



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. 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 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 mfazio@jewishseniorlife.org.

Sincerely,

Mary Fazio, RN
Admission Liaison



Jewish Home

of Rochester

Long-term, Transitional and Memory Care

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: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
City State Zip
optional

E-mail address: _____
optional

2. Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____
City State Zip

3. Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____
City State Zip

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	<u>Applicant</u>	<u>Spouse</u>
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 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.)

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 \$90,000 to \$123,000(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: _____

INSURANCE COVERAGE: Please provide a copy of 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 60 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 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 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.
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

Signature of Power of Attorney/Responsible Party
(If Applicant CAN'T Sign)

Date

08/11/04

Jewish Home of Rochester
Statement Regarding Monthly Income Amounts

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.
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

JHR Representative