Department of Veterans Service

Floyd Veterans Memorial Building
Atlanta, Georgia
30334

State Veterans Home Payment Agreement

Date: _____

Name of Veteran Patient: _____

First Initial of Last Name and Last Four of Social Security Number: _____

Introduction

This is a Georgia State Veterans Home Payment Agreement (Agreement) by and between the Georgia Department of Veterans Service, the Georgia War Veterans Nursing Home in Augusta, Georgia, or the Georgia War Veterans Home in Milledgeville, Georgia and the undersigned veteran patient and/or responsible parties. This is a legal document creating rights and obligations for each person, or party signing the Agreement. Please read the Agreement carefully before you sign it.

References to the Parties

We believe that this Agreement will be more easily understood if we use, where practical, personal pronouns in referring to the parties to this Agreement. References to "we", "our", “home”, the "Facility", and to "our Facility" are references to the Georgia Department of Veterans Service, the Georgia War Veterans Nursing Home, or the Georgia War Veterans Home. References to "you" and "your" are references to any person signing this Agreement

Agreement as Veteran Patient or Responsible Party.

A **Veteran Patient** is an individual who meets the eligibility requirements as stated in Georgia law and is the actual patient who resides in or will reside in the facility.

A **Responsible Party** is an individual who voluntarily agrees to honor certain specified obligations of financial liability of the Veteran Patient. If you sign this Agreement as the Responsible Party you are accepting responsibility for the Veteran Patient and any debts that may be incurred by the Veteran Patient at the facility related to payment of the Daily Fee and the monthly invoice.

Billing and Changes in Rates

Our current Daily Fee is $_____._____. You agree to pay us our Daily Fee for each day of nursing facility care and services we provide to the Veteran Patient. Such payment shall be made one month at a time. We shall provide you with monthly invoices itemizing total charges incurred by you of the Daily Fee time the number of days the veteran patient was a resident in the home during the month. We shall provide you with at least 30 days written notice of any increase in the Daily Fee. Invoices will be issued at the beginning of the month of residency in the home and each subsequent month. Payments will be due and payable no later than 10 days following the date of invoice. In the event of death or discharge, fees paid for days not used will be refunded to the Veteran Patients' responsible party; however, any and all outstanding amounts owed will be due and payable within 10 days after the beginning of the month following the death or permanent discharge of the veteran patient. Payments for partial months will be calculated from the first day of the month through the day prior to death or permanent discharge of the Veteran Patient. Our current Daily Fee is expected for bed holds, including but not limited to, hospitalizations and therapeutic leaves. We neither extend credit nor accept payment in installment.

Advance Payment upon Admission

New admissions to the facility will make payments to the home for the amount of the Daily Fee from the day/date of admission through the last day of the month of admission. Subsequent monthly invoices will be submitted to the Veteran Patients and/or Responsible Parties in accordance with standard invoicing and business procedures.

Collection Costs and Attorneys' Fees

We require you or your Responsible Party agree, as a condition of admission and continued stay in our Facility, to pay attorney's fees or any other costs incurred in collecting payment for the nursing facility care and services we provide to you.

Services

The basic Daily Fee includes payment for healthcare providers (physicians, nurse practitioners, physician's assistants), nursing services and lodging, linens, routine nursing supplies, routine laundry service, regular meals and snacks,

routine therapies, routine equipment, social services, activities, and routine items which are required to meet your needs. It does not include personal services, haircuts or personal items.

Acknowledgements

By signing below, I/we acknowledge my/our understanding and agreement to the stipulations and requirements outlined in this payment agreement.

Veteran Patient and/or Responsible Party:

_____ _____

[Signature of Veteran Patient/If able to sign] [Date]

_____

[Print Name]

_____ _____

[Signature of Responsible Party/Spouse] [Date]

_____

[Print Name]

State Veterans' Home Representative:

_____ _____

[Signature] [Date]

_____

[Print Name]

[Abbreviated Home Name]: _____