Dear Applicant:

Thank you for your interest in the Jewish Home of Rochester. The Home offers excellent care, kosher food, warm companionship, and emphasizes respect and dignity for each resident. ***Please note that the Jewish Home of Rochester is a smoke-free facility. We do not make exceptions to this policy.***

We hope you will choose to apply to the Jewish Home. 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**
- **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 the Jewish Home's Finance Office. Your application cannot be processed without them.

**Please note: If a resident is private pay without third party payer or other insurance coverage in force on the day of admissions, the resident must provide advance payment to the Jewish Home, prior to or on the day of admission, the amount equal to thirty (30) days advance payment of the basic charge not including any charges for ancillary services.

Step Three: Return the enclosed application and copies of all of the above documents to the Jewish Home, attention: Admissions.

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 following agencies can be contacted to complete a PRI and Screen:

- **Traditions in Caring, (585) 241-9580**
- **PRI Services (585) 265-0240**
- **Visiting Nurse Service (585) 787-2233**
- **NAPS, (585) 247-2532**
- **Home Care Plus (585) 214-1000.**
- **Call-Jane Seniors Consulting (585) 242-2030**

The PRI is good for 90 days.

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, 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.

My purpose is to assist you in any way I can. I will be happy to arrange a tour of the facility for you, or you can take a virtual tour at your convenience at **www.jewishhomeroch.org**.

Please contact me if you have any questions at (585) 784-6396. My fax is (585) 341-2497. You can also reach me via e-mail at: **jdobstaff@jewishhomeroch.org**. The Admissions Office is open Monday through Friday from 8:30 a.m. to 5:00 p.m.

Sincerely,

Jennifer Dobstaff, LMSW
Director of Admissions

Application Date: _______________ Date received:_____________

APPLICATION FOR ADMISSION

The Jewish Home of Rochester (JHR) adheres to kosher dietary laws and Passover dietary observance. Therefore, anyone admitted is informed of and agrees to comply with the laws of kashruth. Kosher meals served at the 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.

Name: ____ Maiden Name: ___________________
Last First MI
Address: ____
City State Zip
Telephone: _________________ County of Residence:_________________ Sex:________

Marital Status: ( )Married ( )Widow ( )Single ( )Separated ( )Divorced

Current Location: At home: ( )Yes ( )No If no, Name of Hospital:_________________

Name of Nursing Home or Assisted Living Facility __________________________________

Birthdate: ________________ Birthplace:__________________________ Age:__________

Name of Spouse: __________________________ If deceased when?___________________

U.S. Citizen: ( )Yes ( )No - If NOT a Citizen, do you have a Permanent Visa? ________

Year Permanent Visa Obtained: ______________________

Religion: _____ Jewish _____ Catholic ____ Protestant _____ Other _________________

Name of Synagogue or Church:____

Are either you or your spouse a United States Veteran? ( )Yes ( )No

Have you ever been a Resident of the JHR? ( )Yes ( )No

Have you ever been a Participant of the Day Services at the JHR? ( )Yes ( )No

Have you ever been a Resident of Wolk Manor? ( )Yes ( )No

*This completed application and a PRI (Patient Review Instrument) 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.

NAME OF RELATIVES/FRIENDS IN ORDER THEY SHOULD BE CONTACTED:
(LIST SPOUSE IF APPLICABLE)

1. Name: ______________________ Relationship: ______________

Address: ____
City State Zip

Home Phone: __________ Work Phone: __________ Cell Phone: ________
(Optional)

E-mail address: ________________
(Optional)

2. Name: ______________________ Relationship: ______________

Address: ____
City State Zip

Home Phone: __________ Work Phone: __________ Cell Phone: ________

3. Name: ______________________ Relationship: ______________

Address: ____
City State Zip

Home Phone: __________ Work Phone: __________ Cell Phone: ________

MEDICAL HISTORY (We will request current medical information from physicians listed.)

Current illness and medical condition: ______________________________

Primary Physician's Name: ______________________ Phone: ________
First Last

Address: ____
City State Zip

Specialist's Name: ______________________________________
First Last

Address: ____
City State Zip

Phone Number: ____________________ Specialty: ________________

Specialist's Name: ______________________________________
First Last

Address: ____
City State Zip

Phone Number: ____________________ Specialty: ________________

Dentist's Name:____________________ Phone Number:____________
First Last

Address: ____
City State Zip

(Please use a separate sheet to list additional physicians)

Please list main reasons for submitting application________________________________
____
____

If applicant is currently hospitalized or has been hospitalized within the past 30 days, complete the following:

Name of Hospital: ______________________________ Dates of Stay: ______________

Reason for Hospitalization: ____

PERSON RESPONSIBLE FOR FUNERAL ARRANGEMENTS:

Name: _______________________________________ Relationship: ________________

Home Phone: _________________________ Work Phone: _________________________

Name of Funeral Home: ______________________________ Phone: _______________

Address: ____
City State Zip

FINANCIAL INFORMATION:

All information will be considered confidential. ***This information will need to be updated every 6 months.***

Monthly Income	**Applicant**	**Spouse**
Social Security	$__________________	__________________
Private Pension	$__________________	__________________
Railroad Retirement	$__________________	__________________
Veteran's Benefit	$__________________	__________________
Interest	$__________________	__________________
Dividends	$__________________	__________________
Other	$__________________	__________________
Total Monthly Income	$__________________	__________________

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. You may need to furnish the JHR with up to 36 months of bank statements. There may be a bank fee to obtain this information and we will make every attempt to minimize our request.

1. Name of Bank: ____

   Address: ____
   City State Zip

   Account Number: ___________________________

   Current Balance: ___________________________

2. Name of Bank: ____

Address: ____
City State Zip

Account Number: ______________________

Current Balance: ______________________

3. Name of Bank: ____

Address: ____
City State Zip

Account Number: ______________________

Current Balance: ______________________

*IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH ANOTHER PAGE.

PLEASE LIST BELOW ANY STOCKS, BONDS, or MUTUAL FUNDS HELD IN THE APPLICANT'S NAME AND WHERE EACH IS LOCATED. **PLEASE PROVIDE CURRENT STATEMENTS FOR EACH OF THESE ITEMS.**

1. Type of Investment: _____________________
   Current Value: _________________________
   Where it's held: _______________________ Account #: ______________

2. Type of Investment: _____________________
   Current Value: _________________________
   Where it's held: _______________________ Account #: ______________

*IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH ANOTHER PAGE.

Assets
Are any assets held in trust? ( )Yes ( )No **If yes, please include a copy of trust agreement.**

If applicant is married, please also include all assets for both applicant and spouse.
List total combined assets ____________, less $74,820 to $90,600 (Spousal Allowance for Medicaid), which results in the amount of ____________ available for applicant's care.

FINANCIAL REPRESENTATIVE
Name of Power of Attorney: ___________________________
(**Please include a copy of the Power of Attorney form**.)

Relationship: __________________ Phone Number: ____________________

If there is no Power of Attorney, list who is responsible for applicant's financial affairs:
Name: ___________________________

Relationship: __________________ Phone Number: ____________________

<u>INSURANCE COVERAGE:</u> Please provide a copy of insurance cards (both sides).

Social Security #: ______________________

Medicare #: _________________________ Part A: ( )Yes ( )No Part B:( )Yes ( )No

Blue Cross #: __________________________ Type of Plan: ____________________

Blue Choice #: _________________________ Type of Plan: ____________________

Preferred Care #: _______________________ Type of Plan: ____________________

Medicare D PDP #: _____________________ Type of Plan: ____________________

Other #: ______________________________

Long Term Care Insurance: ( )Yes ( )No **If yes, we will need a copy of the policy**
Company Name and Address: ____
City State Zip

If applicable: ****WE MUST HAVE COMPLETE INFORMATION***
*Medicaid CIN #: ______________________ Case #:________________________
Date of Application: ____________________ Date of Approval: _________________
*DSS Caseworker: ______________________ *Phone #: ______________________
County: ______________________________

During the past 36 months has the applicant owned a home? ( )Yes ( )No
If a home is currently owned, is anyone living in the home? ( )Yes ( )No
If so, whom: ________________ Has the home been sold or transferred? ( )Yes ( )No
If yes, when and to whom____

Have any of the applicant's funds or other assets been transferred or given to a member of your family or anyone else? ( )Yes ( )No If yes, please provide the amount transferred, the date, and to whom the transfer was made. _______________________
____
____

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? ____

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 CARE OF THE APPLICANT.

____ ____________________
Signature of Applicant/Power of Attorney/Responsible Party Date

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, SEXUAL PREFERENCE, BLINDNESS, SOURCE OF PAYMENT OR MARITAL STATUS.

APPLICANT'S DECLARATION

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 upon 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 organizations give full, detailed, and relevant information regarding me to the Jewish Home of Rochester:

1. 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 that now hold or heretofore held my funds, and all persons, firms or corporations that hold my funds, or funds payable to me
4. Any and all persons, firms, or corporations that hold my funds, or funds payable to me
5. Any and all insurance companies by which I am an insured, or that 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

____________________________________ __________________

Signature of Power of Attorney/Responsible Party Date
(If Applicant CANNOT Sign)

08/11/04

Jewish Home of Rochester
Statement Regarding Monthly Income Amounts

I, as Power of Attorney or as the person responsible for ______________________________'s 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. I agree to sign the 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 admission 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. You will not be required to submit payments in excess of the resident's cost of 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. If the resident is not eligible for Medicaid, the entire payment will be applied to the resident's bill unless otherwise directed.

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

______________________________ ______________________
Jewish Home of Rochester Representative Date