

# JEWISH HOME & REHAB CENTER

SAN FRANCISCO CAMPUS FOR JEWISH LIVING



A beneficiary of Jewish Home & Senior Living Foundation and the San Francisco-based Jewish Community Federation.

302 Silver Avenue San Francisco, CA 94112 415.334.2500 sfcjl.org

## APPLICATION FOR ADMISSION

Please complete and return this application to:

**MAIL:**

Jewish Home & Rehab Center  
Admissions Office  
302 Silver Avenue  
San Francisco, CA 94112

**FAX:**

415.651.9871

**E-MAIL:**

admissions@jhsf.org

**FOR OFFICE USE ONLY**

DATE APPLICATION RECEIVED

### APPLICANT INFORMATION

<input type="text"/>			<input type="text"/>		
NAME			PHONE		
<input type="text"/>					
ADDRESS					
<input type="text"/>			<input type="text"/>		
CITY			STATE		ZIP
<input type="text"/>		<input type="text"/>			
SOCIAL SECURITY NUMBER		BIRTH DATE			

Are you a U.S. citizen?  
 Yes  No

Are you a veteran?  
 Yes  No

<input type="text"/>		<input type="text"/>	
RELIGION		LANGUAGES SPOKEN	
<input type="text"/>		<input type="text"/>	
EDUCATION LEVEL		FORMER OCCUPATION	
<input type="text"/>		<input type="text"/>	
FATHER'S NAME		MOTHER'S MAIDEN NAME	
<input type="text"/>		<input type="text"/>	
BIRTH PLACE		<input type="text"/>	

### MARITAL STATUS

Single  Married  Partnered  Widowed  Separated  Divorced

NAME OF SPOUSE OR PARTNER

### INSURANCE INFORMATION

Please submit copies of all health insurance cards and provide numbers below.

<input type="text"/>	<input type="text"/>
MEDICARE NUMBER	MEDI-CAL NUMBER
<input type="text"/>	<input type="text"/>
NAME OF MEDICARE PART D (PRESCRIPTION DRUG) PLAN	MEDICARE PART D NUMBER
<input type="text"/>	<input type="text"/>
NAME(S) OF OTHER HEALTH PLAN	OTHER HEALTH PLAN NUMBER(S)

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## PERSONAL PROFILE

Help us get to know you better! This is your chance to introduce yourself, or your loved one.  
Please tell us your personal story, activities and interests. Please do not include any medical information here.

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## HEALTH INFORMATION

Applicants pursuing admission to Jewish Home & Rehab Center will need to provide medical records from their doctor(s). Incomplete medical records will delay the admission process.

NAME OF PHYSICIAN

PHONE

FAX

E-MAIL

Have you been hospitalized in the past year?  Yes  No

*If yes, please submit a copy of the discharge summary you received from the hospital.*

REASON(S) FOR HOSPITALIZATION

Are you currently receiving nursing care at home?  Yes  No

*If yes, please submit a copy of your home health care assessment.*

TYPE OF ASSISTANCE NEEDED

HOURS PER WEEK

Have you received psychiatric treatment in the last two years?  Yes  No

*If yes, please submit a copy of your latest psychiatric assesment.*

REASON(S) FOR TREATMENT

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## INTERMENT

Have you made any *prepaid* funeral or burial arrangements?  Yes  No

*If yes, please submit a copy of your funeral or burial arrangements.*

<input type="text"/>		<input type="text"/>
NAME OF MORTUARY		PHONE
<input type="text"/>		
ADDRESS		
<input type="text"/>	<input type="text"/>	<input type="text"/>
CITY	STATE	ZIP

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## LEGAL ARRANGEMENTS

HAVE YOU MADE THE FOLLOWING LEGAL ARRANGEMENTS?

*Please include relevant copies of these documents with your application.*

Durable Power of Attorney – Healthcare:  Yes  No

<input type="text"/>	<input type="text"/>
NAME OF AGENT	PHONE

Durable Power of Attorney – Finance:  Yes  No

<input type="text"/>	<input type="text"/>
NAME OF AGENT	PHONE

Conservatorship of person:  Yes  No

<input type="text"/>	<input type="text"/>
NAME OF AGENT	PHONE

Conservatorship of estate:  Yes  No

<input type="text"/>	<input type="text"/>
NAME OF AGENT	PHONE

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## CHILDREN AND/OR RESPONSIBLE PARTIES

<input type="text"/>	<input type="text"/>		
NAME	PHONE		
<input type="text"/>	<input type="text"/>		
ADDRESS	E-MAIL		
<input type="text"/>	<input type="text"/>		
CITY	STATE	ZIP	FAX
<input type="text"/>	<input type="text"/>		
RELATION TO APPLICANT	NAME OF SPOUSE OR PARTNER		

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<input type="text"/>	<input type="text"/>		
NAME	PHONE		
<input type="text"/>	<input type="text"/>		
ADDRESS	E-MAIL		
<input type="text"/>	<input type="text"/>		
CITY	STATE	ZIP	FAX
<input type="text"/>	<input type="text"/>		
RELATION TO APPLICANT	NAME OF SPOUSE OR PARTNER		

If applicable, check here if using supplemental sheet for additional names.

## FINANCIAL INFORMATION

Please provide income verification and financial records. Incomplete verification will delay the admissions process.

### MONTHLY SOURCE OF INCOME

### AMOUNT PER MONTH

Social Security benefits

  
BANK RECEIVING DIRECT DEPOSIT

Supplemental Social Security (SSI)

  
BANK RECEIVING DIRECT DEPOSIT

Pension benefits

  
NAME OF COMPANY

Any other income

  
SOURCE OF INCOME

**TOTAL MONTHLY INCOME:**

### CURRENT BANK ACCOUNTS (SAVINGS AND CHECKING)

Please include recent bank statements with your application.

  
NAME OF BANK  
TYPE OF ACCOUNT  
ACCOUNT NUMBER  
CURRENT BALANCE  
NAME OF BANK  
TYPE OF ACCOUNT  
ACCOUNT NUMBER  
CURRENT BALANCE

If applicable, check here if using supplemental sheet to list additional accounts.

### SECURITIES AND INVESTMENTS (STOCKS, BONDS, NOTES, RETIREMENT)

Do you hold any securities and/or investments?  Yes  No

Please provide the most recent brokerage statement.

### TRUST

Do you have a Trust?  Yes  No If yes, is the Trust revocable?  Yes  No

Please include a copy of the Trust with your application.

### SIGNATURE

Jewish Home & Rehab Center (located on San Francisco Campus for Jewish Living) welcomes and admission is open to older adults of all faiths, ethnicities, and racial backgrounds.

The undersigned hereby applies for admission to Jewish Home & Rehab Center and agrees, if admitted, to comply with all its rules, regulations and by-laws now in force, and such as may hereafter be adopted by its constituted authorities.

  
SIGNATURE OF APPLICANT OR DESIGNEE  
DATE

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 Jewish Senior Living Group

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## CONTACT INFORMATION FOR ADMISSIONS DEPARTMENT

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Admissions Office  
302 Silver Avenue  
San Francisco, CA 94112

### FAX:

415.651.9871

### E-MAIL:

admissions@jhsf.org

PLEASE KEEP THIS PAGE  
FOR YOUR RECORDS

DATE APPLICATION SUBMITTED

## APPLICATION FOR ADMISSION CHECKLIST

Before you submit your application, check that you have included the following information, as applicable:

- Completed Application for Admission (signed & dated)
- Complete Medical Records:
  - Most current history & physical (H&P) from primary care provider
  - If applicable, discharge summaries from hospital stay, skilled nursing, or home health agency within the past 6 months (including face sheets)
  - Most current assessments by any specialists (i.e. Neurology, Psychiatry/Psychology, Cardiology)

### COPIES OF YOUR IDENTIFICATION AND MEDICAL INSURANCE CARDS, AS APPLICABLE

- Photo identification card
- Social Security card
- Medi-Cal card
- Medicare card
- Medicare D card (prescription drug plan) (front & back)
- Supplemental or HMO medical insurance card (front & back)
- Passport and/or citizenship papers

### COPIES OF FINANCIAL AND LEGAL DOCUMENTS, AS APPLICABLE

- Advance Healthcare Directive
- Power of Attorney for healthcare and finances
- Most recent bank statement(s)
- Most recent brokerage statement(s)
- Most recent pension statement(s)
- Most recent Medi-Cal Notice of Action
- Conservatorship papers
- Trust documents
- Mortuary documents
- Most recent Social Security explanation of benefits