JEWISH HOME

Jewish Senior Living Group

Dear Sir or Madam,

Thank you for your interest in long-term care (LTC) at the Jewish Home of San Francisco.

Please fully complete the enclosed application, being sure to include the medical request forms (completed by your doctor) and the required documents listed on the checklist. Incomplete applications will delay the admission process.

Please indicate on the application if you are looking for immediate placement or would like to be placed on our waiting list.

If you have any questions, please contact me using the information below.

Thank you,

Long-Term Care (LTC) Admissions
Jewish Home of San Francisco
302 Silver Avenue
San Francisco, CA 94112

415.469.2246 (phone)
415.520.6945 (fax)
jhsf.org

JEWISH HOME

Jewish Senior Living Group

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 jhsf.org

APPLICATION FOR ADMISSION

Please complete this form and all required medical information.

Application processing fee is $200.
Make checks payable to **Jewish Home of San Francisco**.
No fee is required for Medi-Cal recipients.

MAIL:

Long-Term Care (LTC) Admissions
Jewish Home
302 Silver Avenue
San Francisco, CA 94112

FAX:

415.520.6945

CHECK ONE:

- ☐ I am interested in immediate placement (0-6 months)
- ☐ I am interested in future admission (more than 6 months from now)

APPLICANT INFORMATION

NAME | PHONE

ADDRESS | E-MAIL ADDRESS

CITY | STATE | ZIP

FORMER ADDRESS (IF IN THE LAST THREE YEARS) | FROM | TO

SOCIAL SECURITY NUMBER | MEDICARE NUMBER | MEDI-CAL NUMBER

RELIGION | LANGUAGES SPOKEN

HIGHEST LEVEL OF EDUCATION | FORMER OCCUPATION

ACTIVITIES OF INTEREST, CLUBS, AFFILIATIONS, PLACE OF WORSHIP

BIRTH DATE | BIRTH PLACE | AGE | SEX

FATHER'S NAME | MOTHER'S MAIDEN NAME

U.S. citizenship: ☐ Yes ☐ No
Attach copy of birth certificate and/or Resident Alien Naturalization document.

Are you or your spouse a veteran? ☐ Yes ☐ No

FOR OFFICE USE ONLY

DATE APPLICATION RETURNED

CURRENT RELATIONSHIP STATUS

☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced

NAME OF SPOUSE OR PARTNER | AGE | NUMBER OF CHILDREN

ADDRESS | OCCUPATION

CITY | STATE | ZIP | PHONE

PHONE | PHONE | E-MAIL

☐ If applicable, check here and use supplemental sheet for previous relationships.

CHILDREN OR OTHER INTERESTED PARTIES

NAME | PHONE

ADDRESS | CELL PHONE

CITY | STATE | ZIP | FAX

RELATION TO APPLICANT | AGE | OCCUPATION | E-MAIL

NAME OF SPOUSE OR PARTNER | OCCUPATION

PHONE | PHONE | E-MAIL

NAME | PHONE

ADDRESS | CELL PHONE

CITY | STATE | ZIP | FAX

RELATION TO APPLICANT | AGE | OCCUPATION | E-MAIL

NAME OF SPOUSE OR PARTNER | OCCUPATION

PHONE | PHONE | E-MAIL

☐ If applicable, check here and use supplemental sheet for additional names.

HEALTH INFORMATION

NAME OF PHYSICIAN

PHONE | PHONE | FAX

PLEASE LIST PRIMARY HEALTH ISSUES

Have you been hospitalized in the past year? ☐ Yes ☐ No

REASON(S) FOR HOSPITALIZATION

Are you currently receiving nursing care at home? ☐ Yes ☐ No

TYPE OF ASSISTANCE NEEDED | HOURS PER WEEK

Have you ever received psychiatric treatment? ☐ Yes ☐ No

EXPLAIN TREATMENT

INSURANCE INFORMATION

You must submit copies of all health insurance cards. Please also provide numbers below.

MEDICARE PLAN NUMBER | MEDI-CAL PLAN NUMBER

NAME OF MEDICARE PART D (PRESCRIPTION DRUG) PLAN | MEDICARE PART D PLAN NUMBER

NAME OF OTHER HEALTH PLAN

OTHER HEALTH PLAN NUMBER | OTHER PLAN GROUP NUMBER

Do you have long-term care insurance? ☐ Yes ☐ No

Are you currently receiving veteran's medical benefits? ☐ Yes ☐ No

FINANCIAL INFORMATION

The following is a true statement of all property, securities and investments, cash, bank accounts, insurance policies and assets, or sources of income of any and every kind – either in my possession or held by others for my use or benefit, or in which I may have a present or future interest:

MONTHLY SOURCE OF INCOME		AMOUNT PER MONTH
Social Security benefits	BANK RECEIVING DIRECT DEPOSIT	
Supplemental Social Security (SSI)	BANK RECEIVING DIRECT DEPOSIT	
Other government agencies (Federal/State/City)		
CIVIL SERVICE NUMBER	R.R. RETIREMENT NUMBER	
Veteran's pension		
Company pension	NAME OF COMPANY	
Union pensions	NAME OF UNION	
Other pension	NAME	
Foreign government payments, including pensions, restitutions, and indemnification		
GIVE DETAILS		
Monthly interest from bank accounts		
Monthly dividends from securities		
Interest from securities (treasury notes, corporate bonds, etc.)		
Insurance payments or annuities	NAME OF COMPANY	
Real estate (rents, interest, etc.)		
Bequests, legacies or trusts	NAME OF ESTATE OR TRUST	
Alimony		
IRAs, Keoghs, tax-sheltered annuities		
Contributions from children, relatives and/or friends, etc.		
NAME(S) AND RELATIONSHIP(S)		
	TOTAL MONTHLY INCOME:	0

MONTHLY LIVING EXPENSES

	AMOUNT PER MONTH
Current rent or mortgage payment	
Cost of current nursing care (if applicable)	

CURRENT BANK ACCOUNTS (SAVINGS AND CHECKING)

Please include recent bank statements with your application.

NAME OF BANK | TYPE OF ACCOUNT

ADDRESS | ACCOUNT NUMBER

CITY | STATE | ZIP | CURRENT BALANCE

NAME OF BANK | TYPE OF ACCOUNT

ADDRESS | ACCOUNT NUMBER

CITY | STATE | ZIP | CURRENT BALANCE

☐ If applicable, check here and use supplemental sheet to list additional accounts.

REAL ESTATE (CURRENT RESIDENCE FIRST)

ADDRESS OF PROPERTY

DESCRIPTION OF PROPERTY | CURRENT MARKET VALUE | AMOUNT OF MORTGAGE(S)

Is there anyone sharing this residence with you? ☐ Yes ☐ No

STATE RELATIONSHIP AND LENGTH

ADDRESS OF PROPERTY

DESCRIPTION OF PROPERTY | CURRENT MARKET VALUE | AMOUNT OF MORTGAGE(S)

☐ If applicable, check here and use supplemental sheet to list additional property.

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

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

IF YES, APPROXIMATE TOTAL VALUE

Please provide the most recent brokerage statement and/or list of securities held, with value.

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.

NAME OF TRUSTEE

ADDRESS

PHONE

TOTAL VALUE OF TRUST

MONTHLY INCOME FROM TRUST

BENEFICIARY OF TRUST

PERSONAL LOANS

Does anyone owe you money? ☐ Yes ☐ No

IF YES, EXPLAIN

AMOUNT

Do you owe anyone money? ☐ Yes ☐ No

IF YES, EXPLAIN

AMOUNT

LIST ALL INSURANCE POLICIES THAT HAVE A CASH VALUE

COMPANY | POLICY NUMBER | AMOUNT

COMPANY | POLICY NUMBER | AMOUNT

COMPANY | POLICY NUMBER | AMOUNT

☐ If applicable, check here and use supplemental sheet to list additional policies.

LEGAL ARRANGEMENTS

NAME OF ATTORNEY | PHONE

HAVE YOU MADE THE FOLLOWING LEGAL ARRANGEMENTS?
Please include relevant copies of these documents with your application.

Durable Power of Attorney – Advanced Healthcare Directive: ☐ Yes ☐ No

NAME OF AGENT | PHONE

Durable Power of Attorney – General: ☐ Yes ☐ No

NAME OF AGENT | PHONE

Conservatorship of person: ☐ Yes ☐ No

NAME OF AGENT | PHONE

Conservatorship of estate: ☐ Yes ☐ No

NAME OF AGENT | PHONE

OTHER ARRANGEMENTS

LEGAL ARRANGEMENT | NAME OF AGENT | PHONE

RELATIONSHIP TO APPLICANT | ADDRESS

LEGAL ARRANGEMENT | NAME OF AGENT | PHONE

RELATIONSHIP TO APPLICANT | ADDRESS

LEGAL ARRANGEMENT | NAME OF AGENT | PHONE

RELATIONSHIP TO APPLICANT | ADDRESS

☐ If applicable, check here and use supplemental sheet to list additional legal arrangements.

INTERMENT

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

Do you own a burial plot, vault or crypt? ☐ Yes ☐ No

NAME OF MORTUARY (REQUIRED) | PHONE

ADDRESS

CITY | STATE | ZIP

TRANSFER OF ASSETS / PROPERTY

Have you closed bank accounts, sold, transferred, assigned, made any gifts, or otherwise disposed of any money, securities, insurance policies, real estate or personal property, or other assets within the last five years? ☐ Yes ☐ No If yes, specify below.

DATE CLOSED OR TRANSFERRED | MARKET VALUE | NAME OF RECIPIENT

DATE CLOSED OR TRANSFERRED | MARKET VALUE | NAME OF RECIPIENT

DATE CLOSED OR TRANSFERRED | MARKET VALUE | NAME OF RECIPIENT

☐ If applicable, check here and use supplemental sheet to list additional transfers.

The undersigned hereby applies for admission to the Jewish Home of San Francisco (herein referred to as the Home) and agrees, if admitted, to comply with all the rules, regulations and by-laws of the Home now in force, and such as may hereafter be adopted by its constituted authorities.

Couples are to submit separate applications.

The Jewish Home welcomes and admission is open to older adults of all faiths, ethnicities, and racial backgrounds.

SIGNATURE

I hereby certify to the truth and accuracy of each statement and answer in this application and, if requested, I shall submit verifying proof thereof. I understand that the falsity of any such statement or answer may preclude my admission to the Home or, if admitted, may terminate my residence therein.

I understand that prior to my admission to the Home, I shall be required to make financial arrangements that are satisfactory to me and to the Home.

I further certify that I have read this application, or had it read and fully explained to me in its completed form, and I fully understand the same.

SIGNATURE OF APPLICANT OR DESIGNEE | DATE

PERSONAL PROFILE

Help us get to know you better. Please include personal history, activities and interests.

As appropriate, attach copies of the following (both sides): Social Security card, Medicare Card, Medi-Cal card, Medi-Cal Notice of Action, private insurance card, Resident Alien card, and most recent statements from all financial institutions.

MEDICAL INFORMATION REQUEST CHECKLIST

Applicants pursuing placement at the Jewish Home require a physical exam and order from their doctor. Please be sure to have your doctor complete all medical request forms. Incomplete medical forms will delay the admissions process.

NAME

DATE OF BIRTH

- ☐ Face sheet
- ☐ List of diagnoses
- ☐ Lab reports from the last few months
- ☐ Most recent chest X-ray
- ☐ Most recent EKG
- ☐ Hospital discharge summaries for the past year
- ☐ Physician's orders
- ☐ Medically prescribed diet

AUTHORIZATION FOR RELEASE OF PRE-ADMISSION HEALTH INFORMATION

NAME

DATE OF BIRTH

I authorize the following healthcare providers to release my health information to the Jewish Home for the purpose of assessment and treatment:

Physicians; Hospitals; Convalescent Homes; Assisted Living Facilities; Clinics; Social Service Agencies

Description of health information that may be used or disclosed:

History and Physical; Diagnoses; Orders; Lab Reports; X-Ray Reports; Hospital Admission; Discharge and Progress Notes; Physicians Notes; Nursing Notes; Mental Health Assessments; Social Services Notes; Physical Therapy Notes; Occupational Therapy Notes; Speech Therapy Notes; Dental Notes; Respiratory Therapy Notes; Audiology Notes; Optometry and Ophthalmology Notes; Diet Information

The Jewish Home, a healthcare provider, is bound by HIPAA's privacy practices.

By signing below, I acknowledge that I have read and understand this authorization form.

SIGNATURE OF APPLICANT OR REPRESENTATIVE

DATE

If signed by a representative, please print name and describe relationship or other authority to act.

NAME

RELATIONSHIP

PRE-ADMISSION MEDICATIONS

NAME

DATE

NAME OF MEDICATION | DOSE

NAME OF MEDICATION | DOSE

NAME OF MEDICATION | DOSE

NAME OF MEDICATION | DOSE

NAME OF MEDICATION | DOSE

NAME OF MEDICATION | DOSE

NAME OF MEDICATION | DOSE

NAME OF MEDICATION | DOSE

NAME OF MEDICATION | DOSE

NAME OF MEDICATION | DOSE

INFORMATION REGARDING PERSONAL REPRESENTATIVE

In order to legally and properly transfer personal effects or other property upon the death of a resident, it is important for the Jewish Home to have the name of each resident's personal representative on file.

Your personal representative is the person named as your executor or administrator in your will, or the person named as trustee in your living trust. You may have more than one person listed.

We would like to have a photocopy of your will or trust to ensure that we are taking the proper legal steps. If you change your will or trust, please provide us with a photocopy so that we may keep our records up to date. *Thank You*.

PERSONAL REPRESENTATIVE(S):

NAME | PHONE

ADDRESS | E-MAIL ADDRESS

CITY | STATE | ZIP

NAME | PHONE

ADDRESS | E-MAIL ADDRESS

CITY | STATE | ZIP

SIGNATURE

NAME | DATE