Jewish Home
of Rochester
Long-term, Transitional and Memory Care

Dear Applicant:

Thank you for your interest in the Jewish Home of Rochester. The Home offers excellent care, warm hospitality, and emphasizes respect, dignity and quality of life for each resident. 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.**
- **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 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 admission, the resident must provide advance payment to the Jewish Home, prior to or on the day of admission, an advance payment amount equal to thirty (30) days of the basic charge, not including any charges for ancillary services.

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

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:

- **Call Jane Seniors Consulting (585) 242-2030**
- **Marsha Raines and Associates (585)271-0400**
- **Lifetime Care (585) 214-1000**
- **Visiting Nurse Service (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, 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 the Jewish Home of Rochester 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, the 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 the Jewish Home for you, or you can 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. My fax is (585) 341-2497. You can also reach me via e-mail at **balgase@jewishseniorlife.org**.

Sincerely,

Elizabeth R. Algase
Long Term Care Admission Coordinator
(585) 784-6396
fax (585) 341-2497
Jewish Home of Rochester
2021 Winton Road S.
Rochester, NY 14618

PAYMENT OPTIONS

The Jewish Home of Rochester 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.

PRIVATE PAY

Current private pay rates effective January, 1 2017 are:

	JHR	NYS Tax Assessment at 6.8%	Total Daily Rate
Skilled Nursing			
Semi-private	$431.19	$29.32	$460.51
Private	$455.15	$30.95	$486.10
Gateway Memory Care (6SW)			
Semi-private	$437.16	$29.73	$466.89
Private	$460.14	$31.29	$491.43
Short Term Rehabilitation			
Semi-private	$568.69	$38.67	$607.36
Private	$592.06	$40.26	$632.32
Bariatric Room	$629.06	$42.78	$671.84

Private Room Charge On Rehab $18.00 per day
Private rates apply if the applicant has requested and been approved for a private room on the rehab unit.

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 the 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. 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.

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, the 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
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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

*If additional space is needed, please attach a separate page.

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
Does the applicant have prepaid burial arrangements? ( )Yes ( )No

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 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:_____

(Continued on next page.)

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 a separate 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 you must provide a copy of the Trust Agreement with this application.

What are the assets in Trust? _____

What is funded by the Trust? _____

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:_____

MVP #:_____ 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

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. I understand that I am not 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

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 Social Services all information necessary to complete my Medicaid application and future Medicaid 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 I may need to hire an attorney at my own expense during any fair hearing and appeal process. I also understand that Medicaid Recoveries, Inc. does not provide Medicaid Planning Services. This includes but is not limited to: Advice as to the transfer of assets, Advice to the filing of a spousal refusal, advice as to the filing of an intent to return home, and advice to the filing of any transfer rebuttal. I have been advised to seek the advice of an attorney in the event that I believe that I may require Medicaid Planning Services.

I hereby 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.

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.

This Authorization shall survive my death.

Applicant or POA Signature:_____

Applicant Name(Print):_____

Applicant Social Security Number:_____

Applicant Date of Birth:_____

Date:_____

JEWISH HOME OF ROCHESTER
2021 WINTON ROAD SOUTH
ROCHESTER NY 14618

FISCAL AGENT AGREEMENT

This Agreement made effective the ___ day of _____, 2017 by and between 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 Resident and to provide the services specified in the Admission Agreement; and

WHEREAS, Fiscal Agent has legal access to the assets, income, and 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. The above recitals are incorporated herein and made a part hereof.

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

3. Fiscal Agent hereby certifies that the information set forth in the application 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 to obtain payment from the Resident's assets, income and resources for all of Resident's charges, and to assist Resident to make all payments due in accordance with the terms of the 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.

4. Fiscal Agent agrees that all of 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.

5. Fiscal Agent agrees 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.

6. 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 recertification's that may be required to ensure uninterrupted Medicaid benefits for Resident.

7. If Fiscal Agent is the attorney-in-fact for the Resident through a power of attorney, 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.

8. If the Resident becomes Medicaid eligible, the Fiscal Agent agrees to assure that the Jewish Home is paid monthly that portion of the monthly Medicaid rate (the "NAMI" amount) which the Medicaid agency directs the Resident to pay towards the Resident's cost of care.

9. 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.

10. Fiscal Agent agrees that in order to assist Resident in meeting his/her obligations for any NAMI specified by DSS, if he/she or Resident fails to pay such NAMI in a timely manner, the Jewish Home is directed to apply for and become representative payee of the Resident with respect to Resident's pension.

11. 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 from the Jewish Home and shall not be otherwise used, transferred, diverted, gifted, loaned, or pledged to any other person or party.

12. 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, 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.

13. 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 the truthfulness, accuracy and completeness of each of the statements made herein.

DATED: _____ _____

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

DATED: _____ By:_____

Jewish Home Representative

Before you return your 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 5, 6, 7, 8, 9 &10

___ 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

___Sign Fiscal Agent Agreement

Please return application to:

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

Please contact me at:
(Tel) 585-784-6396
(Fax) 585-341-2497
balgase@jewishseniorlife.org

For more information on the Jewish Home check our website at www.jewishhomeroch.org.