Jewish Home

Dear Applicant:

Thank you for your interest in Jewish Home. We offer excellent care, warm hospitality, and emphasize respect, dignity and quality of life for each resident. We hope you will choose to apply. Here is how to begin:

Step One: Complete the enclosed Admission Application.

Step Two: Along with a completed Admission Application, we need **copies** of the following documents:

- Health Insurance Cards (both sides)
- 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
- Medicare D PDP Card or letter (most recent)

The information you provide, both written and verbal, is considered privileged and will be treated confidentially. These documents are required by Jewish Home's Finance Office. Your application cannot be processed without them.

Step Three: Return the completed Admission Application and copies of all the above documents to Jewish Home, Attention: Admissions, Allison Stadler.

Step Four: 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:

- Danielle Calder PRI & Placement Services (585) 236-1836
- Marsha Raines and Associates (585)271-0400
- Rochester Regional Home Health (585) 214-1000
- UR Medicine Home Care (585) 787-2233
- Senior's Choice Care Management (585) 787-0009

Step Five: When all the information is received, your application will be reviewed for approval, and 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, the special needs of the applicant, an available bed at the appropriate level of care and roommate compatibility. Financial information must be updated every six (6) months to keep the application active.

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

The following two pages provide Payment Options for your review. Please note upon admission, Jewish Home bills for the remainder of that month, plus the next month. Subsequently, residents are billed at the beginning of each month.

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

My goal is to assist you in any way I can. Please contact me if you have any questions at (585) 784-6396. My fax is (585) 424-6671. You can also reach me via e-mail at astadler@jewishhomeroc.org.

Sincerely,

Allison Stadler, BSW
Admission Specialist
(585) 784-6396
Fax (585) 424-6671
Jewish Home
2021 Winton Road S.
Rochester, NY 14618

PAYMENT OPTIONS

Jewish Home willingly accepts applicants regardless of their source of payment. There are several payor options under which one may be eligible.

MEDICARE

If certain medical requirements are met and there has been a three-day hospital stay, the applicant may be eligible for up to 100 days of a combination of full and partial coverage by Medicare. Eligibility is determined within 24 hours of admission, using Medicare guidelines.

Medicare coverage, combined with third party insurance, such as Blue Cross, continues for a maximum of 100 days or as long as the resident continues to need care that meets the Medicare criteria. The resident's care is regularly monitored to determine continued Medicare eligibility. The responsible party is notified immediately when Medicare is discontinued.

MEDICAID

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. While Jewish Home's Accounts Receivable staff is not able to complete a Medicaid application for a resident, they are happy to assist with the process. 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, Jewish Home 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.

OTHER INSURANCE

To assure that an individual is receiving full advantage of benefits from other insurances, we require copies of third-party insurance cards, such as Blue Cross, AARP, etc.

Please note: Upon admission, Jewish Home bills for the remainder of that month, plus the next month. Subsequently, residents are billed at the beginning of each month.

Jewish Home

LONG-TERM CARE APPLICATION FOR ADMISSION

Applicant – please print all information					
Name:				Maiden name:	
Last	First		Middle Initial		
Current address:					
City:		State:		ZIP Code:	
Telephone:		County of residence:		Date of birth:	
Gender:		Male Female Other _____			
Pronoun Preference:		He/Him She/Her They/Them			
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 Home Relationship History			
Have you ever been a resident at Jewish Home?			
Yes	No	If yes, date:	
Have you ever been a resident of Lodge at Wolk Manor, Wolk Manor or The Summit?			
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 Health Care at Jewish Home?			
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			
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 Jewish Home with up to 60 months of bank statements. (There may be a bank fee to obtain this information and we will

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 manages 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

Do you have a Trust?	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

Jewish Home will not be able to complete a Medicaid application for the applicant. Therefore, if a Medicaid application becomes necessary, who will complete 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:	

All of the foregoing information is true and accurate.

_____ _____

Signature of Fiscal Agent/Guardian/Resident Date

This completed application and supporting documents must be submitted to Jewish Home 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 Jewish Home's waiting pool. Placement in the waiting pool is made after an application is fully reviewed and approved.

Jewish Home (JH) adheres to kosher dietary laws and Passover dietary observance. Therefore, anyone admitted to the Farash Tower 6th floor or Cottage 3 is informed of and agrees to comply with the laws of kashruth. Kosher meals served at Jewish Home do not mix milk and meat at the same time. Pork, pork products, and shellfish are not served. Additionally, during the eight-day Passover Holiday, only specially prepared kosher foods are served.

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

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

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.
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 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/Guardian Date
(If Applicant CAN'T sign)

Jewish Home
Statement Regarding Monthly Income Amounts and Medicaid

I, as Power of Attorney or Guardian 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 Jewish Home 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 Jewish Home.

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 Jewish Home 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 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 Jewish Home.

_____ _____

Power of Attorney/ Guardian Date

_____

Jewish Home 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

FISCAL AGENT AGREEMENT

This Agreement made effective the _____ day of _____, 20____ by and between Jewish Home ("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, 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 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 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 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 Jewish Home.

4. Fiscal Agent hereby agrees and covenants that Fiscal Agent will make payment to 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. 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 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 pay from Resident's assets 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, 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 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.

10. 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.

_____ _____

Signature Fiscal Agent Date

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

_____ _____

Signature Jewish Home Representative Date

Before returning this application to Jewish Home, 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:

Allison Stadler
Jewish Home
2021 S. Winton Rd.
Rochester, NY 14618

You may contact me at:
Phone 585-784-6396
Fax 585-341-2497
Email astadler@jewishhomeroc.org

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