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

- On-site full-time physicians
- Expert rehabilitation services
- Recreation therapy programs
- Quality Assurance Compliance Department
- Religious services and spiritual care are available to residents of all faiths
- 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

Bethesda 2018 A Top Vote Getter

BEST NURSING HOMES U.S.News & WORLD REPORT 2017-18

ACHCA American College of Health Care Administrators

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
- Therapy sessions
- Rehabilitation services

AFTERNOONS

- Current events discussions
- Book Club
- Men's group
- Women's Red Hat Society
- And of course, Bingo

EVENINGS

- Evening movie
- Music concert

AT YOUR LEISURE

- Sunday afternoon concerts
- Brain fitness
- Intergenerational programs
- Seasonal and holiday celebrations
- Beauty salon appointments
- Computer and Wi-Fi access

A TASTE OF HEBREW HOME

— a sample of our daily menu —

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

APPLICATION

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.

1. INCOME

	APPLICANT How much? How often?	SPOUSE How much? How often?
☐ Social Security ☐ SSI		
☐ Gov't pension (source _____)		
☐ Private pension (source _____)		
☐ IRA, Keogh (source _____)		
☐ Dividends (itemize)		
☐ Interest (source _____)		
☐ Other income (trust funds, rentals, etc.)		

2. ASSETS

BANK ACCOUNTS/CD'S

Bank	Jointly with	Amount on Deposit

STOCKS AND BONDS

Company	# Shares	Owned by	Dividend	Market Value

REAL ESTATE

Locations	Owned by	Mortgage	Market Value

LIFE INSURANCE W/ CASH VALUE

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.
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Mail to: **6121 Montrose Road, Rockville MD 20852**, or fax to: 301-770-8518.
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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. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

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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:

OTHER FINDINGS

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

HOSPITALIZATIONS

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

If yes, please state reason:

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

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.

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

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 _____