TRANSFER AGREEMENT BETWEEN THE COUNTY OF SANTA CLARA AND NATIVIDAD MEDICAL CENTER

This Transfer Agreement ("**Agreement**") is entered into as of July 1, 2013 ("**Effective Date**"), between the County of Santa Clara ("County"), on behalf of Santa Clara Valley Medical Center ("VMC"), located at 751 South Bascom Avenue, San Jose, California, and Natividad Medical Center ("Natividad") located at 1441 Constitution Boulevard, Salinas, CA 93906.

RECITALS

A. Natividad recognizes that on certain occasions trauma patients (i.e. burn, acute rehabilitation and spinal cord injuries) require specialized care and services beyond the scope of services available at Hospital, and that optimal care of these patients requires transfer from Hospital's emergency department or inpatient services to facilities with specialized services.

B. Natividad medical staff and administration have identified VMC as a facility offering specialized staff and facilities for acute medical services.

C. Natividad and VMC recognize the privilege of an attending physician and the right of the patient, for him/herself or through a relative or guardian, to request transfer to an alternate facility

NOW, THEREFORE, the Parties agree as follows:

DEFINITIONS

1. "**Transferring Hospital**" is the hospital or facility from which the patient is being transferred. This hospital or facility is Natividad Medical Center.

2. "**Receiving Hospital**" is the hospital to which the patient is being transferred. This hospital is Santa Clara Valley Medical Center.

3. "**Transferring Physician**" is the physician initiating and responsible for the patient's transfer at Transferring Hospital.

4. "**Receiving Physician**" is the physician who accepts responsibility for the care of the patient at Receiving Hospital.

5. "**Stabilize**" and "**Emergency Medical Condition**" have the same meanings as these terms are defined in the EMTALA regulations (42 C.F.R. §489.24) setting forth the responsibilities of hospitals in emergency cases.

AGREEMENT

1. **Duties of Transferring Hospital**. The Transferring Hospital or Transferring Physician, as indicated, shall have the following duties and obligations in connection with a patient's transfer under this Agreement:

(a) **Authorization to Transfer**. The Transferring Physician shall authorize the transfer of the patient to the Receiving Hospital, including documenting in the patient medical record the medical necessity or other reason for the transfer of the patient to the Receiving Hospital and the medical condition of the patient at the time of transfer. The Transferring Hospital and Physician shall determine that the patient is appropriate for transfer in accordance with all applicable Federal or state laws and regulations regarding patient transfers as well as with applicable requirements of the Transferring Hospital's transfer policies and EMS transfer guidelines.

(b) **Obtaining Consent for the Transfer**. The Transferring Hospital or Transferring Physician shall obtain the consent of the Receiving Hospital and a Receiving Physician for the transfer.

(1) The consent of the Receiving Hospital shall be obtained by telephone, facsimile or other electronic means, by contacting the Receiving Hospital in accordance with procedures set forth in **Exhibit A**.

(2) The Transferring Hospital/Physician will use best efforts to provide clear, accurate communication of patient data and clinical status, including assigning clinical personnel, as appropriate and feasible, to provide (or be immediately available to provide) information as to a patient who has a complex or unstabilized condition or requires a higher level of care.

(3) In order to be in compliance with SCVMC Infection Prevention Policy, The Transferring Physician will complete the Infection Prevention Transfer Patient Screening Form (see Attachment C). Since resistant organisms are difficult to eradicate once established and can have serious epidemiologic implications in the hospital setting, SCVMC requires the completion of Attachement C prior to the acceptance of the patient unless doing so would delay in material deterioration in the patient's medical condition. Patients with an Emergency Medical Condition will not be denied transfer based on the information contained in Attachment C.

(3) At the time of initial contact, the Transferring Hospital will provide the following information to the Receiving Hospital --

- The patient's name and date of birth (gender as applicable);
- Whether patient is an emergency patient or an inpatient;
- The patient's diagnosis and description of the patient's clinical condition;
- Infection Prevention screening for communicable diseases;
- The patient's clinical status, including whether the patient has an Emergency Medical Condition, and if so, whether the Condition is Stabilized;
- The reason for the transfer (i.e., higher level of care, lack of required specialty services, lack of beds, inadequate staffing, patient request, etc.); and
- The estimated time of arrival of the patient.

(4) As necessary for the Receiving Hospital and Physician to evaluate the clinical needs of the patient and their respective capability and capacity to meet those needs, the Transferring Hospital or Physician will provide (orally or electronically) pertinent clinical information to the Receiving Hospital and Physician, so long as the Transferring Physician determines that any delay in providing the information will not result in a material deterioration in the patient's medical condition.

(5) If the Receiving Hospital confirms that it has capacity and capability to accept the patient, the Transferring Hospital or Transferring Physician will obtain the consent of the Receiving Physician. The Receiving Hospital will assist the Transferring Hospital or Transferring Physician in contacting a qualified Receiving Physician who may be available to accept the patient.

(6) The Transferring Hospital and Transferring Physician will document in the patient record the consent of the Receiving Hospital and Receiving Physician, including the time and date and the names of the Receiving Physician and Receiving Hospital representative who have respectively consented to the transfer.

(c) **Insurance Information**.

(1) If the transfer involves a patient with an Emergency Medical Condition that is ***not*** Stabilized, the Transferring Hospital will not provide the Receiving Hospital or Physician any insurance or financial information until the Receiving Hospital and Receiving Physician have accepted the patient.

(2) If the Transferring Hospital/Physician advises the Receiving Hospital that the patient is an inpatient or the patient's condition is Stabilized, the Transferring Hospital will provide the Receiving Hospital the patient's insurance information (including the name and telephone number of the patient's health plan, patient ID # or member #).

(d) **Patient Transportation**. The Transferring Hospital and Transferring Physician are responsible to arrange appropriate and safe transportation that is appropriate for the patient's medical condition, including designation of (i) appropriate equipment for the transfer, (ii) treatment orders during transport, and (iii) the level of professional personnel (including physicians and hospital personnel, when appropriate) who should accompany the patient during transfer.

(1) If there is a delay in the transfer process that will result in the patient's arrival at the Receiving Hospital by more than one (1) hour beyond the estimated time of arrival, or the ambulance or other patient transport is re-directed enroute to another hospital, the Transferring Hospital (if aware of the delay or diversion) will immediately notify the Receiving Hospital.

(2) Except as otherwise agreed by the Parties with respect to a specific transfer, the Transferring Facility shall remain responsible for the patient until he/she arrives at the Receiving Facility, at which time the responsibility for the patient's care will shift to the Receiving Facility.

(3) The Transferring Hospital shall be financially responsible, including billing, for the transport of the patient to the Receiving Hospital. The Receiving Hospital shall not pay for the cost of transportation of the patient to the Receiving Hospital unless the Receiving Hospital is legally obligated to do so.

(e) **Transfer of Patient Records**. The Transferring Hospital will forward (with the patient or by electronic means) copies of those portions of the patient's medical record that are relevant to the transfer and continued care of the patient, including copies of records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided and results of tests and procedures.

(1) If a patient has an Emergency Medical Condition that has ***not*** been Stabilized, the records will include (i) a copy of the patient's informed consent to the transfer or the physician's certification that the medical benefits of the transfer outweigh the risks of transfer; and (ii) if an on-call physician at the Transferring Hospital failed or refused to examine or treat the patient within a reasonable time, the name and address of the on-call physician.

(2) If all necessary and relevant medical records are not available at the time the patient is transferred, the records will be forwarded by the Transferring Hospital within four (4) hours of the transfer.

(f) **Patient Notice and Consent**. The Transferring Facility will comply with patient notice and consent requirements applicable to the transfer. The Transferring Hospital will recognize the right of the patient to make an informed refusal of consent to treatment or transfer in accordance with applicable law;

(g) **Transfers for Tests/Procedures**. If a transfer is for the purposes of a specific procedure or test and the patient will return to the Transferring Hospital, the Transferring Hospital will comply with the procedures set forth in the Addendum to this Agreement.

(h) **Personal Property**. Unless the patient is being transferred for a specific procedure or test and will return to the Transferring Hospital, the Transferring Facility will transfer the patient's personal property (such as money and valuables) and information related to these items, or make other appropriate disposition of personal property, in accordance with its policy and procedure for the inventory and safekeeping of patient valuables.

(i) **Patient Rights/Preference**. If the patient is an emergency patient whose condition is Stabilized or is an inpatient, the Transferring Hospital will (i) comply with applicable contractual, statutory and regulatory obligations that might exist between the patient and his/her health plan or designated provider; and (ii) recognize the right of the patient to transfer to the hospital and/or physician of his/her choice.

2. **Responsibilities of the Receiving Hospital.** The Receiving Hospital shall have the following duties and obligations in connection with a patient transfer under this Agreement:

(a) **Conditions for Patient Acceptance**. The Receiving Hospital will accept a patient transferred in accordance with this Agreement and provide or arrange for the provision of medical services to the patient, provided –

(1) The Receiving Hospital has appropriate beds, equipment, staff and service capacity to meet the expected needs of the patient;

(2) A Receiving Physician on the Receiving Hospital's Medical Staff has accepted the patient; and

(3) The patient meets the Receiving Hospital's admission criteria applicable to the patient.

(b) **Response Time**. If the transfer involves a patient with an Emergency Medical Condition that is ***not*** Stabilized, the Receiving Hospital will exercise reasonable efforts to respond to the Transferring Hospital within thirty (30) minutes after receiving the request to transfer the patient.

(c) **Admissions Process**. The Receiving Hospital will be responsible for the admissions and/or registration process for each patient accepted by the Receiving Physician, as follows:

(1) The admission requirements of the Receiving Hospital will be completed prior to the transfer except if the patient has an Emergency Medical Condition that is not Stabilized at the time of the transfer.

(2) Except for the transfer of a patient who has an Emergency Medical Condition that is not Stabilized at the time of the transfer –

- The admission process will include provision by the Transferring Hospital of patient demographic and insurance information relating to coverage of medical services (such as Medicare, Medicaid HMO, etc.) and pertinent medical and demographic information regarding the patient; and submit a completed PreRegistration Form signed by the patient or patient's representative (see Attachment A) with complete information.
- A VMC Conditions of Admission Form signed by either the patient or the patient's legal representative (see Attachment B).
- The Transferring Hospital will obtain prior authorization from the patient's payor, or other person for the transfer and the admission or other medical care services to be provided by the Receiving Hospital if (i) obtaining prior authorization is required by the payor prior to the transfer and/or admission; and (ii) requesting such authorization is otherwise permitted by law. Proof of this prior authorization will be submitted to VMC prior to or no later than the time of transfer. The Transferring Hospital will be financially responsible for charges for services for all patients requiring preauthorization for whom pre-authorization is not secured and shared with VMC prior to or at the time of transfer.

(d) **Transfers for Tests/Procedures**. If the transfer is for the purpose of a specific procedure or test, Receiving Hospital will comply with procedures set forth in the Addendum of this Agreement.

(e) **Transportation**. When appropriate and within its capabilities, or upon request by the Transferring Hospital, the Receiving Hospital or Physician will consult with the Transferring Hospital or Physician as to the transport of the patient.

(f) **Patient Valuables**. The Receiving Hospital will maintain policies for the acknowledgement and inventory of any patient valuables transported with the patient.

3. **Return Transfers**.

(a) When a patient transferred under this Agreement no longer requires the specialized services of the Receiving Facility and is stable for transfer back to the Transferring Facility, consistent with all applicable requirements under federal and state law (including patient notice and consent requirements), the Transferring Facility shall accept the transfer back of the patient if it has the capability to provide continuing care to the patient, and shall make best efforts to accomplish the transfer within a maximum of forty-eight (48) hours, including, without limitation the following:

(1) Reserving a bed and giving the patient priority over non-emergency admissions in order to ensure prompt placement of the patient;

(2) Identifying a physician at the Transferring Facility who will be responsible for the patient; and,

(3) Providing appropriate personnel, equipment and services to assist the Receiving Facility with the return transfer of the patient.

(b) In the event the Transferring Facility is unable to accept the transfer back of the patient within forty-eight (48) hours of the request by Receiving Facility, the Chief Executive Officer (or designee) of the Transferring Facility will promptly confer with the Chief Executive Officer (or designee) of the Receiving Facility about the reasons for such inability, and they shall develop a plan to expedite the transfer back of the patient as promptly as possible. Unless agreed by the parties otherwise, if a delay in the return transfer results in denied payment days for VMC, then the Transferring Facility (who is expected to re-admit the transferred patient) will be financial responsible for the cost of the extended stay at VMC.

(c) In order to facilitate return transfers, each Party shall establish policies and procedures to (i) identify bed availability for returning patients; and (ii) communicate with the Transferring Hospital in a timely manner in order to provide information necessary for assuring bed availability for a returning patient.

4. **Disputes**.

(a) If a dispute arises between the Parties during the course of a pending transfer relating to the clinical status and needs of the patient or the method of transportation, the judgment of the Transferring Physician shall take precedence solely for purposes of facilitating a timely decision on the transfer. If a dispute between the Parties arises or continues after a final decision has been made by the Receiving Hospital and Physician on the acceptance of a transfer, the judgment of the Transferring Physician shall not be dispositive in the resolution of the dispute.

(b) To the extent permitted by law, the parties will cooperate in the mutual review of a transfer that the Receiving Hospital identifies as implemented in a manner that is a possible violation of state or federal law, or this Agreement.

(c) All patient transfers will be done on an equitable basis, without regard to financial or diagnostic desirability.

5. **Disaster/Emergency Situation**. In the event of an area-wide disaster or national, state or local emergency situation, which requires the evacuation of patients, each Party agrees to admit evacuated patients from the other Party, to the extent there is physical capacity to do so, and when consistent with local disaster evacuation orders and protocols.

6. **Independent Contractor.**

(a) The Parties are at all times independent contractors with respect to their relationship with one another, the purpose of which is to promote continuity of patient care consistent with applicable laws and regulations. Nothing in this Agreement shall create nor be construed as creating any agency, partnership, joint venture or other corporate relationship between Parties.

(b) The governing body of each Party shall have the exclusive control over its policies, management, assets and affairs. Neither Party shall assume any liability by virtue of this Agreement for any debts or obligations of either a financial or a legal nature incurred by the other Party to the Agreement. Nothing in this Agreement shall affect or interfere with the (i) bylaws, rules and regulations of a Party as they relate to medical staff membership and the clinical privileges of the members of each Party's medical staff; or (ii) the services and admission policies of each Party.

7. **Charges for Services.**

(a) Charges for services performed by either Party shall be billed and collected by the Party rendering the services directly from the patient, third party payer or other source legally responsible for payment (including, if applicable, pursuant to Paragraph 7(b) below). Except as set forth in paragraph 7(b) below, neither Party shall have any liability to the other for such charges unless mutually agreed to in writing in advance.

(b) If a Party has a legal obligation (whether imposed by statute or by contract) to provide or pay for care for a patient who is to be transferred under this Agreement, the Party having the responsibility shall be liable for the reasonable charges of the other Party for providing medically necessary services and care.

8. **Non-Exclusive.** This Agreement shall be non-exclusive between the Parties. Nothing in this Agreement shall be construed as limiting the rights of either Party to contract with any other health facility on a limited or general basis.

9. **Compliance with Law.** The Parties shall comply with all applicable federal, state and local laws, regulations and ordinances, including applicable standards of the Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the parties.

(a) To the extent that any provision of this Agreement conflicts with EMTALA or state licensing laws for the provision of emergency services and care, as such laws may be amended, the provisions of EMTALA or the state licensing laws, as applicable, shall take precedence over and/or automatically supersede any inconsistent provisions of this Agreement.

(b) Each Party shall at all times be licensed by the State Department of Public Health, and certified by the Medicare and Medicaid programs.

10. **Term.** This Agreement shall be effective on the Effective Date and shall continue for two years thereafter unless and until terminated as follows:

(a) By either Party without cause, upon thirty (30) days prior written notice to the other Party; or

(b) Upon material breach of this Agreement, the non-breaching Party may terminate this Agreement on twenty (20) days written notice of the termination to the beaching Party. The notice shall state the acts or omissions which constitute the material breach. Material breach of this Agreement shall include, without limitation, violation of any federal, state or local statutes or regulations related to patient transfers. Remedy of the alleged material breach to the satisfaction of the Party giving notice within fifteen (15) days of the notice shall reinstate the Agreement.

11. **Amendments**. This Agreement may be amended at any time by a written agreement signed by the parties hereto. Nothing in this Agreement shall prevent the Parties from entering a separate agreement, or otherwise modifying the terms of this Agreement, for a specific patient transfer between the Parties.

12. **Miscellaneous**.

(a) **Notice.** Any notice required or permitted by this Agreement shall be effective and shall be deemed delivered upon placing in the mail, by certified or registered mail, postage prepaid, or upon personal delivery as follows:

To: SANTA CLARA VALLEY MEDICAL CENTER:	To: NATIVIDAD MEDICAL CENTER
Santa Clara Valley Medical Center 2325 Enborg Lane, Suite 220 San Jose, CA 95128	Natividad Medical Center 1441 Constitution Boulevard Salinas, CA 93906
Attn: Director of Planning & Business Development	Attn: Trauma Coordinator

(b) **Invalid Provision.** In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the parties hereto in the same manner as if the invalid or unenforceable provision were not part of this Agreement.

(c) **Maintenance of Records**. Each Party shall maintain all documentation relating to transfers under this Agreement, including transfer requests, acceptances and denials, for a minimum period of five (5) years from the date of the request for a transfer, or as otherwise required by the maintaining Party's policies and procedures, or by law.

(d) **Name Use**. Neither Party shall use the name of the other Party in any promotional or advertising material without the expressed written consent of the other Party. This Agreement shall not constitute an endorsement by either Party of the other Party, and it shall not be so used.

(e) **Governing Law**. This Agreement shall be construed in accordance with the laws of the State of California. Venue for disputes under this Agreement shall be the County of Santa Clara.

(f) **Insurance**. Each party hereto warrants it shall obtain and maintain policies of general and its professional liability insurance or self-insurance during the term hereof, at its own sole cost and expense, covering its activities in performance hereof. The coverage to be provided under this section shall be in minimum amounts of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) annual aggregate..

(g) **Indemnification**. Natividad agrees to indemnify, defend, and hold harmless the County, its supervisors, officers, employees, and agents from any and all liabilities, claims, damages, losses, reasonable attorney's fees, and other reasonable costs of defense (including costs incurred prior to commencement of a lawsuit) resulting from or attributable to acts or omissions of the Natividad or any of its employees, agents or subcontracts in the performance of this Agreement.

(h) **Assignment and Delegation**. Neither Party hereto shall assign or transfer this Agreement, in whole or in part, or any its rights duties, or obligations under this Agreement, without the prior written consent of the other Party hereto.

(i) **Entire Agreement**. This Agreement contains the entire understanding of the Parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the Parties relating to such subject matter.

(j) **No Smoking**. Natividad and its employees, agents and subcontractors, shall comply with the County's No Smoking Policy, as set forth in the Board of Supervisors Policy Manual section 3.47 (as amended from time to time), which prohibits smoking: (1) at the Santa Clara Valley Medical Center Campus and all County-owned and operated health facilities, (2) within 30 feet surrounding county-owned buildings and leased buildings where the County is the sole occupant, and (3) in all County vehicles.

(k) **Non-Discrimination.** The Parties shall comply with all applicable Federal, State, and local laws and regulations, including Santa Clara County's policies, concerning nondiscrimination and equal opportunity in contracting. Such laws include, but are not limited to, the following: Title VII of the Civil Rights Act of 1964 as amended; Americans with Disabilities Act of 1990; The Rehabilitation Act of 1973 (§§ 503 and 504); California Fair Employment and Housing Act (Government Code §§ 12900 et seq.); and California Labor Code §§ 1101 and 1102. The Parties shall not discriminate against any patient, employee, subcontractor or applicant for employment because of age, race, color, national origin, ancestry, religion, sex/gender, sexual orientation, mental disability, physical disability, medical condition, political beliefs, organizational affiliations, or marital status in the recruitment, selection for training including apprenticeship, hiring, employment, utilization, promotion, layoff, rates of pay or other forms of compensation. Nor shall the Parties discriminate in provision of services provided under this contract because of age, race, color, national origin, ancestry, religion, sex/gender, sexual orientation, mental disability, physical disability, medical condition, political beliefs, organizational affiliations, or marital status. A violation of this provision shall be deemed a material breach.

(l) **Non-waiver.** No waiver of a breach, failure of any condition, or any right or remedy contained in or granted by the provisions of this Agreement will be effective unless it is in writing and signed by County. No waiver of any breach, failure, right, or remedy will be deemed a waiver of any other breach, failure, right, or remedy, whether or not similar, nor will any waiver constitute a continuing waiver unless the writing signed by the County so specifies.

(m) **Debarment.** Natividad guarantees that it, its employees, contractors, subcontractors or agents are not suspended, debarred, excluded, or ineligible for participation in Medicare, Medi-Cal or any other federal or state funded health care program, or from receiving Federal funds as listed in the List of Parties Excluded from Federal Procurement or Non-procurement Programs issued by the Federal General Services Administration. Natividad must within 30 calendar days advise the Center if, during the term of this Agreement, Natividad becomes suspended, debarred, excluded or ineligible for participation in Medicare, Medi-Cal or any other federal or state funded health care program, as defined by 42. U.S.C. 1320a-7b(f), or from receiving Federal funds as listed in the List of Parties Excluded from Federal Procurement or Non-procurement Programs issued by the Federal General Services Administration.

(n) **Cooperation with review**. Natividad shall cooperate with County's review of performance pursuant to this Agreement upon request.

(o) **No Third Party Beneficiaries**. This Agreement shall not confer any rights on any persons other than the County and Natividad, and shall not be enforceable by any other person on the basis of third party beneficiary theory or otherwise.

(p) **Access to Books and Records.** If and to the extent that, Section 1861 (v) (1) (1) of the Social Security Act (42 U.S.C. Section 1395x (v) (1) (1) is applicable, Hospital shall maintain such records and provide such information to Center and to applicable state and federal regulatory agencies, and shall permit such entities and agencies, at all reasonable times upon request, to access books, records and other papers relating to the Agreement hereunder, as may be required by applicable federal, state and local laws, regulations and ordinances. Hospital agrees to retain such books, records and information for a period of at least four (4) years from and after the termination of this Agreement.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Effective Date.

County of Santa Clara

7-15-13

Paul Lorenz — Date
Chief Executive Officer
Santa Clara Valley Medical Center

Natividad Medical Center

7/2/13

Chief Executive Officer — Date
Natividad Medical Center

7/11/13

David McGrew — Date
Chief Financial Officer
Santa Clara Valley Health & Hospital System

Approved:

7-24-13

County Executive — Date

Approved as to form and legality:

7/11/13

Deputy County Counsel — Date

ADDENDUM FOR TRANSFERS FOR SPECIFIC TEST OR PROCEDURES WHERE THE PATIENT WILL BE RETURNING TO THE TRANSFERRING HOSPITAL

1. **Responsibilities of Transferring Hospital**. In the event of a transfer for a specific procedure or procedures and the patient will be returning thereafter to the Transferring Hospital --

(a) The Transferring Physician shall (i) obtain the patient's consent for the transfer as well as for the procedure(s), including documenting the consents in writing when required; and (ii) determine the mode of transport, equipment and personnel for the transfer.

(b) The Transferring Hospital shall comply with all applicable laws relating to the transfer of the patient and agree to accept the return of the patient upon completion of the procedure(s) at the Receiving Hospital.

(c) The Transferring Hospital shall be financially responsible, including billing, for the transport of the patient to and from the Receiving Hospital. The Receiving Hospital shall not pay for the cost of transportation unless the Receiving Hospital is legally obligated to do so.

(d) Except for the transfer of a patient with an Unstabilized Emergency Medical Condition, the Transferring Hospital shall obtain prior authorization from the patient's payor or other person for the transfer and the procedure if (i) prior authorization is required by the payor prior to the transfer and/or procedure; and (ii) requesting such authorization is otherwise permitted by law.

2. **Responsibilities of the Receiving Hospital**. In the event the transfer is for a specific procedure or procedures and the patient will be returned thereafter to the Transferring Hospital --

(a) The Receiving Hospital shall be responsible for assuring that the requested procedure(s) are performed promptly and that, as soon as possible, the patient is returned to Transferring Hospital.

(b) Before returning the patient, the Receiving Physician shall determine that the patient's condition is Stabilized for transfer to the Transferring Hospital. In the event the patient's condition is not Stabilized for the transfer, the Receiving Hospital will arrange for an appropriate physician to care for the patient until such time as the patient's condition is Stabilized for the transfer. When the patient's condition is Stabilized, the Receiving Hospital agrees to return the patient in an expeditious manner, subject to the patient's (and, if applicable, payor's) consent.

(c) The Receiving Hospital shall forward a copy of all pertinent medical records with the patient. The medical records should reflect the patient's condition while at Receiving Hospital, the procedures and services performed on the patient at Receiving Hospital, including the results. Records that are not available at the time of the return transfer shall be forwarded as soon as they become available.

(d) Except as arranged by the Transferring Hospital, the Receiving Hospital shall be responsible for coordinating for the patient's return to Transferring Hospital, including the responsibility for selecting an appropriate mode of transportation and appropriate personnel, including physicians and hospital personnel, when appropriate, to accompany the patient.

EXHIBIT A

PROCEDURE FOR OBTAINING RECEIVING HOSPITAL'S CONSENT FOR PATIENT TRANSFER

Natividad Medical Center:

In the event any patient of Natividad is deemed by that facility to require specialized services of SCVMC and the transfer is deemed medically appropriate, the transferring Physician shall call SCVMC to arrange for appropriate treatment as completed herein.

Natividad may request consultation for the purpose of transfer as follows:

i.	Spinal Cord Injury:	408-885-4495
ii.	Trauma:	408-885-4495
iii.	Pediatric Trauma	408-885-5260
iv.	Burn:	408-885-6666

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Hospital Transfer Pre-Admission Data Form

ATTACHMENT A

Name of Transferring Institution: _____

Today's Date: _____

VMC MRN: _____

PATIENT INFORMATION

1. Legal Name (*Last, First, Middle*)	2. Place of Birth	3. Date of Birth	4. Age	5. Gender M / F	6. Marital Status: ☐ Married ☐ Divorced ☐ Never Married ☐ Legally Separated ☐ Registered Domestic Partner ☐ Widowed	7. Social Security Number
8. Address (*Street, City, State, Zip Code*)	9. Mailing Address (*Street, City, State, Zip Code*)	10. Best phone number to reach you	11. Alternate Phone Num. to reach you			
12. E-Mail Address	13. Employer	14. Occupation	15. Work Address (*Street, City, State, Zip Code*)	16. Work Phone		
17. Emergency Contact	18. Relationship to Patient	19. Emergency Contact Address (*Street, City, State, Zip Code*)	20. Emergency Contact Phone Number	21. Emergency Contact Alternate Phone		
22. Person Responsible for Paying Hospital Bill (*Guarantor*)	23. Relationship to Patient	24. Guarantor Address (*Street, City, State, Zip Code*)	25. Guarantor Phone	26. Guarantor Alternate Phone		

27. The government requires hospitals to collect statistical information on Race and Ethnicity. Providing this information is voluntary.

Race: ☐ White ☐ African-American ☐ Asian/Pacific Islander ☐ Latino ☐ Other _____ ☐ Decline to answer

28. Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer

29. Preferred Language

30. Are you a U.S. Citizen? Yes / No	31. Do you have permanent residency status? Yes / No. If yes, how long? Length: _____years, _____months	32. Are you a resident of Santa Clara County? Yes / No	33. Are you any of the following? Yes / No. If Yes, check all that apply: ☐ Victim of Domestic Violence ☐ A refugee ☐ Haitian ☐ Seeking Asylum ☐ On Temporary Protection Status

34. Please list maiden names and/or other names and aliases you have used:

INSURANCE COVERAGE INFORMATION

35. **PRIMARY INSURANCE** ☐ **Yes** ☐ **No**

If No, did you have insurance within the past 90 days? Yes / No.

If your coverage ended within the past 90 days, provide the date your coverage ended:

Date:

36. If your coverage ended within the past 90 days, select the ***reason*** that your coverage ended:

☐ Loss of Job ☐ Cobra Coverage Ended ☐ Other _____ ☐ Employee Benefits Terminated by Employer

37. Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Unemployed ☐ Self-Employed

38. Insurance Company	39. Insurance Company Phone	40. Policy Number	41. Group Number	42. Sponsor's Name	43. Sponsor's Gender M / F	44. Sponsor's Birth Date
45. Sponsor's Employer	46. Sponsor's Employer Address	47. Sponsor's Work Phone	48. Sponsor's Social Security Num.	49. Patient's Relationship to Sponsor		

50. **SECONDARY OR SUPPLEMENTAL INSURANCE** ☐ **Yes** ☐ **No**

51. Insurance Company	52. Insurance Company Phone	53. Policy Number	54. Group Number	55. Sponsor's Name	56. Sponsor's Gender M / F	57. Sponsor's Birth Date
58. Sponsor's Employer	59. Sponsor's Employer Address	60. Sponsor's Work Phone	61. Sponsor's Social Security Num.	62. Patient's Relationship to Sponsor		

63. **WORK RELATED INJURY** ☐ **Yes** ☐ **No**

64. Employer at Time of Injury	65. Employer Address (*Street, City, State, Zip Code*)	66. Employer Phone	67. Date of Injury
68. Name of Workers Compensation Insurance	69. Workers Compensation Insurance Address (*Street, City, State, Zip Code*)	70. Workers Comp. Insurance Phone	71. Claim Number

UNITED STATES MILITARY SERVICE

72. Have you ever served, or are you currently serving, in the U.S. Military Service? Yes / No

73. What branch? ☐ USA ☐ USAF ☐ USMC ☐ USN ☐ USCG

74. Current Status: ☐ Active Duty ☐ Reserves ☐ National Guard ☐ Military Retiree ☐ Veteran

75. Dates of Service:

76. Serial No.

77. If currently on Active Duty, enter Organization & Duty Station:

78. Military I.D. Card Number:

79. Effective Date:

80. Expiration Date:

81. Pay-Grade/Rank:

82. Are you currently receiving VA medical benefits? Yes / No

83. If Yes, what type?

For Patients Having No Healthcare Insurance Only Complete this Section: FINANCIAL ASSISTANCE QUESTIONS PERTAIN TO THE PATIENT

1.	Are you applying for assistance with bills for current or past services at SCVMC and/or clinics operated by SCVMC? If yes, please indicate date and place of service.	YES / NO
2.	Are you applying for assistance with bills for future services at SCVMC and/or clinics operated by SCVMC? If yes, please describe types of anticipated services:	YES / NO
3.	Are you in a state medical assistance program? If yes, please provide the following information: Name of program: County: Patient Identification #	YES / NO
4.	Are you being treated for injuries covered by a Third Party Liability, such as an Auto Insurance Company? If yes, please provide the following information: Name of Auto Insurance or Attorney: _____ Auto Insurance/Attorney phone: _____ Injury date: Claim/Case #	YES / NO
5.	Are you a Victim of Crime? If yes, please provide the following information: Date of injury: _____ Name of Case Worker: _____ Case Worker Phone: _____ Case #:	YES / NO
6.	Are you or any member of your household covered by: ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part C ☐ Medicare Part-D ☐ Medi-Cal ☐ Medicaid? If yes, please provide the following information: ID # Effective Date: Person covered:	YES / NO
7.	Do any of the following conditions apply to you? ☐ I Have a disability that is expected to last 12 months or longer ☐ I am Legally Blind ☐ I am Pregnant ☐ I am Receiving Food Stamps	YES / NO
8.	Do you have children or dependents? If yes, please provide the following information: Number of Children or Dependents; Ages of Children or Dependents:	YES / NO
9.	Have you applied for Medi-Cal within the past 90 days? If yes, please mark status of application: ☐ Denied ☐ Pending	YES / NO
10.	Have you worked during the last year?	YES / NO
11.	Are you already receiving care at SCVMC? If yes, please provide doctor's name: _____ What clinic would you prefer to go to for your care?	YES / NO

For Patients with No Health Information Only Complete this Section: INFORMATION			
Monthly Income Sources	**Applicant**	**Spouse or Other**	**Combined Monthly Income**
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Cash Income	$	$	$
1. Other Income	$	$	$
2.	$	$	$
3.	$	$	$
TOTAL COMBINED MONTHLY INCOME	$	$	$

UNEMPLOYMENT: If you do not have a monthly income, please explain how you take care of your monthly expenses. You will also need to sign an *Affidavit of No Income.*

ASSETS: Include all bank accounts and investment accounts (IRA's, CD's, Savings, Checking, Money Market, 401(k), Stocks, Bonds etc.)

Bank Name	Branch Address	Account Number	Current Balance
			$
			$
			$
			$
			$
TOTAL ASSETS (for all accounts, including other accounts on which you sign, or share)			$

ADDITIONAL INFORMATION AND COMMENTS

All Patients Complete this Section: SIGNATURE

I certify under penalty of perjury by my signature that the information I have provided as required in this agreement is true and complete to the best of my knowledge and belief. I am fully responsible to inform SCVHHS and any programs for which I may be eligible, including, but not limited to, the various Medication Assistance Programs, of any change in my residency, financial status, and/or third party coverage. I also certify by my signature that I have read and understand all the foregoing and that I agree to have Medication Assistance Program staff act on my behalf for all eligible medications. I give my consent to release my information to Pharmaceutical Companies for auditing purposes in the Bulk Replacement Patient Assistance.

I certify that all information is valid and complete and hereby authorize Santa Clara Valley Health & Hospital System to request a credit check report and/or verify any of the above information as deemed necessary.

Applicant Signature	**Date**	**Spouse/Other Signature**	**Date**
Application Assistant's Name (PRINT ONLY)	**Location**		**Date**

ATTACHMENT B

SANTA CLARA
VALLEY
MEDICAL
CENTER

Conditions of Admission

Name of Patient: _____

1. Consent to Medical and Surgical Procedures: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services and which may include but are not limited to laboratory procedures, x-ray examination, medical and surgical treatment or procedures, anesthesia, or hospital services rendered for the patient under the general and special instructions of the patient's physician or surgeon. If I deliver an infant while a patient of this hospital, I agree that these same Conditions of Participation apply to the infant.

2. Nursing Care: The hospital provides general duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. It is agreed that should the patient or his/her legal representative request the services of a special duty nurse, without an order from the patient's physician, that such services must be arranged for by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

3. Teaching Institution: SCVMC is a teaching facility, training physicians, surgeons, nurses and other health care personnel. At the request, and under the supervision, of the attending physician, I agree that residents, interns, medical students, post-graduate fellows, visiting faculty members and other health care personnel in training may participate in the care of the patient. Certain medical services may be provided by individuals who do not have a physician's certificate but are qualified to participate in a special program as a visiting faculty member.

4. Financial Agreement: The undersigned agrees to pay for services rendered, in accordance with the regular rates and terms established for such services at the hospital, and agree that, pursuant to California Civil Code section 2881, et seq., the hospital has a contractual first lien against any subsequent judgment or compromise regarding the injuries or condition for which the patient receives medical services.

5. Personal Valuables: Patients are encouraged to leave personal items at home, It is understood and agreed that the hospital maintains a fireproof safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents, furs, fur coats and fur garments, or other articles that are not placed in the safe. The liability of the hospital for loss of any personal property deposited with the hospital for safe keeping is limited by law to five hundred dollars ($500.00) unless a written receipt for a greater amount has been obtained from the hospital by the patient.

6. Assignment of Insurance/Medical Benefits to the Hospital: The undersigned authorizes, whether he/she signs as an agent or as patient, direct payment to the hospital of any insurance/ medical benefits otherwise payable to or on behalf of the undersigned for this hospitalization or for these outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's regular charges. It is agreed that payment to the hospital, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

7. Photography: I consent to the taking of pictures, videotapes or other electronic reproductions of the patient's medical or surgical condition or treatment, and the use of the pictures, videotapes or electronic reproductions, for treatment or internal or external activities consistent with the Hospital's mission, such as education and research, conducted in accordance with Hospital policies and applicable law.

SANTA CLARA
VALLEY
MEDICAL
CENTER

8. Interpreter Services: Interpreter Services are available 24 hours a day, 7 days a week, at no cost for non-English speaking and hearing and speech-impaired patients and their families. If you need an interpreter, let us know when you call Valley Connection (1-888-334-1000) to register, make an appointment, or are being admitted to the hospital. Or contact Language Services (1-888-334-1000; TDD 1-408-971-4068). (California Relay Services is also available: TDD 1-800-735-2929).

If you have a complaint, contact:

Language Services Coordinator
751 S. Bascom Av., San Jose, CA 95128 1-408-808-6150

Customer Service Department
751 S. Bascom Av., San Jose, CA 95128
1-800-351-1818 or 1-408-885-4826

State of California Department of Health Services
Licensing & Certification
One Almaden Bl, 9th Fl, San Jose, CA 95113
1-800-554-0348 or 1-408-277-1784

California Relay Services
1-800-735-2922; TDD 1-800-735-2929

9. Advance Directives:

❑ I do ❑ I do not have an Advance Directive _____ (initial)

I have been asked to provide a copy of my Advance Directive _____(initial)

I have received the SVCMC "Patient Information" booklet _____ (initial)

I want additional information about Advance Directives ❑ Yes ❑ No _____(initial)

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____
Patient

_____
Date/Time of Signing

_____
Witness

_____
Patient's Agent or Representative

_____
Relationship to Patient

ATTACHMENT C

Infection Prevention Transfer Patient Screening

Since resistant organisms are difficult to eradicate once established and can have serious epidemiologic implications in the hospital setting, SCVMC requires the following Infection Prevention information on the patient you wish to transfer to SCVMC. Please FAX to Admitting, who will forward this information to the accepting physician or designee:

Patient's name: _____

Hospital: _____

Diagnosis: _____

Date of Injury: _____

Infectious Disease History: _____

1. Has the patient been exposed to any communicable disease(s)? Yes ☐ No ☐
   If yes, what disease(s)? _____
   If yes, what was the date of the exposure? _____
2. Does the patient have any infectious diseases and/or infections? Yes ☐ No ☐
3. If so, have cultures been done? Yes ☐ No ☐
4. Do any of the organisms have unusual resistance patterns? Yes ☐ No ☐
5. If resistant, please identify organism. _____
6. Has the patient been infected or colonized with:
   - methicillin-resistant *Staphylococcus aureus* (MRSA)? Yes ☐ No ☐
   - vancomycin-resistant Enterococci (VRE)? Yes ☐ No ☐
   - organism with extended spectrum beta-lactamase (ESBL)? Yes ☐ No ☐
7. If previously infected or colonized with MRSA or VRE, do you have current cultures and sensitivities (C&S) of nares or throat swab (MRSA), urine (if catheterized), trach, rectal swab (VRE), and all wounds which indicate absence of MRSA or VRE? (Patient must not be on effective antibiotics for these organisms for 48 hours prior to cultures.) Yes ☐ No ☐
8. Other comments:

_____

_____

_____
Print Name

_____ _____
Signature Date

SCVMC FAX number is _____