" or the "Act"), a facility must protect and promote the rights of each resident, including each of the following rights:

1. To a dignified existence, self determination, and communication with and access to persons and services inside and outside the Facility. To exercise his/her rights as a resident of the Facility and as a citizen or resident of the United States.

2. To be free from interference, coercion, discrimination, or reprisal from the Facility in exercising his/her rights.

3. To inspect and purchase photocopies of all records pertaining to the Resident, upon written request and 24 hours notice to the Facility.

4. To be fully informed in language that he/she can understand of his/her rights, all rules and regulations governing resident conduct and responsibilities during the stay at the Facility and his/her total health status, including but not limited to, his/her medical condition.

5. To refuse treatment and refuse to participate in experimental research.

6. To manage his/her financial affairs. The Facility shall not require the Resident to deposit his/her personal funds with the Facility.

7. To choose a personal attending physician.

8. To be fully informed in advance about care and treatment that may affect his/her well being.

9. Unless adjudge incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

10. To personal privacy and confidentiality of his/her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits and meetings of family and resident groups. This does not require the Facility to provide a private room for group meetings.

11. To approve or refuse the release of personal and clinical records to any individual outside the Facility. The right to refuse release of personal and clinical records does not apply when the Resident is transferred to another health care institution or record release is required by law or third party payment contract. The Resident and the Resident's current medical records within twenty-four (24) hours of a request, except on weekends or holidays.

12. To voice grievances with respect to treatment or care without discrimination or reprisal.

13. Prompt efforts by Facility to resolve grievances the Resident may have, including grievances regarding the behavior of other residents.

14. To examine the results of the most recent survey of the Facility conducted by Federal or State surveyors and any plan of corrections in effect with respect to the Facility. Survey results shall be posted by the Facility in a place readily accessible to residents.

15. To receive information from agencies acting as client advocates and be afforded the opportunity to contact those agencies.

16. To refuse to perform services for the Facility.

17. To perform services for the Facility if he/she chooses, when:
    a. The Facility has documented the need or desire to work in the plan of care.
    b. The plan specifies the nature of the services performed and whether the services are voluntary or paid.
    c. Compensation for paid services is at or above prevailing rates.
    d. The Resident agrees to work arrangement.

18. To privacy in written communications.

19. To send and receive mail promptly that is unopened.

20. To have access to stationery, postage, and writing implements at the Resident's own expense.

21. To receive visitors. Subject to the Resident's right to withdraw or deny consent at any time, the Facility shall provide the Resident's immediate family or other relatives with immediate access to the Resident. Immediate access to the Resident will be provided to others who are visiting with the Resident's consent, subject to reasonable restrictions and the Resident's right to deny or withdraw consent at any time.

22. The immediate access to the Resident by any representative of the Secretary of HHS, any representative of the State, the Resident's individual physician, the state long-term care ombudsman, the agency responsible for the protection and advocacy system for developmentally disabled individuals, and the agency responsible for the protection and advocacy system for mentally ill individuals.

23. To regular access to the private use of a telephone.

24. To retain and use personal possessions, including some furnishings and appropriate clothing as space permits, unless to do so would infringe upon the rights of health and safety of other residents.

25. To share a room with his/her spouse, when the Resident's spouse lives in the Facility, both spouses consent, and the spouses attending physicians approve.

26. To self-administer drugs unless the interdisciplinary team has determined that this practice is unsafe for the Resident.

27. To be free from any physical restraints or psychoactive drugs which are not required to treat the Resident's medical symptoms, and which are administered for the purposes of discipline or convenience.

28. To be free from verbal, physical, or mental abuse, corporal punishment, and involuntary seclusion.

29. To choose activities, schedules, and health care consistent with his/her interests, assessments, and plan of care.

30. To interact with members of the community both inside and outside the Facility.

31. To make choices about aspects of his/her life in the Facility that are significant to the Resident.

32. To organize and participate in resident groups in the Facility.

33. To participate in social, religious, and community activities that do not interfere with the rights of the other Facility residents.

34. To reside and receive services in the Facility with reasonable accommodation of individual needs and preferences, except when the health and safety of the individual or other residents would be endangered.

35. To receive notice before the Resident's room or roommate in the Facility is changed, except in emergencies. The Facility reserves the right to determine room assignment or resident placement. The Facility shall endeavor to honor the requests of the Resident whenever possible. The Resident has the right to refuse a transfer to another room in the Facility if the purpose of the transfer is to relocate the Resident from a portion of the Facility that is a skilled nursing facility to a portion of the Facility that is not such a skilled nursing facility, without jeopardizing the resident's eligibility for Medicare or Medicaid benefits.

36. To be informed as to his/her rights to accept or refuse medical care and to make advance directives regarding care, and not to have his/her care conditioned upon, or to be discriminated against based upon, whether or not he/she has executed an advance directive regarding care.

Frequently Asked Questions about Mediation and Arbitration

We hope that you will be pleased with the care and services we provide!

If an issue arises, however, we encourage and ask you and your family to openly and directly communicate about it with us. We sincerely hope that we can amicably address and resolve the issue with you, without the need for attorney or court involvement. If we are unable to do so, however, we believe that mediation and arbitration are the next best steps to take for resolving any issues or disputes with you.

I. MEDIATION

A. What is Mediation?

Mediation is a process used to resolve issues between people, or "disputes." The parties select a third-party, who is a neutral person, to act as a mediator. The mediator will not decide the outcome of a dispute, or who is right or wrong. Using learned skills, the mediator will help try and guide the parties towards reaching a mutually agreeable resolution.

B. What are the advantages of Mediation?

1. Mediation is less expensive than going through the court system process and having a court or jury decide a dispute through a trial.
2. Mediation is faster than the court system and can be scheduled at the parties' mutual convenience, instead of being based on the court's calendar.
3. Mediation discussions, including information about residents and their medical conditions, may be kept CONFIDENTIAL, instead of being disclosed in publicly filed documents in the court system.

II. ARBITRATION

A. What is Arbitration?

If mediation is not successful, arbitration can be used instead of going to court.

In 1925, the United States Congress enacted the Federal Arbitration Act to recognize and uphold the use of the arbitration process for resolving disputes outside and instead of through the court system.

In a 1995 legal case named Allied-Bruce Terminix, the United States Supreme Court recognized the following benefits of arbitration:

1. Arbitration is less expensive than litigation, or going through the court system process
2. Arbitration has simpler rules
3. Arbitration minimizes hostility
4. Arbitration does not disrupt dealings among the parties; and
5. Arbitration is more flexible in scheduling than the court system.

B. How Do You Start the Arbitration Process?

Our Arbitration Process works like this: one of us notifies the other about the dispute and that we wish to pursue arbitration to resolve it. After we mutually agree upon who the Arbitrator will be, the party who sends notice will then file a claim form with the arbitration administrator. The Arbitrator will hear each party's side of the story and evidence. Unlike a mediator, the Arbitrator WILL decide the dispute and if warranted, can issue an award, just like a judge or jury in the court system. The Arbitrator's decision and award WILL BE FINAL. ***This means that neither party may file a lawsuit or go through the court system; in other words, by agreeing to arbitrate a dispute, the parties are giving up, or waiving, their right to have a judge or jury decide it.***

C. Who will be the Arbitrators?

The Arbitrator will be an independent third party with experience in long-term care matters, and will be either a former judges or a lawyer. In our arbitration process, we will both choose and agree upon who the Arbitrator will be.

D. <u>Can the parties obtain the same remedies as in the court system?</u>

Yes! Arbitrators can award the same damages and remedies that can be awarded by a court or jury, in accordance with state or federal law.

We also suggest that you visit the National Arbitration Forum website at www.arbitration-forum.com for additional information regarding mediation and arbitration.

ANCILLARY CHARGES
(Items and Services Not Covered By Medicare and Medicaid)

The Facility may charge the Resident for the items and services listed below, as Medicare and Medicaid do not cover or pay for them. These are ancillary services, and will only be provided if the Resident (or responsible party or the Resident's physician with the Resident's approval) asks for and receives them. The costs listed below are estimates, and may change from time to time.

Item or Service	Estimated Cost
Audiology Services (from audio screening to hearing devices)	$100 - $2000
Beauty Salon and Barber Shop*	
Cosmetic and Grooming Items	$5 - $30
Dental Services (billed directly by Dentist)	$40 - $400
Flowers and Plants	$20 - $70
Newspapers and other reading materials	$20 - $60
Physical, Occupational & Speech Therapy Services (unless part of a specialized rehabilitative therapy services program ordered by the physician meeting certain regulatory requirements)	$__ per 15min.
Personal Clothing	Avg $35/item
Personal Comfort Items (including smoking materials)	$2 - $35/item
Private Rooms **	$_____/day
Privately Hired Nurses and Nursing Assistants	$15 - $35/hour
Social Events and Entertainment (outside the scope of the facility's Activities Program)	$25 - $50/event
Specially Prepared or Alternative Food (at Resident's request)	$5 - $50/meal
Telephone Service - billed direct	$60/month
Cable Television Service - billed direct	No Charge
Transportation by Ambulance to a Physician's Office (unless as a part of your plan of care under the Medicare program)	$300- 600/trip

*Includes those services not routinely covered by facility staff

**If you receive Medicaid and the Facility places you in a private room at its own discretion, the Facility will not charge you an additional cost for use of that private room. However, if you request a private room, you may be charged a private room rate differential.

AMERICAN ARBITRATION ASSOCIATION®

Healthcare Due Process Protocol

American Arbitration Association®
American Bar Association
American Medical Association
Commission On Health Care Dispute Resolution

Final Report
July 27, 1998

The views expressed herein have not yet been approved by the ABA House of Delegates or the Board of Governors of the American Bar Association and accordingly should not be construed as representing the policy of the American Bar Association. Similar approval processes are also necessary at the AAA® and AMA.

I. Introduction

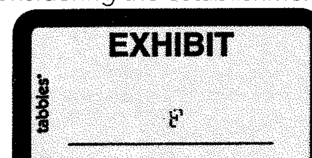
In the Fall of 1997, the leading associations involved in alternative dispute resolution, law, and medicine collaborated to form a Commission on Health Care Dispute Resolution (the Commission). The Commission's goal was to issue, by the Summer of 1998, a Final Report on the appropriate use of alternative dispute resolution (ADR) in resolving disputes in the private managed health care environment. This Final Report discusses the activities of the Commission from its formation in September 1997 through the date of this report, and sets forth its unanimous recommendations.

II. Summary of Recommendations

The Commission unanimously makes the following recommendations:

- Alternative dispute resolution can and should be used to resolve disputes over health care coverage and access arising out of the relationship between patients and private health plans and managed care organizations.
- Alternative dispute resolution can and should be used to resolve disputes over health care coverage and access arising out of the relationship between health care providers and private health plans and managed care organizations.
- In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises.
- It is essential that due process protections be afforded to all participants in the ADR process.
- Review of managed health care decisions alternative dispute resolution complements the concept of internal review of determinations made by private managed health care organizations.

These findings and recommendations are articulated in detail in this Final Report. They are meant to provide guidance not only to private managed health care organizations considering the voluntary adoption of ADR programs as a form of review of plan determinations, but also to legislative and regulatory bodies considering the establishment of standards governing the use of ADR in the health plan environment.



III. Formation of the Commission

In August 1997, leaders of the American Arbitration Association (AAA), American Bar Association (ABA), and American Medical Association (AMA) met in Chicago and determined to form a commission to study and make recommendations on the appropriate use of ADR in the private managed health care environment. This first time joint effort by the AAA, ABA, and AMA underscored the need to provide the public with a fast, just, and efficient system of resolving health care disputes without having to resort to costly and time-consuming court litigation.

In forming the Commission, the convening institutions expressed the hope that as the health care environment continues to evolve, the dispute resolution models and due process safeguards developed by the Commission will be implemented by managed health care organizations across the nation to give consumers the opportunity to have a prompt resolution of their disputes, while at the same time assuring that the parties' Constitutional and other legal rights and remedies are protected. A concomitant goal was to provide guidance to legislative and related bodies who are developing systems to regulate the managed health care relationship.

Another main goal identified in the early stages of the Commission's deliberations is promoting greater awareness and understanding of the use of mediation, arbitration, and other out-of-court settlement techniques as methods for resolving disputes over health care coverage and access in the managed health care environment.

The conveners established the following objectives of the Commission: studying and making recommendations on the application of alternative dispute resolution to coverage and access issues in the managed health care arena, the development of appropriate due process standards to be applied to ADR in this context, and the development of model ADR procedures for use in managed health care relationships.

In the weeks following the Chicago organizational meeting, each institution named its representatives to the Commission, and the first working session took place on September 22, 1997, in Chicago.

Each of the convening institutions possesses expertise and guidance essential to the success of the Commission:

The leader in conflict management since 1926, the American Arbitration Association is a not-for-profit, public service organization dedicated to the resolution of disputes through the use of negotiation, mediation, arbitration, and other voluntary dispute settlement techniques. In 1997, more than 78,000 cases were filed with the Association in a full range of matters. Through 37 offices nationwide and cooperative agreements with arbitral institutions in 38 other nations, the AAA provides a forum for the hearing of disputes, rules and procedures and a roster of impartial experts to hear and resolve cases.

The American Bar Association is the world's largest voluntary professional association with more than 392,000 members. As the national voice for the legal community, the ABA's mission is to serve the public and the profession by promoting justice, professional excellence, and respect for a just rule of law.

The American Medical Association is the nation's leading organization of physicians. Formed more than 150 years ago, the AMA is a partnership of physicians and their professional associations dedicated to promoting the art and science of medicine and the betterment of public health. The AMA serves its nearly 300,000 member physicians and their patients by establishing and promoting ethical, educational, and clinical standards for the medical profession and by advocating for the highest principle of all—integrity of the patient/physician relationship.

The Commission met as follows:

- September 22, 1997 in Chicago
- October 27, 1997 in Chicago
- December 8, 1997 in New York City
- January 12, 1998 in Washington
- March 6, 1998 in New York City
- April 29, 1998 in Washington

In the course of these meetings, the Commission accomplished the following:

- established its membership and governance
- established its mission
- identified objectives
- identified substantive areas of study
- established its methodology
- issued a press release on November 17, 1997
- identified presenters (oral and written)
- established funding for presenter reimbursement
- heard presentations
- received written submissions
- made various governmental leaders aware of the Commission's work
- issued an Interim Progress Report on January 20, 1998
- issued this Final Report on July 27, 1998

IV. Membership and Governance

The Commission is co-chaired by Jerome J. Shestack, president of the ABA, William K. Slate II, president and chief executive officer of the AAA, and Dr. Percy Wootton, president of the AMA. The Secretary and Rapporteur is George H. Friedman, Senior Vice President of the AAA. The Recording Secretary is Scott Carfello, Regional Vice President of the Chicago office of the AAA.

Each of the institutions has four representatives on the Commission, as follows:

<u>For the American Arbitration Association:</u>

Howard J. Aibel, Esq.
Thomasina Rogers, Esq.
J. Warren Wood, III, Esq.
Max Zimny, Esq.

<u>For the American Bar Association:</u>

Hon. Arlin Adams
Kimberlee K. Kovach, Esq.
Lawrence A. Manson, Esq.
Roderick B. Mathews, Esq.

<u>For the American Medical Association:</u>

Dr. Charles Barone
Dr. Donald Palmisano
Carter Phillips, Esq.
Ron Pollack, Esq.

A roster describing the affiliations of the Commission members appears as Exhibit I of the Appendix of this Final Report.

V. Mission

The Commission on Health Care Dispute Resolution adopted the following mission statement:

> *...to evaluate and make recommendations as to how alternative dispute resolution should be used to provide a just, prompt, and economical means of resolving disputes over access to health care treatment, and coverage, in the private health plan/managed care environment.*

VI. Identified Need

The determination of the three sponsoring institutions to form the Commission was prescient. In the several months that followed the creation of the Commission, the general topic of health care has become a subject of national discourse. The President's Advisory Commission on Consumer Protection and Quality (President's Advisory Commission) in March 1998 issued a final report to the President. This group, comprised of representatives from a broad base of participants in the health care process, was formed in March 1997. In its final report to the President, this Commission urges the creation of a Patient's Bill of Rights. Legislative initiatives, at both the state and federal levels, were commenced with a goal of addressing the emerging issues in health care. Parties in the health care arena engaged in a national dialogue on how to address the many issues relating to the delivery of health care in the United States. A recurrent theme in all of these efforts was a recognized need to establish fair, neutral, swift, and economical means for settling disputes among participants in managed health care relationships.

While the Commission recognized that there are a variety of other health care relationships, its primary focus was on private managed care. According to the Final Report of the President's Advisory Commission (March 1998, p. 164), some 140 million Americans are covered by some form of private (i.e., non-governmental) health insurance. Today, three-fourths of Americans with private health insurance are enrolled in some form of managed care system (*Report of Proposed Recommendations on Process for Resolving Consumer Differences with Managed Health Care Plans*, ABA Commission on Legal Problems of the Elderly, June 1998, p.1). Given the nature of these relationships, and the sheer number of covered persons, disputes are inevitable.

Alternative dispute resolution has emerged as an accepted means of resolving disputes outside of the court system. The early working hypothesis of the convening institutions and the Commission members was that ADR can and should play an important, effective role in resolving disputes among participants in private managed health care relationships. After hearing often compelling presentations about the need for appropriate means of resolving disputes quickly, fairly, and efficiently, the Commission believes this hypothesis has been borne out.

The Commissioners note that a few states have enacted some form of legislation regulating the relationships between patients and managed health care organizations, (see, for example, Ohio's Physician-Health Plan Partnership Act of 1997), providing at some point for external review of certain health plan determinations. They also observe that similar legislation has been introduced in Congress, and that the President's Advisory Commission in Chapter Ten of its *Final Report to the President* encourages independent, external review of certain claim denials.

While these myriad efforts and activities to one extent or another involve various forms of ADR as part of the internal review process, external appeals, or both, the Commissioners concluded that there was a clear need to add definition and depth to these concepts. Stated differently, as managed health care organizations move to voluntarily embrace ADR as a form of external review, and as legislative and regulatory bodies provide direction to health plans regarding the development of external review programs, guidance and information will be needed to address how best to utilize ADR in this context. It is the Commission's objective to provide such guidance by issuing this Final Report.

VII. Objectives

There was unanimity among Commission members that ADR would facilitate the resolution of disputes in the private managed health care area which are not resolved through internal review procedures offered by the managed health care organization. In view of its overall objective of promoting the prompt and fair application of ADR in the managed health care area, the Commission identified the following main objectives:

- develop model ADR procedures for use in the managed care area (in effect, a "Restatement on Health Care ADR");
- identify substantive areas in the managed health care environment that would be suitable for resolution by alternative dispute resolution. Examples discussed included a host of coverage and access issues, such as access to specific healthcare providers, access to needed treatment or necessary care, experimental treatment, medical necessity, and reasonableness of cost;
- establish due process criteria for the use of ADR to resolve health care disputes. Examples discussed included due process procedures for ADR systems, timing of the agreement to use ADR, and informed, knowing, and voluntary use of ADR.

VIII. Areas of Study

The Commission's general focus was to study and make recommendations on the applicability of alternative dispute resolution in the private managed health care environment. It identified the following general subject matters for consideration:

- access to specific health care providers
- access to needed treatment
- access to specific health care facilities
- medical necessity of treatment
- experimental treatment
- reasonableness of cost
- continuity of care
- disclosure of information to consumers
- development of drug formularies
- out-of-area coverage
- provider communication with patients
- utilization management

Given the complexity and importance of ADR in the private managed health care setting, the Commission determined not to study the applicability of ADR to medical malpractice, Medicare, specific provisions of health care insurance contracts, or general access to health care outside of the private managed health care relationship. This does not mean that the concepts articulated in this report are not applicable to other health care relationships, such as indemnity plans

(i.e., those in which the patient seeks reimbursement from a health insurer for the cost of medical care received). The Commission is also aware that managed health care tort liability concepts are developing. These concepts may result in new types of civil claims that may be resolved by means of ADR, just as ADR is used today in many jurisdictions for resolving personal injury civil claims.

IX. Methodology

The Commission's method of operation was to seek oral and written presentations from a wide array of key organizations and individuals, to inform the Commission's thinking in developing specific ADR models and areas of application. Included in this pool of advisors were: health care providers, patient advocacy groups, health care insurers (managed health care organizations, health maintenance organizations, and indemnity plans), health insurance associations, public health officials and groups, elder care groups, and law and medical school faculty.

Overall, thirty-seven individuals or organizations responded orally or in writing to 79 written invitations to submit comments or other information to the Commission. A listing of these individuals/organizations appears as Exhibit II of the Appendix of this Report (Individuals and Organizations Contacted by the Commission for Written Submissions). The Commission's Secretary also corresponded with the President's Advisory Commission, advising of the work of the AAA/ABA/AMA Commission. The information was directed specifically to Secretary of Health & Human Services Donna Shalala and Secretary of Labor Alexis Herman (co-chairs), with a copy delivered to President Clinton. Also, various Congressional leaders were advised of the work of the Commission. ABA President Shestack arranged for the Commission's work to be showcased at the ABA's 1998 Annual Meeting, in the form of a program devoted to the use of ADR to resolve health care disputes.

Oral presentations were made at Commission meetings held on October 27, 1997; December 8, 1997; January 12, 1998; March 6, 1998; and April 29, 1998, by the following individuals:

Mary Ellen Bliss
Federal Affairs Action Team
American Association of Retired Persons

Chris Carey
Staff Member
House Committee on Education and the Workforce

Edward Dauer
Dean Emeritus
University of Denver College of Law

Michael Duffy
Director, Office of Consumer Affairs and Business Regulation
Massachusetts Consumer Affairs Commission
(and Boaz Yavnai - research assistant)

Elizabeth Hadley
Legislative Counsel for Health Policy
National Association of Insurance Commissioners

Matt Keast
Staff Member
Office of Congressman Charles Norwood

Kurt Lawson
ABA Section of Taxation

Len Marcus
Director, Health Care Negotiations
Harvard School of Public Health

F. William McCalpin
Chair
ABA Commission on Legal Problems of the Elderly

Julie Miller
Director, Policy Analysis
Blue Cross & Blue Shield Association

Dr. Donald Palmisano
Trustee

Ron Pollack
Executive Director
Families USA
(member of Commission)

David Richardson
President
Center for Health Dispute Resolution

Elizabeth Rolph
RAND

Dr. Clarke Russ
Institute for Conflict Resolution in Health Care
(Chair, Board of Medicine, Commonwealth of Virginia)

Grey Till
General Counsel
Blue Cross & Blue Shield of Alabama
(member of Commission)
American Medical Association

Oral presentations were followed by questioning from the Commission and its staff. In some instances, this process was quite intense, but the intention always was to illuminate the nature of the problem and to evaluate carefully the range of realistic alternatives available.

X. Alternative Dispute Resolution Methods and Models

A. Introduction

As courts and administrative agencies become less accessible to civil litigants, patients, health care providers, and managed health care organizations have begun to explore ADR as a way promptly and effectively to resolve disputes. A wide range of dispute prevention and resolution procedures allow the participants to develop a fair, cost-effective, and private forum to resolve disputes.

As part of its work, the Commission reviewed a number of ADR processes which may be appropriate for the resolution of disputes and disagreements which occur among patients, families, health care providers, and managed health care organizations. The use of external, independent ADR is typically not available until after all remedies are exhausted within the managed health care organization. Usually, managed health care plans will offer some form of internal review, by which a provider or participant can challenge the plan's action. While this review can and should include some elements of ADR, the Commissioners contemplate ADR playing a role in the next step - i.e., as a form of independent external review or appeal. Based on the information adduced during the course of its work, the Commission has concluded that there is a clear need to help all participants better understand how ADR works, what forms ADR takes, and what problems to avoid.

In submitting these ADR Models, the Commission does not wish to suggest that these methods are exclusive or that in some instances other procedures may not be appropriate. Rather, in its study the Commission has concluded that these are the primary ADR methods or procedures which would be most responsive to the types of managed health care disputes as outlined in Section XI of this Final Report (Areas in the Private Managed Health Care Environment Where ADR Can Be Helpful). The ADR processes summarized below also assume the presence and need for a neutral third party. To be sure, the Commission recognizes and affirms that direct negotiation among the parties and internal appeal mechanisms are often appropriate first steps in any dispute resolution scheme. The work of the Commission, however, was to explore processes which involve the use of a neutral third party dispute resolver, either to facilitate a negotiated resolution among the parties (e.g., mediation) or to render a decision (e.g., arbitration).

The Commission submits that perhaps of greatest importance are the fundamental guiding principles of efficiency, of both time and money, and fairness. Characteristics of the ADR procedures presented here, and in detail in Exhibit III of the Appendix to this Final Report (Alternative Dispute Resolution Models, are to be supplemented by the due process protocols set forth in Section XII (Due Process Standards).

B. ADR Models

The Commission submits the following proposed neutral models for ADR as prototypes for use in those matters or disputes involving managed health care. A consistent theme throughout is an effort to maintain a "level playing field" for all participants. Fully-developed models and explanations are set forth in Exhibit III of the Appendix.

Ombuds: A neutral third party (either from within or outside the program) is designated to receive information regarding managed health care disputes, and to confidentially investigate and propose settlement of complaints. The ombudsperson may also provide information on how the dispute resolution process works.

Fact-finding: The investigation of a complaint by an impartial third person (or team) who examines the complaint, considers the facts ascertained, and issues a non-binding report.

Consensus-building: A process which involves the use of a neutral third party, often referred to as a convener, who assists numerous persons or groups in arriving at a consensus through a structured negotiation among chosen representatives of all stakeholders.

Mediation: The process in which the parties discuss their disputes with an impartial person who assists them in reaching a settlement. The mediator may suggest ways of resolving the dispute but may not impose a settlement on the parties. Mediation offers the advantage of informality, with reduced time and expense needed to resolve disputes.

Arbitration: The submission of disputes to one or more impartial persons pursuant to established procedures, generally for final and binding determination. Variants include non-binding arbitration. There are four major types of arbitration agreements:

- pre-dispute, final and binding arbitration
- pre-dispute, nonbinding arbitration
- post-dispute, final and binding arbitration, and
- post-dispute, nonbinding arbitration.

The concept of the timing of the agreement to arbitrate is discussed in Section XII of this Final Report (Due Process Standards) and in Exhibit III of the Appendix (Alternative Dispute Resolution Models). *It is worth noting here, however, that the Commission's unanimous view is that in disputes involving patients and/or plan subscribers, binding arbitration should be used only where the parties agree to same after a dispute arises.*

ADR Hybrids: The combination of one or more ADR formats, frequently in sequence. For example: "Med/Arb" is mediation followed by arbitration in the event mediation is not successful. The number of potential ADR hybrids is virtually unlimited.

C. The "ERISA Problem"

As stated above, the Commissions focus was on the use of ADR in the private managed health care environment. It is worth noting that the overwhelming majority of individuals covered by private health plans obtained this coverage through an employer-provided health plan. According to the President's Advisory Commission, 123 million American receive health insurance through their employer, while only 10 to 16 million Americans purchase directly their own coverage (*Final Report*, p. 164). The Employee Retirement Income Security Act of 1974 (ERISA) governs, among other things, all health benefit plans that are employer-provided, establishing standards for the enforcement of "consumer" rights under employer-provided health plans.

By its terms, ERISA preempts the states from providing different remedies for denials of health benefits. Thus, an individual covered by an employer-provided health plan, under ERISA, may not invoke tort or contract law remedies in state courts, and is thus limited to seeking judicial intervention for only the following remedies:

- providing the covered service, or reimbursing the cost of the service;
- directing the plan to act;
- clarifying future benefits.

A question arose concerning whether the use of ADR as a form of external review of health plan determinations might be precluded by the ERISA preemption. It was the conclusion of the Commission, however, that ERISA does not preclude the parties from voluntarily adopting the use of ADR— even binding forms of ADR—to resolve disputes among them. It may well be that legislative clarification would be helpful to avoid confusion or concern over the appropriate use of ADR in the managed health care area, but specific recommendations in this regard would be beyond the scope of the Commission's charge from the convening institutions.

XI. Areas in the Private Managed Health Care Environment Where ADR Can Be Helpful

A. Introduction

The Commission's major focus was on one type of dispute in the private managed health care context—"consumer v. plan." Nevertheless, the Commission recognizes that managed care involves a range of disputes (and alliances) among a number of participants, including buyers, plans, providers in the plans, providers not in the plans, as well as consumers. The disputes that exist in this area are those that exist in the traditional insurance context as well, i.e., the long-standing insurance coverage issues, which now more frequently arise because the insurer/managed plan may simply be saying "no" more frequently.

In addition, in managed care, the "consumer v. plan" dispute is often a "consumer + provider v. plan" dispute, in which the issue is whether the provider can perform services with the expectation of payment from the plan, and the consumer is convinced by the provider that the services will be beneficial. There are also "provider v. plan" disputes that can involve a provider not in the plan. For example, the provider may want to participate in, or dispute, some out-of-plan payment policy.

Finally, there are also a series of "purchaser/plan/provider" disputes arising. In some markets, the larger employers are beginning to determine and select provider networks without regard to a plan's decisions. Thus, it can be anticipated that "provider v. purchaser v. plan" disputes will arise, especially as data collection and reporting begin to dominate, and plans and providers dispute the data/reports.

B. Matching ADR Process to Dispute Type

The Commission considered developing a matrix that matched specific types of managed health care disputes to specific ADR methods. In the final analysis, however, it seemed more efficient and useful to identify both broad categories of potential disputes and subcategories of areas of conflict that would be well served by an ADR procedure. This is presented schematically in Exhibit IV of the Appendix (Matrix of Areas of Disputes Amenable to ADR). It was the consensus of the Commission that a form of ADR would be appropriate for resolving the identified categories and subcategories of disputes, but that identifying a particular form of ADR as the single most appropriate means of resolving a particular dispute type was an inappropriate limitation on the parties' discretion.

C. Detailed Analysis of Potential Disputes

Managed health care disputes for which alternate dispute resolution is particularly appropriate include: medical necessity; length of stay; medical appropriateness of place or provider; situations requiring early coordination of treatment by various disciplines such as mental health or substance abuse planning or planning for outcomes among medical, social, psychological, legal and ethical experts; reduction or termination of services; over or under-utilization of resources or facilities; physician or patient concerns about utilization incentives or disincentives; bioethical conflicts; staff disagreements; interpersonal disputes; access to appropriate procedures and equipment and access between providers and outside networks; and, in general, disputes involving non-monetary outcomes.

Health care ADR is best and most effective where the parties have legitimate and serious issues in dispute, and external review of a decision made by a managed health care organization is called for. Generally, limitations on such use of ADR processes for external review should be by exception only. At the same time, appropriate thresholds should be established so as not to overburden available health care ADR resources with either frivolous claims involving mere misunderstandings or miscommunications, or disputes of such high complexity as to defy resolution (e.g. whether the plan should be essentially re-written to cover new cutting edge, experimental technology or treatment). Unequivocal contract provisions, such as health care insurance eligibility requirements and coverage limitations and exclusions, are generally not appropriate for health care ADR because it is usually not the province of ADR to rewrite unambiguous contract provisions. Intra-family disputes over treatment plans or modalities are probably best dealt with by other means.

ADR processes are, however, well suited to managed health care situations where the need for specialized, confidential, non-precedential disposition is critical. ADR is particularly valuable when rules are unclear or are ambiguous or where the stakes for the interested parties are very high, or where strong emotions such as distrust or the need for retribution are present. In a typical indemnity health plan, grievances by consumers usually involve denial of payment to providers after services have been rendered. In a managed health care arrangement, services are pre-authorized and disputes usually involve denial of access to health care services. The majority of disputes between the consumer and the private managed health care organization thus involve benefit coverage issues and coverage for out of plan services. These potential areas of conflict are set forth below.

1. Health Plan Coverage Issues (within health plan or with affiliated providers)
    a. Surgical procedures (denial for surgery, usually elective surgery)
    b. Cosmetic surgery (denial of request for service)
    c. Dental/oral surgery (denial of request for service)
    d. Durable medical equipment (denial of requests for equipment)
    e. Procedures and tests (denial of specific lab tests, x-rays, other diagnostic procedures)
    f. Physical therapy/occupational therapy (denial of request for services)
    g. Denial of referral from primary care provider to specialists or other providers requiring Referrals
    h. Mental health services (denial of request for specific therapy or treatment program length)
    i. Second opinions
    j. Restricted formulary (denial of specific medications and treatment regimens not included in health plan formulary)
    k. Excessive wait time for access to needed service
    l. Home health care benefits
    m. Length of stay (discharge from hospital or other health care facility before consumer feels he/she is able)
    n. Hospice
2. Out of Health Plan Coverage Issues (not part of plan or nonaffiliated providers)
    a. Out of area (out-of-state) coverage for needed medical services
    b. Emergency services (nonaffiliated hospital/ER)

- **c.** Access to nonaffiliated primary care providers
- **d.** Access to nonaffiliated specialty care providers
- **e.** Access to nonaffiliated mental health services
- **f.** Admission to nonaffiliated hospitals
- **g.** Second opinions with nonaffiliated providers (primary care or specialty care)
- **h.** Access to nonaffiliated dental/oral surgery

3. Access to nontraditional/"alternative" Medical Care

4. Experimental Care/"Last Chance" Therapy (as stated above, the issue amenable to ADR is not whether the contract should be re-written to include experimental care or "Last Chance" Therapies—since managed health care plans may specifically exclude such coverage—but, in instances in which experimental care is a covered benefit, whether such treatment is medically necessary or appropriate)

5. Continuity of Care Issues (continued treatment of preexisting conditions by current provider not affiliated with the health plan when health plan coverage is switched: pregnancy, oncology, primary care/continuation of treatment plan including prescriptions)

6. Time-Sensitive Situations (any dispute between a consumer and a health plan where the timing of access to the disputed service has a permanent adverse effect on treatment outcome: emergency care, out-of-state care, transplants, oncology, surgery, potentially terminal conditions)

7. Customer Service Issues (complaints regarding health care providers, health care workers, processes, wait times)

XII. Due Process Standards

A. Background

The members of the Commission believe that mediation and arbitration of health care disputes—conducted with proper due process safeguards—should be encouraged in order to provide expeditious, accessible, inexpensive, and fair resolution of disputes. As ADR systems are developed for resolving private managed health care disputes, it is essential that such systems provide adequate levels of procedural due process protections for all involved.

The nature of the relationship between plans and patients or providers is such that little, if any, negotiation over terms—including external review or ADR systems—takes place. Since these ADR systems or external review procedures will invariably not be the product of a negotiated agreement, the Commission believes it would be especially useful to set forth key aspects of procedural due process, to ensure a "level playing field" for resolving health care disputes by ADR. Similarly, these due process protocols can serve as guidance for legislators or regulators as they focus on establishing fair and appropriate methods for resolving health care disputes.

Due process protocols for the use of ADR have also been developed in two other areas—employment and consumer—where, as in health care, the establishment and terms of the ADR system are matters not generally subject to negotiation. Those protocols, which the Commissioners drew upon in developing the *Due Process Protocol for the Resolution of Health Care Disputes*, appear respectively as Exhibits V and VI of the Appendix of this Report.

B. Covered Relationships

The Due Process Protocol for the Resolution of Health Care Disputes contained in this section was developed for a wide range of transactions arising out of the private managed health care relationship. As described in Section XI of this Report (Areas in the Private Managed Health Care Environment Where ADR Can Be Helpful), these can include: "consumer v. plan" disputes, "provider v. plan" disputes, and "purchaser v. plan v. provider" disputes.

The purpose of the Protocol is not to define each and every type of health care dispute in which due process standards for the use of ADR are needed. The Commission believes that as a matter of general principle, any ADR system developed in the health care environment would be well-served by adhering to the due process concepts articulated below.

C. A Due Process Protocol for Resolution of Health Care Disputes

Principle 1: Fundamentally Fair Process

All parties are entitled to a fundamentally fair ADR process. As embodiments of fundamental fairness, these Principles should be observed in structuring ADR Programs.

Principle 2: Access to Information Regarding ADR Program

Full and accurate information regarding the program, in writing, should be provided by the plan to patients and providers in plain, easily understood language. If a substantial number of users speak languages other than English, the material describing the program should be available in other languages. The information regarding the program should include a description of the process, the role of the parties, the means of selecting neutrals, the rules of conduct of the parties and the neutrals, and an accurate description of fees and expenses.

After a dispute arises, participants should have access to all information necessary for effective participation in ADR. Disputes over exchanges of information should be resolved by the neutral.

Principle 3: Knowing and Voluntary Agreement to use ADR

The agreement to use ADR should be knowing and voluntary. Consent to use an ADR process should not be a requirement for receiving emergency care or treatment. In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises.

Principle 4: Neutrality and Independence

1. *Independent and Impartial Neutral:* All parties are entitled to a neutral who is independent and impartial.
2. *Independent Administration:* Administration of the ADR program should be neutral, and independent of the parties. In no event should the ADR program be administered by the health plan. Administrative services should include the maintenance of a panel of prospective neutrals, facilitation of neutral selection, collection and disbursement of neutral fees and expenses, oversight and implementation of ADR rules and procedures, and monitoring neutral qualifications, performance, and adherence to pertinent rules, procedures, and ethical standards.
3. *Standards for Neutrals:* The rules of administration should guarantee impartiality in selecting neutrals and require conformity with ethical standards of conduct.
4. *Selection of Neutrals:* All parties should have an equal voice in the selection of neutrals in connection with a specific dispute.
5. *Disclosure and Disqualification:* Neutrals should be required to disclose to the administering agency any circumstance likely to affect impartiality, including any bias or financial or personal interest which might affect the result of the ADR proceeding, or any past or present relationship or experience with the parties or their representatives, including past ADR experiences. The administrator should communicate any such information to the parties and other neutrals, if any. Upon objection of a party to the continued service of a neutral, the administrator should determine whether the neutral should be disqualified and should inform the parties of its decision. The disclosure obligation of the neutral and procedure for disqualification should continue throughout the period of appointment.

Principle 5: Quality and Competence of Neutrals

All parties are entitled to competent, qualified neutrals. ADR administrators are responsible for establishing and maintaining standards for neutrals in ADR programs they administer. Neutrals serving in health care disputes should have

knowledge and experience in health care matters. Disputes concerning the provision of medical care based on medical necessity standards should be resolved by neutrals who are qualified to render medical decisions in the particular medical branch and related specialty involved in the dispute.

The creation of a roster containing the foregoing qualifications dictates the development of a training program to educate existing and potential mediators and arbitrators as to the relevant law, and the substantive, procedural and remedial issues likely to be encountered in the conduct and control of arbitration hearings and mediation sessions.

Principle 6: Right to Representation

It is recommended that plans provide, at their expense, the services of an ombudsperson whose function would be to explain the dispute resolution process to patients, and to provide an initial screening of the case.

All parties participating in the ADR process have the right, at their own expense, to be represented by an attorney or other spokesperson of their own choosing. The ADR procedures should direct the parties to referral services for representation of bar associations, legal service associations, unions, consumer organizations, and the like.

Principle 7: ADR Hearings

1. *Fair Hearing:* The pre-hearing and hearing should be conducted with adequate notice and with a fair opportunity to be heard and to present relevant evidence and witnesses. There should be a right to examine and cross-examine witnesses, and to argue orally and/or in writing. The right to present relevant evidence should include access to relevant books and records. The hearing and determination through mediation or arbitration should be private and confidential, unless the parties agree otherwise.
2. *Place of Arbitration or Mediation:* The place of the proceedings should be reasonably accessible to the parties and to the production of relevant evidence and witnesses. In cases involving a patient, the place should be in close proximity to the patient's place of residence. If the parties are unable to agree on the place of arbitration or mediation, the administering agency or the neutral should determine that issue. In a case of acute emergency, it may be appropriate to conduct the arbitration or mediation by telephone or other electronic means.
3. *Confidentiality:* Consistent with general expectations of privacy in ADR, the neutral should make reasonable efforts to maintain the privacy of ADR hearings to the extent permitted by applicable law. In arbitration, the arbitrator should carefully consider claims of privilege and confidentiality in addressing evidentiary issues.

Principle 8: Reasonable Time Limits

ADR proceedings should occur within a reasonable time, and without undue delay. The rules governing ADR should establish specific reasonable time periods for each step in the ADR process and, where necessary, set forth default procedures in the event a party fails to participate in the process after reasonable notice. The Commission recommends the following general timeframes for resolving disputes: acute emergencies—24 hours; emergencies—72 hours; non-emergencies—60 days.

Principle 9: Settlement in Mediation or Award in Arbitration

1. *Mediation Settlement:* Any settlement in mediation or other non-binding form of ADR should be in writing.
2. *Arbitration Award:* The arbitration award should be in writing, and should be accompanied by an opinion, where requested by any party. In the case of an acute emergency, the arbitrator may make a preliminary award orally. The arbitrator should be empowered to grant whatever relief would be available in court under law or in equity. There should be limited judicial review. Courts should defer to the arbitrator's award absent manifest disregard of clearly defined governing law.

Principle 10: Costs in Mandated, Nonbinding ADR Processes

If mediation is mandated, the cost thereof should be at the expense of the health plan.

As provided in Principle 3, binding ADR arbitration should not be mandated in cases involving patients. Nonbinding arbitration may be required, as can binding arbitration in cases not involving patients, in which case the plan should pay the costs of at least one day of hearing before a single arbitrator, including the arbitrator's fees and expenses. If there are additional days of arbitration, or more than one arbitrator, the costs should be shared equally, subject to the arbitrator's authority to determine the allocation of costs.

XIII. Conclusion

The Commission concludes that alternative dispute resolution has a valuable role to play in the resolution of disputes arising out of the private managed health care relationship. ADR complements internal review programs, serving as the next efficient and effective step for resolving unsettled claims. ADR can function effectively as a means of external review or appeal of determinations made by managed health care organizations. It is essential, however, that ADR programs be developed with due process safeguards for the rights of all participants in the process.

The Commission urges that its recommendations be used as guidance by legislative bodies, regulators, and policy leaders, as well as private managed health care organizations establishing ADR programs.

XIV. Planned Course of Future Action

The Commission met both its short-term major goal of the promulgation of an Interim Progress Report by late January 1998, and the longer-term goal of publication of this Final Report by the Summer of 1998. Each of the Commissioners has signed off on the Final Report as individuals representing, but not necessarily binding, their respective organizations. The Final Report will be presented for timely review by the three sponsoring organizations, and will then be widely disseminated to diverse groups (i.e., provider organizations, patient advocacy groups, employer groups, employee groups, labor, consumer groups, academia, government, regulatory agencies, managed health care organizations and health plans).

Following review by the three sponsoring organizations, a Final Report will be released.

The members of the Commission appreciate the opportunity to play a role in helping to shape the public debate over the use of ADR as a means of resolving disputes in the private managed health care arena.

Submitted this 27th day of July 1998

George H. Friedman
Commission Rapporteur and Secretary,

To the Co-Chairs: Jerome J. Shestack, Esq.; William K. Slate II, Esq.; Percy Wootton, M.D.

Appendix

I. Commission Roster

Commissioners

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II. Individuals and Organizations Contacted by the Commission for Written Submissions

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Karen	Agnagni	CEO & President	American Association of Health Plans
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Mike	Astrue		Biogen, Inc.
Mary Ellen	Bliss	Federal Affairs Team	American Association of Retired Persons
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Jay D.	Christiansen	Chair Health	Law Section, Faegre & Bensen
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Tom	Jorgenson		Calfee, Halter & Griswold
Matt	Keast	Staff Member	Office of Hon. Cong. Charles Norwood
Irene	Koch	Assistant General Counsel	Maimonides Medical Center
William	Kowalski		AETNA
Kurt	Lawson	Representative	ABA Section of Taxation
Brian	Lindberg	Director	Coalition on Cons. Protection/Qlty. Hlth. Care
Ronald E.	Mallen	Chair	Special Committee on Medical Prof. Liability
Mark	Manner	Partner	Harwell, Howard, Hyne, Gabbert & Manner
Len	Marcus	Director	Health Care Negotiations
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Clayton	McWhorter	Chairman	LifeTrust America

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Jay	Naftzger	Chair	Rush Prudential Health Plans
Martha R.	Nolan		United HealthCare
Margaret	O'Kane	President	National Comm. for Qual. Assurance ("NCQA")
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Mary	Rowe	Ombudsperson	Sloan School

First Name	Last Name	Title	Affiliation
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Alan G.	Selbst		Houston Endodontic Specialists
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Katie	Wade		CIGNA
Robert	Wagener		Center for Medical Ethics & Mediation
Gayle	Warden	President & CEO	Henry Ford Health Systems
Linda R.	Williams		
Roger	Wilson	Senior VP & GC	Blue Cross & Blue Shield Association
Alan	Wise	CEO	Coventry Corp
Edward K.	Wissing	CEO	American Home Patient, Inc.

III. Alternative Dispute Resolution Models

The models set forth below are by no means exhaustive; they represent sensible approaches to the major forms of alternative dispute resolution. In designing any ADR system, care should be taken to tailor the system to the specific needs of the parties. Guidance on the process of developing dispute resolution systems, as well as model language for various provisions and features of ADR clauses, can be found in *Drafting Dispute Resolution Clauses,* published by the American Arbitration Association (1997).

A. Ombuds

The ombuds process involves a neutral third party who is often employed or appointed by an institution, whose primary role is the investigation of complaints, as well as their prevention and resolution. An ombudsperson may also make recommendations with respect to the resolution of the matter, but cannot make a binding decision.

The most even-handed, fair, and appropriate ADR system will not work effectively if parties are not aware of the existence of the program, or are not educated as to how the system works. Therefore, another key role of the ombudsperson is to provide information on the dispute resolution process, both internal and external. In effect, the ombudsperson serves as a system guide to users, providing useful information about how the managed health care organization resolves disputes.

With regard to those matters involving the provision of health care, it is suggested that those plans which desire to put in place an ombuds system of dispute resolution observe the following guidelines. The ombuds should be a person with a medical education and experience. While the ombuds will likely be an employee of the managed health care organization, it is suggested that the ombuds process, if opted for, should also involve the participation of the patient's family and/or significant other, where desired and appropriate. While much should be left to the discretion of the ombudsperson, it is recommended that the health care provider, as well as the plan decision maker, also be included in the preliminary discussions and fact gathering.

In some models, the ombudsperson's function is strictly neutral. In others, the ombudsperson acts as a patient advocate. The Commission takes no position on which model is most desirable.

B. Mediation

In mediation, a neutral third party, the mediator, facilitates the voluntary and mutually acceptable resolution of a dispute. A non-adversarial approach to dispute resolution, mediation emphasizes direct communication among the parties and creativity in problem solving. The mediator's role is to help the disputants explore issues, needs and settlement options. The mediator may point out issues that the disputants may have overlooked and in some instances offer suggestions, but resolution of the dispute rests with the disputants themselves.

- The benefits of successfully mediating a dispute to settlement vary, depending on the needs and interests of the parties. The most common advantages are that:
- parties are directly engaged in the negotiation of the settlement;

- the mediator, as a neutral third party, can view the dispute objectively and can assist the parties in exploring alternatives which they might not have considered on their own;
- as mediation can be scheduled at an early stage in the dispute, a settlement can be reached more quickly than in litigation;
- parties generally save money through reduced legal costs and less staff time;
- parties enhance the likelihood of continuing their business relationship;
- creative solutions or accommodations to special needs of the parties can become a part of the settlement;
- a high probability of settlement. A frequently-cited mediation settlement rate is 85% (statistical data provided by the American Arbitration Association, Client Services Group, June 1998).

1. Providing for Mediation

The parties can provide for the resolution of future disputes by including a mediation clause in their contract. A typical mediation clause reads as follows:

> *If a dispute arises out of or relates to this policy/contract or the breach thereof and if the dispute cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute by mediation administered by [named ADR provider], prior to resorting to arbitration, litigation, or some other dispute resolution procedure.*

The clause may also provide for the qualifications of the mediator, the method of payment, the locale of meetings, and any other item of concern to the parties.

2. Requesting and Scheduling the Mediation

Although mediations can originate at various times, including as an adjunct procedure to pending litigation (including appeals), it is anticipated that mediation will occur when a dispute between the patient and the managed health care organization initially arises and before other, more formal means of dispute resolution such as arbitration or a lawsuit is initiated.

In the case of health care, timing is of the essence and the mediation agreement (or mediation clause) should specifically spell out the time within which a mediation must be conducted, after such has been requested or demanded. In fact, one of the primary advantages to the mediation process is that a mediation conference can be scheduled very quickly and requires a relatively small amount of preparation time. In cases of emergency, the mediation should be scheduled in accordance with the time frames in Principle 8 of the *Due Process Protocol for the Mediation and Arbitration of Health Care Disputes* (Section XII of this Final Report).

When a party files a Request for Mediation, the requesting party should forward a copy of the mediation clause contained in the contract under which the dispute arose.

The mediation should be conducted at a location which is convenient for both the patient and family as well as the provider and the plan decision maker. Priority consideration should also be given to the health and well being of the patient in terms of the ability to travel, when determining the location of the mediation session. The duration of the mediation session itself may also need to be abridged if the patient's health imposes such limitations. Consideration should also be given to the managed health care organization decision-maker, particularly in non-emergency matters, such as the ability to participate in several mediations at a given time.

In those situations where the health of a party makes it difficult for their personal appearance at the mediation, latitude should be given to the mediator for the use of telephones, video conferencing, and the Internet as alternative methods for communication and participation (*Protocol*, Principle 7(2)).

3. Qualifications and Selection of the Mediator(s)

Upon receipt of a Request for Mediation or the Submission to Dispute Resolution, the administrator will appoint a qualified mediator to serve on the case. All participants (which include family members or significant others of the patient seeking treatment, who are not considered actual parties) will be provided biographical information about the mediator. The parties are instructed to review the sketch closely and advise the administrator of any objections they may have to the appointment. Since it is essential that all parties have complete confidence in the mediator's ability to be fair and impartial, any mediator not acceptable to the parties will generally not serve. In the situation where there has not been a designation of an administrator, the party seeking the mediation should notify the other by the means specified in the mediation agreement, and the mediator will be selected as provided in the agreement of the parties.

Mediators serving in health care disputes should have knowledge and experience in health care matters. Disputes concerning the provision of medical care based on medical necessity standards should be heard by mediators who are qualified to render medical decisions in the particular medical branch and related specialty involved in the dispute (*Protocol*, Principle 5), although this is ultimately a matter for determination by the parties given the consensual, nonbinding nature of mediation. General dispute resolution qualities in mediators for these cases include, but are not limited to the following: commitment to impartiality and objectivity; dispute management skills, including excellent communication abilities; judicious temperament: impartiality; patience; courtesy; respect of bar or business community for integrity; strong academic background and professional or business credentials. The mediator must also be committed to compliance with the nationally-recognized *Model Standards of Conduct for Mediators*, promulgated by the American Arbitration Association, the American Bar Association, and the Society of Professionals in Dispute Resolution.

In some instances, the use of co-mediation may be appropriate. Co-mediation involves two mediators who simultaneously and equally mediate the matter. For example, in situations that are quite complex in terms of technology or science, where expertise from two or more disciplines is needed, it is advocated that the parties consider using a co-mediation model. And, in some cases where the number of parties affected, and hence participants in the process is large, or, where the issues presented for resolution are very diverse, co-mediation is also recommended.

4. Participant Preparation for Mediation

To prepare for mediation, each of the participants may wish to define and analyze the primary issues in dispute, and recognize the parameters of the given situation. This would include what can realistically be expected, time constraints, available resources, legal ramifications, generally accepted practices, options for alternative treatment, costs, and the like. Each person or organization should also attempt to identify and prioritize the needs and interests in settling the dispute. Determination of alternative courses of action, positions, tradeoffs, and exploration of a variety of possible solutions in advance of the session can be helpful. To reach a mutually acceptable agreement through mediation, it is usually necessary that each party be willing to make reasonable and legitimate proposals, which accommodate needs of the other party. Since disputes are often the result of misunderstandings or a lack of understanding about the matter, parties should be prepared with facts, documents, and sound reasoning to support claims and desired outcome. In doing so, it is also helpful to the process if some consideration is given to the other party's needs, demands, strengths and weaknesses, positions, and version of facts and perceptions.

5. Presence and Participation in the Mediation

All participants in the mediation should come to the session prepared with all of the information, including documentation that they feel will be necessary to discuss their respective cases. Parties are, of course, entitled to representation by counsel. At the beginning of the session, mediators describe the procedures and ground rules covering each party's opportunity to talk, order of presentation, decorum, discussion of unresolved issues, use of caucuses, and confidentiality of proceedings.

After the introductory matters, each party will be provided the opportunity to describe respective views of the dispute. The initiating party discusses his/her understanding of the issues, the facts surrounding the dispute, what he/she wants, and why. The other parties then have the same opportunity to make presentations. In this initial session, the mediator gathers as much information as possible and appropriate under the circumstances as well as attempts to clarify discrepancies. The mediator tries to understand the perceptions of each party, their interests, and their positions on the issues. It is imperative, however, that the mediator remain neutral on the issues, and refrain from providing an opinion on the ultimate outcome of the matter.

When joint discussions have reached a stage where no further progress is being made, the mediator may decide to meet with each party privately, or in caucuses. While holding separate sessions with each party, the mediator may shuttle back and forth. By discussing all options, parties can assess the consequences of continuing or resolving the dispute.

- Gaining certain knowledge or facts from these meetings, a mediator can selectively use the information derived from each side to:
- reduce the hostility between the parties and help them to engage in a meaningful dialogue on the issues at hand;
- open discussions into areas not previously considered or inadequately developed;
- communicate positions or proposals in understandable or more palatable terms;
- probe and uncover additional facts and the real interests of the parties;

- help each party to better understand the other parties' views and evaluations of a particular issue, without violating confidences;
- narrow the issues and each party's positions and deflate extreme demands;
- gauge the receptiveness for a proposal or suggestion;
- explore alternatives and search for solutions;
- identify what is important and what is expendable;
- prevent regression or raising of surprise issues; and
- structure a settlement to resolve current problems and future parties' needs.

6. The Role of the Mediator

The mediator acts as a facilitator to keep discussions focused and avoid new outbreaks of disagreement. The mediator also assists the parties in communicating with, and ultimately understanding, the other parties. In particular, the mediator should work with the parties to: narrow the issues and each party's positions, and deflate extreme demands; gauge the receptiveness for a proposal or suggestion; explore alternatives and search for solutions; structure a resolution which will not only resolve current problems, but moreover is likely to meet and satisfy the parties' needs in the future. The mediator serves not as an advocate for any party or position, but rather as an "agent of reality." The mediator is likely to urge each party to think through demands, priorities, and views, and deal with the other party's contentions.

During the mediation, whether in private or joint sessions, the mediator works with the parties to narrow differences and attempts to acquire agreement on both major and minor issues. At appropriate times, the mediator may offer suggestions about a final settlement, stress the consequences of failure to reach agreement, emphasize the progress which has been made, and formalize offers to achieve an agreement.

The mediator will often have the parties negotiate the final terms of a settlement while together in a joint session. The mediator will then verify the specifics of the agreement and make sure that the terms are comprehensive, specific, and clear in the final session.

7. The Mediated Settlement

It is anticipated that in the majority of cases, the mediation session will result in an agreement among the parties. In these cases, when the parties reach an agreement, the terms should be reduced to writing, usually by the mediator, or in the event of legal representation, the parties' lawyers, signed by all present, and copies distributed. In those matters where pending litigation exists, the parties or their counsel may also request that the agreement be put in the form of an agreed judgment or consent award. In the event that the issue is critical, from a medical standpoint, and time is of the essence, a party may elect to telephonically or electronically convey the agreement to the appropriate and necessary person or organization.

If the mediation fails to reach a settlement of any or all of the issues, the parties may agree to submit to binding arbitration. Such arbitration would be administered under the appropriate arbitration rules as agreed by the parties. In

accordance with most available mediation rules, court rules of evidence, or the parties' submission to mediation, the information offered in mediation may not be used in arbitration (or in subsequent litigation).

8. Costs

As provided in Principle 10 of the *Due Process Protocol for the Resolution of Health Care Disputes*, if mediation is mandated by the managed health care organization, the costs of the process (mediation filing fee, and mediator compensation and expenses) should be borne by the plan. If the parties mutually agree to utilize mediation, these costs should be borne equally or as otherwise agreed to by the parties.

In no instance should the mediator's compensation be contingent upon a specific outcome. Should any dispute arise about the costs of the mediation, it is recommended that such be submitted first to mediation, and in the event of no agreement, to arbitration. The neutral mediator or arbitrator should have no interest in the outcome of the fee dispute.

C. Arbitration

Arbitration is referral of a dispute to one or more impartial persons for a decision on the matter. Arbitrations may result in either final and binding determinations, or alternatively, be merely advisory in nature. An adversarial process, arbitration results in a determination being made by a neutral third party, based upon the presentation of evidence and argument by the parties or their counsel. Private and confidential, it is designed for quick, practical, and economical settlements.

1. Providing for Arbitration

Arbitration clauses are common in a number of contracts. The clause will govern the procedure, and can be simple or quite detailed in the elements included. As provided in Principle 3 of the *Protocol*, in disputes involving patients, binding forms of ADR, such as arbitration, should be used only where the parties agree to same after a dispute arises. A binding arbitration clause, however, may be perfectly appropriate for other relationships in the private managed health care area, such as disputes between health care providers and managed health care organizations. A sample of a simple contractual arbitration clause for use in such instances is as follows:

> *Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration administered by [named ADR provider] in accordance with its [applicable] rules and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.*

Parties can exercise additional control over the arbitration process by adding specific provisions to arbitration clauses or, when a dispute arises, through the modification of certain of the arbitration rules to suit a particular dispute. For example, stipulations may be made regarding confidentiality of proprietary information used, evidence, locale, the number of arbitrators, and the issues subject to arbitration. The parties may also provide for expedited arbitration procedures, including the time limit for rendering an award, if they anticipate a need for hearings to be scheduled on short notice. It is anticipated that this will likely be the case in a number of situations addressed in the health care area. All such mutual agreements will be binding on the administrator of the process, as well as the arbitrator.

For disputes involving patients, there are two ways to provide for post-dispute submission to binding arbitration. The first is to include a provision in the managed health care policy providing consideration of submission to binding arbitration, after a dispute arises. The following clause can be utilized:

Any controversy or claim arising out of or relating to this policy/contract that is not resolved by the parties, shall, upon the written agreement of the parties after the dispute arises, be settled by arbitration administered by [named ADR provider] under its [applicable] rules, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

If the managed health care policy does not provide for optional, post-dispute binding arbitration, the parties are free to submit an existing dispute to arbitration by using the following clause:

We, the undersigned parties, hereby agree to submit to arbitration administered by the [named ADR provider] under its [applicable] rules the following controversy: (cite briefly). We further agree that the above controversy be submitted to (one) (three) arbitrator(s). We further agree that we will faithfully observe this agreement and the rules, that we will abide and perform any award rendered by the arbitrator(s), and that judgment of the court having jurisdiction may be entered on the award.

2. Timing of Agreement to Arbitrate

As stated in Section X(B) of this Final Report (ADR Models) there are four major types of agreements to arbitrate:

- pre-dispute, final and binding arbitration
- pre-dispute, nonbinding arbitration
- post-dispute, final and binding arbitration, and
- post-dispute, nonbinding arbitration.

It is worth elaborating on what these concepts mean:

Pre-dispute, final and binding arbitration: The parties agree in advance to use arbitration to resolve disputes and they are bound by the outcome.

Pre-dispute, nonbinding arbitration: The parties agree in advance to use arbitration to resolve disputes, but they are not bound by the outcome.

Post-dispute, final and binding arbitration: The parties have the option, after a dispute arises, of deciding to arbitrate unresolved issues, and they are bound by the outcome.

Post-dispute, nonbinding arbitration: The parties have the option, after a dispute arises, of deciding to arbitrate unresolved issues, but they are not bound by the outcome.

The first form of arbitration (pre-dispute, final and binding arbitration) engendered considerable discussion among the Commission members. As provided in Principle 3 of the *Due Process Protocol for the Resolution of Health Care Disputes*, the agreement to use arbitration (or any form of ADR) should be knowing and voluntary. This of course assumes that full and accurate information regarding the ADR program is provided by the plan to participants (*Protocol*, Principle 2). In the Commission's view, participation in ADR should not be a requirement for receiving emergency medical care or treatment, (*Protocol*, Principle 3), and good practice dictates that a patient in an emergency situation not be approached at that time to consent to ADR.

As regards binding arbitration, it may be technically correct that a provision in a managed health care plan requiring binding arbitration is "voluntary" in the sense that a patient or subscriber who has received clear notice of this fact has, by accepting the health coverage, agreed to this term of the policy. Nonetheless, it was the Commissioners view that in disputes involving patients, binding arbitration should be used only where the parties agree to arbitrate after a dispute arises (*Protocol*, Principle 3).

3. Benefits of Arbitration

Arbitration has several claimed or perceived benefits. To a certain extent, the benefits may be inferred either from experience or from knowledge of the arbitration process. There has been some research which sets forth the perceptions of participants in the ADR process (see, for example, Deloitte & Touche Litigation Services *1993 Survey of General and Outside Counsels: Alternative Dispute Resolution* (1993)). Major benefits of arbitration are as follows:

- *Expert Neutrals:* The arbitrators have expertise in the subject matter in dispute, as well as training in the arbitration process;
- *Speed:* There is no docket or backlog in arbitration. Hearings are scheduled as soon as the parties and the arbitrator have dates available;
- *Cost Savings:* Because of the limited discovery and the informal hearing procedures, as well as the expedited nature of the process, the parties save on legal fees and transactional costs;
- *Confidentiality:* Arbitration is a private process. There is generally no public record of the proceedings; and
- *Limited Discovery:* Extensive, litigation-like discovery is generally not associated with arbitration. Necessary document exchanges will take place as directed by the arbitrator.

4. Administration; Requesting and Scheduling Arbitration

It was the Commission's view that administration of ADR arising out of health plans be neutral and independent of the parties, and that in no event should an ADR program be administered by a health plan (*Protocol*, Principle 4(1)). This will ensure to a reasonable extent that administration of disputes will be handled with dispatch and without inherent conflicts of interest. This element of the Protocol is in accord with the leading court case dealing with the issue of independence of ADR case administration, *Engalla v. Kaiser Permanente Medical Group Inc.*, 938 P.2d 903 (Cal. 1998).

In an administered system, the administrator will be responsible for the management of most details and arrangements. In each matter, the designated administrator would consult all parties and arbitrators to determine a mutually convenient day and time for the hearing. If the parties cannot agree, the arbitrator is empowered to set dates.

All parties should endeavor to conduct the arbitration hearing at a location that is convenient for both the patient and family as well as the provider and the plan decision-maker. In some instances, this will require travel costs for the arbitrator, and such should be allocated in the agreement to arbitrate, if not in a prior arbitration clause. As provided in Principle 8 of the *Due Process Protocol*, consideration should also be given to the health and well-being of the patient in terms of the ability to travel, when determining the location of the hearing.

At the request of any party, or at the discretion of the administrator, an administrative conference with the administrator and the parties and/or their representatives will be scheduled in appropriate cases to expedite the proceedings. This is particularly pertinent in cases where time is critical and life threatening matters are at issue.

5. Qualifications and Selection of Arbitrators

Selected qualities in arbitrators include the following: commitment to impartiality and objectivity; dispute management skills; judicious temperament: impartiality, patience, courtesy; respect of bar or business community for integrity; and strong academic background and professional credentials. Arbitrators serving in health care disputes should have knowledge and experience in health care matters. Disputes concerning the provision of medical care based on medical necessity standards should be resolved by arbitrators who are qualified to render medical decisions in the particular medical branch and related specialty involved in the dispute (*Protocol*, Principle 5).

The conduct of arbitrators should be guided by the *Code of Ethics for Arbitrators in Commercial Disputes* of the AAA and ABA (*Protocol*, Principle 4(3)).

6. Preparation for the Arbitration Hearing

The administrator will usually be in contact with the parties and/or their representatives in advance of the hearing. Because arbitration is an adversarial procedure, direct communication between the parties should be generally prohibited so to avoid the danger that one side will offer arguments or evidence that the other has no opportunity to rebut.

In complex cases, at the request of any party or at the discretion of the arbitrator or the administrator, a preliminary hearing with the parties and/or their representatives may be conducted. In addition, in order to expedite the process, documents should be exchanged and provided to the arbitrator(s) at least three days in advance, except for those cases scheduled within less than seven days. In those instances, the document exchange shall be no less than 24 hours, unless so waived by agreement.

The right to representation in arbitration by counsel or another authorized person is guaranteed by the *Due Process Protocol* set forth herein (Principle 6), as well all modern arbitration statutes. A party who desires to be represented should notify the other side and file a copy of the notice with the case administrator at least three days before the hearing. When arbitration is initiated by a representative or when the respondent replies through a representative, however, such notice is deemed to have been given.

If a transcript of the hearing is needed, the parties are responsible for making the arrangements and notifying the other parties of such arrangements in advance of the hearing. In those instances where a party is unable, due to health difficulties, to be present at the arbitration, the arbitrator should be immediately notified and measures undertaken to provide an alternative method of testimony, such as telephone, videotape, video-conferencing and the use of the Internet.

7. Presentation of the Case

Arbitration hearings are conducted somewhat like court trials, except that arbitration is usually less formal. Arbitrators are generally not required to follow strict rules of evidence, unless otherwise agreed by the parties. They must hear all of the evidence material to an issue but they may determine for themselves what is relevant. Arbitrators will therefore be inclined to accept evidence that might not be allowed by judges. However, this does not mean that all evidence will be considered of equal weight. Direct testimony of witnesses is usually more persuasive than hearsay evidence, and facts will be better established by documents and exhibits than by argument only.

In these situations where the health of one party makes it difficult for personal appearance at the arbitration hearing, wide latitude should be given by the arbitrator(s) for the use of video-conferencing, the Internet, and other modes of communication that can obviate the need for an in-person hearing, if deemed necessary by the arbitrator. Furthermore, in cases of acute emergency, the arbitrator may determine to conduct the hearing by telephone (*Protocol*, Principle 7(2)), and other creative means, such as the Internet.

It is customary for the claimant to proceed first with its case, followed by the respondent. This order may be varied, however, when the arbitrator thinks it necessary. In any event, the "burden of proof" is not on one side more than the other; each party must try to convince the arbitrator of the correctness of its position and no hearing is closed until both have had a full opportunity to do so. That is why it is equally the responsibility of the claimant and the respondent to present their cases to the arbitrator in an orderly and logical manner. This may include:

- An opening statement that clearly but briefly describes the controversy and indicates what is to be proved. Such a statement lays the groundwork and helps the arbitrator understand the relevance of testimony to be presented.
- A discussion of the remedy sought. This is important because the arbitrator's power is conferred by the agreement of the parties. Each party should try to show that the relief it requests is within the arbitrator's authority to grant.
- Introduction of witnesses in a systematic order to clarify the nature of the controversy and to identify documents and exhibits. Cross examination of witnesses is important, but each party should plan to establish its case by its own witnesses.
- A closing statement that should include a summary of the evidence and arguments and a refutation of points made by the opposition.

Above all, a cooperative attitude is essential for effective arbitration. Overemphasis or exaggeration, concealment of facts, introduction of legal technicalities with the objective of delaying proceedings is discouraged.

8. The Role of the Arbitrators

The arbitrator's role is akin to that of a judge hearing a case without a jury: to listen to the presentations, review the evidence presented, and upon evaluation, make a decision on the matter. The arbitrator is not bound by the strict rules of evidence or trial procedure, unless same is desired by the parties.

9. The Award

The award is the decision of the arbitrator on the matters submitted to him or her under the arbitration agreement. If the arbitration panel consists of more than one arbitrator, the majority decision is binding. The purpose of the award is to dispose of the controversy finally and conclusively, and to rule on each claim submitted. While the arbitrator is generally viewed as a "creature of the parties' contract," and must make his or her award within the limits of the arbitration agreement, the *Protocol* (Principle 9(2)) provides that "the arbitrator should be empowered to grant whatever relief would have been available in court under law or in equity."

The award as a matter of law must be in writing. The *Protocol* (Principle 9(2)) relaxes that requirement somewhat, in that in cases of acute emergency, the arbitrator is permitted to make a preliminary award orally. In such instances, however, a written award would still follow as required by law.

In general business disputes, arbitrators are not as a rule required to write opinions explaining the reasons for their decisions. In view of the issues involved in health care disputes, however, the Commission recommends that the award be accompanied by an opinion where requested by any party (*Protocol*, Principle 9(2)). An opinion would serve the dual purposes of helping a patient or provider better understand the outcome, and also serving as guidance to health plans in terms of future actions and behavior.

The power of the arbitrator ends with the making of the award. An award may not be changed by the arbitrator, once it is made, unless the parties agree to restore the power of the arbitrator or unless the law provides otherwise.

10. Costs

As provided in the *Protocol* (Principle 10) binding arbitration should not be mandated in disputes involving patients. It may be mandated in disputes not involving patients, as can nonbinding arbitration in any dispute. Where arbitration is mandated, the plan should pay the costs of at least one day of hearing before a single arbitrator (including the arbitrator's fee and expenses). If there are additional days of arbitration, the costs should be shared equally, subject to the power of the arbitrator to allocate costs. In some jurisdictions, the dominant party may be required to pay all arbitrator compensation where the use of arbitration is mandated by that party (see, e.g., *Cole v. Burns International Security Services,* 105 F.3d 1465 (D.C. Cir. 1997) (employment arbitration).

Where arbitration is consensual, the administrative fees and the costs of compensating the arbitrator will generally be borne as provided in the parties' arbitration agreement. Failing that, administrative fees are generally advanced by the

filing party, and arbitrator's compensation is advanced equally by the parties. Both of these costs may be allocated by the arbitrator in the award.

Arbitrators generally charge a rate consistent with his or her stated rate of compensation, beginning with the first day of service. Should any dispute arise about the costs of the proceeding, it is recommended that such be submitted first to mediation, and, in the event of no agreement, to arbitration.

D. Hybrid Processes of ADR

In some instances, two or more ADR processes may be combined or used succeeding one another; this is often referred to as hybrid procedures. The advantage of such an arrangement is that if one process fails to achieve resolution, additional procedural options exist, and, where the final step is binding arbitration, comes with the assurance of finality. In situations where time is of the essence, it is important that the parties have the capability of achieving a final resolution rapidly.

One example of a hybrid ADR form is Mediation/Arbitration (Med/Arb). A clause can be inserted into a contract that provides first for mediation under an agreed upon set of mediation rules. In the event the mediation does not reach resolution of the matter, then the dispute would then go to arbitration under the agreed upon arbitration rules. Set forth below is a sample med/arb clause:

> *If a dispute arises out of or relates to this policy/contract, or the breach thereof, and if said dispute cannot besettled through direct discussions, the parties agree to first endeavor to settle the dispute in an amicable manner by mediation administered [named ADR provider] under its Mediation Rules. Thereafter, any unresolved controversy or claim arising out of or relating to this contract, or breach thereof, shall upon the written agreement of the parties after the dispute arises, be settled by arbitration administered by [named ADR provider] in accordance with its [applicable] Rules, and judgment upon the Award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.*

IV. Matrix of Areas of Disputes Amenable to ADR

In Plan

Disputed Service	Timeframe for resolution	Example	Comments
Surgical Services	Depends on procedure Maximum 30 days	Hysterectomy	2nd opinion useful; clinical guidelines
Cosmetic Surgery	6 months +	Breast reduction or augmentation	Psychological effects of not doing need consideration
Dental/Oral Surgery	90 days	TMJ dysfunction	Separate dental insurance may cover
Durable Medical Equipment	30 days	Glucose monitor for diabetics, wheel chairs, nebulizers	Clinical standards/ guidelines useful
Procedures & Tests	30 days	CT Scan for headaches, repreat cholesterol tests, abdominal ultrasound	Clinical standards/ guidelines useful
Physical Therapy & Occupational Therapy	30 to 60 days	Excess services per plan speech therapy for children	For children:overlap Coverage with school system; work disability an issue
Denial of Referral	30 days	Dermatology, OB/GYN, Ortho	Limited referral may be acceptable; open access to OB/GYN recommended
Mental Health	30 to 60 days	Length of treatment, length of stay	opinion useful
Second Opinion	30 days	In Network vs out of Network 2nd opinion	Can be used in mediation

Disputed Service	Timeframe for resolution	Example	Comments
Hospice	30 days	Terminal cancer care	Quality of "end of life"
Restricted Formulary	60 days	Paxil instead of Prozac; generic vs nongeneric; switch of medication	2nd opinion; clinical guidelines
Excessive Wait Times	30 days	Waits of 60 days for diagnostic services	Service standards shoud be in place
Home Health Care	30 days	Number of visits for specific care 24hr neonatal discharge follow-up; early discharge from hospital	With decreasing LOS in hospitals, more need for home health care nursing
Length of Stay	24 hours	Any discharge felt to be early	Goal of hospitalization should be communicated to patient on admission
Out of area coverage for medical services	30 days—sooner if care is emergent	Dispute would normally be regarding payment after services rendered	Health plans should have provisions for out of area coverage
Emergency services	30-60 days if service has been rendered	Dispute would normally be regarding payment after services rendered	Health plans should have "prudent layperson" language for ER services
Access to non affiliated primary care providers	60 days	Desire to keep personal doctor	Continuity of care issues
Access to non affiliated specialty care providers	30 days	Desire to see previously seen specialist or specific program	Limited referral a possibility
Access to nonaffiliated mental health providers	30-60 days	Desire to keep current specialist; desire for specific program	Limited referral a possibility

Disputed Service	Timeframe for resolution	Example	Comments
Admission to nonaffiliated hospital	Depends on nature of admission	Desire for admission to University Hospital/ Mayo Clinic	Limited referral a possibility
Second opinion with nonaffiliated providers	30 days	Desire for consultation at a University Hospital/Mayo Clinic	Limited referral a possibility
Access to nonaffiliated dental/oral surgery	30-60 days		Limited referral a Possibility
Access to nontraditional "alternative" medical care	60 days	Chiropractic/podiatry if not covered; herbal treatments, acupuncture	
Experimental care	30 days (or less depending on condition)	In the past, bone marrow treatments	Should be part of study conducted by reputable health science program
Continuity of care issues	30 days	Switch of insurance during pregnancy, cancer treatment	
Time sensitive situations	Depends on medical condition	Dialysis, cancer treatments, withdrawal	
Customer service	Varies	Failure to respond to inquiry	

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A Due Process Protocol for Mediation and Arbitration of Statutory Disputes arising out of the Employment Relationship

May 9, 1995

The following protocol is offered by the undersigned individuals, members of the Task Force on Alternative Dispute Resolution in Employment, as a means of providing due process in the resolution by mediation and binding arbitration of employment disputes involving statutory rights. The signatories were designated by their respective organizations, but the protocol reflects their personal views and should not be construed as representing the policy of the designating organizations.

Genesis

This Task Force was created by individuals from diverse organizations involved in labor and employment law to examine questions of due process arising out of the use of mediation and arbitration for resolving employment disputes. In this protocol we confine ourselves to statutory disputes.

The members of the Task Force felt that mediation and arbitration of statutory disputes conducted under proper due process safeguards should be encouraged in order to provide expeditious, accessible, inexpensive and fair private enforcement of statutory employment disputes for the 100,000,000 members of the workforce who might not otherwise have ready, effective access to administrative or judicial relief. They also hope that such a system will serve to reduce the delays which now arise out of the huge backlog of cases pending before administrative agencies and courts and that it will help forestall an even greater number of such cases.

A. Pre or Post Dispute Arbitration

The Task Force recognizes the dilemma inherent in the timing of an agreement to mediate and/or arbitrate statutory disputes. It did not achieve consensus on this difficult issue. The views in this spectrum are set forth randomly, as follows:

- Employers should be able to create mediation and/or arbitration systems to resolve statutory claims, but any agreement to mediate and/or arbitrate disputes should be informed, voluntary, and not a condition of initial or continued employment.
- Employers should have the right to insist on an agreement to mediate and/or arbitrate statutory disputes as a condition of initial or continued employment. Postponing such an agreement until a dispute actually arises, when there will likely exist a stronger predisposition to litigate, will result in very few agreements to mediate and/or arbitrate, thus negating the likelihood of effectively utilizing alternative dispute resolution and overcoming the problems of administrative and judicial delays which now plague the system.
- Employees should not be permitted to waive their right to judicial relief of statutory claims arising out of the employment relationship for any reason.
- Employers should be able to create mediation and/or arbitration systems to resolve statutory claims, but the decision to mediate and/or arbitrate individual cases should not be made until after the dispute arises.

The Task Force takes no position on the timing of agreements to mediate and/or arbitrate statutory employment disputes, though it agrees that such agreements be knowingly made. The focus of this protocol is on standards of exemplary due process.

B. Right of Representation

1. Choice of Representative

Employees considering the use of or, in fact, utilizing mediation and/or arbitration procedures should have the right to be represented by a spokesperson of their own choosing. The mediation and arbitration procedure should so specify and should include reference to institutions which might offer assistance, such as bar associations, legal service associations, civil right organizations, trade unions, etc.

2. Fees for Representation

The amount and method of payment for representation should be determined between the claimant and the representative. We recommend, however, a number of existing systems which provide employer reimbursement of at least a portion of the employee's attorney fees, especially for lower paid employees. The arbitrator should have the authority to provide for fee reimbursement, in whole or in part, as part of the remedy in accordance with applicable law or in the interests of justice.

3. Access to Information

One of the advantages of arbitration is that there is usually less time and money spent in pre-trial discovery. Adequate but limited pre-trial discovery is to be encouraged and employees should have access to all information reasonably relevant to mediation and/or arbitration of their claims. The employees' representative should also have reasonable pre-hearing and hearing access to all such information and documentation.

Necessary pre-hearing depositions consistent with the expedited nature of arbitration should be available. We also recommend that prior to selection of an arbitrator, each side should be provided with the names, addresses and phone numbers of the representatives of the parties in that arbitrator's six most recent cases to aid them in selection.

C. Mediator and Arbitrator Qualification

1. Roster Membership

Mediators and arbitrators selected for such cases should have skill in the conduct of hearings, knowledge of the statutory issues at stake in the dispute, and familiarity with the workplace and employment environment. The roster of available mediators and arbitrators should be established on a non-discriminatory basis, diverse by gender, ethnicity, background, experience, etc. to satisfy the parties that their interests and objectives will be respected and fully considered.

Our recommendation is for selection of impartial arbitrators and mediators. We recognize the right of employers and employees to jointly select as mediator and/or arbitrator one in whom both parties have requisite trust, even though not possessing the qualifications here recommended, as most promising to bring finality and to withstand judicial scrutiny. The existing cadre of labor and employment mediators and arbitrators, some lawyers, some not, although skilled in conducting hearings and familiar with the employment milieu is unlikely, without special training, to consistently possess knowledge of the statutory environment in which these disputes arise and of the characteristics of the non-union workplace.

There is a manifest need for mediators and arbitrators with expertise in statutory requirements in the employment field who may, without special training, lack experience in the employment area and in the conduct of arbitration hearings and mediation sessions. Reexamination of rostering eligibility by designating agencies, such as the American Arbitration Association, may permit the expedited inclusion in the pool of this most valuable source of expertise.

The roster of arbitrators and mediators should contain representatives with all such skills in order to meet the diverse needs of this caseload.

Regardless of their prior experience, mediators and arbitrators on the roster must be independent of bias toward either party. They should reject cases if they believe the procedure lacks requisite due process.

2. Training

The creation of a roster containing the foregoing qualifications dictates the development of a training program to educate existing and potential labor and employment mediators and arbitrators as to the statutes, including substantive, procedural and remedial issues to be confronted and to train experts in the statutes as to employer procedures governing the employment relationship as well as due process and fairness in the conduct and control of arbitration hearings and mediation sessions.

Training in the statutory issues should be provided by the government agencies, bar associations, academic institutions, etc., administered perhaps by the designating agency, such as the AAA, at various locations throughout the country. Such training should be updated periodically and be required of all mediators and arbitrators. Training in the conduct of mediation and arbitration could be provided by a mentoring program with experienced panelists.

Successful completion of such training would be reflected in the resume or panel cards of the arbitrators supplied to the parties for their selection process.

3. Panel Selection

Upon request of the parties, the designating agency should utilize a list procedure such as that of the AAA or select a panel composed of an odd number of mediators and arbitrators from its roster or pool. The panel cards for such individuals should be submitted to the parties for their perusal prior to alternate striking of the names on the list, resulting in the designation of the remaining mediator and/or arbitrator.

The selection process could empower the designating agency to appoint a mediator and/or arbitrator if the striking procedure is unacceptable or unsuccessful. As noted above, subject to the consent of the parties, the designating agency should provide the names of the parties and their representatives in recent cases decided by the listed arbitrators.

4. Conflicts of Interest

The mediator and arbitrator for a case has a duty to disclose any relationship which might reasonably constitute or be perceived as a conflict of interest. The designated mediator and/or arbitrator should be required to sign an oath provided by the designating agency, if any, affirming the absence of such present or preexisting ties.

5. Authority of the Arbitrator

The arbitrator should be bound by applicable agreements, statutes, regulations and rules of procedure of the designating agency, including the authority to determine the time and place of the hearing, permit reasonable discovery, issue subpoenas, decide arbitrability issues, preserve order and privacy in the hearings, rule on evidentiary matters, determine the close of the hearing and procedures for post-hearing submissions, and issue an award resolving the submitted dispute.

The arbitrator should be empowered to award whatever relief would be available in court under the law. The arbitrator should issue an opinion and award setting forth a summary of the issues, including the type(s) of dispute(s), the damages and/or other relief requested and awarded, a statement of any other issues resolved, and a statement regarding the disposition of any statutory claim(s).

6. Compensation of the Mediator and Arbitrator

Impartiality is best assured by the parties sharing the fees and expenses of the mediator and arbitrator. In cases where the economic condition of a party does not permit equal sharing, the parties should make mutually acceptable arrangements to achieve that goal if at all possible. In the absence of such agreement, the arbitrator should determine allocation of fees. The designating agency, by negotiating the parties' share of costs and collecting such fees, might be able to reduce the bias potential of disparate contributions by forwarding payment to the mediator and/or arbitrator without disclosing the parties' share therein.

D. Scope of Review

The arbitrator's award should be final and binding and the scope of review should be limited.
Dated: May 9, 1995

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VI. Due Process Protocol for Consumer Disputes

A Due Process Protocol for the Mediation and Arbitration of Consumer Disputes
April 17, 1998

Principle 1. Fundamentally-Fair Process

All parties are entitled to a fundamentally-fair ADR process. As embodiments of fundamental fairness, these Principles should be observed in structuring ADR Programs.

Principle 2. Access to Information Regarding ADR Program

Providers of goods or services should undertake reasonable measures to provide consumers with full and accurate information regarding Consumer ADR Programs. At the time the Consumer contracts for goods or services, such measures should include (1) clear and adequate notice regarding the ADR provisions, including a statement indicating whether participation in the ADR Program is mandatory or optional, and (2) reasonable means by which Consumers may obtain additional information regarding the ADR Program. After a dispute arises, Consumers should have access to all information necessary for effective participation in ADR.

Principle 3. Independent and Impartial Neutral; Independent Administration

1. *Independent and Impartial Neutral.* All parties are entitled to a Neutral who is independent and impartial.
2. *Independent Administration.* If participation in mediation or arbitration is mandatory, the procedure should be administered by an Independent ADR Institution. Administrative services should include the maintenance of a panel of prospective Neutrals, facilitation of Neutral selection, collection and distribution of Neutral's fees and expenses, oversight and implementation of ADR rules and procedures, and monitoring of Neutral qualifications, performance, and adherence to pertinent rules, procedures and ethical standards.
3. *Standards for Neutrals.* The Independent ADR Institution should make reasonable efforts to ensure that Neutrals understand and conform to pertinent ADR rules, procedures and ethical standards.
4. *Selection of Neutrals.* The Consumer and Provider should have an equal voice in the selection of Neutrals in connection with a specific dispute.
5. *Disclosure and Disqualification.* Beginning at the time of appointment, Neutrals should be required to disclose to the Independent ADR Institution any circumstance likely to affect impartiality, including any bias or financial or personal interest which might affect the result of the ADR proceeding, or any past or present relationship or experience with the parties or their representatives, including past ADR experiences. The Independent ADR Institution should communicate any such information to the parties and other Neutrals, if any. Upon objection of a party to continued service of the Neutral, the Independent ADR Institution should determine whether the Neutral should be disqualified and should inform the parties of its decision. The disclosure obligation of the Neutral and procedure for disqualification should continue throughout the period of appointment.

Principle 4. Quality and Competence of Neutrals

All parties are entitled to competent, qualified Neutrals. Independent ADR Institutions are responsible for establishing and maintaining standards for Neutrals in ADR Programs they administer.

Principle 5. Small Claims

Consumer ADR Agreements should make it clear that all parties retain the right to seek relief in a small claims court for disputes or claims within the scope of its jurisdiction.

Principle 6. Reasonable Cost

1. *Reasonable Cost.* Providers of goods and services should develop ADR programs which entail reasonable cost to Consumers based on the circumstances of the dispute, including, among other things, the size and nature of the claim, the nature of goods or services provided, and the ability of the Consumer to pay. In some cases, this may require the Provider to subsidize the process.
2. *Handling of Payment.* In the interest of ensuring fair and independent Neutrals, the making of fee arrangements and the payment of fees should be administered on a rational, equitable and consistent basis by the Independent ADR Institution.

Principle 7. Reasonably Convenient Location

In the case of face-to-face proceedings, the proceedings should be conducted at a location which is reasonably convenient to both parties with due consideration of their ability to travel and other pertinent circumstances. If the parties are unable to agree on a location, the determination should be made by the Independent ADR Institution or by the Neutral.

Principle 8. Reasonable Time Limits

ADR proceedings should occur within a reasonable time, without undue delay. The rules governing ADR should establish specific reasonable time periods for each step in the ADR process and, where necessary, set forth default procedures in the event a party fails to participate in the process after reasonable notice.

Principle 9. Right to Representation

All parties participating in processes in ADR Programs have the right, at their own expense, to be represented by a spokesperson of their own choosing. The ADR rules and procedures should so specify.

Principle 10. Mediation

The use of mediation is strongly encouraged as an informal means of assisting parties in resolving their own disputes.

Principle 11. Agreements to Arbitrate

Consumers should be given:

- **a.** clear and adequate notice of the arbitration provision and its consequences, including a statement of its mandatory or optional character;
- **b.** reasonable access to information regarding the arbitration process, including basic distinctions between arbitration and court proceedings, related costs, and advice as to where they may obtain more complete information regarding arbitration procedures and arbitrator rosters;
- **c.** notice of the option to make use of applicable small claims court procedures as an alternative to binding arbitration in appropriate cases; and,
- **d.** a clear statement of the means by which the Consumer may exercise the option (if any) to submit disputes to arbitration or to court process.

Principle 12. Arbitration Hearings

1. *Fundamentally-Fair Hearing.* All parties are entitled to a fundamentally-fair arbitration hearing. This requires adequate notice of hearings and an opportunity to be heard and to present relevant evidence to impartial decision-makers. In some cases, such as some small claims, the requirement of fundamental fairness may be met by hearings conducted by electronic or telephonic means or by a submission of documents. However, the Neutral should have discretionary authority to require a face-to-face hearing upon the request of a party.
2. *Confidentiality in Arbitration.* Consistent with general expectations of privacy in arbitration hearings, the arbitrator should make reasonable efforts to maintain the privacy of the hearing to the extent permitted by applicable law. The arbitrator should also carefully consider claims of privilege and confidentiality when addressing evidentiary issues.

Principle 13. Access to Information

No party should ever be denied the right to a fundamentally-fair process due to an inability to obtain information material to a dispute. Consumer ADR agreements which provide for binding arbitration should establish procedures for arbitrator-supervised exchange of information prior to arbitration, bearing in mind the expedited nature of arbitration.

Principle 14. Arbitral Remedies

The arbitrator should be empowered to grant whatever relief would be available in court under law or in equity.

Principle 15. Arbitration Awards

1. *Final and Binding Award;* Limited Scope of Review. If provided in the agreement to arbitrate, the arbitrator's award should be final and binding, but subject to review in accordance with applicable statutes governing arbitration awards.
2. *Standards to Guide Arbitrator Decision-Making.* In making the award, the arbitrator should apply any identified, pertinent contract terms, statutes and legal precedents.

3. *Explanation of Award.* At the timely request of either party, the arbitrator should provide a brief written explanation of the basis for the award. To facilitate such requests, the arbitrator should discuss the matter with the parties prior to the arbitration hearing.

Dated: April 17, 1998

Some of the signatories to this Protocol were designated by their respective organizations, but the Protocol reflects their personal views and should not be construed as representing the policy of the designating organizations

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