HEBREW HOME OF GREATER WASHINGTON

SMITH-KOGOD & WASSERMAN RESIDENCES

Charles E. Smith Life Communities

WELCOME

Thank you for your interest in the Hebrew Home of Greater Washington.

For 105 years, the Hebrew Home has provided expert rehabilitation and compassionate long-term care.

What makes the Hebrew Home so special?

We have, for instance, full-time, on-site physicians who work exclusively for the Hebrew Home. They have a passion for helping senior patients and foster an atmosphere of person-centered care. A rich schedule of programs throughout the day offers choices that enable seniors to continue to enjoy life-long interests. And for those with memory care needs, secure areas with special programming are available.

We can't wait to show you around.

If you need assistance with any portion of the application, or if you wish to arrange a visit, please contact our admissions team at 301.770.8476. They will keep you posted on the status of your application, and the availability of an appropriate placement. Just a note on what to submit:

- Complete personal, insurance, and financial information on the two-sided application form. Mail, fax, email, or bring it in with you, whatever is most convenient.
- Medical information is submitted to our admissions office on the Pre-Admission Medical History and the 3871B Medical Eligibility Review form. Your primary care physician needs to complete both forms.

We know that choosing a new home for yourself or a loved one can be challenging, and we are here to help you through every step and to answer any questions you might have.

Sincerely,

Neal White
Administrator, Hebrew Home

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WELCOME

Thank you for your interest in the Post-Acute Care Center.

For 105 years, the Hebrew Home has provided expert rehabilitation and care. What makes the Hebrew Home such a special choice for recovery and rehabilitation?

Full-time, on-staff, on-site physicians. An outstanding track record for recovery and return home. No additional cost for a private room, freshly redecorated and located on a floor dedicated to post-acute care. The new Dekelboum Rehabilitation Center is an amazing space, with truly advanced equipment and areas to practice daily skills to get back home safely and with confidence.

All post-acute admissions to the Hebrew Home begin with the hospital discharge planner or social worker. They will contact our admissions team and fax the medical information to us at 301.770.8518.

If you need any assistance with the application, or if you wish to arrange a visit, please contact our admissions team at 301.770.8476. We also have a clinical nurse liaison who can come to the hospital to complete a medical assessment, if needed.

Depending on your individual situation:

- **Patients admitting from the hospital under the Medicare Part A benefit** will need to have had a qualifying stay in a hospital (usually three nights or longer), and the attending physician must also recommend sub-acute rehabilitation or skilled nursing. If the hospitalization was less than three nights, see below.
- **Patients with HMO/PPO coverage** will need to have authorization from their insurance company. This process begins with the hospital's discharge planner/social worker. Once initiated, the admissions counselor at the Hebrew Home will follow up with the insurance company.
- **Patients paying privately or those with less than a qualifying hospital stay** will need to complete an application form. A rate sheet is enclosed, and an admissions counselor will answer any questions you might have.

We know that choosing the right place for recovery can be challenging, and we are here to help you through every step and to answer any questions you might have.

Sincerely,

Neal White
Administrator, Hebrew Home

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A TYPICAL **DAY**

As you make your selections from ample choices at mealtimes, you'll find our culinary staff and team are here to meet your needs and tastes. You'll also find that **mealtime is an opportunity to chat with neighbors, be a part of our extended community, and find the assistance you need**. Your day will be designed around you – whether your preference is to find a quiet spot to read the day's news, or to take advantage of our extensive programming.

MORNING

Programs and Trips

Shakespeare class

Art with Lee

"Let's Get Fit"

Music with Liz

Therapy sessions as prescribed

A Taste of the Hebrew Home

Choice of juices, breads, cereals

Hot entrées such as scrambled egg, waffle with syrup, matzo brie, oatmeal with bran

AFTERNOON

Programs and Trips

In the News

Book Club

Torah Portion with Rabbi Michaels

Men's Schmooze Group

Red Hat Ladies group

Bingo

Therapy sessions as prescribed

A Taste of the Hebrew Home

Lentil soup

Broccoli and cheese quiche

Blintzes

S'mores bars

EVENING

Programs and Trips

Evening movie

Poker night

A Taste of the Hebrew Home

Matzo ball soup

Challah and wine

Roast chicken with cranberry sauce

Baked sweet potato

Spinach, onions, and mushrooms

Honey cake

LEISURE TIME

Sunday afternoon concerts • Brain games/trivia • Intergenerational programs • Seasonal and holiday celebrations • Daily minyan available at Wasserman Residence • Oneg Shabbat • Ratner beauty salon appointments available • Computer/technology stations open • Visiting volunteers • Rutstein Wi-Fi Café

Please call 301.770.8476 for further details.

www.hebrew-home.org

1/2015

HEBREW HOME OF GREATER WASHINGTON

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APPLICATION

Date _____

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**.

Please print clearly or type

☐ Mr. ☐ Dr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other _____

PROSPECTIVE RESIDENT _____ Date of birth _____

Address _____

City _____ State _____ ZIP _____

Phone number _____ Religious affiliation _____

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?

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 _____

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

Where? _____

Date admitted _____

Person to contact about this application

Name _____

Relationship _____

Address _____

City _____ State ___ ZIP _____

Phone *Home* _____ *Work* _____

Mobile _____ *Fax* _____

Email _____

Additional person to contact about this application

Name _____

Relationship _____

Address _____

City _____ State ___ ZIP _____

Phone *Home* _____ *Work* _____

Mobile _____ *Fax* _____

Email _____

— Please complete other side and sign application —

OVER >>

FINANCIAL PROFILE FOR _____

Resident's name

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		Spouse	
	How much?	*How often?*	*How much?*	*How often?*
☐ Social Security ☐ SSI				
☐ Gov't pension (Source _____)				
☐ Private pension (Source _____)				
☐ IRA, Keogh (Source _____)				
☐ Dividends (Itemize below) _____				
☐ Interest (Source _____)				
☐ Other income (Trust funds, rentals, etc.) _____				

2. ASSETS — This must reflect current assets for both applicant and spouse.

Bank Accounts/CD's	Bank	Jointly with	Amount on Deposit

Stocks and Bonds	Company	# Shares	Owned by	Dividend	Market Value

Real Estate	Location	Owned by	Mortgage	Market Value

Life Insurance with 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 _____

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PRE-ADMISSION MEDICAL HISTORY

Physician must complete and sign.

Mail to **6121 Montrose Road, Rockville MD 20852**, or fax to **301.770.8518**. Date _____

If you have questions, please call **301.770.8476**.

Please print clearly or type

PATIENT NAME _____ Date of birth _____

Sex: ☐ M ☐ F Assessment date/Date last seen _____

Patient address _____

Phone _____ Mobile phone _____

Physician name _____ Phone _____

Address _____

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 complete second page*

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: _____

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

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

If yes, please state reason: _____

Physician signature: _____ Date _____