St John's HOME



ADMISSIONS APPLICATION

☐ St. John's Home ☐ Penfield Green House Homes ☐ Rehabilitation Services

APPLICANT

Last Name:_____ First Name:_____ Middle Initial:_____

Street:_____ City/State/ZIP: _____

Phone: (__ __ __) __ __ __ - __ __ __ __ Gender: ☐ Male ☐ Female

Is the applicant a U.S. Citizen? ☐ Yes ☐ No If not, what is the county of citizenship? _____

Social Security Number: __ __ __ - __ __ - __ __ __ __ Date of Birth (mm/dd/year): __ __ / __ __ / __ __ __ __

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other:_____

Race:_____ Religion:_____

Where is the applicant currently? ☐ Home ☐ Hospital ☐ Skilled Nursing Facility ☐ Assisted Living Facility

Has the applicant had a previous nursing home stay in the past year? ☐ Yes ☐ No

If yes, dates of stay and where: _____

Has the applicant been hospitalized in the past 30 days? ☐ Yes ☐ No Dates of stay:_____

Name of Hospital:_____ Reason for hospitalization: _____

EMERGENCY CONTACTS

FIRST CONTACT

☐ Power of Attorney ☐ Health Care Proxy

Name: _____

Relationship: _____

Street Address:_____

City:_____ State:_____ ZIP: _____

Home Phone: (__ __ __) __ __ __ - __ __ __ __

Work Phone: (__ __ __) __ __ __ - __ __ __ __

Cell Phone: (__ __ __) __ __ __ - __ __ __ __

Email:_____

SECOND CONTACT

☐ Power of Attorney ☐ Health Care Proxy

Name: _____

Relationship: _____

Street Address:_____

City:_____ State:_____ ZIP: _____

Home Phone: (__ __ __) __ __ __ - __ __ __ __

Work Phone: (__ __ __) __ __ __ - __ __ __ __

Cell Phone: (__ __ __) __ __ __ - __ __ __ __

Email:_____

MEDICAL

PRIMARY CARE PHYSICIAN

Name: _____

Address: _____

City: _____

State: _____ ZIP: _____

Phone: (__ __ __) __ __ __ - __ __ __ __

Fax: (__ __ __) __ __ __ - __ __ __ __

SPECIALIST

Name: _____

Address: _____

City: _____

State: _____ ZIP: _____

Phone: (__ __ __) __ __ __ - __ __ __ __

Fax: (__ __ __) __ __ __ - __ __ __ __

ADVANCE DIRECTIVES

Health Care Proxy: ☐ Yes ☐ No

Living Will: ☐ Yes ☐ No

DNR (Do Not Resuscitate): ☐ Yes ☐ No

MOLST: ☐ Yes ☐ No

We do require copies of the above documents upon admission.

INSURANCE

Medicare Number: _____ ☐ Part A ☐ Part B

MVP Number: _____ Medicare Blue Choice Number: _____

Blue Choice Senior Number: _____ Blue Cross/Blue Shield: _____

Medicaid Number: _____

Caseworker's Name: _____ Caseworker's Telephone Number: _____

We do require copies of the above documents upon admission.

LONG TERM CARE INSURANCE

Company: _____

Policy Number: _____ Per Day Benefit: $_____

We do require copies of the above documents upon admission.

FINANCIALS

MONTHLY INCOME

	APPLICANT	SPOUSE
Social Security	_____	_____
Retirement Pension	_____	_____
Interest Dividends	_____	_____
Wages/Income	_____	_____
Other	_____	_____
Total Monthly Income	**$**_____	**$** _____

ASSETS

	APPLICANT	SPOUSE
Checking Account	_____	_____
Savings Account	_____	_____
C.D. Money Market/Stocks	_____	_____
Trusts	_____	_____
Other	_____	_____
Total Assets	**$**_____	**$**_____

Does the applicant own a home? ☐ Yes ☐ No If yes, what is the value of the property?_____

Liquid assets available to pay for applicants care: $ _____ Initials _____ Date _____

Has the applicant given away, gifted, or transferred any assets within the past 60 months of the date of this application?

☐ Yes ☐ No If yes, how much?_____ Date of transfer: _____

Have you or a family member consulted with an attorney or financial advisor regarding payment for nursing home care?

☐ Yes ☐ No If yes, please provide the person's name and phone number: _____

FINANCIAL REPRESENTATIVE

Name of Power of Attorney:_____

Relationship:_____ Phone: (_ _ _) _ _ _ - _ _ _ _

HOW DID YOU HEAR ABOUT ST. JOHN'S?

☐ Television ☐ Newspaper ☐ Radio ☐ Internet ☐ Event ☐ Friend ☐ Family Member ☐ Other: _____

Please share why you chose St. John's:_____

_____

APPLICATION COMPLETED BY:

Printed Name:_____ Relationship to Applicant: _____

Signature: _____

☐ St. John's home
150 HIGHLAND AVE
ROCHESTER NY 14620

☐ St. John's PENFIELD homes
65 AND/OR 75 SONOMA DRIVE
FAIRPORT, NY 14559

FISCAL AGENT AGREEMENT

This Agreement made effective the_____day of_____, 20____ by and between St. John's and _____, residing at _____(street), _____(city,)_____ (state,)_____ (zip), (hereinafter "Fiscal Agent") as an individual with legal access to funds or resources of _____ (hereinafter "Resident".)

WHEREAS, St. John's 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 St. John's 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 St. John's 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 St. John's.

5. Fiscal Agent agrees that Fiscal Agent will make payment to St. John's 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 St. John's 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 St. John's 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, St. John's 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,
St. John's 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 St. John's prior to and/or at the time of admission shall be used to satisfy in full all future bills from St. John's 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 St. John's 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 St. John's. Please sign as yourself; do not sign as POA)

DATED: _____ By:_____

St. John's Representative

stjohnsliving.org

150 Highland Avenue, Rochester, NY 14620 • 585-760-1300