



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:

- **Irene Calder PRI & Placement Services (585) 236-1836**
- **Marsha Raines and Associates (585)271-0400**
- **Lifetime Home Care (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, 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](http://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](mailto: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

## 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, 2021 are:

|  | <u>JHR</u> | <u>NYS Tax Assessment</u><br><u>at 6.8%</u> | <u>Total Daily Rate</u> |
|--|------------|---|-------------------------|
| <u>Skilled Nursing</u>                                   |            |   |                         |
| Semi-private   | \$480.58   | \$32.68                                     | \$513.26                |
| Private  | \$507.31   | \$34.50                                     | \$541.81                |
| Private Suite  | \$516.75   | \$35.14                                     | \$551.89                |
| Green House Cottage                                      | \$516.75   | \$35.14                                     | \$551.89                |
| <br>   |            |   |                         |
| <u>Dawn, Eva, &amp; Jacques Lipson Memory Care (4NE)</u> |            |   |                         |
| Semi-private   | \$487.25   | \$33.13                                     | \$520.38                |
| Private  | \$512.87   | \$34.88                                     | \$547.75                |
| Private Suite  | \$521.92   | \$35.49                                     | \$557.41                |
| <br>   |            |   |                         |
| <u>Short-Term Rehabilitation</u>                         |            |   |                         |
| Private  | \$565.22   | \$38.43                                     | \$603.65                |

## **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 of Rochester

## 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: |                             | 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 <i>Life</i> 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) |

| <b>Medical History</b>  |                |    |
|---|----------------|----|
| 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: |    |

| <b>Primary physician</b> |        |      |  |
|--------------------------|--------|------|--|
| Name:                    |        |      |  |
| Office phone:            |        |      |  |
| Address:                 |        |      |  |
| City:                    | State: | Zip: |  |

| <b>Specialist physician</b> |        |            |  |
|-----------------------------|--------|------------|--|
| Name:                       |        | Specialty: |  |
| Office phone:               |        |            |  |
| Address:                    |        |            |  |
| City:                       | State: | Zip:       |  |

| <b>Specialist physician</b> |        |            |  |
|-----------------------------|--------|------------|--|
| Name:                       |        | Specialty: |  |
| Office phone:               |        |            |  |
| Address:                    |        |            |  |
| City:                       | State: | Zip:       |  |

| <b>Dentist</b> |        |            |  |
|----------------|--------|------------|--|
| 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?             |             |               | No |

| Financial Information   |
|---|
| If married, please include financial information for spouse.  |
| <b>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.</b> 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                       |           |        |  |
| <b>Total Monthly Income</b> |           |        |  |

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



|                      |          |           |                 |
|----------------------|----------|-----------|-----------------|
| <b>Bonds</b>         | Yes      | No        | <b>Balance:</b> |
| Holder's name        |          |           |                 |
| Account number       |          |           | <b>Balance:</b> |
| <b>IRA/401K/403B</b> | Yes      | No        |                 |
| Holder's name:       | Balance: | Account # |                 |
| Holder's name:       | Balance: | Account # |                 |
| Holder's name:       | Balance: | Account # |                 |

|   |  |
|---|--|
| <b>Total Assets</b>   |  |
| If applicant is married, list total combined assets, including any assets not listed above: |  |
|   |  |
|   |  |
|   |  |

| <b>Real Estate</b>  |        |    |
|---|--------|----|
| 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: |    |

| <b>Fiscal Agent (manages financial obligations for applicant)</b>                                       |  |             |                            |     |    |
|---|--|-------------|----------------------------|-----|----|
| Is there a Power of Attorney:   | Yes  | No          | Is there a Legal Guardian: | Yes | No |
| Name:   | <i>Please provide a copy of documentation.</i> |             |                            |     |    |
| 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. <i>Provide a <b>complete copy</b> of all trust documents.</i> |     |                          |
| 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                             |                  |   |
| <i>If yes, we will need a <b>complete copy</b> of the policy</i> |     |                                |                  |   |
| 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 |

| <b>Medicaid</b>  |  |                  |               |    |
|--|--|------------------|---------------|----|
| 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. 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

\_\_\_\_\_  
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.

The Jewish Home of Rochester (JHR) adheres to kosher dietary laws and Passover dietary observance. Therefore, anyone admitted to the Tower 6<sup>th</sup> floor or Cottage 3 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.

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 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.
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  
(If Applicant CAN’T sign)

\_\_\_\_\_  
Date

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: \_\_\_\_\_

**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.

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Signature Fiscal Agent

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Date

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

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Signature Jewish Home Representative

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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](mailto:balgase@jewishseniorlife.org)

For more information on the Jewish Home, please visit our website at [www.jewishhomeroch.org](http://www.jewishhomeroch.org).