ASSISTED LIVING RESIDENCE ADMISSION AGREEMENT SIGNATURE PAGE

Community: _____ ("We" or "Us")

Resident: «First_Name» «Last_Name» ("You")

Responsible Person(s): «ResponsiblePartyFirstName» «ResponsiblePartyLastName» ("Responsible Person(s)")

Effective Date: «LeaseSegmentStartDate» ("Effective Date")

Date of Occupancy: _____ ("Date of Occupancy")

Apartment Number: «RoomNumber»

Calculation of Basic Rate:

1.) Housing Accommodations & Basic Services: «Rent»

Levels of Care Services:

2.) Personal Care Level: «CareLevel»

Monthly Personal Care Fee: $

Medication Program Level: «MedLevel»

3.) Monthly Medication Program Fee: $

4.) Simple Nursing Tasks: $

Second Person Fee (If Applicable):

Second Person Monthly Fee: $

Second Person Personal Care Level:

5.) Second Person Monthly Personal Care Fee: $

Second Person Medication Program Level:

6.) Second Person Monthly Medication:

7.) Simple Nursing Tasks: $

Program Fee: $

Basic Rate for First Month:* $_____

Basic Monthly Rate for Second Month and thereafter subject to Adjustments pursuant to Section 3(f):* $_____

APPROVED
BY NYS Department of Health
2/3/17 (date)
(project manager)

Atria SENIOR LIVING

*** PLEASE NOTE THAT A HIGHER RATE IS CHARGED DURING THE FIRST MONTH. THE HIGHER FIRST MONTH'S RATE IS REFUNDABLE DURING THE FIRST MONTH ON A PER DIEM BASIS PURSUANT TO SECTION 3(H) OF THIS AGREEMENT, AND IS NONREFUNDABLE AFTER THE FIRST MONTH. A LISTING OF RATES FOR ALL ROOM TYPES IS PROVIDED TO EACH PROSPECTIVE RESIDENT PRIOR TO SIGNING THIS AGREEMENT.**

APPROVED
BY NYS Department of Health
2/3/17 (date)
(project manager)

Atria SENIOR LIVING

AGREEMENT AUTHORIZATION

By signing below, you acknowledge that you have read this Residency Agreement, including the pages and the attachments that follow this signature page, understand and agree to abide by the terms and conditions therein and the obligations created by such documents, and acknowledge that you have received a duplicate copy of the Residency Agreement and all attachments referenced in the Residency Agreement.

_____ _____

Community Representative Date

_____

Title

_____ _____

Signature of Resident Date

_____

Printed Name of Resident

_____ _____

Signature of Resident's Representative, if any Date

_____

Printed Name of Resident's Representative, if any

_____ _____

Signature of Legal Representative, if any Date

_____

Printed Name of Legal Representative, if any

_____ _____

Signature of Responsible Person Date

_____

Printed Name of Responsible Person

APPROVED
BY NYS Department of Health
2/3/17 (date)
(project manager)