



## Julian J. Leavitt Family Jewish Nursing Home

*A Program of Jewish Geriatric Services*

### Programs of Jewish Geriatric Services, Inc.

- ★ Julian J. Leavitt Family  
Jewish Nursing Home
- ★ Ruth's House  
An Assisted Living Residence  
Dedicated by:  
Ruth and David B. Katz  
The Ruth and Ralph G.  
Webber Family
- ★ Spectrum Home Health Care
- ★ Spectrum Home Care
- ★ Wernick Adult Day Health  
Care Center
- ★ JGS Family Medical Care  
and House Calls
- ★ Genesis House

Hello:

This is the Application for Admission to the Jewish Nursing Home. Please complete it to the best of your ability and return it to us as soon as you can.

Here are a few very important items to keep in mind:

- For proper consideration you must attach copies of the applicant's health insurance cards (Medicare, Medex, Medicaid, other secondary Health Insurance, i.e. HMOs, Health Care Proxy, and any Durable Power of Attorney documentation.)
- It is of the utmost importance that you complete page 10 that is the Medical Authorization page. The process of obtaining medical information from the physician's office or hospital cannot begin unless this page has been signed. We also need the Medical Authorization signature for our nurse to begin her assessment.

After the completed application has been received by us, a member of our nursing staff will arrange to meet you to assess your (loved one's) nursing care needs.

Please call us if you have any questions concerning the application or admission process. You can also reach our JGS SeniorCare Resource service at extension 1330.

Sincerely,  
Social Services Department



**Joint Commission**  
on Accreditation of Healthcare Organizations

On the Harry and Jeanette Weinberg Campus  
770 Converse Street • Longmeadow, MA • 01106-1786 • Tel: 413-567-6211 • Fax: 413-567-0175  
[www.jewishgeriatric.org](http://www.jewishgeriatric.org)

**JULIAN J LEAVITT FAMILY JEWISH NURSING HOME, INC.**  
**770 Converse St, Longmeadow, MA 01106-1786**

**APPLICATION FOR ADMISSION**

Date \_\_\_\_\_ 200\_\_\_\_\_ Admission Requested for: Date \_\_\_\_\_

Telephone No. \_\_\_\_\_

Name \_\_\_\_\_  
Last First M.I.

Hebrew Name \_\_\_\_\_

Present Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I live in: Own house \_\_\_ Apartment \_\_\_ With relatives \_\_\_ With children \_\_\_ Other Nursing Home \_\_\_

Attach Address History (last 6 years if different)

Date of Birth \_\_\_\_\_ Birthplace \_\_\_\_\_ Age \_\_\_\_\_

Father's Name \_\_\_\_\_ Birthplace \_\_\_\_\_

Father's Hebrew Name \_\_\_\_\_

Mother's Maiden Name \_\_\_\_\_ Birthplace \_\_\_\_\_

Are you a citizen of the United States of America? Yes \_\_\_\_\_ No \_\_\_\_\_  
Alien Registration No. \_\_\_\_\_ If Naturalized,  
Or Naturalization No. \_\_\_\_\_ When and where? \_\_\_\_\_

Education \_\_\_\_\_

Occupation/Trade \_\_\_\_\_ Last Employment \_\_\_\_\_

Religious Affiliation \_\_\_\_\_ Veteran? Yes \_\_\_\_\_ No \_\_\_\_\_

Marital Status: Single \_\_\_ Divorced \_\_\_ Separated \_\_\_

Married \_\_\_\_\_ My Spouse's name is \_\_\_\_\_

Widowed \_\_\_\_\_ Spouse's name \_\_\_\_\_

\_\_\_\_\_  
Date of Death

Number of children: Sons \_\_\_ Daughters \_\_\_

CHILDREN

<u>Name</u>	<u>Address &amp; Zip Code</u>	<u>Occupation</u>	<u>Telephone numbers</u>	
			<u>Home</u>	<u>Business</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you appointed a Health Care Proxy? Yes \_\_\_ No \_\_\_

Have you appointed a Guardian? Yes \_\_\_ No \_\_\_

Have you appointed a Durable Power of Attorney? Yes \_\_\_ No \_\_\_

If yes: Name \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_ Relationship \_\_\_\_\_

**Original signed copies are required at a time of admission.**

Name of nearest of kin (to be notified in case of illness) \_\_\_\_\_

Address \_\_\_\_\_ Telephone No. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If no children, please provide two local contacts or interested party.

<u>Name</u>	<u>Kinship</u>	<u>Other Relatives</u>	
		<u>Address</u>	<u>Tel. No.</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**APPLICATION FOR ADMISSION**  
**FINANCIAL INFORMATION**

**PAYMENT PLANS**

How do you intend to pay for your nursing home stay? (Please include all that apply.)

Private Pay \_\_\_\_\_

LTC Insurance \_\_\_\_\_

Medicare \_\_\_\_\_

Other Insurance \_\_\_\_\_

Mass Health \_\_\_\_\_

Other (describe) \_\_\_\_\_

VA \_\_\_\_\_

\_\_\_\_\_

**INCOME**

1. Social Security No. \_\_\_\_\_ \$ \_\_\_\_\_ monthly

2. Medicare No. \_\_\_\_\_ Medex No. \_\_\_\_\_ Plan \_\_\_\_\_

3a. Other Health or Accident Insurance \_\_\_\_\_

3b. Medicaid No. (if applicable) \_\_\_\_\_

4. Government pension: (indicate by underscoring)

Veterans, Federal, State, Local, Railroad Retirement \_\_\_\_\_ \$ \_\_\_\_\_ monthly

5. Pensions from private employers \_\_\_\_\_ \$ \_\_\_\_\_ monthly

6. Interest, dividends, or insurance annuity \_\_\_\_\_ \$ \_\_\_\_\_ monthly

7. Rent from house or property \_\_\_\_\_ \$ \_\_\_\_\_ monthly

8. Supplemental Security Income \_\_\_\_\_ \$ \_\_\_\_\_ monthly

9. Trust Funds or other Income Sources \_\_\_\_\_ \$ \_\_\_\_\_ monthly

Total Monthly Income \$ \_\_\_\_\_



## **Julian J. Leavitt Family Jewish Nursing Home Summary of Financial Requirements for Admission**

In order to maintain the Home's high standards of care and service, it is the obligation of the resident and/or individual legally responsible for payment of obligations of the resident (for example, the guardian or conservator) to assure payment of all charges. To facilitate the planning of your admission, we have summarized your contractual obligations to pay your nursing home bill under our standard Service Agreement. Our policies are in accordance with federal and state regulations.

Residents will be accepted for admission only under the following payment conditions:

1. Private Pay – You and your responsible party are responsible for payment of the full published charges for care and services. The aggregate daily rate is due and payable monthly in advance on the first day of each month. Other charges are due and payable not later than ten (10) days after billing. The daily rates may be adjusted from time to time, normally annually on January 1. You will receive 60 days advance written notice of any change.
2. Medicare or other Third-Party Payment Plan (Veteran's Benefits or commercial insurance) – We will accept payment from such in lieu of our daily rate; however, all co-payments, coinsurance, Patient Pay Amounts or charges and fees for non-covered items and services are your or your responsible party's responsibility and are required to be paid in full and in advance on the first day of each month.
3. Medicaid – If at any time you or your responsible party are unable to pay or expect to become unable to pay the private daily rate and other charges, you agree to immediately apply for, and diligently pursue, medical assistance from Mass Health. This will include your cooperating in complying with all requirements of such agency, including prompt submission of any and all information which Mass Health requires to process the application so that such assistance can be paid on your behalf to the nursing home, however, the obligation to apply and qualify for assistance is yours or your responsible party.

You or your responsible party remain responsible for paying our daily private pay rate and fees while your application for public assistance benefits is pending, or in the event the application is denied.

Once you receive approval from Medicaid and we are in receipt of a Medicaid number, we will accept payment from Medicaid. You or your responsible party will be responsible for any Patient Pay Amounts and any and all charges and fees not covered by Medicaid. To assist you, we request that a copy of any application for public assistance be provided to us. It will be reviewed by the Home's Business Office, and you and your responsible party may be contacted should there be any questions.

Once your application is approved, you or your responsible party agree to release to the Nursing Home all pension payments, Social Security benefits, and other such monies that may be due per Mass Health. These amounts are known as the Patient Pay Amounts.

**APPLICATION FOR ADMISSION**  
**HEALTH INFORMATION**

1. Diagnosis of illness: Primary \_\_\_\_\_

Secondary \_\_\_\_\_

2. Primary Physician \_\_\_\_\_ Address \_\_\_\_\_

3. Mental Condition: Alert \_\_\_\_\_ Impaired \_\_\_\_\_  
Extent of Impairment: Occasionally \_\_\_\_\_ Continuously \_\_\_\_\_  
Describe any behavior problems, if applicable \_\_\_\_\_

4. Is patient self care? Yes \_\_ No \_\_  
If no, assistance needed with \_\_ eating \_\_ dressing \_\_ bathing  
With assistance (please check) \_\_ cane \_\_ walker \_\_ wheelchair \_\_ person

5. Are senses impaired (please check): Sight \_\_ Hearing \_\_ Speech \_\_ Other \_\_\_\_\_

6. Allergies \_\_\_\_\_

7. Special Diet: Yes \_\_ No \_\_  
If yes, describe \_\_\_\_\_

8. Incontinent: Urine \_\_\_\_\_ Feces \_\_\_\_\_

1. Prosthetic devices or other special needs/equipment \_\_\_\_\_

10. Pertinent past medical history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Physicians consulted during past two years:

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____

3. Hospitalizations during the past five years:

Name of Hospital	From	To	Reason

12. Nursing Home stays within past year:

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13. Are you currently receiving services from any community agency? Yes \_\_\_ No \_\_\_

Name of Community Agency \_\_\_\_\_

14. Have you been a resident in, or applied to, any other institution? If answer is yes, please explain:

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15. Burial Arrangements:

Name of Funeral Home \_\_\_\_\_

Do you have Advanced Directives or a Living Will? Yes \_\_\_ No \_\_\_

(If yes, a copy is required at time of admission)

Reason for seeking admission \_\_\_\_\_

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**CONFIRMATION OF APPLICANT AND RESPONSIBLE PARTY**

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I do hereby represent, warrant and covenant that:

- All the foregoing statements and declarations made by me are true;
- I have fully and fairly answered each question;
- I have not concealed or misrepresented any material fact; and that
- I have not knowingly or otherwise omitted or failed to specify in this application any property belonging to me or to which I may be entitled or in which I may have interest.

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant  
Or Power of Attorney/Guardian

Witnessed by \_\_\_\_\_

Witnessed by \_\_\_\_\_

\_\_\_\_\_  
Signature of Responsible Party

**JULIAN J. LEAVITT FAMILY JEWISH NURSING HOME**  
**SPECIAL MEDICAL AUTHORIZATION**

This authorizes release to the Julian J. Leavitt Jewish Nursing Home any information it requests from any doctor, hospital, clinic, nursing home to whom I am or have been known. This authorization includes psychiatric history and treatment as well as any other form of medical treatment, medical or nursing history or care received.

Witnessed by:

\_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant, Durable Power of Attorney  
or Guardian

Date: \_\_\_\_\_