REFERRAL PACKET FOR

LONG-TERM CHRONIC CARE HOSPITAL

1200 Centre Street, Boston Ma 02131-1097
[877] 822-4722
www.hebrewseniorlife.org

UPDATED 10/09/20

HARVARD MEDICAL SCHOOL
AFFILIATE

LONG-TERM CHRONIC CARE REFERRAL

Thank you for your interest in the Chronic Care Program and Hebrew SeniorLife, a private, non-profit organization. For over 100 years, the Center has been providing compassionate care to the elderly. Since 1903, the Center has grown from a small home in Dorchester serving a handful of elderly, to an internationally recognized leader in the field of senior care. At the main campus in Roslindale, we provide unparalleled quality of care to our long-term patients. At the Gloria Adelson Field Health Center in Dedham, we have taken our knowledge of delivering quality care one-step further. With this new campus we have turned patient care into a revolutionary movement allowing for more choices in a home environment.

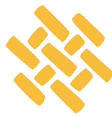
Our long-term patients live in the neighborhoods and are cared for by a team of nurses, certified nursing assistants, a social worker, physician, and recreational therapist. Physical therapy, occupational therapy, creative arts therapy, speech/language pathology, and respiratory therapy are also available as needed to patients of the Centers. Our in-house staff of primary care physicians specializing in geriatric medicine provides comprehensive care to the Centers patients. Complementing the team of physicians, nurses and therapists are specialists in dentistry, podiatry, audiology, dermatology, neurology, cardiology, and more, all of whom are available on-site at the Centers.

We hope you find the enclosed information helpful. In this referral packet you will find answers to frequently asked questions, as well as the cost of care. *If you are interested in admission to one of the Centers, I encourage you to complete the enclosed Referral Packet and related documents and return them to us at your first opportunity.*

If you have never visited the Hebrew Rehabilitation Center or the Gloria Adelson Field Health Center, we invite you to contact the Admissions Department to schedule a tour. Please call us with any questions about the Centers, or the referral process. We appreciate your interest in Hebrew Senior Life and look forward to assisting you.

Once again, thank you for your interest.

UPDATED 10/09/20



HOW TO MAKE A REFERRAL

We understand that the process of making a referral to a Long-Term Chronic Care Program can be challenging. We are committed to helping in the process as much as we can. If you have any questions regarding the referral process, please call us at (617) 363-8372.

To make a referral to the Chronic Care Program at the Centers, please complete and submit the enclosed referral packet. We ask that you provide all of the information requested, including the financial information, and print clearly. Once your referral has been received, both the clinical and the financial assessment can begin.

To help us expedite the admission process, please include with your referral packet:

- ☐ **One authorization form (enclosed) signed by either the applicant or Health Care Proxy (we will gather the applicant's medical records).**
- ☐ **Copies of health insurance cards (both sides)**
- ☐ **Copy of Durable Power of Attorney**
- ☐ **Copy of Health Care Proxy**
- ☐ **Copy of Guardianship Decree (if applicable)**
- ☐ **Verification for all assets listed in financial page of referral form (i.e. bank statements, Trust documents, etc.)**

Please send your Referral Packet and materials listed above to:

Central Admissions Office
1200 Centre Street
Boston, MA 02131-1097

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REFERRAL FOR ADMISSION

☐ **HEBREW REHABILITATION CENTER BOSTON**

☐ **HEBREW REHABILITATION CENTER / DEDHAM AT NEWBRIDGE ON THE CHARLES**

REFERRAL NAME

LAST NAME ______ FIRST NAME ______ MIDDLE ______ GENDER ☐ M ☐ F

STREET ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

RESIDENCE TYPES: ☐ HOUSE ☐ APARTMENT ☐ WITH FAMILY ☐ ASL/NURSING ☐ SENIOR HOUSING

IF AT TEMPORARY LOCATION (E.G. HOSPITAL OR REHAB) PLEASE PROVIDE NAME AND LOCATION ______

( ) HOME PHONE ______ ( ) WORK PHONE ______ ( ) CELL PHONE ______

EMAIL ______

SOCIAL SECURITY NO. ______ AGE ______ BIRTH DATE / / ______ US CITIZEN ☐ Y ☐ N

ETHNICITY: ☐ AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ NATIVE AMERICAN ☐ OTHER

BIRTH PLACE ______ RELIGION ______ PRIMARY LANGUAGE ______

MARITAL STATUS: ☐ SINGLE ☐ PARTNER ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

SPOUSE/PARTNER NAME (IF APPLICABLE) ______

NAME OF PERSON COMPLETING THIS APPLICATION ______

RELATIONSHIP TO REFERRAL ______

HOW DID YOU LEARN ABOUT HRC ______

OFFICE USE ONLY	
DATE RECEIVED: COPY TO FISCAL:	COORDINATOR:

UPDATED 10/09/20

MEDICAL INFORMATION

PLEASE PROVIDE NAME, ADDRESS & PHONE NUMBERS OF REFERRAL'S MEDICAL CARE PROVIDERS:

PHYSICIAN NAME	SPECIALTY	ADDRESS/ZIP	PHONE
	Primary Care		

DOES THE REFERRAL HAVE A PACEMAKER? ☐ **YES** ☐ **NO**
IF YES PLEASE INDICATE PHYSICIAN MANAGING PACEMAKER:

PHYSICIAN NAME	ADDRESS/ZIP	PHONE

PLEASE LIST ANY HOSPITAL ADMISSIONS IN THE PAST 2 YEARS, INCLUDING PSYCHIATRIC AND NURSING HOME ADMISSIONS:

HOSPITAL	DATES	ADDRESS/PHONE	REASON FOR HOSPITALIZATION

HEALTH INSURANCE INFORMATION

You must submit copies of all health insurance cards including Medicare, Medigap (Medex, AARP, etc.), MassHealth, HMOs, other insurance, and notices of eligibility for state or federally funded programs.

MEDICARE INFORMATION

Medicare Number	Are you enrolled in a Medicare HMO (e.g. Secure Horizons, First Seniority)? ☐ YES ☐ NO
Do you have Medicare Part A? ☐ YES ☐ NO Part B? ☐ YES ☐ NO	Do you have Medicare Part D? ☐ YES ☐ NO Insurance I.D. # BIN #: Group No #: Effective Date:
If you are not eligible for Medicare, please explain:	

SUPPLEMENTAL INSURANCE

Plan Name (e.g. Medex Bronze)	Policy #	
Company Name, Address and Phone Number (e.g. Blue Cross of Massachusetts):		
Who is the insured? ☐ Patient ☐ Spouse	Name on Policy (if other than applicant)	
Policy Type ☐ Individual ☐ Group	Group Name (if applicable)	Group # (if applicable)

MASSHEALTH/MEDICAID

MassHealth Number	RID Number	SUFFIX CODE
Date Medicaid Application Filed	Location Filed ☐ Revere ☐ Taunton ☐ Springfield ☐ Tewksbury ☐ Other	
I am not already enrolled on Medicaid, but I believe I may be eligible for Medical Assistance/Medicaid ☐ YES ☐ NO		

UPDATED 10/09/20

FINANCIAL INFORMATION (CONFIDENTIAL)

INCOME	MONTHLY AMOUNT
Social Security	$
SSI	$
Pension	$
Trust	$
Other Monthly Income	$

ASSETS	DESCRIPTION	AS OF (DATE)	VALUE
Real Estate Owned			$
Savings Account			$
Checking Account			$
Retirement Account			$
Stocks and Bonds			$
Other Assets*			$
TOTAL ASSETS: Submit verification/s (recent statements) for above			$

Transferred Assets: Have you transferred any assets in the past 60 months? ☐ **YES, Date** / / ☐ **NO**

If "Yes" Submit Verifications with this application.

LONG-TERM CARE INSURANCE ☐ **YES** ☐ **NO** **(If yes, please provide copy of policy and updated schedule page)**

IS THERE A REVOCABLE OR IRREVOCBALE TRUST ESTABLISHED? ☐ **YES** ☐ **NO** **(If yes, please provide a copy of trust)**

IS THERE A PRE-NEED BURIAL CONTRACT? ☐ **YES** ☐ **NO**

PERSON RESPONSIBLE FOR THE PATIENT'S FINANCIAL MATTERS:

NAME ____________________

ADDRESS ____________________

PHONE ____________________

RELATIONSHIP TO APPLICANT ____________________

CONTACT INFORMATION

PLEASE LIST THE NAMES AND ADDRESSES OF FAMILY MEMBERS AND FRIENDS WHO SHOULD BE CONTACTED WITH INFORMATION AND/OR IN CASE OF EMERGENCY. WE WILL BE USING THIS INFORMATION BOTH PRE-ADMISSION AND ONCE THE REFERRAL HAS BEEN ADMITTED.

EMERGENCY CONTACT #1

☐ MR. ☐ MRS. ☐ MS.

LAST NAME FIRST NAME MIDDLE

STREET ADDRESS CITY STATE ZIP CODE

RELATIONSHIP TO REFERRAL

( ) HOME PHONE ( ) WORK PHONE ( ) CELL PHONE

SEASONAL ADDRESS (IF APPLICABLE) CITY STATE ZIP CODE

FROM / TO / DATES ( ) SEASONAL PHONE EMAIL

ROLE(S) CHECK ALL THAT APPLY

☐ Accountant ☐ Attorney ☐ Durable Power Of Attorney ☐ Elder Advocate ☐ Health Care Proxy ☐ Trustee

☐ Legal Conservator ☐ Legal Guardian ☐ Power of Attorney ☐ Paralegal ☐ Temporary Guardian

EMERGENCY CONTACT #2

☐ MR. ☐ MRS. ☐ MS.

LAST NAME FIRST NAME MIDDLE

STREET ADDRESS CITY STATE ZIP CODE

RELATIONSHIP TO APPLICANT

( ) HOME PHONE ( ) WORK PHONE ( ) CELL PHONE

SEASONAL ADDRESS (IF APPLICABLE) CITY STATE ZIP CODE

FROM / TO / DATES ( ) SEASONAL PHONE EMAIL

ROLE(S) CHECK ALL THAT APPLY

☐ Accountant ☐ Attorney ☐ Durable Power Of Attorney ☐ Elder Advocate ☐ Health Care Proxy ☐ Trustee

☐ Legal Conservator ☐ Legal Guardian ☐ Power of Attorney ☐ Paralegal ☐ Temporary Guardian

CONTACT INFORMATION CONTINUED

EMERGENCY CONTACT #3

LAST NAME | FIRST NAME | MIDDLE | ☐ MR. ☐ MRS. ☐ MS.

STREET ADDRESS | CITY | STATE | ZIP CODE

RELATIONSHIP TO APPLICANT

( ) HOME PHONE | ( ) WORK PHONE | ( ) CELL PHONE

SEASONAL ADDRESS (IF APPLICABLE) | CITY | STATE | ZIP CODE

FROM / TO / DATES | ( ) SEASONAL PHONE | EMAIL

ROLE(S) CHECK ALL THAT APPLY

☐ Accountant ☐ Attorney ☐ Durable Power Of Attorney ☐ Elder Advocate ☐ Health Care Proxy ☐ Trustee

☐ Legal Conservator ☐ Legal Guardian ☐ Power of Attorney ☐ Paralegal ☐ Temporary Guardian

EMERGENCY CONTACT #4

LAST NAME | FIRST NAME | MIDDLE | ☐ MR. ☐ MRS. ☐ MS.

STREET ADDRESS | CITY | STATE | ZIP CODE

RELATIONSHIP TO APPLICANT

( ) HOME PHONE | ( ) WORK PHONE | ( ) CELL PHONE

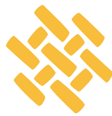
SEASONAL ADDRESS (IF APPLICABLE) | CITY | STATE | ZIP CODE

FROM / TO / DATES | ( ) SEASONAL PHONE | EMAIL

ROLE(S) CHECK ALL THAT APPLY

☐ Accountant ☐ Attorney ☐ Durable Power Of Attorney ☐ Elder Advocate ☐ Health Care Proxy ☐ Trustee

☐ Legal Conservator ☐ Legal Guardian ☐ Power of Attorney ☐ Paralegal ☐ Temporary Guardian



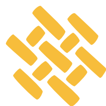
The next form is an authorization form that allows Hebrew SeniorLife to request medical records from doctors and/or hospitals on your behalf.

Please ONLY fill out the referral's name, date of birth and Social Security number. **IF POSSIBLE, PLEASE HAVE THE REFERRED INDIVIDUAL SIGN THESE FORMS.** This form may also be signed by the Health Care Proxy if the referred individual is not able to sign for themselves.

If you have any questions, feel free to contact us at 617-363-8372.

Thank you for your cooperation.

Sincerely,



Central Admissions
1200 Centre Street
Boston, MA 02131-1097

UPDATED 10/09/20

AUTHORIZATION FORM / FOR THE RELEASE OF PROTECTED HEALTH INFORMATION TO HSL

PATIENT NAME (PLEASE PRINT)

/ /

DATE OF BIRTH

SOCIAL SECURITY NUMBER

By signing this Authorization Form, I understand that I am giving my authorization to HSL's designated medical record or database custodians to request my protected health information (PHI) from the following person(s) or organization(s) named below:

NAME OF HEALTH CARE PROVIDER

STREET ADDRESS

CITY

STATE

ZIP CODE

( )

TELEPHONE NUMBER

( )

FAX NUMBER

I specifically authorize the use and disclosure of the following PHI: ______________________________

The information to be used or disclosed pursuant to this authorization form may include information relating to behavioral and mental health observations, which are part of the medical record.

I may revoke this authorization at any time by notifying HSL in writing to the Medical Records Department/1200 Centre Street/Boston, MA 02131-1097 of my intent to revoke this authorization. A revocation form can also be obtained by contacting the Medical Records Department. However, I also understand that such a revocation will not have any effect on any information already disclosed to HSL before HSL received my written notice of revocation.

Unless earlier revoked, this authorization will expire on the 180th day of signing or as otherwise specified below:

If neither federal nor state privacy laws apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by privacy laws.

I may impact and receive a copy of the information to be used and disclosed pursuant to this Authorization form. Please make such intentions clear to the Medical Records Custodian when submitting the Authorization form.

This Authorization is voluntary and I may refuse to sign this form.

I understand that I am not required to sign this authorization form in exchange for receiving treatment form HSL.

SIGNATURE OF PATIENT OR HEALTH CARE PROXY

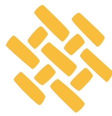
DATE

PRINTED NAME OF PATIENT

PRINTED NAME OF HEALTH CARE PROXY (IF APPLICABLE)

RELATIONSHIP GIVING REPRESENTATIVE AUTHORITY TO ACT FOR PATIENT (IF APPLICABLE)

UPDATED 10/09/20



FREQUENTLY ASKED QUESTIONS

WHAT DOES 24/7 CARE MEAN?

- Our nursing team is available 24/7 in a communal setting with shared resources
- Each patient is assigned to a primary Nurse and PCA
- Integrated multi-disciplinary care is provided based on an assessment with medical providers available on-site or by phone
- We will provide a complete contact list for your loved one's care team upon admission

WHAT KIND OF REHAB SERVICES DO WE PROVIDE?

- Physical Therapy, Occupational Therapy, Speech Language Pathology, and Expressive Therapy
- An assessment to determine rehab needs will be conducted within 7 business days of admission

CAN I KEEP MY PRIMARY CARE PROVIDER?

- One of our clinicians will be your primary medical provider and will make outside referrals as deemed necessary by the Primary Care Provider

CAN I BRING IN OUTSIDE SERVICES FOR MY LOVED ONE?

- Outside medical professionals are not permitted
- Private companions are allowed at 3rd party expense and need to follow HSL policy (i.e. companions cannot provide care)

CAN I BRING MY OWN MEDICATION?

- All medications must to be approved by an HSL provider and pharmacist

CAN MY LOVED ONE LEAVE THE FACILITY FOR NON-MEDICAL VISITS?

- Patients may leave for up to 6 hours/day
- Overnight stays are not permitted
- Medical approval by a provider and 48 hours of notice to the nursing team are required

DOES SOMEONE ACCOMPANY MY LOVED ONE DURING OUTSIDE MEDICAL APPOINTMENTS TO SEE SPECIALISTS OR FOR PROCEDURES?

- Families are encouraged to accompany loved ones to specialists
- If families are unable to attend, and if it is a medically necessary appointment, we will provide an accompanying staff member

HOW DO YOU PROVIDE 24/7 CARE?

- Routine checks are individualized according to the needs of the patient
- We are a restraint, bed alarm, and chair alarm-free facility

WHO WILL HRC CONTACT IF NECESSARY?

- The Health Care Agent will be the point of contact
- If the Health Care Proxy and/or patient request involvement of another family member, this needs to be communicated to the health care team and that any medical decision would still be the responsibility of the Health Care Proxy Agent

HOW FREQUENTLY SHOULD YOU EXPECT THAT HSL WILL CONTACT YOU?

You can expect to be contacted for the following:

- Change in medical/mental status
- Significant medication change
- Semi-annual Care Coordination meetings
- Quarterly check-ins from floor team leadership
- Outbreak of illness and temporary floor closures
- Invitation to events
- Significant organizational changes/updates

WHAT IS THE TYPICAL POPULATION AND THE SOCIAL ENVIRONMENT ON THE FLOOR?

- Each floor has patients with varying cognitive and physical abilities
- We offer center-wide programming and social activities for patients of all levels
- Opportunities for interaction with patients from other floors
- We constantly assess a patient's needs and interests, and encourage appropriate activities. ***It is the patient's choice to attend.***

WHAT IS MY ROLE AS A FAMILY MEMBER?

- You are complementary to our team and are encouraged to share input on your loved one's likes and desires or any observed changes
- You are welcome to attend activities with your loved one

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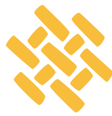


OFF-CAMPUS VISIT FACT SHEET

Can my loved one leave the premises of the Hebrew Rehabilitation Center?

Yes, if your loved one is approved for an off-campus visit, they may leave the facility in accordance with our policies and procedures. Due to the need to ensure safety, we cannot allow overnight visits.

What is an off-campus visit?

An off campus visit is any trip outside the facility (for a maximum duration of 6 hours) with a family member/companion/ or responsible person that has been approved as safe by the health care team. Additionally, the off campus visit procedures will only be in place for trips off campus for non-medical reasons.

How can my loved one be approved for an off-campus visit?

A provider must evaluate anyone who wishes to go out of the facility to determine whether they are medically stable and able to be safe while out of the facility for a short span of time (less than 6 hours). Upon receipt of a formal request for an off-campus leave, your loved one will be evaluated and if the provider and care team feel a leave is safe, the medical provider will place an order to approve the visit.

Is a new medical order for an off campus visit needed every time my loved one wishes to go out?

No, a medical order for an off-campus visit will be good for three months provided there is no acute medical situation, such as change in mental status, or any change in condition that would impact your loved one safely leaving the facility.

Can my loved one go off campus at any time?

The family and individual seeking time off campus must collaborate with the nursing staff to determine a time that best coordinates care and medication administration.

How can I coordinate an off-campus visit if my loved one will require medications during this time?

Staff cannot provide medications to be administered outside of the facility on short notice, so the health care team needs to consider if the medication times can be altered to accommodate the off-campus visit. In situations that are planned and medications is needed, staff and pharmacy require 48 hours of advance notice for the pharmacy to prepare and dispense medications for a trip off campus.

On the day of an off-campus visit, what is the process for leaving and returning to the facility?

The family member/activated health care agent/individual/responsible person must verbally communicate and receive approval from the floor nurse to take their loved one out of the facility and communicate the time of return. Upon return back to the floor, the family member must check in with the nursing staff so an evaluation from the nurses can be made and medications and treatments provided as needed.

Are there circumstances in which my loved one can go out of the facility for longer than 6 hours?

In limited circumstances, an exception may be granted for an off-campus visit for lasting longer than 6 hours. The clinical team, in collaboration with the individual/activated health care agent/designee, may develop a plan as long as the care team feels that safe care and coordination of care can be maintained for the extended period of time.

UPDATED 10/09/20

LONG-TERM CHRONIC CARE PRICING

HEBREW REHABILITATION CENTER, EFFECTIVE OCTOBER 1, 2020, SUBJECT TO CHANGE

Hebrew Rehabilitation Center provides extended medical and rehabilitative care for patients with long-term chronic or serious illnesses at locations in Boston and at NewBridge on the Charles in Dedham. At either location, you can expect the same quality of care that Hebrew Rehabilitation Center has been offering since 1903.

Rates are on a per-day basis by room type and offer options for MassHealth members and those paying privately for their care. For more information, contact the Admissions Office at 617-363-8372.

TRADITIONAL

	Boston		Dedham	
Room	**Daily Rate**	**Private Room Supplement**	**Daily Rate**	**Private Room Supplement**
Semi Private (Shared Bath)	$515 – $530	0		
Private (Shared Bath)	$540 – $555	$25	$595	0
Preferred Private (Private Bath)	$565 – $575	$45	$641	$45

MEMORY CARE

	Boston		Dedham	
Room	**Daily Rate**	**Private Room Supplement**	**Daily Rate**	**Private Room Supplement**
Semi Private (Shared Bath)	$550	$0		
Private (Shared Bath)	$590	$25	$602	0
Preferred Private (Private Bath)	$610	$45	$660	$60

MassHealth covers semi-private accommodation; however, a MassHealth member who wishes private accommodation may have a third party pay the daily private room supplement. If a private pay, private room patient converts to MassHealth and would like to remain in a private room, third party payment of the private room supplement is expected. If the patient declines to pay the private room supplement, the patient will be placed on a waiting list for the next available private room with a shared bath or semi-private room.

UPDATED 10/09/20

ADMISSION NOTICE: NOTICE OF MEDICARE NON-COVERAGE

PATIENT NAME ______________________

ADMISSION DATE/DATE OF NOTICE ______________________

ATTENDING PHYSICIAN ______________________

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear ______________________,

The Hebrew Rehabilitation Center has reviewed your application and we believe that Medicare is not likely to pay for your admission for **ONGOING MANAGEMENT AND THERAPEUTIC CARE FOR YOUR MEDICAL CONDITION(S) DO NOT REQUIRE INPATIENT HOSPITAL CARE.** This notice, however, is not an official Medicare decision. This determination was based upon the Hebrew Rehabilitation Center's understanding and interpretation of the available Medicare coverage policies and guidelines.

IF YOU DISAGREE WITH OUR FINDING:

- You should talk to your doctor about this notice and any further health care you may need.
- You also have the right to an appeal, that is, an immediate review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to make formal decision about whether your admission is covered by Medicare. See page 2 for instructions on how to request a review and contact the QIO.

IF YOU DECIDE TO GO AHEAD WITH THE ADMISSION, YOU WILL HAVE TO PAY FOR:

- ☐ Customary charges for all services furnished after the receipt of this notice, except for those services for which you are eligible under Medicare Part B (for admission notices issued not later than 3:00PM on the date of admission.)
- ☐ Customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Medicare Part B (for admission notices issued after 3:00PM on the day of admission.)

IF YOU WANT AN IMMEDIATE REVIEW OF YOUR CASE:

- Call the QIO immediately at the number listed below or you may call the QIO at any point during your stay.
- You may also call the QIO for quality care issues.

— QIO CONTACT INFORMATION: KEPRO AT 1-888-319-8452 OR TTY: 1-855-843-4776 —

IF YOU DO NOT WANT AN IMMEDIATE REVIEW:

- You may still request a review 30 calendar dates from the date of receipt of this notice by calling the QIO at the number above.

RESULTS OF THE QIO REVIEW:

- The QIO will send you a formal decision about whether your stay is appropriate according to Medicare's rules and will tell you about your reconsideration and appeal rights.
  - IF THE QIO FINDS THAT YOUR FACILITY CARE IS COVERED, you will be refunded any money you may have paid the facility except for any applicable co-pays, deductibles, and convenience items or services normally not covered by Medicare.
  - IF THE QIO FINDS THAT YOUR FACILITY CARE IS NOT COVERED, you are responsible for payment for all non-covered services beginning on ____________ (Date of notice as explained in this notice).

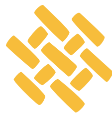
— FOR MORE INFORMATION YOU MAY CALL 1-800-MEDICARE (1-800-633-4227), OR TTY 1-877-486-2046 —

Please sign your name, the date and time. Your signature does not mean that you agree with this notice, just that you received the notice and understand it.

SIGNATURE OF PATIENT OR REPRESENTATIVE ______________________ DATE / TIME ______________________

PLEASE PRINT NAME ______________________

UPDATED 10/09/20



HARVARD MEDICAL SCHOOL
AFFILIATE

WHAT IS THE PATIENT PAID AMOUNT?

The Patient Paid Amount (PPA) is the monthly mount of income that Medicaid determines the patient must contribute toward own care starting in the first month of Medical eligibility.

How to calculate your PPA:

Your PPA = (Total amount of your monthly income) – (Total amount of allowances)

Examples of monthly income:

Social Security (Net), Supplemental Security Income (SSI), Pension (Gross), Annuity, Veteran's benefits, Trust and Dividends

Examples of allowances:

Personal Needs Allowance*(PNA/$72.80 per month), Health Insurance Premiums, Medicare Part D Prescription Premium, VA Allowance, Community Spouse Resource Allowance, and Guardianship Fees.

**Personal Needs Allowance (PNA) is the monthly sum of money that patient who receives Medicaid (MassHealth) may retain from their personal income.*

For Medicaid (MassHealth) recipient, it is important to keep your assets below $2,000, which is the Medicaid regulation. During the transition period from Medicaid-pending to Medicaid eligibility, monies that would be classified as "income" should not be spent on anything except PPA payments to Hebrew Rehabilitation Center (HRC).

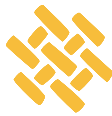
The best practice is to have Social Security, Pension, Annuity, and etc. directed to HRC by allowing us to become representative payee. HRC requires [patient's signature to authorize the direct deposit.

What does HRC have to do with the PPA that is directly deposited?

- HRC transfers the PNA ($72.80) into the patient's Personal Needs Account at HRC, where it is available for the patient to spend at the beauty salon, gift shop and etc.
- HRC pays the supplement insurance premium.
- The rest of the PPA goes toward paying for patient's care.

If you have any questions, please feel free to contact Admission Coordinator at Fiscal Services Department at 617-971-5828.

UPDATED 10/09/20



PATIENT PAID AMOUNT (PPA) AGREEMENT

Upon admission, Hebrew Rehabilitation Center (HRC) shall provide Long-Term Chronic Care services to you in exchange for payment. You are responsible for paying for the care and services we provide to you.

HRC participates in the Medicaid Program (also known as MassHealth) as a provider of the Long-Term Chronic Care services and agrees to accept payment from Medicaid in lieu of our customary daily private rate. You, however, remain responsible for paying the Patient Paid Amount (PPA) and charges for items and services Medicaid does not cover. The PPA is the amount of monthly income that Medicaid determines you must contribute to the cost of your care.

By signing this agreement, you do hereby agree to have your monthly PPA directed to HRC by allowing us to become representative payee. Please note that you may be responsible for any other items and services not covered under Medicaid.

Failure to comply with Medicaid regulations concerning PPA payments may result in termination of Medicaid coverage and involuntary discharge from HRC.

- Will agree to allow HRC representative payee for Social Security benefits
- Will agree to allow HRC representative payee for Pension/Annuity benefits

PATIENT SIGNATURE DATE

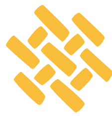
PATIENT'S AUTHORIZED REPRESENTATIVE SIGNATURE DATE

PATIENT'S AUTHORIZED REPRESENTATIVE

WITNESS SIGNATURE DATE

PRINT NAME

UPDATED 10/09/20



Hebrew Rehabilitation Center

Hebrew SeniorLife

HARVARD MEDICAL SCHOOL AFFILIATE

SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENT IN LONG-TERM CHRONIC CARE PROGRAM

Supplemental Security Income (SSI) decreases to $72.80/month on the day patient is admitted into Long-Term Chronic Care facility with Medicaid bebenfits.

- It may take several months for Social Security office to notify you that the amount has changed, and you may continue to receive full benefits each month. However, please do not spend more than the allotted amount of $72.80 per month.
- In case of any overpayment, you will receive a letter from Social Security office and be asked to pay back any overpayment that has been made.

ANY Patient admitted to a Long-Term Chronic Care facility with Medicaid benefits is only entitled to $72.80 per month.

- Once admitted to Long-Term Chronic Care facility, Social Security office will split the household benefit and issue individual Social Security payments for any patient with a spouse each month.
- Once the spouse admitted to Hebrew Rehabilitation Center (HRC) will receive the SSI decrease of $72.80
- Please note until Social Security office has decreased the patients' benefits and all funds have been redirected to the HRC, **the outside bank account must remain open.**

Please arrange to have SSI ($72.80/month) come directly to Hebrew Rehabilitation Center (HRC) and placed in the patient's Personal Needs Account at HRC, where it is available for the patient to spend personal expenses at the beauty salon, gift shop, etc.

If you have any questions, please feel free to contact Admission Coordinator at Fiscal Services Department at 617-971-5828.

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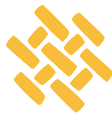

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LONG-TERM CHRONIC CARE PROGRAM DAILY RATE INFORMATION

1) The daily room rate* includes the routine services and amenities that are NOT covered by Medicare Part B, such as**

- Room and board
- Routine nursing services and routine personal care assistance
- Linen and laundry service
- Medications***
- On-site vision and hearing (subject to HRC program guidelines)
- On-site recreational and wellness activities, religious services, cultural programs, and social events

2) Additional charges apply for the physician, nurse practitioner, rehab (physical, occupational, speech therapy), radiology, lab, and other medical services. These services are typically covered by the patient's Medicare Part B and Medigap policies.**

3) The following optional services are available for additional fees:

- Telephone service
- Cable television service
- On-site beauty parlor and barber shop
- Dry cleaning, newspaper delivery, guest meals, off-site events

***The routine services listed in 1) above are NOT covered by Medicare Part A (Hospital), Medicare Part B (Medical), or Medicare Supplement Insurance (Medigap); they must be paid by personal funds, long-term care insurance, and/or for those who have met the eligibility requirements, by Long-Term Care MassHealth (Medicaid).**

Per 2) above, Medicare Part B and Medigap insurance cover Part B – billable services such as physician/ nurse practitioner, therapies, (physical, occupational, and speech), radiology and lab. Patient needs to be enrolled in Medicare Part B or in an equivalent plan that covers part B-covered services. HRC recommends that patient also carries a Medicare Supplement Insurance policy to cover deductible and coinsurance. **Unless patient is on MassHealth (Medicaid), HRC will bill any portion of these 2) services not paid by Medicare Part B or Medigap insurance to the patient.

If a patient is enrolled in a Medicare HMO-type insurance plan, HRC will assist with conversion back to regular Medicare A and B as soon as possible. The care management and referrals authorizations provided by such an HMO plan no longer apply once the patient is admitted to the HRC long-term chronic care program, since care is managed by HRC's network of physicians and providers, making the HMO plan no longer appropriate.

*****Medications. It is important patient maintains enrollment in a Medicare Part D prescription drug plan.** As a service to you HRC will bill the Medicare part D plan on behalf of the patient. Once a patient qualifies for MassHealth (Medicaid), it is switched to a zero-premium Medicare Part D plan.

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/ /

PATIENT NAME (PLEASE PRINT) DATE OF BIRTH

NAME YOU PREFER TO BE CALLED AGE

WHERE WERE YOU BORN?

WHERE DID YOU GROW UP?

WHAT IS YOUR PRIMARY LANGUAGE?

HOW DO YOU IDENTIFY? (PLEASE CHECK)

- ☐ MALE
- ☐ FEMALE
- ☐ TRANSGENDER

(PLEASE CHECK)

- ☐ HETEROSEXUAL
- ☐ BISEXUAL
- ☐ LESBIAN
- ☐ GAY

FAMILY/FRIENDS/PETS

SPOUSE / SIGNIFICANT OTHER:

NAME AGE CITY OF RESIDENCE ☐ LIVING ☐ DECEASED

OTHER SIGNIFICANT RELATIONSHIPS: (CHILDREN, GRANDCHILDREN, SIBLINGS, FRIENDS....)

1. NAME RELATIONSHIP AGE SPOUSE CITY OF RESIDENCE ☐ LIVING ☐ DECEASED
2. NAME RELATIONSHIP AGE SPOUSE CITY OF RESIDENCE ☐ LIVING ☐ DECEASED
3. NAME RELATIONSHIP AGE SPOUSE CITY OF RESIDENCE ☐ LIVING ☐ DECEASED
4. NAME RELATIONSHIP AGE SPOUSE CITY OF RESIDENCE ☐ LIVING ☐ DECEASED
5. NAME RELATIONSHIP AGE SPOUSE CITY OF RESIDENCE ☐ LIVING ☐ DECEASED
6. NAME RELATIONSHIP AGE SPOUSE CITY OF RESIDENCE ☐ LIVING ☐ DECEASED

PETS:

1. PETS NAME TYPE OF PET COMMENTS
2. PETS NAME TYPE OF PET COMMENTS
3. PETS NAME TYPE OF PET COMMENTS

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EDUCATION

NAME OF SCHOOL / UNIVERSITY	DEGREE	YEARS ATTENDED	COMMENTS
NAME OF SCHOOL / UNIVERSITY	DEGREE	YEARS ATTENDED	COMMENTS

MILITARY SERVICE

☐ YES ☐ NO

BRANCH / RANK	YEARS SERVED	WARTIME SERVICE	COMMENTS

EMPLOYMENT HISTORY

HISTORY OF JOBS HELD COMMENTS

1.

2.

3.

SOCIAL ACTIVITIES

FAVORITE HOBBIES / ACTIVITIES / MUSIC/ TRAVEL/ SPORTS

1.

2.

3.

CLUBS / MEMBERSHIPS (PAST OR PRESENT)

1.

2.

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LIFESTYLE/CHARACTER

HOW WOULD YOU DESCRIBE YOUR PERSONALITY?

WHAT IS CALMING OR SOOTHING TO YOU? WHAT MAKES YOU HAPPY?

WHAT IRRITATES/ BOTHERS OR FRUSTRATES YOU?

SIGNIFICANT EVENT(S) THAT HAVE IMPACTED YOUR LIFE:

ANY OTHER CONCERNS/ISSUES YOU WOULD LIKE TO SHARE:

RELIGION/SPIRITUALITY

RELIGIOUS BACKGROUND:

CURRENT SPIRITUAL / RELIGIOUS NEEDS:

DAILY ROUTINE

DESCRIBE TYPICAL AM ROUTINE:

DESCRIBE TYPICAL PM ROUTINE:

SLEEP SCHEDULE

WAKING TIME: ____________ **BEDTIME:** ____________ **NAPS:** ____________

BEDTIME ROUTINE: ____________

ACTIVITIES OF DAILY LIVING

DO YOU NEED ASSISTANCE WITH THE FOLLOWING? (CHECK YES OR NO)

	YES	NO	EQUIPMENT USED (PLEASE CHECK)	OTHER INFORMATION
BATHING	☐	☐	☐ GRAB BARS ☐ SHOWER CHAIR ☐ HAND-HELD SHOWER (IF AVAILABLE) FREQUENCY: ______	PREFERENCE (PLEASE CHECK): ☐ SHOWER ☐ SPONGE BATH
GROOMING	☐	☐		PREFERENCE: ______
DRESSING / UNDRESSING	☐	☐		PREFERENCE: ______
TOILETING	☐	☐	PLEASE CHECK: ☐ RAISED TOILET SEAT ☐ COMMODE ☐ URINAL ☐ ADULT BRIEFS ☐ UNDERGARMENTS ☐ PADS	PLEASE CHECK: ☐ CONTINENT ☐ INCONTINENT, BLADDER ☐ INCONTINENT, BOWEL
WALKING	☐	☐	☐ WALKER ☐ WHEELCHAIR ☐ CANE ☐ BRACE OTHER: ______	
CURRENT MODE OF TRANSFERS (CHAIR TO BED, ETC.):	☐	☐	☐ MECHANICAL LIFT ☐ ASSISTANCE FROM OTHER PEOPLE OTHER: ______	
EATING	☐	☐	DENTURES? ☐ UPPER ☐ LOWER ☐ PARTIALS	FEEDING TUBE? ☐ YES ☐ NO

HOW DO YOU LIKE TO TAKE MEDICATION? ☐ WITH WATER ☐ WITH JUICE ☐ WITH APPLESAUCE

OTHER: ______

FOOD/ALLERGIES

SPECIAL DIET: ______

FAVORITE FOODS / SNACKS: ______

FOOD ALLERGIES: ______

OTHER ALLERGIES: ______

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COMMUNICATION

DO YOU HAVE ANY DIFFICULTIES COMMUNICATING OR UNDERSTANDING? (PLEASE CIRCLE)

NO ISSUES NAMING OBJECTS HAVE FEW WORDS FOLLOWING CONVERSATIONS

WORD FINDING MAKING NEEDS KNOWN UNDERSTANDING INSTRUCTIONS OTHER: ____________

COMMENTS: ____________

VISION

ADAPTIVE EQUIPMENT NEEDED: GLASSES CONTACTS OTHER: ____________

COMMENTS: ____________

HEARING

DO YOU HAVE DIFFICULTY HEARING? YES NO

ADAPTIVE EQUIPMENT USED: HEARING AIDE AMPLIFICATION DEVICE

HEARING AIDS: LEFT RIGHT

COMMENTS: ____________

ADDITIONAL INFORMATION

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW? ____________

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