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Memo to Facility Staff (may be discarded after reading)

Subject: Important: What to Do About Lapsed Medicaid

Team,

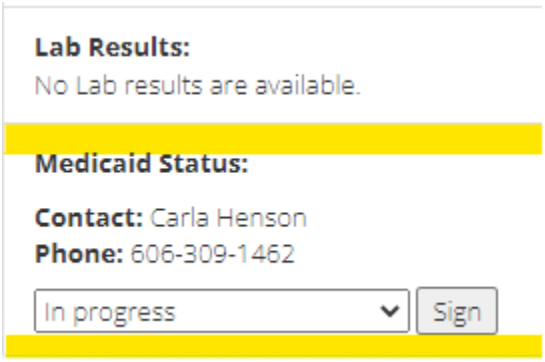
We've updated the Stepworks EMR to address a crucial issue. **This is a critical part of your job responsibility**, so please read carefully.

We expect more patients with **expired Medicaid coverage** (due to the end of the public health emergency). If we do not help them re-enroll with Medicaid, Stepworks will not get paid for their treatment.

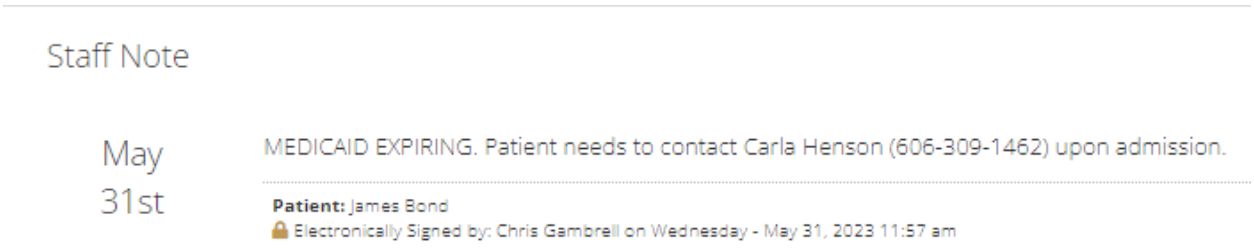
What You Have to Do

For every new admission, check the chart carefully. If the patient needs to re-enroll in Medicaid, you will see two things:

1. A KYnector's contact information (on the **left** side of the chart):



2. A staff note under the screening:

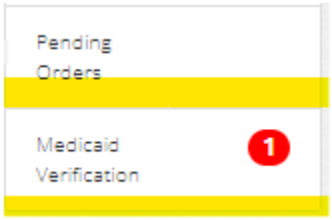


If you see these notes,

1. The **team member conducting the admission is responsible to help the patient contact the KYnector.**
2. After helping them contact the KYnector, select one of the following options and click **sign**:
    - **"Process completed"** means everything is in place: the patient's Medicaid will be reinstated.
        - No further action is needed.
    - **"Reached KYnector's voicemail"** means you helped the patient leave a message (be sure and give the KYnector the facility's direct number).
        - Tell your shift supervisor you expect a call from the KYnector.
        - During your next shift, check on this patient's Medicaid status.
    - **"Patient too intoxicated"** means the patient cannot call yet.
        - Tell your shift supervisor to put the situation in the shift report.
    - **"More information needed"** means the KYnector needs something from the patient.
        - Help the patient make phone calls and gather the required information.
        - **Edit the note** (include what information is still needed).
        - Tell your shift supervisor to put the situation in the shift report.
3. Have the patient sign a release for the KYnector.

4. If you did not successfully connect with the KYnector, tell your shift supervisor.

On the facility dashboard, you'll now see a new option underneath Pending Orders: **"Medicaid Verification."** The **red number** indicates the number of patients who have not completed the above process. **Shift Supervisors:** you must check this number at the beginning of each shift and see if anything needs to be done to help the patient get Medicaid coverage.



It is crucial to help the patient contact Medicaid as close to their time of admission as possible. If a KYnector calls the facility for the patient, we will need to get the patient immediately to speak with them. It's possible that a different KYnector than the one on the ROI could call the facility. **You may still get the patient for them**, *you* just cannot give the KYnector additional information on the patient.

Thanks for your flexibility and attention to this significant issue. We believe these updates to the EMR will help us better serve our incoming patients, many of whom may not recognize that their insurance coverage has lapsed.

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Admission Checklist

Refer to the **Admission Guide** for steps to take before/when the patient arrives.

Patient Information and Vitals

Patient Name: _____
First Middle Last

Date of Arrival: _____ / _____ / _____ Time of Arrival: _____ : _____ ☐ A. M. ☐ P. M.

How did the patient get here? _____

Date of Last Use: _____ / _____ / _____ Time of Last Use: _____ : _____ ☐ A. M. ☐ P. M.

Substances Used: _____

_____

Amount of Last Use: _____ Method of Last Use: _____

BAL: _____ BP: _____ Pulse: _____ Temp: _____ Resp: _____ O2: _____

☐ Is the patient extremely intoxicated? (Breathalyze them every hour until they blow below 0.200.)

Weight: _____ Appetite: _____

Allergies: _____

Hygiene: _____

Sleep: _____

☐ Run CIWA or COWS scales using the data above.

Payment and Admission Confirmation

- ☐ all printed intake forms completed
- ☐ patient understands confidentiality and "release of information" to relatives/loved ones
- ☐ received payment and gave receipt
- ☐ documented payment
- ☐ copies of insurance cards scanned/uploaded to EMR (if not, request)
- ☐ IC Status MAP form completed if the patient has been incarcerated or if requested by the Access Center
- ☐ photo taken

Search and Urine Screens

- ☐ searched patient's person/belongings/clothing/bags according to Stepworks policies
- ☐ completed **Patient Admission Inventory**

Review "Search and Urine Screens" in the **Admission Guide**.

UDS Results: _____

_____

HCG Result (females): ☐ Positive ☐ Negative

House Orientation

- ☐ Tour/Introductions
- ☐ Patient Workbook (enter therapist, clinical rounds, and phone/visitation/med times)
- ☐ Visitation Times/Guidelines
- ☐ Phone Privileges
- ☐ House Rules
- ☐ Family Therapy
- ☐ Bed Assignment
- ☐ Chores/Chore List
- ☐ Daily Schedule
- ☐ Food/Drink Location/Policy
- ☐ Laundry Location/Policy
- ☐ Medication Procedures
- ☐ How to Seek Assistance from Stepworks team
- ☐ Emergency Procedures
- ☐ Tobacco Product Areas
- ☐ First Aid/Accident Reporting
- ☐ Grievance Procedure
- ☐ Treatment Planning/Therapist Role
- ☐ Receiving Mail/Deliveries
- ☐ Behaviors that Affect Privileges
- ☐ Alcohol Use/Contraband Policy
- ☐ Grounds for Discharge
- ☐ Managing Anxiety/Early Discharge Thought

Early Discharge Prevention

Ask the patient, **"If you begin to talk about requesting an early discharge, what could we say (or remind you of) that might encourage you to stay?"**

Patient's response: _____

_____

_____

_____

_____

_____

_____

☐ Ask the patient to complete the **Intake Survey** on the designated iPad.

Documentation Checklist

☐ scan/upload **insurance cards** (front/back) to the EMR

☐ scan/upload all **intake forms** to the EMR

☐ then shred (except Patient Admission Inventory and Third-Party Payer)

☐ paper **Patient Admission Inventory** goes with patient's luggage

☐ **Third-Party Payer** goes to admin

☐ document **Admission Date/Time, search and urine screen results**, and patient's **Mental Status** (use questionnaire)

☐ document admission in the **Communication Book**

☐ add patient to the **Bed Board**

☐ document **Court Order** (if applicable)

Order Labs and Schedule Assessments

☐ CBC, CMP, HEP B, HEP C, RPR with reflex to FTA-ABS, and HIV

☐ nursing assessment

☐ biopsychosocial assessment

☐ provider assessment (room setup)

Team Member Signature: _____ Date: _____ / _____ / _____

Fee Agreement

Stepworks Recovery Centers, LLC ("Stepworks"), a Kentucky limited liability company, and _____ ("Patient"), hereby enter into this Fee Agreement ("Agreement") for Stepworks to provide substance abuse treatment services to Patient for the fees and under the conditions outlined herein.

Services

- ☐ Substance Abuse Assessment
- ☐ Residential Detox
- ☐ Residential Treatment
- ☐ Partial Hospitalization
- ☐ Intensive Outpatient Treatment
- ☐ Group Therapy
- ☐ Individual Therapy
- ☐ Other (explain): _____

Estimated Fees[1]

Estimated Total Charges:	
Estimated Insurance Payments:	
Estimated Patient Responsibility:	
Non-Refundable Deposit:	

[1]All fees are estimates only. Fees are based on a number of factors, including insurance requirements, allotted days per treatment type, length of patient stay, and insurance utilization and review.

Other Fees

There are some additional charges that the Patient may incur while at Stepworks that are not included in this Fee Agreement. These include but are not limited to: medications, books, toiletry items, drug screens, cancellation fees, and other miscellaneous fees. These charges are hard to estimate and generally not covered under insurance plans. These fees are payable at the time of service. Upon request, an itemized statement may be provided at discharge.

Refund Policy

The Patient acknowledges that the successful treatment of chemical dependency often requires negative consequences for destructive decision-making. Therefore the Patient agrees that premature discharge from residential services will result in forfeiture of any and all funds deposited as part of this agreement. Premature discharge is defined as any discharge occurring prior to the completion of treatment goals. This includes but is not limited to the event in which request for premature discharge is beyond the control of the Patient (e.g. transfer to another facility due to unexpected medical conditions). If a refund is due, and the original payment was made by credit or debit card, the applicable amount of credit/debit card fees paid by Stepworks to process the transaction will be withheld from the refund amount.

Insurance Policy

The Patient agrees to provide information regarding health insurance and other health care benefits to which the Patient may be entitled. The Patient assigns payment(s), if any, from insurance carrier(s)/health benefit plan(s) to Stepworks for services rendered. The direct payment assigned and authorized includes any medical insurance benefits entitled, including any major medical benefits otherwise payable to the Patient under the terms of the policy, but not to exceed the balance due for services rendered. **The Patient understands that if the Patient's insurance company or health maintenance organization does not consider the services rendered as covered or has not authorized the services, then the Patient will be fully responsible for payment to Stepworks for services rendered.** The Patient also understands and acknowledges that in the case of out-of-plan or out-of-network services, there may be reduced benefits, and the Patient may be required to pay a larger co-pay, co-insurance, or other charges. In the event that the insurance company does not reimburse these services rendered, the Patient acknowledges that the Patient will be responsible for any balance that the insurance company declines to pay.

Stepworks requires the Patient to make payment at the time of service. Prompt payment allows us to control costs and keep our fees to a minimum. Patients with a standard copayment (e.g. $10/$12/$15 per visit) are required to pay it at the time of service. Patients whose co-insurance is based on a percentage of the charge are required to pay an estimated percentage of their bill at the time of service. Such payment will be applied toward the Patient's ultimate responsibility. If the Patient has a deductible that has not been met, the insurance carrier will apply services to that deductible. Stepworks requires the Patient to pay any deductibles at the time of service.

If the Patient has insurance coverage, Stepworks is glad to help the Patient resolve the maximum allowable benefits and will file the claim(s) for the Patient. If the insurance carrier fails to process the Patient's claim within 45 days of the date of service, the balance becomes the Patient's responsibility. In the event of a problem with insurance, the Patient will assist Stepworks in contacting the insurance carrier. The Patient should be aware that few insurance companies volunteer to cover all medical costs. Stepworks is committed to providing the best treatment to the Patient and charges what is usual and customary. The Patient is responsible for

payment regardless of any insurance company's assessment of usual and customary rates, which may not reflect the current standard and cost of care in the area.

By executing this Agreement, the Patient authorizes the release of information to entities for the purpose of satisfying billed charges and/or facilitating utilization review or otherwise complying with obligations of state or federal law. Information which may be released for this purpose includes financial information and protected health information and medical records for services rendered, including records related to treatment for substance abuse. Such information may be released to the Patient's insurance carrier, managed care plan, or other payor, including past or present employer(s), authorized private review entities or entities acting on their behalf, authorized chart reviewers, billing agents, collection agents, our attorneys or insurance companies, the Social Security Administration, the Centers for Medicare and Medicaid, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency.

The Patient agrees to pay all charges for which the Patient may be legally responsible, including but not limited to health insurance deductibles, copayments, and non-covered services. In the event that the Patient's account must be placed with an attorney or collection agency to obtain payment, the Patient agrees to pay reasonable attorney's fees and a collection fee of $50.

The Patient agrees to allow Stepworks to retain copies, imprints, etc., of a credit card or checking account routing number to ensure prompt payment for these services. This authorization is in effect for all future claims until the Patient chooses to revoke it in writing.

Entire Agreement

This Agreement represents the entire agreement between Stepworks and the Patient with respect to the subject matter hereof. This Agreement supersedes all prior agreements, including but not limited to all prior written and oral statements.

Governing Law

This Agreement and the rights of the parties hereunder shall be governed, interpreted, and enforced in accordance with the laws of the Commonwealth of Kentucky.

Headings

All headings herein are inserted only for convenience and ease of reference and are not to be regarded in the construction or interpretation of any provision of this Agreement.

Severability

If any provision of this Agreement is found to be illegal, invalid, or unenforceable under present or future laws effective during the term of this Agreement, such provision shall be fully severable; and this Agreement shall be construed and enforced as if such illegal, invalid, or unenforceable provision had never been included in this Agreement; however, the remaining provisions of this Agreement shall remain in full force and effect and shall not be affected by the provision in question or by its severance from this Agreement. Furthermore, in lieu of such illegal, invalid, or unenforceable provision, there shall be added to this Agreement a provision as similar in terms to the provision in question as may be possible and legal, valid, and enforceable, and such a revised provision shall be construed and enforced as a valid part of this Agreement.

Arbitration

Any dispute arising out of or in connection with this Agreement, including any matter regarding its existence, validity, or termination, shall be settled by arbitration under the Rules of the American Arbitration Association for Commercial Disputes (the "Rules"). The number of arbitrators shall be one (1) if all parties to the dispute agree on the arbitrator. If there is a disagreement on selection of a sole arbitrator, the number of arbitrators shall then be three (3), with the arbitrators appointed in accordance with the Rules from a panel of arbitrators in Louisville, Kentucky. The place of arbitration shall be Louisville, Kentucky, or such other place as the parties to the dispute shall agree in writing. The arbitration proceedings shall be conducted in the English language, and the arbitral award shall be rendered in writing in the English language stating the reasons for the award. Judgment upon the award rendered by the arbitrator or arbitrators may be entered in any court having jurisdiction thereof and shall be binding on the parties hereto. The costs of arbitration, including reasonable legal fees and costs, shall be borne by either or both parties in whatever proportion as the arbitrator or arbitrators may award.

Rights of Third-Party Payment Source

This Agreement is entered into among Stepworks and the Patient for the exclusive benefit of Stepworks and the Patient. This Agreement is expressly not intended for the benefit of any other person. Except and only to the extent provided by applicable statute, no third party shall have any rights under this Agreement or any agreement between Stepworks and the Patient. In particular, no family members or other persons who may pay Stepworks on behalf of the Patient for the services provided according to this Agreement shall be entitled to any rights under this Agreement.

Patient Signature: _____ Date: ____ / ____ / ____

Team Member Signature: _____ Date: ____ / ____ / ____

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Patient Admission Inventory

Patient Name: _____ Admission date:: ____ / ____ / ____

Use this form to document patients' belongings and their condition. While we dispose of contraband, most items are returned to patients when they leave.

Not sure if an item is contraband or simply prohibited? Ask your supervisor.

Allowed Items

- [ ] body wash, shampoo, conditioner
- [ ] lotion
- [ ] toothpaste

Prohibited Items

- [ ] cell phone: _____
- [ ] cell phone accessories (charger, earbuds)
- [ ] electronic devices (camera, tablet, laptop)
- [ ] CDs, DVDs, TVs
- [ ] aerosol products (shaving cream, deodorant, hair spray)
- [ ] perfume/cologne
- [ ] nail polish, nail polish remover
- [ ] hair dyes, chemical hair straighteners
- [ ] electronic cigarettes
- [ ] loose tobacco, tobacco logs, paraphernalia for rolling cigarettes
- [ ] battery-powered toothbrushes
- [ ] stuffed animals
- [ ] urns
- [ ] prescription or over-the-counter medications (unless approved)

- ☐ liquid content with alcohol (mouthwash, hand sanitizer)
- ☐ ace bandages
- ☐ sharpie markers
- ☐ outside food, drink, candy, chewing gum
- ☐ sexual content (condoms, pornography)
- ☐ weapons (knives, guns, sharps)
- ☐ clothing with inappropriate content (drugs, alcohol, bars, offensive/satanic language or imagery)
- ☐ revealing clothing (shirts exposing midriff, low-cut tops, tube tops, spaghetti straps, form-fitting, shorts cut above mid-thigh)
- ☐ bandanas
- ☐ open tobacco products (cigarettes, dip)
- ☐ Zippo lighter, lighter fluid
- ☐ flashlight
- ☐ work or employment material
- ☐ controlled or illegal substances, alcohol (properly dispose)
- ☐ drug paraphernalia (properly dispose in sharps container)
- ☐ containers with unidentified substances (properly dispose)
- ☐ other: _____

Are any items already damaged? Describe: _____

_____

_____

Describe bags/luggage: _____

Team Member signature: _____ Date: ____ / ____ / ____

I understand that the items above are prohibited. This Patient Admission Inventory completely/accurately describes the belongings I brought to Stepworks. I understand that Stepworks cannot fully guarantee their condition until my discharge but will take reasonable precautions against damage and theft.

Patient signature: _____ Date: ____ / ____ / ____

Complete the section below when the patient discharges.

The patient's belonging were returned on this date: ____ / ____ / ____

These items appear to be missing (notify the facility administrator): _____

_____

_____

Team Member signature: _____ Date: ____ / ____ / ____

I received all the belongings I brought to Stepworks (except destroyed contraband and the items listed above as missing).

Patient signature: _____ Date: ____ / ____ / ____

Special Event Authorization for Release of Information

I understand that there will be events held at Stepworks where I may come in contact with the general public. These events may include open houses, the tours of the facility, or special interest interviews held by the media.

I hereby authorize Stepworks to release the following general information:

- ☐ My presence at Stepworks
- ☐ Guest questions
- ☐ Other (describe): _____

Note: All clinical data will be excluded.

I understand that I can revoke my consent at any time except when disclosure has already taken place. Otherwise this consent will expire on _____ / _____ / _____ or 90 days from the date signed.

Patient Signature: _____ Date: _____ / _____ / _____

Witness Signature: _____ Date: _____ / _____ / _____

_____ Date: _____ / _____ / _____

I decline any special event authorization.

Witness Signature: _____ Date: _____ / _____ / _____

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Media Release Form

I hereby grant **Stepworks Recovery Centers, LLC** ("the company") permission to the rights of my image, likeness, and sound of my voice as recorded on audio or video without payment or any other consideration for use by the company. I understand that my image may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or voice recording. By signing this release, I understand this permission signifies that all content may be electronically displayed via the Internet (e.g. stepworks.com, Facebook, Twitter, Instagram, etc.) or other settings. There is no time limit on the validity of this release, nor is there any geographic limitation on where these materials may be distributed.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name: _____ Phone: (_____) _____ - _____

_____

Street Address City Zip Code

Email: _____

Signature: _____ Date: _____ / _____ / _____

If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent or legal guardian is also required.

Signature: _____ Date: _____ / _____ / _____

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COVID-19 Patient Disclaimer

COVID-19 is a viral illness that is highly contagious and easily spreads to close contacts such as you will find in a residential treatment center. Our facilities attempt to limit the spread of illnesses through good handwashing practices, regular disinfection of surfaces, and the wearing of surgical masks by anyone who has a respiratory illness.

However, **we cannot guarantee that you will not be exposed to COVID-19 in our facility.**

By accepting admission into our facility, you agree to the risks inherent in a group residential setting. These risks include exposure to contagious persons without symptoms and exposure to contagious persons with symptoms. By accepting admission into our facility, you accept all risks and liabilities associated with COVID-19 and agree to hold Stepworks Recovery Centers, LLC, and its employees harmless for any injury or expense that might arise from exposure to COVID-19.

Patient Signature: _____ Date: ____ / ____ / ____

Patient Printed Name: _____ Date of Birth: ____ / ____ / ____

Witness Signature: _____

Printed Name of Witness: _____

STAFF ONLY: Please upload to the patient's chart in the EMR.