MIAMI JEWISH HEALTH SYSTEMS
5200 NE 2nd Avenue
Miami, Florida 33137

ADMISSIONS OFFICE (305) 762-1500

Dear Applicant

Thank you for your interest in the Miami Jewish Health Systems.

Enclosed please find the **long term care application** for our nursing home. In order to expedite process, please complete the application and return the documents listed on page 2 to the Admissions Department at your earliest convenience.

We will be happy to assist you in any way possible to complete the application. Please contact the Admissions Department at 305-762-1500 if you require additional information or assistance.

We look forward to serving your needs!

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Jackie Sardina
Admissions Manager
Phone: 305-762-1500
Fax: 305-675-0927
jsardina@mjhha.org

5200 NE 2nd Avenue
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LONG TERM CARE APPLICATION **CHECKLIST**

The information we are requesting below is vital. Please complete the application and return the documents listed below to the Admissions Department at your earliest convenience. Missing documents may delay the process. If you are unable to submit any documentation, please explain: ______________________________

1. **The Application (pages 3-6 attached)**
2. **Signed "Consent and Release of Information Form" (page 7 attached)**
3. **Copy of Medicare, Social Security, and Insurance Cards**
4. **Copy of applicant's most recent Income Tax Return**
5. **Copy of any Advance Directives, i.e. Living Will, Power of Attorney, Health Care Surrogate, etc.**
6. **Proof of Citizenship or Alien Care: Birth Certificate, Passport**
7. **Copies of the last three (3) months of Bank Statements**
8. **Copies of any Real Estate (land, house, condo, etc.) Maintenance, Property Taxes, Property Insurance, Mortgage Statement.**
9. **Copies of any Life Insurance Policy. A letter stating face value, cash value and loan value.**
10. **Copy of Pre-paid Funeral Arrangements**
11. **Copies of Stocks, Bonds, IRA or any other form of (saving) Assets**
12. **If applicant is married the above information is needed for the spouse as well as the utility bills ex. FPL, Water, Telephone, and Medicare Supplement Insurance. It will be determined by DCF if community spouse can keep monthly income of spouse being placed in the nursing home.**
13. **If private pay we need to collect two months in advance.**
14. **All income must be turn in monthly to the facility, including Social Security Check, Pension, Annuities, VA and all other source of income by the third day of each month.**

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LONG TERM CARE APPLICATION

ADMISSIONS OFFICE (305) 762-1500

I. PERSONAL DATA

NAME ____________________MEDICARE # ___________________ MEDICAID # ___________________S.S. # _________________
ADDRESS _________________________________ APT# __________ CITY ___________STATE _________ZIP CODE ______________
PHONE (____) ____________________ DATE OF BIRTH: _______________ AGE ___________PLACE OF BIRTH: _______________
EMAIL ____
CITIZEN OF ________________________ DATE & PLACE OF NATURALIZATION____
APPLICANT'S FATHER'S NAME _______________________ APPLICANT'S MOTHER'S MAIDEN NAME _________________________
PREVIOUS OCCUPATION ___________________________________ RELIGION _____________________ RACE _________________
DO YOU SPEAK ENGLISH? YES ☐ NO ☐ OTHER LANGUAGES YOU SPEAK ____
EDUCATIONAL LEVEL (Last grade completed) _________________________________MARITAL STATUS _____________________
NAME OF SPOUSE _________________________________ LIVING? YES ☐ NO ☐ (YEAR OF DEATH ________)

II. FAMILY DATA: (List all Living and Pertinent Family Members)

NAME ____ RELIGION/RELATIONSHIP: _______________________________________

PHONE HOME (_____) _____________________ WORK (________) ______________CELL (_________) ______________________
ADDRESS _________________________________ APT# __________ CITY ___________STATE _________ZIP CODE ______________
OCCUPATION ____ AGE __________ MARITAL STATUS ______________________
EMAIL ____

NAME ____ RELATIONSHIP: _______________________________________
PHONE HOME (_____) _____________________ WORK (________) ______________CELL (_________) ______________________
ADDRESS _________________________________ APT# __________ CITY ___________STATE _________ZIP CODE ______________
OCCUPATION ____ AGE __________ MARITAL STATUS ______________________
EMAIL ____

NAME ____ RELATIONSHIP: _______________________________________
PHONE HOME (_____) _____________________ WORK (________) ______________CELL (_________) ______________________
ADDRESS _________________________________ APT# __________ CITY ___________STATE _________ZIP CODE ______________
OCCUPATION ____ AGE __________ MARITAL STATUS ______________________
EMAIL ____

IN ORDER OF PREFERENCE, WHOM DO WE CONTACT IN AN EMERGENCY?

NAME ____RELATIONSHIP: _______________________________________
PHONE HOME (_____) _____________________ WORK (________) ______________CELL (_________) ______________________

NAME ____ RELATIONSHIP: _______________________________________
PHONE HOME (_____) _____________________ WORK (________) ______________CELL (_________) ______________________

III. MEDICAL DATA

WHO IS YOUR PRIMARY CARE PHYSICIAN?

NAME	ADDRESS	PHONE	SPECIALTY
______________	______________	__________	__________

TO WHAT HOSPITALS HAVE YOU BEEN ADMITTED IN THE LAST YEAR?

HOSPITAL	CITY/STATE	DATE	ILLNESS/PROBLEM
______________	______________	__________	______________
______________	______________	__________	______________

TO WHAT OTHER FACILITIES HAVE YOU BEEN ADMITTED TO IN THE LAST 5 YEARS? (ASSISTED LIVING, NURSING HOMES, REHAB CENTER, PSYCHIATRIC FACILITY)?

NAME	ADDRESS	TYPE	LENGTH OF TIME
__________	________________	__________	______________
__________	________________	__________	______________

LIST YOUR CURRENT MEDICAL PROBLEMS: ____

____

LIST ANY ALLERGIES TO FOOD OR MEDICATION ____

IV. DAILY LIVING

DO YOU EMPLOY HELP AT HOME? YES ☐ NO ☐ HOW MANY DAYS? _____ HRS PER DAY ___________

TYPE OF HELP NEEDED: ☐ DRESSING ☐ TOILETING ☐ WALKING ☐ EATING ☐ BATHING
☐ MEDICATING ☐ CLEANING ☐ SHAVING ☐ OTHER______________________

V. RESPONSIBILITY AND INSURANCE

DO YOU HANDLE YOUR OWN FINANCES? YES ☐ NO ☐ IF NO, IS THERE SOMEONE WHO HAS ACCESS TO YOUR MONEY AND COULD HANDLE YOUR FINANCES FOR YOU WHEN NECESSARY? YES ☐ NO ☐

WHO IS THE PERSON RESPONSIBLE FOR YOUR FINANCES?

NAME ________________________________ RELATIONSHIP:________________________

PHONE (__________) ______________ Work (________) ______________ Cell (_________) __________

ADDRESS ______________________ APT# ________ CITY _________ STATE ________ ZIP CODE __________

DOES ANYONE HOLD YOUR POWER OF ATTORNEY? YES ☐ NO ☐

IF YES, WHO HOLDS IT? Name: ______________________ Relationship: ____________________

Phone: (__________) ______________________

DO YOU HAVE ADVANCE DIRECTIVES: ☐ LIVING WILL ☐ DESIGNATION OF HEALTH CARE SURROGATES
☐ DO NOT RESUSCITATE AND LIFE PROLONGING MEASURES ☐ POWER OF ATTORNEY FOR HEALTH CARE

DO YOU AND/OR YOUR FAMILY INTEND TO PAY YOUR COST-OF-CARE? YES ☐ NO ☐

DO YOU HAVE MEDICARE COVERAGE? YES ☐ NO ☐ IF YES, WHICH ONE: PART A ☐ PART B ☐

ARE YOU AN HMO MEMBER? YES ☐ NO ☐
IF YES, WHICH HMO ______________________________

DO YOU HAVE SUPPLEMENTAL INSURANCE? YES ☐ NO ☐
IF YES, NAME OF COMPANY ______________________ POLICY# ______________________

DO YOU HAVE LONG TERM CARE INSURANCE? YES ☐ NO ☐

DO YOU HAVE LIFE INSURANCE? YES ☐ NO ☐
IF YES, LIST BELOW:

COMPANY	POLICY #	FACE VALUE	CASH SURRENDER VALUE

VI. FINANCIAL DATA

A. MONTHLY INCOME FROM:

SOCIAL SECURITY	$__________	PENSION	$__________
V.A. BENEFITS	$__________	INTEREST INCOME	$__________
TRUST INCOME	$__________	STOCK & SECURITIES DIVIDENDS	$__________
ANNUITIES/INSUR. INCOME	$__________	OTHER (______________)	$__________

TOTAL MONTHLY INCOME **$**__________

B. BANK ACCOUNTS (Single and Joint)

1) BANK ______________________ BRANCH ADDRESS: ______________________
ACCT. NO. ______________________ BALANCE $ ______________ TYPE OF ACCT. ______________
MATURITY DATE ______________ IS THERE A DIRECT DEPOSIT TO THIS ACCOUNT? YES ☐ NO ☐
IF YES, FROM WHERE: SOCIAL SECURITY ☐ PENSION ☐ OTHER ______________

2) BANK ______________________ BRANCH ADDRESS: ______________________
ACCT. NO. ______________________ BALANCE $ ______________ TYPE OF ACCT. ______________
MATURITY DATE ______________ IS THERE A DIRECT DEPOSIT TO THIS ACCOUNT? YES ☐ NO ☐
IF YES, FROM WHERE: SOCIAL SECURITY ☐ PENSION ☐ OTHER ______________

3) BANK ______________________ BRANCH ADDRESS: ______________________
ACCT. NO. ______________________ BALANCE $ ______________ TYPE OF ACCT. ______________
MATURITY DATE ______________ IS THERE A DIRECT DEPOSIT TO THIS ACCOUNT? YES ☐ NO ☐
IF YES, FROM WHERE: SOCIAL SECURITY ☐ PENSION ☐ OTHER ______________

C. SECURITIES

1) NAME ______________________ TYPE ______________________
BROKERAGE NAME ______________________ ADDRESS ______________________
OF SHARES ______________________ CURRENT VALUE: ______________________

2) NAME ______________________ TYPE ______________________
BROKERAGE NAME ______________________ ADDRESS ______________________
OF SHARES ______________________ CURRENT VALUE: ______________________

D. REAL ESTATE (Includes land, Homestead, burial plot)

DESCRIPTION OF PROPERTY: ______________________
ADDRESS OF PROPERTY: ______________________
CURRENT MARKET VALUE: $__________ MORTGAGE BALANCE: $ __________ MONTHLY PAYMENT:$__________

DESCRIPTION OF PROPERTY: ______________________
ADDRESS OF PROPERTY: ______________________
CURRENT MARKET VALUE: $__________ MORTGAGE BALANCE: $ __________ MONTHLY PAYMENT:$__________

E. IN THE LAST 3 YEARS, DID YOU SELL/QUIT-CLAIM DEED ANY PROPERTY(S)? YES ☐ NO ☐

F. DO YOU OWN A BUSINESS? YES ☐ NO ☐

VII. FUNERAL POLICY:

DO YOU HAVE A PREPAID FUNERAL POLICY? YES ☐ NO ☐
IF YES, FUNERAL HOME: ______________________

SIGNATURE OF THE APPLICANT: ______________________ **DATE:** __________

SIGNATURE OF PERSON COMPLETING THE APPLICATION: ______________________

PRINTED NAME: ______________________ **RELATIONSHIP:** __________ **DATE:** __________

FOR OFFICE USE ONLY

Date Application Received: ______________________

Date Evaluated at the Clinic: ______________________

Recommended Placement: ______________________

Other Information: ______________________

Miami Jewish Health Systems
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Miami, Florida 33137

RELEASE OF INFORMATION AUTHORIZATION

Patient's Name: ________________________ **Date of Birth:** ________________

Social Security #: ________________

I hereby authorize ________________________ **and request the copies of my medical records be released and sent to Miami Jewish Health Systems.**

For Admission Dates: ________________________

From: ________________________ **to present.**

Information to be released:

Complete medical record to include psychiatric or substance abuse information.

Purpose of Disclosure: ____

Evaluation for admission

I release the above mentioned facility of all responsibility and legal liability for loss of confidentiality by compliance with authorization. I understand I may remove this consent in writing, at any time before the information has been released.

________________________	________________________
Signature of Patient	**Date**
________________________	________________________
Patient Representative (print name)	**Relationship**
________________________	________________________
Signature of Patient Representative	**Date**

PLEASE SEND COPIES OF THE ABOVE REQUESTED INFORMATION TO:

ADMISSIONS DEPARTMENT
MIAMI JEWISH HEALTH SYSTEMS
5200 NE 2ND AVENUE
MIAMI, FL 33137
(305) 762-1500

MIAMI JEWISH HEALTH SYSTEMS

PRIVATE DUTY ASSISTANTS AND COMPANIONS

We have a private duty employment requirement – All certified Nursing Assistants and Companions are required to be registered with and work for a State of Florida licensed Nursing Registry or Home Health Agency in order to work as a caregiver for any resident at the Miami Jewish Health Systems.

This requirement ensures that everyone working at the facility has undergone license verification, a criminal background check, drug screening, a TB test and proof of good health as well as HIV/AIDS training, CPR certification and recent work related references.

We have our own agency – Douglas Gardens Home Care. You are not limited to our agency and may employ your own Certified Nursing Assistant through any Registry/Agency as long as they are licensed in the state of Florida and will pay the aid directly on your behalf. You can be assured that our own nursing staff will continue to supervise the actual care on the units.

Hiring of the attendant will be accomplished by contacting an appropriately licensed Registry/Agency and a private duty attendant will be assigned for the frequency and number of hours desired. The Registry/Agency will bill the family and pay the attendant unless other arrangements are made between you and the Registry/Agency that contracts your private duty aide. Staff members in nursing, social work, medicine and psychology will be available to make recommendations concerning the amount and type of private duty assistance needed; however, they will not be personally involved in the hiring or payment of the attendants.

In compliance with State and Federal requirements, before starting work at MJHS, all attendants are required to attend a 2 hour orientation video provided on the Campus. Also the attendant must report to Social Service office for application and procedures.

OUR PRIVATE DUTY AGENCY

Douglas Gardens Home Care
5200 NE 2nd Avenue
Miami, FL 33137
PH: (305) 762-3880
Fax: (305) 762-3884