Jewish Home of Rochester

Long-term, Transitional and Memory Care

Dear Applicant:

Thank you for your interest in the Neurobehavioral Rehabilitation Program (NBRP) at the Jewish Home of Rochester. This is a 20-bed specialized skilled nursing facility unit to serve individuals with a neurological impairment such as traumatic brain injuries, Parkinson's disease, dementia, mood disorder/depression, anxiety disorder and psychosis. Treatment plans are individualized and focus on conflict resolution and behavioral management strategies. Discharge planning begins upon admission, focusing on individualized goals and desired outcomes for each individual. The objective of the interdisciplinary team is to help patients reach their own maximum health and functional ability in order to successfully manage their daily routine within their own community after discharge.

Here are the steps to applying:

Step One: Complete the enclosed admission application.

Step Two: Along with the completed admission application, we need **copies** of the following documents, if applicable:

- **Health Insurance Cards (both sides) Medicare D PDP Card or letter (most recent**
- **Social Security Card**
- **Medicare Card**
- **Medicaid Card (both sides)**
- **Power of Attorney**
- **Health Care Proxy**
- **Current bank statements and other financial account statements.**
- **Trusts Agreement**
- **Long Term Care Insurance Policy**

(The information you provide, both written and verbal, is considered privileged and will be treated confidentially. Your application cannot be processed without them.)

Step Three: New York State Law requires a current Patient Review Instrument (PRI) and Screen. This is an assessment tool used to determine the level of care an individual requires. The PRI is good for 90 days. The following agencies can be contacted to complete a PRI and Screen if you receive Medicaid:

- **Lifetime Home Care (585) 214-1000**
- **UR Medicine Home Care (585) 787-2233**

Step Four: Return the completed admission application and copies of all of the above documents to the Jewish Home, Attention: Admissions, Elizabeth Algase. Upon receipt of the

application, Michael Celento, NBRP Director, will begin the clinical assessment. You will be notified of the admission decision.

Last Step: All approved applicants are placed in a waiting pool from which placements are made according to the care needs of the applicant. Admission is based on additional factors, as well. These include, but are not limited to, special needs of the applicant and an available bed at the appropriate level of care. Financial information must be updated every six (6) months to keep the application active.

PAYMENT OPTIONS: The Jewish Home of Rochester willingly accepts applicants regardless of their source of payment. There are several payor options for the NBRP for which one may be eligible.

PRIVATE PAY

Upon admission, the Jewish Home bills for the remainder of that month, plus the next month. Subsequently, residents are billed at the beginning of each month. Current private pay rates effective January, 1, 2022 are:

Skilled Nursing	JHR	NYS Tax Assessment at 6.8%	Total Daily Rate
Private	$628.21	$42.72	$670.93

MEDICAID

Chronic Care Medicaid, a program funded by the federal, state and local governments, pays for nursing home care if a resident meets certain financial criteria and completes the application process with the Monroe County Department of Social Services, or the county of residence at the time of application. As part of the application process, the county will request copies of financial statements for any bank or investment accounts that were in the resident's name during the sixty (60) months prior to application. The Jewish Home employs an outside company, *Medicaid Recoveries* to work with the resident and family to initiate and complete the Medicaid process. A resident receiving Medicaid is required by law to complete a recertification process annually.

If an eligibility determination has not been made by the county prior to admission, JHR staff will require additional information, such as sixty (60) months of bank statements, etc., in preparation for that process.

Often, when it is determined that a resident is eligible for Medicaid, the county requires that any monthly income the resident receives, such as Social Security or pension, must be used to

pay for nursing home care and to continue payment of supplemental health insurance premiums. The resident on Medicaid receives a personal allowance of $50.00 each month.

Please note that the Jewish Home of Rochester is a smoke-free facility. We do not make exceptions to this policy.

The Admissions Office is open Monday through Friday, 8:00 a.m. to 4:30 p.m. I will be happy to arrange a tour of the Jewish Home for you, or visit our website at your convenience at www.jewishhomeroch.org.

My goal is to assist you in any way I can. Please contact me if you have any questions at (585) 784-6396, fax (585) 424-6671, or email at balgase@jewishseniorlife.org.

Sincerely,

Elizabeth R. Algase
Long Term Care Admission Coordinator
(585) 784-6396
Fax (585) 424-6671
Jewish Home of Rochester
2021 Winton Road S.
Rochester, NY 14618

Jewish Home
of Rochester

NEUROBEHAVIORAL REHABILITATION PROGRAM ADMISSION APPLICATION

Applicant – please print all information					
Name:				Maiden name:	
Last	First	Middle Initial			
Current address:					
City:		State:		ZIP Code:	
Telephone:		County of residence:		Gender: Male Female	
Date of birth:		Birthplace:			
Previous address:					
Marital status:	Married	Widow	Single	Separated	Divorced
Spouse name:				If deceased, date of death:	
US Citizen? Yes No					
Religion:		Place of Worship:			
US Veteran?	Yes	No	Branch		
Current location:		At home: Yes No			
If no, name of hospital, Nursing Home or Assisted Living facility:					
Facility contact/Social Worker:				Phone:	

Jewish Senior *Life* Relationship History			
Have you ever been a resident at the Jewish Home?			
Yes	No	If yes, date:	
Have you ever been a resident of Lodge at Wolk Manor, Wolk Manor or the Summit at Brighton?			
Yes	No	If yes, date:	
Have you ever been a participant at Marian's House?			
Yes	No	If yes, date:	
Have you ever been a participant at Adult Day Care at Jewish Senior Life?			
Yes	No	If yes, date:	

Primary contact #1					
Name:					
Relationship:					
Address:					
City:	State:			Zip:	
Home phone:		Cell phone:		Work phone:	
Email address:					
Power of Attorney:	Yes No	Health Care Agent:	Yes No		

Primary contact #2					
Name:					
Relationship:					
Address:					
City:	State:			Zip:	
Home phone:		Cell phone:		Work phone:	
Email address:					
Power of Attorney:	Yes No	Health Care Agent:	Yes No		

Primary contact #3					
Name:					
Relationship:					
Address:					
City:	State:			Zip:	
Home phone:		Cell phone:		Work phone:	
Email address:					
Power of Attorney:	Yes No	Health Care Agent:	Yes No		
Please use an additional sheet if more than three primary contacts.					

Insurance Coverage							
Social Security number:							
Medicare policy number:							
Part A?	Yes	No		Part B?	Yes	No	
Excellus Medicare Blue Choice policy number:							
MVP policy number:							
United Health Care Medicare policy number:							
Aetna Medicare policy number:							
Cigna policy number:							

Medicare D PDP policy number:
BC/BS policy number:
AARP policy number:
Other (list name and policy number)

Medical History			
The Admissions Coordinator will request current medical information from physicians listed.			
Current illness and medical condition:			
Please list main reasons for submitting application:			
Has the applicant been hospitalized within the past 30 days?		Yes	No
If yes, name of hospital:	Dates of stay:		
Reason for hospitalization:			
Has the applicant had a previous nursing facility stay in the past 12 months?		Yes	No
If yes, name of facility:	Dates of stay:		

Primary physician			
Name:			
Office phone:			
Address:			
City:	State:	Zip:	
Specialist physician			
Name:		Specialty:	
Office phone:			
Address:			
City:	State:	Zip:	
Specialist physician			
Name:		Specialty:	
Office phone:			
Address:			
City:	State:	Zip:	
Dentist			
Name:		Specialty:	
Office phone:			
Address:			
City:	State:	Zip:	
Please use an additional sheet if necessary.			

Funeral arrangements			
Name of responsible party to contact at time of death:			
Relationship to applicant:			
Home phone:	Cell phone:	Work phone:	
Funeral home:		Phone number:	
Has a pre-burial account been established?		Yes	No

Financial Information
If married, please include financial information for spouse.
Please provide current bank statements for all accounts listed. **Copies of the most recent bank and/or financial statements are required for processing this application.** This information will need to be updated every 6 months as requested by Admissions. You may need to furnish the Jewish Home with up to 60 months of bank statements. (There may be a bank fee to obtain this information and we will make every attempt to minimize our request.)

Income				
Monthly		**Applicant**		**Spouse**
Salary				
Social Security				
Retirement Pension				
Veteran's Benefits				
Interest/Dividends				
Other				
Total Monthly Income				

Assets			
Checking account	Yes	No	**Balance:**
Name of bank		Last 4 digits of acct #:	
Savings account	Yes	No	**Balance:**
Name of bank		Last 4 digits of acct #:	
Life Insurance Cash Value	Yes	No	**Value:**
Company name			
Certificate of Deposit	Yes	No	**Balance:**
Holder's name		Last 4 digits of acct #:	
Stocks	Yes	No	**Balance:**
Holder's name			
Account number			
Annuities	Yes	No	**Balance:**
Holder's name			
Account number			
Are you drawing income?	Yes	No	
Does this have cash value?	Yes	No	**Balance:**
Non-retirement investment?	Yes	No	

Bonds	Yes	No	**Balance:**
Holder's name			
Account number			**Balance:**

IRA/401K/403B	Yes	No	
Holder's name:		Balance:	Account #
Holder's name:		Balance:	Account #
Holder's name:		Balance:	Account #

Total Assets	
If applicant is married, list total combined assets, including any assets not listed above:	

Real Estate		
Does the applicant own a home?	Yes	No
Spouse, disabled adult or child in the home?	Yes	No
Have you sold the home in the past 5 years?	Yes	No
Was it sold at fair market value?	Yes	No
Please list all real estate assets. Include property and building address as well as approximate value.		
	Value:	
	Value:	
	Value:	

Fiscal Agent (manages financial obligations for applicant)					
Is there a Power of Attorney:	Yes	No	Is there a Legal Guardian:	Yes	No
Name:			*Please provide a copy of documentation.*		
Relationship:					
Address:					
City:	State:			Zip:	
Home phone:		Cell phone:		Work phone:	
Email address:					
If there is no Power of Attorney or Guardian, who is responsible for the applicant's financial affairs:					
Name:					
Relationship:					
Address:					
City:	State:			Zip:	
Home phone:		Cell phone:		Work phone:	

Have you gifted or transferred anything out of your name – money or property greater than $2,000 in the past 60 months? If yes, please provide amount and dates of transfer.	Yes	No

Trusts					
Have you created a trust in the past 60 months?				Yes	No
Is this a revocable trust?				Yes	No
Please list any and all trusts you have created or to which you contributed assets. *Provide a **complete copy** of all trust documents.*					
Trustee Name(s):					
Beneficiaries:					
Date created:		Date funded:			
What are the assets in the trust?					
What bank account(s) are used for this trust?		Last 4 digits of acct #:			

Have you consulted with an attorney regarding payment for nursing home care?	Yes	No
If so, provide attorney's name and telephone number.		
Will this attorney be handling a Medicaid application?	Yes	No

The Jewish Home will not be able to complete a Medicaid application for the applicant. Therefore, if a Medicaid application becomes necessary, who will be responsible for completing it?
Name:

Long Term Care Insurance								
Do you have Long Term Care Insurance?							Yes	No
*If yes, we will need a **complete copy** of the policy*								
Company name:								
Address:								
SNF Daily rate			How many days of this benefit?					
Current account balance			NYS Partnership plan?		Yes	No		
Have you met your eligibility/elimination period?							Yes	No
If not, what is your eligibility/elimination period?								
Inflation rider?	Yes	No	Percentage _____	Annual month and date of inflation increase				

Medicaid					
If applicable, have you been approved for:					
Chronic Care Medicaid				Yes	No
Community Medicaid				Yes	No
Medicaid CIN number		County			
Date of application		Date of approval			
DSS Caseworker		Phone number			
County					
Do you have a Medicaid Managed Long-Term Care Plan, i.e., I-Circle, Fidelis, VA?				Yes	No
Case manager name:			Phone number:		

Purpose of Referral to Neurobehavioral Rehabilitation Program		
Is the referring agency willing to participate in the applicant's treatment at Jewish Home of Rochester and follow up with behavioral plans post discharge?	Yes	No

Expected Treatment Outcomes Upon Applicant's Discharge from Neurobehavioral Rehabilitation Program

Clinical Information		
Description of problem behavior(s) the applicant is exhibiting:		
Is the behavior predictable?	Yes	No
Comments:		
How long has the behavior been going on?		
Comments:		

When does the behavior typically occur (i.e., time of day, day of week, circumstances or events)?
What interventions have been tried? For how long? What were the results?
Based on reports from family, friends and direct care staff, describe the applicant's personality and behavior before the problem behavior(s) began.
Since the applicant's admission to your agency, describe any changes in the following: 1) caregivers; 2) level of family involvement/visits; 3) routine/program schedule; 4) medications; 5) medical status; 6) appetite; 7) sleep; 8) mood; 9) mental status; 10) any other notable factors. Please include dates where possible.

List the applicant's psychiatric diagnoses, when the applicant was diagnosed, and who provided the diagnoses.		

Does the applicant have a history of psychiatric or substance use disorder treatment (i.e., ED visits, outpatient, partial hospitalization, sub-acute inpatient stays, hospitalizations, etc.)?	Yes	No

If yes, provide the dates and outcomes/discharge dispositions of the treatment episodes.	

****Please include with this application all available behavioral health documentation and records, including any: assessments, progress notes, and discharge summaries.*

Does the applicant have a history of any of the following:

Psychotic symptoms (i.e., delusions, hallucinations, etc.)	Yes	No

If yes, provide details regarding symptoms, dates, interventions and outcomes.

Suicidality	Yes	No

If yes, provide details regarding symptoms, dates, interventions and outcomes.

Homicidality	Yes	No

If yes, provide details regarding symptoms, dates, interventions and outcomes.

Aggression (physical or verbal) in the last 30 days	Yes	No
If yes, describe the behavior in detail.		

List the applicant's other diagnoses and/or conditions, including date of diagnosis/onset and who provided the diagnosis.

Medication List

Medication	Dosage	Frequency	Start Date	Used For

Is the applicant medically stable? Does the applicant have the clinical need for IVs, tube feedings, oxygen, or central lines? Does the applicant have any acute exacerbations?	Yes	No
If yes to any of the above, provide details.		

What are the applicant's hobbies and interests? What is most likely to positively motivate the applicant?

Describe any routines or rituals that are important to the applicant (i.e., hygiene, morning/evening, leisure, eating/nutrition, etc.).	
Person Completing This Form	
Name:	Title:
Relationship to Applicant:	Contact Number:

All of the foregoing information is true and accurate. I also agree that the funds that are currently or have been in the name of the applicant have been or will be used for the long-term care of the applicant.

_____ _____

Signature of Fiscal Agent/Responsible Party/POA Date

This completed application and supporting documents must be submitted to the Jewish Home of Rochester before an individual can be considered for admission. Submission of such an application does not create automatic entitlement to admission, or mean that the applicant will automatically be placed in the Home's waiting pool. Placement in the waiting pool is made after an application is fully reviewed and approved.

FEDERAL AND NEW YORK STATE LAW PROHIBIT THIS HEALTH CARE FACILITY FROM DENYING ADMISSION TO ANYONE BECAUSE OF RACE, CREED, COLOR, NATIONAL ORIGIN, AGE, SEX, DISABILITY, MILITARY STATUS, SEXUAL ORIENTATION, BLINDNESS, SOURCE OF PAYMENT OR MARITAL STATUS.

APPLICANT'S DECLARATION and HIPAA RELEASE

I hereby apply for admission to the Jewish Home of Rochester. If I am admitted to the Jewish Home of Rochester, I agree to comply with all of its rules and policies and I will sign on my admission, the Admission Agreement, which the Home requires as a condition of admission.

I hereby expressly authorize and request that each of the following persons, agencies, and/or organizations give full, detailed, and relevant information regarding me to the Jewish Home of Rochester:

1. The Social Security Administration
2. Any and all physicians, dentists, social workers, psychologists, nurses, technicians, clinics, hospitals, and psychiatric facilities where I have been a patient (including any and all mental health and/or substance use disorder information).
3. Any and all banks and bankers which now hold or heretofore held my funds; and all persons, firms, or corporations which hold my funds or funds payable to me
4. Any and all persons, firms, or corporations which hold my funds or funds payable to me
5. Any and all insurance companies by which I am an insured or which hold my funds or funds payable to me

I also hereby agree to provide such other necessary instruments, as may be requested, to efficiently complete this application for admission.

_____ _____

Signature of Applicant only Date

_____ _____

Applicant's Printed Name Date of birth

_____ _____

Signature of Power of Attorney/Responsible Party Date
(If Applicant cannot sign)

Jewish Home of Rochester
Statement Regarding Monthly Income Amounts and Medicaid

I, as Power of Attorney or as the person responsible for _____,
Financial affairs, agree to sign all documentation required to change the address on any and all monthly social security or pension payments, so that these payments will be sent directly to the Jewish Home of Rochester to be used for the resident's cost of care. As required under Medicaid law, this will come into effect at the time the resident needs to apply for Medicaid. I agree to sign that required paperwork on the resident's day of admission to the Jewish Home of Rochester.

I also agree that beginning with the first month of Medicaid eligibility and continuing until the change of address has been implemented by the payer, to submit upon receipt, all funds received on behalf of the resident to the Jewish Home of Rochester to pay for the resident's care as Medicaid includes these payments in the Net Available Monthly Income (NAMI) the resident is required to pay toward their care.

If the resident is eligible for Medicaid, I understand that the $50.00 allowed for the resident's personal needs, may either be deposited into an individual fund for the resident or maintained at the Jewish Home or returned to me.

I understand that all the above referenced payments will be applied against the resident's account and will appear on the monthly statements that I receive from the Jewish Home of Rochester.

_____ _____
Responsible Party Date

_____
JHR Representative

MEDICAID
RECOVERIES INC

MEDICAID RECOVERIES, INC. AUTHORIZATION

I hereby authorize Medicaid Recoveries, Inc. as my agent to complete my Medicaid application and future Medicaid recertifications (the "Services"). In order to complete the Services, I hereby authorize Medicaid Recoveries, Inc. to request and collect all information necessary to complete all required documentation, including the right to review my medical records relating to my eligibility for Medicaid coverage. I understand and acknowledge that I have not paid any fee to Medicaid Recoveries, Inc. for such services and that I will not be required to pay any fee to Medicaid Recoveries, Inc. in the future.

Without limiting the foregoing, I hereby authorize Medicaid Recoveries, Inc. to obtain a certification of my birth record and a verification of the following information for the purpose of processing my Medicaid application: social security number, TPQY from Social Security Administration, date and place of birth, citizenship, school records, marital status, including death certificate of spouse, benefit amount, Medicare claim number, effective dates of Medicare, and any bank verification including verification of deposits and withdrawals, balances in accounts, statements, transaction histories, loans, mortgages, 1099s, tax returns, life insurance, health insurance premiums, long term care, any other insurance information, pension plans, annuities, all retirement accounts including 401K plans, mutual funds, stocks, bonds, including information from the Bureau of the Public Debt, trusts, burial funds, burial plots, disability, worker's compensation, unemployment benefits, Veteran benefits, VA discharge papers, shelter, housing verification, as well as any other income or resources.

I hereby authorize Medicaid Recoveries, Inc. to release to the appropriate office of the Department of Human Services all information necessary to complete my Medicaid application and future Medicaid recertifications, even after my death. I further authorize Medicaid Recoveries, Inc. to release to my nursing home and its attorneys any information that Medicaid Recoveries, Inc. obtains in connection with the completion of my Medicaid application and future Medicaid recertifications, including the status of any Medicaid application or recertifications, even after my death.

I hereby certify that, to the best of my knowledge, all information that has been and will be provided to Medicaid Recoveries, Inc. in connection with the Medicaid application and/or recertification process shall be accurate and complete in all respects.

I understand and acknowledge that Medicaid Recoveries, Inc. is not authorized to practice law and that I may hire an attorney at any time. I also understand that Medicaid Recoveries, Inc. does not provide Medicaid Planning Services. Medicaid Planning Services that Medicaid Recoveries, Inc. will not be providing includes but is not limited to advice regarding: the transfer of assets, the filing of a spousal refusal, the filing of an intent to return home, the filing of any transfer rebuttal, analysis/review of trust agreements and the legal analysis of a Medicaid decision that may result in legal representation at a Fair Hearing or judicial appeal. I also understand that the Client will be required to obtain a legally appointed representative of the Client's estate at the Client's sole expense in order for Medicaid Recoveries to proceed with the Services if the client expires before the application is submitted. I understand and agree that I should seek the advice of an attorney in the event that I wish to obtain Medicaid Planning Services.

I hereby acknowledge that although I may have been provided the form of this Authorization by my nursing home as a convenience, I am engaging Medicaid Recoveries, Inc., an entity that is separate and distinct from my nursing home, to provide the Services. I also understand and acknowledge that I have been advised by my nursing home that in the event that I have any questions regarding this Authorization that I should contact Medicaid Recoveries, Inc. at (585) 288-8820.

I further understand that my Medicaid application cannot be submitted until the applicant has received one full month of care where Medicaid is needed and Medicaid Recoveries, Inc. has received an invoice for such care. I also understand that it may take up to ninety (90) days from the date that Medicaid is needed to submit my application.

This Authorization shall survive my death.

Applicant or POA Signature:_____

Applicant Name(Print):_____

Applicant Social Security Number:_____

Applicant Date of Birth:_____

Date:_____

254 EMPIRE BOULEVARD ROCHESTER, NY 14609 OFFICE (585) 288-8820 FAX (585) 288-8824

JEWISH HOME OF ROCHESTER
2021 Winton Road South
Rochester, NY 14618

FISCAL AGENT AGREEMENT

This Agreement made effective the _____ day of _____, 20____ by and between the Jewish Home of Rochester (the "Jewish Home") and _____, residing at _____ (street), _____ (city, state, zip), (hereinafter "Fiscal Agent"), as an individual with legal access to funds or resources of _____ (hereinafter "Resident").

WHEREAS, the Jewish Home is reviewing whether to admit this Resident and to provide the services specified in the Resident Admission Agreement; and

WHEREAS, Fiscal Agent has legal access to the income, funds or other resources of the Resident; and

WHEREAS, Fiscal Agent agrees and acknowledges that the Jewish Home will rely on the Fiscal Agent's agreements contained herein.

NOW, THEREFORE, for good and valuable consideration, the parties hereby agree as follows:

1. Fiscal Agent hereby agrees to promptly and timely assist the Resident in fulfilling his/her responsibilities under the Resident Admission Agreement.

2. Fiscal Agent hereby certifies that the information set forth in the Application for Admission to the Jewish Home is true, complete and accurate to the best of Fiscal Agent's knowledge, and Fiscal Agent hereby agrees to promptly and timely cooperate with the Jewish Home in obtaining payment from the Resident's funds for all of Resident's charges, and to assist Resident to make all payments due on a timely basis in accordance with the terms of the Resident Admission Agreement. Fiscal Agent is not required, and is not being asked, to pay for the Resident's care from Fiscal Agent's assets or income.

3. Fiscal Agent agrees that Resident's assets, income, Medicare and insurance benefits and other resources will be used to timely pay all of Resident's charges incurred at the Jewish Home.

4. Fiscal Agent hereby agrees and covenants that Fiscal Agent will make payment to the Jewish Home of all charges, fees and expenses, payments for physician visits and all properly authorized additional charges and rate increases from the Resident's assets, income, Medicare and insurance benefits and other resources.

5. Fiscal Agent agrees that if the Resident becomes eligible for Medicaid benefits, Fiscal Agent shall promptly and timely initiate, complete and file an application for Medicaid benefits and all subsequent recertifications that may be required by Medicaid to ensure uninterrupted Medicaid benefits for Resident. The Jewish Home agrees to assist Fiscal Agent in completing the Medicaid application process, if specifically requested by Fiscal Agent.

6. If Fiscal Agent is the attorney-in-fact for the Resident through a power of attorney, Fiscal Agent appoints the Jewish Home as limited Power of Attorney for Resident for the purpose of obtaining bank and financial information necessary to complete Resident's Medicaid application.

7. If the Resident becomes Medicaid eligible, the Fiscal Agent agrees to assure that the Jewish Home is paid that portion of the monthly Medicaid rate (the "NAMI" amount) on a monthly basis which the Medicaid agency may direct the Resident to pay towards the cost of care.

8. Fiscal Agent personally agrees that if he/she is representative payee or otherwise receives or controls any of Resident's NAMI, and if he/she or Resident fails to pay such NAMI in a timely manner, the Jewish Home is hereby directed to apply for and become representative payee of the Resident to provide for the direct deposit of Social Security benefits upon the filing of the Resident's Medicaid application.

9. Fiscal Agent agrees, warrants and covenants that all of Resident's assets, income, insurance benefits and all other resources as disclosed to the Jewish Home prior to and/or at the time of admission shall be used to satisfy in full all future bills and invoices from the Jewish Home and shall not be otherwise used, transferred, diverted, gifted, loaned, or pledged to any other person or party.

10. Fiscal Agent represents and warrants that no transfer of Resident's assets, income, Medicare or insurance benefits or other resources, has taken place or will occur which would prevent Resident from qualifying for Medicaid benefits. If a transfer is made and if it is later determined that such a transfer results in a full or partial denial of Medicaid benefits for any period of time, Fiscal Agent shall take any and all steps necessary to immediately return such assets, income, benefits or other resources to Resident's use in order for Resident to fully qualify for Medicaid.

11. Fiscal Agent expressly understands that the Jewish Home is relying upon each and every statement, representation, covenant and warranty by Fiscal Agent in this Agreement and in the financial statements presented by Resident and Fiscal Agent prior to and/or upon admission and, in light thereof, Fiscal Agent expressly represents and warrants to the Jewish Home the truthfulness, accuracy and completeness of each of the statements made herein.

12. Fiscal Agent agrees and understands that any Transfer of Resident's Assets that impoverishes or results in the impoverishment of Resident is or may constitute a fraudulent conveyance, and that any such Transfer may result in the Resident being transferred to a different room at the Jewish Home to which transfer Fiscal Agent expressly consents.

13. Fiscal Agent agrees to pay damages to the Jewish Home caused by a breach of his/her personal responsibilities under this Agreement, including but not limited to attorneys' fees and costs.

_____ _____

Signature Fiscal Agent Date

Please sign as yourself; do not sign as POA. This is an agreement between you and the Jewish Home.

_____ _____

Signature Jewish Home Representative Date

Before returning this application to the Jewish Home of Rochester, please check to make sure that the following items are included:

___ Completed application form with signature on pages 7-12

___ Copies of all Health Insurance Cards (front and back), including Medicare and Social Security

___ Copy of Power of Attorney papers

___ Copy of Health Care Proxy

___ Copy of current statements for all bank and other financial accounts

___Copy of Long Term Care Insurance Policy (if applicable)

___ Copy of Trust Agreement (if applicable)

___ Signed Medicaid Recoveries Form

___Signed Fiscal Agent Agreement

Please return the completed, signed application to:

Elizabeth R. Algase
Jewish Home of Rochester
2021 S. Winton Rd.
Rochester, NY 14618

You may contact me at:

Phone 585-784-6396
Fax 585-341-2497
Email balgase@jewishseniorlife.org

For more information on the Jewish Home, please visit our website at www.jewishhomeroch.org.