

# Welcome to Hebrew Home of Greater Washington

## AWARD-WINNING LONG-TERM CARE

Hebrew Home of Greater Washington is the largest nursing home in the Mid-Atlantic region. Our long-term care team is dedicated to delivering award-winning quality and person-centered care and promoting the dignity of older adults.



## HEBREW HOME OF GREATER WASHINGTON HIGHLIGHTS

- » Religious services and spiritual care are available to residents of all faiths
- » Restaurant-style, certified kosher dining options
- » On-site amenities include a library, beauty salon, banking services, Wi-Fi access and personal laundry service
- » Access to community events on campus
- » Indoor and outdoor community areas
- » Clinical Excellence Department
- » BCAT® Cognitive Center of Excellence
- » On-site full-time physicians
- » Expert rehabilitation services
- » Recreation therapy programs
- » Individualized, person-centered engagement
- » 24/7 Nursing Care



SCAN TO  
LEARN MORE

HEBREW HOME OF GREATER WASHINGTON

# Quality, Customized Care

At Hebrew Home of Greater Washington, we care for residents with a person-centered approach shaped by our commitment to quality. From expert medical care to welcoming social and spiritual programs, residents have within reach everything they need to live a full life.

## MORNINGS

- » Shakespeare class
- » Creative arts classes
- » Wellness classes
- » Rehabilitation services

## AFTERNOONS

- » Current events discussions
- » Book Club
- » High tea
- » Fitness classes
- » Interactive music programs
- » Culinary events
- » In-suite, 1:1 activities
- » Outdoor activities
- » And of course, Bingo

## EVENINGS

- » Evening movie
- » Music concert
- » Shabbat services

## AT YOUR LEISURE

- » Afternoon concerts
- » Brain fitness featuring BCAT® activities
- » Intergenerational programs
- » Seasonal and holiday celebrations
- » Beauty salon appointments
- » Computer and Wi-Fi access

## DAILY MENU SAMPLE

— Certified Kosher Dining Options —

### BREAKFAST MENU

- » Choice of juices, fresh-baked muffins and cereals
- » Waffles with syrup
- » Oatmeal

### LUNCH MENU

- » Lentil soup
- » Broccoli and cheese quiche
- » S'mores bars

### DINNER MENU

- » Horseradish-crusted salmon
- » Roast chicken and cranberry sauce
- » Chicken soup with matzo balls
- » Baked sweet potato
- » Spinach, onion and mushrooms
- » Bread pudding



HEBREW HOME OF GREATER WASHINGTON

# Services & Rates

## DAILY RATES

Long-term care daily rates are based on assistance needed with activities of daily living including: bathing, eating, dressing, toileting and mobility/transfer.

**LEVEL 1** assistance with 1–2 activities of daily living.....**\$481**

**LEVEL 2** assistance with 3 activities of daily living.....**\$526**

**LEVEL 3** assistance with 4 or more activities of daily living.....**\$556**

**LEVEL 4** assistance with 4 or more activities of daily living and 1 or more specialized services.....**\$568**

*Examples of specialized services: wound care, tube feeding, incontinence care, communicable disease care, stable tracheostomy care, central intravenous line, or peripheral intravenous line.*

## + ADDITIONAL OPTIONS

**Post-Acute Care Center**.....**\$728/day**

**Deluxe Suites**.....**\$110/day**

**Incontinence Supplies**.....**\$10/day**

**Oxygen Concentrators & Supplies**.....**\$20/day**

**Preadmission-Acquired Wound Care**.....**\$35/day**

**Rehabilitation Therapy Services (PT, OT, SP)**.....**\$62/unit**

**Beauty Salon Services**

**In-Suite Telephone and Cable Television Service**

**Personal Transportation**



## Your long-term care daily rate includes:

- » Highly trained nursing staff
- » On-site full-time physicians
- » 24-hour care and services
- » Life enriching activities, events and programming
- » Free Wi-Fi and computer stations
- » Kosher dining menus and culinary services
- » Personal laundry, linens and housekeeping
- » Pastoral counseling and spiritual programming
- » Quarterly resident care plan review
- » Social services
- » Memory care – specially trained associates in BCAT®

**Please note:** Insurance may cover some items not included in the daily rate—such as medications, physician visits, laboratory fees and therapy sessions.

Please complete this application front and back and return to our Admission Office.  
Mail to: **6121 Montrose Road, Rockville MD 20852**, or fax to: 301-770-8518.  
If you have questions about your application, please call 301-770-8476

Today's Date \_\_\_\_\_

## PROSPECTIVE RESIDENT

Mr.  Dr.  Mrs.  Ms.  Miss  Other \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_ Fax \_\_\_\_\_

**Marital Status**  Married  Single  Widowed  Separated  Divorced **US Citizen?**  Yes  No

Social Security Number \_\_\_\_\_ Medicaid Number \_\_\_\_\_

Medicare Number \_\_\_\_\_  Part A  Part B  Medicare HMO/Advantage?

**If you have been in a nursing facility or hospital in the past 60 days, please tell us a little information:**

Name of Facility: \_\_\_\_\_ Date Admitted: \_\_\_\_\_

## SUPPLEMENTAL HEALTH INSURANCE

Policy # \_\_\_\_\_

Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

## LONG-TERM CARE INSURANCE

Policy # \_\_\_\_\_

Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

## MEDICARE PART D

Policy # \_\_\_\_\_

Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

## PERSON TO CONTACT ABOUT APPLICATION

Full Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

## ADDITIONAL CONTACT PERSON

Full Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_

Phone (work) \_\_\_\_\_

Phone (cell) \_\_\_\_\_

Email \_\_\_\_\_

— PLEASE BE SURE TO COMPLETE AND SIGN THE OTHER SIDE OF THIS APPLICATION —

**FINANCIAL PROFILE FOR \_\_\_\_\_**

This information is required for admission. We respect your right to privacy: this information will be kept confidential to be used exclusively for the purpose of admissions. If there is a spouse, please complete pertinent sections. If you need more space, attach additional pages. Please provide two months of financial statements. Additional documents may be requested, up to a five-year history. We would be happy to discuss any special concerns with you.

	<b>APPLICANT</b> How much? How often?	<b>SPOUSE</b> How much? How often?
<input type="checkbox"/> Social Security <input type="checkbox"/> SSI	_____	_____
<input type="checkbox"/> Gov't pension (source _____)	_____	_____
<input type="checkbox"/> Private pension (source _____)	_____	_____
<input type="checkbox"/> IRA, Keogh (source _____)	_____	_____
<input type="checkbox"/> Dividends (itemize)	_____	_____
<input type="checkbox"/> Interest (source _____)	_____	_____
<input type="checkbox"/> Other income (trust funds, rentals, etc.)	_____	_____

**2. ASSETS**

<b>BANK ACCOUNTS/CD'S</b> Bank	Jointly with	Amount on Deposit
_____	_____	_____
_____	_____	_____

<b>STOCKS AND BONDS</b> Company	# Shares	Owned by	Dividend	Market Value
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

<b>REAL ESTATE</b> Locations	Owned by	Mortgage	Market Value
_____	_____	_____	_____
_____	_____	_____	_____

<b>LIFE INSURANCE W/ CASH VALUE</b> Company	Policy owned by	Beneficiary	Cash Value
_____	_____	_____	_____
_____	_____	_____	_____

**OTHER ASSETS** \_\_\_\_\_

**3. TRANSFERS**

Have any resources been sold, transferred, given away or otherwise disposed of within 5 years prior to this application?  Yes  No

If yes, please describe and include date of transfer: \_\_\_\_\_

**4. OUTSTANDING DEBT**

Type \_\_\_\_\_ Amount Due \_\_\_\_\_

I understand that when Medicare coverage or other primary insurance benefits end, the patient will need to pay privately or be eligible for Maryland Medicaid. I certify that all information provided is accurate and complete as of this date, and I understand that any information provided will be used only for the application process and eventual admission. I also direct and authorize the Hebrew Home of Greater Washington to give and receive information from any medical or social work practitioner, social agency, clinic, hospital or nursing home where the patient has been or will potentially be treated.

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

# PRE-ADMISSION MEDICAL HISTORY

## Physician must complete and sign.

Please complete this application front and back and return to our Admission Office.  
Mail to: **6121 Montrose Road, Rockville MD 20852**, or fax to: 301-770-8518.  
If you have questions about your application, please call 301-770-8476.

Today's Date \_\_\_\_\_

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender:  Male  Female      Assessment Date / Date Last Seen \_\_\_\_\_

Patient Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient Phone \_\_\_\_\_ Patient Mobile Phone \_\_\_\_\_

## PHYSICIAN INFORMATION

Physician Name \_\_\_\_\_ Physician Phone \_\_\_\_\_

Physician Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## PATIENT HISTORY

Is patient free from infectious TB?  Yes  No      Determined by:  CXR  PPD      Date \_\_\_\_\_

Allergies \_\_\_\_\_

T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ B/P \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

Diet (include supplements and tube feeding solution)

\_\_\_\_\_  
\_\_\_\_\_

Diagnoses

- |          |           |
|----------|-----------|
| 1. _____ | 8. _____  |
| 2. _____ | 9. _____  |
| 3. _____ | 10. _____ |
| 4. _____ | 11. _____ |
| 5. _____ | 12. _____ |
| 6. _____ | 13. _____ |
| 7. _____ | 14. _____ |

— PLEASE BE SURE TO COMPLETE AND SIGN THE OTHER SIDE OF THIS APPLICATION —

**MEDICATIONS**

Medication	Dosage	Frequency	Route

Are any of the above medications new, being frequently adjusted, or are there any other problems associated with them?

Yes  No

If yes, please explain:

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**OTHER FINDINGS**

Please list any pertinent findings (signs/symptoms, complications, lab results, etc.):

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**HOSPITALIZATIONS**

Have there been any hospitalizations in the last three months?  Yes  No

If yes, please state reason:

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Physician Signature

Date

# FINANCIAL APPLICATION CHECKLIST

## ALL APPLICANTS

Please provide the last four months of financial statements including, but not limited to, the following accounts:

- Bank Accounts
- Money Market Accounts
- Brokerage Accounts
- Trust Accounts
- IRAs
- Credit Union Accounts

## APPLICANTS APPLYING FOR (LTC) LONG-TERM CARE MEDICAID

Has the applicant filed taxes with the IRS in the past five years?

*Provide the complete Federal tax returns to include schedules and 1099s for the past five years.*

Has the applicant NOT filed taxes with the IRS in the past five years?

*Provide the last five years of financial statements for all accounts both open and closed in the past five years (see types of accounts listed above). The required statements for this five year span include January, April, July and October for each of the five years.*

Does the applicant have a life insurance policy(s)?

*Provide ledger page to determine current cash value of the policy. The cash value of a life insurance policy is considered an asset when applying for Medicaid.*

Has the applicant established a trust account?

*Provide copy of related trust account documentation to specify type of trust.*

- Irrevocable
- Medicaid Compliant Annuity
- Revocable
- Special Needs Trust

### *Please note:*

- If additional accounts are discovered in the review of disclosed assets, additional information will be requested and may delay the financial decision for admission.
- All financial information should include applicant and spouse accounts where applicable.
- If applicant is divorced, please provide copy of the divorce decree to determine if alimony is calculated in the assets.

## CONTACT PERSON

**ALL APPLICANTS** must establish a single contact person responsible for providing all supporting documentation to complete the financial review prior to admission. Please specify contact:

Print Name \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_