FRIENDLY HOME
nursing care & rehabilitation

ADMISSIONS APPLICATION

Name:_____ Social Security Number:_____

Address: _____ Zip:_____

Telephone: _____ County of Residence:_____

Date of Birth: _____ Marital Status: Married Widowed Divorced Single

Gender at Birth: Male Female Gender Identity: Male Female

Preferred Name: _____ Preferred Pronouns: _____

Religion _____ Place of Worship _____

U. S. Citizen: Y N If naturalized citizen, date:_____

Is the applicant currently working? Y N Is the applicant a veteran? Y N

Occupation:_____ Employer _____

Is the applicant's spouse currently working? Y N Is the applicant's spouse a veteran? Y N

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? Y N

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

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

Name: **Specialty:** **Telephone/Fax Numbers:**

_____

_____

_____

Have Advanced Directives been established (MOLST, Living Will, DNR, Health Care Proxy)? Y N

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? Y N Is this account irrevocable? Y N

INSURANCE

Please provide a copy of all cards (both sides)

Medicare:_____ Part A: Y N Part B: Y N

Medicaid: _____ County: :_____

Case Worker Name and Number: _____

Does the applicant have a Medicaid Managed Long Term Care Plan? (i.e. Fidelis, I-Circle) Y N

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: Y N

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: Y N Health Care Agent: Y N

Name:_____ Relationship: _____

Address: _____ Zip:_____

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

Email Address _____

Power Of Attorney: Y N Health Care Agent: Y N

FISCAL AGENT

(manages financial obligations for applicant)

Name of Power of Attorney/Guarantor _____ Relationship: _____

Address: _____ Zip: _____

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

Email Address _____

Has a conservator/guardian been appointed? Y N ***(Please provide a copy.)***

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): Y N Amount: _____

Checking Account: Y N Amount _____ Name of Bank: _____

Savings Account: Y N Amount _____ Name of Bank: _____

Certificates of Deposit: Y N Value: $ _____

In whose name is this asset held? _____

Stocks: Y N Value: $ _____

In whose name is this asset held? _____

ASSETS CONTINUED:

Annuities: Y N Value: $ _____

In whose name is this asset held? _____

Is the applicant drawing income? Y N

Does this have cash value? Y N Value: $ _____

Money Market: Y N Value: $ _____

In whose name is this asset held? _____

Bonds: Y N Value: $ _____

In whose name is this asset held? _____

IRAs/401K/403B: Y N Value: $ _____

In whose name is this asset held? _____

Real Estate: Does the Applicant own a home? Y N

Does a Spouse, disabled adult or child live in the home? Y N

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 Department of Social 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, greater than $2,000? Y N
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 ? Y N

If yes, please explain: _____

_____

TRUSTS:

Has the applicant established any trusts? Y N

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? Y N

If yes, please provide name and telephone number: _____

LIABILITIES: (for example: mortages, 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 opportunity to move to a private room will be based on the following conditions: 1) the Home is able to maintain its census by having an appropriate candidate to fill the vacated semi-private room, 2) there are no Members requiring a private room based on medical or psychiatric needs, 3) the available private room meets the Member's physical and safety needs, and 4) the Member is private pay.

Members residing in private rooms will be relocated to semi-private rooms once they are Medicaid pending unless they have paid privately for two or more years. Members residing in Lindsay Place suites will need to have private pay resources for the duration of their stay.

Please note: The Transitional Care Center is comprised of all private rooms. These guidelines only pertain to our long term care Members.

I, _____, certify that this information is accurate and true to the best of my knowledge.

_____ _____

Signature of Applicant/Responsible Party **Date**

_____

Relationship to Applicant

The Friendly Home respects the rights of all people and applications are considered without regard to race, creed, color, age, gender, marital status, disability, actual or perceived sexual orientation, gender identity or expression, HIV status, national origin, 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 made effective the _____ day of _____, 20_____ by and between the Friendly Home and _____ (Fiscal Agent) , residing at _____(street), _____(city,) _____ (state,) _____(zip), (hereinafter "Fiscal Agent") as an individual with legal access to funds or resources of _____ (applicant, hereinafter "Member").

WHEREAS, the Friendly Home is reviewing whether to admit Member and to provide the services specified in the Member Admission Agreement; and

WHEREAS, Fiscal Agent has legal access to the assets, income, and other resources of the Member; and

Now, therefore, for good and valuable consideration, the parties hereby agree as follows:

1. Fiscal Agent expressly understands that the Friendly Home is relying on each and every statement, representation and warranty made by Fiscal Agent in this Agreement and in the financial statements presented by Member and Fiscal Agent in the Application For Admission (the "Application") prior to or upon admission and, in light thereof: (a) Fiscal Agent expressly represents and warrants to the Friendly Home the truthfulness, accuracy and completeness of each of the statements made in the Application and this Agreement; and (b) Fiscal Agent expressly agrees that any material omissions, misstatement or misrepresentation of information in the Application or this Agreement may result in the Member being transferred to a different room at or discharged from the Friendly Home to which transfer or discharge Fiscal Agent consents.

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

3. Fiscal Agent agrees, represents and warrants that Member's assets, property, income, Medicare and other insurance benefits, and other resources disclosed to the Friendly Home in the Application (the "Assets") are complete, accurate and available to timely pay all of Member's charges incurred at the Friendly Home pursuant to the Member Admission Agreement.

4. Fiscal Agent agrees that he/she shall make or facilitate full payment from and with the Member's Assets of all charges, fees and expenses for nursing home care, physician visits and authorized additional charges, as well as subsequent rate increases, pursuant to the Member Admission Agreement.

5. Fiscal Agent agrees and warrants that from the date hereof Member's assets shall not be transferred, diverted, gifted or pledged or in any other way used or misused by Fiscal Agent (a "Transfer") so as to prevent Member from paying all charges due to the Friendly Home or from qualifying for uninterrupted Medicaid benefits or so as to otherwise breach the Member Admission Agreement or this Agreement.

6. Fiscal Agent represents and warrants that no Transfer of Member's Assets has taken place which would prevent Member from qualifying for Medicaid benefits. If a Transfer is, was or will be made, and if it is later determined that the Transfer was in violation of Medicaid law

or this Agreement, Fiscal Agent agrees that he/she shall take any and all steps necessary to immediately return such Assets to Member's use in order for Member to fully qualify for Medicaid.

7. Fiscal Agent agrees to promptly notify the Friendly Home in writing when the value of the Member's Assets available to pay for the charges incurred at the Friendly Home is $45,000.00, and Fiscal Agent further agrees to promptly complete or assist Member in completing an application for Medicaid.

8. Fiscal Agent agrees timely to provide the Friendly Home with any and all accurate and complete records and supporting documents required to complete any Medicaid application or recertification of Medicaid for the Member, including without limitation banking and financial records, and Fiscal Agent directs all institutions, entities and individuals to release to the Friendly Home all banking and financial records of Member's accounts. The Friendly Home agrees to assist Fiscal Agent in completing the Medicaid application process, as specifically requested by Fiscal Agent.

9. If Fiscal Agent is the attorney-in-fact for the Member through a power of attorney, by signing this Agreement Fiscal Agent hereby appoints the Friendly Home as limited Power of Attorney for Member for the purpose of obtaining banking and financial records for Member's accounts as necessary to complete Member's Medicaid application and any subsequent recertifications.

10. If the Member becomes Medicaid eligible, the Fiscal Agent agrees to pay or facilitate payment monthly to the Friendly Home, or any other entity identified by the Medicaid agency, the Net Available Monthly Income (the "NAMI") which the Medicaid agency directs the Member to pay towards the Member's cost of care, regardless of such amount.

11. Fiscal Agent agrees that if he/she is representative payee or otherwise receives or controls any of Member's NAMI, and if he/she or Member fails to pay such NAMI in a timely manner, the Friendly Home is hereby directed to apply for and become representative payee of the Member to provide for the direct deposit of Social Security benefits upon the filing of the Member's Medicaid application.

12. Fiscal Agent agrees to pay damages to the Friendly Home caused by a breach of his/her personal responsibilities under this Agreement including, without limitation, reasonable attorneys' fees and costs.

13. Fiscal Agent agrees and understands that any Transfer of Member's Assets that impoverishes or result in the impoverishment of Member is or may constitute a fraudulent conveyance, and that any such Transfer may result in the Member being transferred to a different room at or discharged from the Friendly Home to which transfer or discharge Fiscal Agent expressly consents.

_____ _____

Dated

Fiscal Agent
This agreement is between you and the Friendly Home. It must be signed by you individually. It <u>cannot</u> be signed as POA.

_____ 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 applicant'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).

PERSONAL CAREGIVING AND COMPASSIONATE CAREGIVING VISITORS IN NURSING HOMES

Effective June 1, 2021, New York State enacted the Essential Caregiver Law (10 NYCRR 415.3 (d)(3)) which allows families to designate a minimum of two personal and compassionate caregivers. This means during a declared Public Health Emergency, these individuals will be permitted to visit the nursing home when normal visitation is shut down. Please note that the Department of Health and The Friendly Home do retain the right to limit visitation due to an increase in local infection rates, inadequate staff capacity, an acute emergency situation such as loss of an essential service (i.e. power) or because the personal caregiver poses a threat to the safety and well-being of the resident or any resident or personnel in the facility.

Visitors must follow infection control protocols such as wearing appropriate Personal Protection Equipment (PPE), testing for communicable diseases and health screenings as required. Visitors must also adhere to The Friendly Home's set standards for maximum frequency, duration and total number of personal caregivers allowed to visit at one time.

Personal and Compassionate Caregivers designations will be reviewed by the Interdisciplinary teams quarterly to ensure accuracy.

Please list the people who will be designated as Personal and Compassionate Caregiver below:

1._____

2._____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

For questions regarding the Essential Caregiver Law, please contact Shireen Bertino, Director of Social Work and Admissions at *585-789-3102* or *sbertino@friendlyhome.org*.

Revised: May 2024

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 CMS's guide to selecting a nursing home: *https://www.medicare.gov/care-compare/en/assets/resources/nursing-home/02174-nursing-home-other-long-term-services.pdf?redirect=true.*

The following web addresses can provide quality and compliance information:

https://profiles.health.ny.gov/nursing_home/index
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/?providerType=NursingHome&redirect=true
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.