FRIENDLY HOME
nursing care & rehabilitation

Admissions Application

Name: _____ Security Number: _____

Address: _____ Zip: _____

Telephone: _____ County of Residence: _____

Date of Birth: _____ (MM/DD/YYYY) Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single

Gender Identity (optional, as identified by the Resident): _____

(This information is requested solely to ensure respectful communication and appropriate care, is voluntary, and will be kept confidential in accordance with federal and New York law)

Preferred Name: _____ Preferred Pronouns: _____

Religion _____ Place of Worship _____

U.S. Citizen: ☐ Yes ☐ No If naturalized citizen, date: _____ (MM/DD/YYYY)

Is the applicant currently working? ☐ Yes ☐ No Is the applicant a veteran? ☐ Yes ☐ No

Occupation: _____ Employer _____

Is the applicant's spouse currently working? ☐ Yes ☐ No Is the applicant's spouse a veteran? ☐ Yes ☐ No

Current location of Applicant: _____

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

Name of Hospital: _____ Dates of Stay: _____

Reason for Hospitalization: _____

Has the applicant had a previous nursing facility stay? ☐ Yes ☐ No

If yes, please give the name of the facility and dates of stay: _____

Does the applicant plan to move into a nursing home within 30 days? ☐ Yes ☐ No

Please list names of physicians, including specialists and dentists: *(use a separate sheet, if necessary)*

Name	Specialty	Telephone/Fax Numbers

Have Advanced Directives been established (MOLST, Living Will, DNR, Health Care Proxy)? ☐ Yes ☐ No

Please list: _____

Please provide a copy of all Advanced Directives at the time of admission.

Name of Funeral Home _____ Telephone Number: _____

Has a pre-need burial account been established? ☐ Yes ☐ No Is this account irrevocable? ☐ Yes ☐ No

INSURANCE

Please provide a copy of all cards (both sides)

Medicare: _____ Part A: ☐ Yes ☐ No Part B: ☐ Yes ☐ No

Medicaid:_____ County:_____

Case Worker Name and Number: _____

Does the applicant have a Medicaid Managed Long Term Care Plan? (i.e. Fidelis, iCircle?) ☐ Yes ☐ No

If yes, which plan _____ Case Manager Name and Number _____

Other Insurance: _____

Medicare D Plan (prescription plan): _____

Long Term Care Insurance (please include a copy of the policy): _____

SNF daily rate _____ Lifetime Benefit:_____ NYS Partnership Plan: ☐ Yes ☐ No

PRIMARY CONTACTS

Please list in order to be contacted (Use a separate sheet if necessary)

Name: _____ Relationship: _____

Address:_____ Zip: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Email Address _____

Power Of Attorney: ☐ Yes ☐ No Health Care Agent: ☐ Yes ☐ No

Name: _____ Relationship: _____

Address:_____ Zip: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Email Address _____

Power Of Attorney: ☐ Yes ☐ No Health Care Agent: ☐ Yes ☐ No

FISCAL AGENT

(manages financial obligations for applicant)

Name of Power of Attorney/Other Agent _____ Relationship: _____

Address:_____ Zip: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Email Address _____

Has a conservator/guardian been appointed? ☐ Yes ☐ No ***(Please provide a copy of applicable documentation.)***

FINANCIALS

(If married, please include financial information for spouse)

MONTHLY INCOME:	**Applicant:**	**Spouse:**
Salary:	_____	_____
Social Security:	_____	_____
Retirement Pension:	_____	_____
RMD of Retirement:	_____	_____
Veteran's Benefits:	_____	_____
Interest/Dividends:	_____	_____
Other:	_____	_____
Total Monthly Income:	**$**_____	**$**_____

ASSETS:

Life Insurance (cash value): ☐ Yes ☐ No Amount: _____

Checking Account: ☐ Yes ☐ No Amount_____ Name of Bank:_____

Savings Account: ☐ Yes ☐ No Amount_____ Name of Bank:_____

Certificates of Deposit: ☐ Yes ☐ No Value: $ _____

In whose name is this asset held? _____

Stocks: ☐ Yes ☐ No Value: $ _____

In whose name is this asset held? _____

ASSETS CONTINUED:

Annuities: ☐ Yes ☐ No Value: $ _____

In whose name is this asset held? _____

Is the applicant drawing income? ☐ Yes ☐ No

Does this have cash value? ☐ Yes ☐ No Value: $ _____

Money Market: ☐ Yes ☐ No Value: $ _____

In whose name is this asset held? _____

Bonds: ☐ Yes ☐ No Value: $ _____

In whose name is this asset held? _____

IRAs/401K/403B: ☐ Yes ☐ No Value: $ _____

In whose name is this asset held? _____

Real Estate: Does the Applicant own a home? ☐ Yes ☐ No

Does a Spouse, disabled adult or child live in the home? ☐ Yes ☐ No

Please list all Real Estate assets. Please include property and building address as well as approximate value:

_____

_____

ASSET TRANSFERS:

Current look back period when applying for Medicaid is five (5) years. It is important to know that transfers of assets within this look back period could potentially result in a penalty or denial of Medicaid eligibility by the applicable Department of Social Service/Human Services.. Assets can be monetary but can also include real estate, land, stocks and investments.

Has the applicant gifted or transferred anything out of his/her name, money or property (especially amounts greater than $2,000)?
☐ Yes ☐ No
If yes, please explain and provide dates of transfer: _____

_____

_____

Has the applicant given away any cash, or sold/transferred any cash, real estate, income or personal property in the past or created a trust in the past 60 months ? ☐ Yes ☐ No

If yes, please explain: _____

_____

TRUSTS:

Has the applicant established any trusts? ☐ Yes ☐ No

Please list any and all trusts the applicant has created or to which they contributed assets. (***Please provide a copy of all trust documents.)***

Trustee	Beneficiaries	Date Created/Funded

Has the applicant consulted with an attorney or financial advisor regarding payment for nursing home care? ☐ Yes ☐ No

If yes, please provide name and telephone number: _____

LIABILITIES: (for example: mortgages, liens, credit cards, loans) Amount

_____ $_____

_____ $_____

_____ $_____

Total Liabilities **$_____**

I hereby declare that the statement of assets and monthly income levels are true to the best of my knowledge and belief.

Upon completion of this form, I acknowledge that the total of the applicant's resources is $_____,

and these assets and income will be utilized for the services and care provided by The Friendly Home. This statement must be completed for admission consideration.

Additional information/comments, which may be helpful in processing this application: _____

_____

_____

Why did you choose The Friendly Home? _____

GUIDELINES FOR LONG TERM CARE SINGLE ROOM ASSIGNMENT

The Friendly Home recognizes that private rooms are a limited resource and are assigned in a manner that is consistent with applicable federal and New York State law, resident rights, and the Facility's operational and clinical needs.

Assignment to a private room for long-term care residents will be based on the following considerations:

1. ***Clinical Necessity***
   Priority for private room assignment will be given to residents who require a private room due to documented medical, psychiatric, behavioral, infection-control, or safety needs, as determined by the interdisciplinary care team.
2. ***Resident Needs and Safety***
   The available private room must be appropriate to meet the resident's physical, functional, and safety requirements.
3. ***Facility Census and Operational Considerations***
   The Facility must be able to appropriately manage its census and room utilization, including the availability of a suitable roommate for any vacated semi-private room.
4. ***Resident Preference***
   Requests for private rooms that are based solely on resident preference may be accommodated when available and when consistent with Facility operations and applicable reimbursement rules.
5. ***Payment Considerations***
   Residents shall not be denied a private room or required to relocate solely based on Medicaid eligibility or Medicaid pending status. Where a resident voluntarily elects a private room for non-clinical reasons, any applicable private-room differential will be addressed in accordance with federal and New York State Medicaid requirements and Facility policy.
6. ***Ongoing Review***
   Private room assignments may be reviewed periodically based on changes in resident clinical needs, census demands, or regulatory requirements. Any room change will be conducted in a manner that respects resident rights and minimizes disruption.

Transitional Care Center
The Transitional Care Center is comprised entirely of private rooms. These guidelines apply only to long-term care residents and do not apply to residents admitted solely for short-term or transitional care services.

Important Notice: The Friendly Home complies with 42 C.F.R. § 483.15, 10 NYCRR § 415.3, and all other applicable federal and New York State laws and regulations governing nursing facility admissions.

I, _____, certify that all of this information provided on this Admissions Application is accurate, true, and complete to the best of my knowledge. I also agree to update this information in the future as requested by The Friendly Home and/or at any time when the information has changed. The completion and submission of this information is significant and an essential component of the admissions process, and it will be relied upon by The Friendly Home in the event of admission. In completing this Admissions Application, I understand that the submission of this Application does not require The Friendly Home to accept admission nor does it guarantee admission to the Facility.

_____ _____

Signature of Applicant/Responsible Party **Date**

_____

Relationship to Applicant

The Friendly Home respects the rights of all people and applications are considered in a non-discriminatory fashion. State and Federal laws prohibit discrimination in admission, retention and care of residents who are appropriate for placement in a skilled nursing facility in accordance with all applicable federal and state legal requirements on the basis of race, creed, color, blindness, age, marital status, physical handicap or disability, national origin, gender/ gender identity or expression, actual or perceived sexual orientation, sexual preference, HIV status, or sponsor. The Friendly Home is a smoke-free campus.

CONSENT FOR RELEASE OF INFORMATION TO THE FRIENDLY HOME

Applicant Name: _____ Date of Birth: _____

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 Friendly Home:

1. Social Security Administration
2. Any and all physicians, dentists, social workers, psychologists, nurses, technicians, clinics, hospitals, and psychiatric facilities, Nursing Homes, Assisted Living 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

_____ _____

Signature of Applicant Date

(OR)

_____ _____

Signature of Responsible Party Date

_____

Relationship to Applicant

The Friendly Home
3156 East Avenue
Rochester NY 14618

FISCAL AGENT AGREEMENT

Must be completed and signed for application consideration

This Agreement is made effective the _____day of _____, 20_____by and between The Friendly Home ("Facility") and

_____, residing at
_____(street),

_____(city,) _____(state,) _____(zip), (hereinafter "Fiscal Agent") as an individual with legal access to funds or resources of _____(applicant, hereinafter "Resident").

WHEREAS, the Facility is a residential health care facility and Facility has agreed to admit and provide services to Resident, and Resident may require intervention or assistance to fulfill payment obligations to the Facility; and

WHEREAS, pursuant to federal regulations at 42 CFR 483.15(a)(3) and New York State regulations at 10 NYCRR 415.3(b)(6), Facility may request and require a resident representative who has legal access to the Resident's income or resources available to pay for the Facility's care to sign an agreement, such as this Fiscal Agent Agreement, without incurring personal financial liability, to provide Facility payment from the Resident's income or resources;

NOW, THEREFORE, in consideration of the Facility's agreement to admit the Resident and provide the services specified in the Admission Agreement, and for other good and valuable consideration, the parties hereby agree as follows:

1. Fiscal Agent stipulates that this Financial Agreement is based upon valuable and sufficient consideration, including but not limited to, past consideration from the Facility's admission of the Resident to the Facility and all services and other things of value provided to Resident since Resident's admission to the Facility.

2. Fiscal Agent expressly understands that the Facility is relying on each and every statement, representation and warranty made by Fiscal Agent in this Fiscal Agent Agreement and in the financial statements and information presented by Resident and Fiscal Agent in the Application For Admission (the "Application") prior to or upon admission and, in light thereof: Fiscal Agent expressly represents, warrants, and certifies to the Facility the truthfulness, accuracy and completeness of each of the statements made in the Application and this Fiscal Agent Agreement.

3. This Financial Agreement incorporates the applicable terms of the Admission Agreement and shall be construed in all cases as though the Admission Agreement is valid and binding upon the Resident and Facility. Fiscal Agent stipulates that the Facility is entitled to payment for the Resident's stay from Resident's income or resources (e.g., Medicare, Medicaid, and insurance benefits) and agrees that the amount owed to the Facility shall be calculated based upon the terms of the Admission Agreement.

4. Fiscal Agent expressly affirms and warrants, as permitted by the regulations noted in the "Whereas" clause above, that Fiscal Agent has legal access to the Resident's income or resources available to pay for the Facility's care to the Resident.

5. As detailed throughout this Financial Agreement, Fiscal Agent agrees to use Fiscal Agent's legal access to the Resident's income

or resources to promptly and timely assist the Resident in fulfilling his/her financial responsibilities under the Admission Agreement by providing the Facility payment from the Resident's income or resources. Specifically, Fiscal Agent agrees that Resident's assets or other resources to which Fiscal Agent has legal access or control will be used to timely pay for the following: all the Resident's charges, fees, and expenses at the Facility, including but not limited to, payments for physician visits and all properly authorized additional charges and rate increases at the Facility.

6. Fiscal Agent agrees to notify the Facility when the Resident's assets and resources have declined to $45,000.00 above the Medicaid eligibility level to allow sufficient time for a Medicaid application to be processed. Fiscal Agent agrees to assist Resident in initiating and completing any application, recertification, and appeal for Medicaid benefits on behalf of the Resident. Fiscal Agent agrees to fully cooperate with the local county Department of Social Services or other comparable agency ("DSS") in securing the Resident's continued eligibility for Medicaid benefits, including but not limited to, submitting any documentation requested by DSS. Fiscal Agent agrees that although Facility may offer assistance in its discretion, the Resident remains responsible for any application, recertification, or appeal for third-party benefits (including without limitation Medicaid, Medicare, and private insurance).

7. If the Facility provides a referral to any third party to assist with obtaining any third-party benefits for the Resident, accepting such a referral is entirely optional and does not represent an endorsement by the Facility. Fiscal Agent agrees that any determination by a third-party benefit provider/payor concerning eligibility or the amount of any co-pay, co-insurance, NAMI, or cost sharing amount is binding upon the Resident. If any payor or provider of third-party benefits determines that Resident is not eligible and/or not covered for any portion of Resident's stay, the amount owed to Facility shall be the applicable private pay rate.

8. Fiscal Agent also agrees to the following based on Fiscal Agent's legal authority:

a. Fiscal Agent authorizes the Facility to obtain documentation and information from, and to assist Resident with submitting any necessary application, appeal, or other materials to, any third-party benefits provider such as long-term care insurance, Medicaid, and Medicare. As noted above, Fiscal Agent agrees that although Facility may offer assistance in its discretion, the Resident remains responsible for any application, recertification, or appeal for third-party benefits (including without limitation Medicaid, Medicare, and private insurance).

b. Fiscal Agent agrees to provide Facility with all records and supporting documents required to complete such Medicaid application or recertification of Medicaid, including without limitation, banking and financial records, and Fiscal Agent directs all institutions, entities and individuals to release to Facility all records of Resident's accounts.

c. Fiscal Agent will comply with requests for information necessary to complete Resident's Medicaid application or recertification in a prompt manner.

d. Fiscal Agent authorizes DSS, Medicare, and any other third-party payors to provide information to Facility and/or the Facility's agents concerning Resident's eligibility for Medicaid, recertification of Medicaid, and/or any other applicable insurance.

9. Fiscal Agent agrees, as the agent of the Resident, to adhere to Resident's obligations for any Net Available Monthly Income ("NAMI") specified by DSS. By signing this Agreement, Fiscal Agent expressly authorizes the Facility to apply for and become representative payee for the Resident's Social Security income, to apply for and become payee of any other Resident income, and to use such Social Security and other Resident income that the Facility receives directly to pay the Facility's bill, in the following instances: (a) at the time the Resident is eligible to start receiving Medicaid benefits; and/or (b) at any time, if Resident fails to ensure payment of NAMI in accordance with the Admission Agreement.

10. Fiscal Agent agrees that, except for a monthly personal needs allowance for the Resident, all the Resident's income, assets,

and other resources, including Medicare and insurance benefits, shall be used to pay the Facility and shall not be used, transferred or in any way misused in a manner that denies the Facility payment for the Resident's stay or prevents the Resident from qualifying for Medicaid.

11. Fiscal Agent agrees to take all steps necessary to effectuate the terms of this Financial Agreement, including without limitation, by signing additional authorizations as may be required.

12. Fiscal Agent expressly warrants that, to Fiscal Agent's knowledge, 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.

13. Fiscal Agent directly authorizes the Facility and its agents to communicate with third parties in connection with the terms of the Admission Agreement and this Fiscal Agent Agreement, including without limitation, to debt collectors for purposes of collection of any debt owed by Resident to Facility.

14. Fiscal Agent agrees to provide a copy of any Power of Attorney document (or other representative document(s)) for the Resident to the Facility. Fiscal Agent hereby appoints Facility as a limited Power of Attorney for the Resident for obtaining banking, financial, and related information for Resident.

15. Fiscal Agent shall notify the Facility of any changes in the Resident's financial status as soon as possible, and should Fiscal Agent lose legal access to the Resident's funds or resources, Fiscal Agent shall inform the Facility immediately.

16. Fiscal Agent is <u>not</u> being required under this Financial Agreement to personally guarantee payment to the Facility for the Resident's care, and no provision of this Financial Agreement is intended to hold the Fiscal Agent <u>personally</u> responsible (from Fiscal Agent's own funds) for paying the Facility for the Resident's care. The Resident (utilizing the Resident's funds or resources) remains ultimately responsible for paying the Facility.

17. Fiscal Agent agrees to sign a new version of this Financial Agreement in the event of a change in the law or regulations, including but not limited to, the federal and/or state regulations noted in the "Whereas" clause above as well as any interpretive guidance from the applicable agencies.

This Fiscal Agent Agreement may be signed in one or more counterparts, all of which constitute one and the same instrument.

_____ _____

Dated Fiscal Agent

This Agreement is between you and The Friendly Home. It must be signed by you individually.

_____ By: _____

Dated The Friendly Home Representative

It is mandated that The Friendly Home be notified three (3) months prior to the exhaustion of resources available for the Resident's care so that the Medicaid application can be initiated. The Friendly Home reserves the right to request additional financial information including, but not limited to, copies of financial statements and/or the most recently completed 1089 form(s).

Effective 9/15/21

Both the New York State Department of Health (NYSDOH) and the Centers for Medicare and Medicaid Services (CMS) maintain information on nursing homes that includes performance on quality measures, complaints, inspection results, and citations and enforcement actions, as well as any penalties imposed on the nursing home. CMS has created a tool called Care Compare to help consumers search for and select nursing homes and other health care providers.

According to CMS, the information it maintains on nursing homes should be used with other information you gather about providers and facilities in your area. In addition to reviewing the Care Compare information, you should talk to your doctor, social worker, or other health care providers when choosing a provider. Additional tips for selecting a nursing home can be found in the following guide to selecting a nursing home:

https://www.medicare.gov/publications/02174-your-guide-to-choosing-a-nursing-home

The following web addresses can provide quality and compliance information:

https://profiles.health.ny.gov/nursing_home/index#5.79/42.868/-76.809

On the New York State Department of Health (NYSDOH) site, select the nursing home by name after selecting the appropriate Region/County from the dropdown menu, and open the Inspections tab to view any Complaints, Inspection results including any Citations, and any Enforcement actions against the nursing home.

https://www.medicare.gov/care-compare/

On the Centers for Medicare and Medicaid Services (CMS) Care Compare site, enter the name of the nursing home in the search box. Click on the name of the nursing home to view Inspection results as well as any penalties that have been imposed.