St. Joseph's Home since 1886...

Skilled Nursing Care

Thank you for your interest in St. Joseph's Home.

St. Joseph's Home is a not for profit 82 bed skilled nursing facility that has been providing care since 1886. It is licensed by the New York State Department of Health and is affiliated with the Roman Catholic Diocese of Ogdensburg.

St. Joseph's Home is dedicated to providing a comprehensive program including: Medical, Social, Nursing, Spiritual, Rehabilitation, and Support Services.

This packet includes:

1. Application for admission
2. Pre-admission study
3. Pre-admission physical form

If you have any questions, or you need assistance completing the forms, please do not hesitate to call us. We can be reached at (315) 393-3780 ext. 1014.

950 Linden Street . Ogdensburg, New York 13669
315-393-3780 . Fax: 315-393-3847
Web Site: www.stjh.org

St. Joseph's Home
Ogdensburg, New York

The Long Term Care Application Process

1) The completed application should be returned to the Social Services office, St. Joseph's Home. It is imperative that complete and accurate information be provided and if clarification of any questions is required, please call (315) 393-3780, Ext. 1014.

2) A physician's pre-admission physical form is required if the applicant resides in the community and will be forwarded to the identified family physician by our Social Worker. If the applicant is in the hospital or another nursing facility, all required information will be gathered by our Social Worker.

3) A PRI (Patient Review Instrument) must be completed for applicants residing in the community. This assessment helps the nursing home in determining the level of care required. This form requires updating if placement does not take place within ninety days. The cost of the assessment is $200 and is paid out of pocket.

4) Please include the following documents along with the application to St. Joseph's Home
   - Health Care Proxy
   - Do Not Resuscitate orders (DNR) / MOLST form
   - Living Will
   - Power of Attorney
   - Insurance cards
   - Social Security card
   - Medicare card
   - Medicaid card / Managed Long Term Care Card
   - Prescription drug plan card
   - COVID vaccination card

   We would be happy to make copies of this information for you.

5) Financial information: Our Facility does not accept Medicaid pending status. Payments that are accepted include Private Payment or Medicaid approved.
If you need to apply for Medicaid coverage our social worker can assist you in obtaining the documents and discussing specifics of the process.

6) St. Joseph's Home has a respite program, two (2) rooms to accommodate short-stay admissions. The services are pre-arranged and limited to one or more periods from five (5) to thirty (30) days not to exceed more than 42 days in any one year. A stay of less than five (5) days may be approved on an exception basis.

7) Whenever possible, we recommend the applicant and/or family arranges to visit out home for a tour.

ST. JOSEPH'S HOME
Ogdensburg, New York 13669

2022 ITEMIZED COSTS

ROOM AND BOARD:

Private Room	$292.10 Per Day
Semi-Private Room	$ 283.97 Per Day

PHYSICAL THERAPY	$ Per Medicare Schedule
OCCUPATIONAL THERAPY	$ Per Medicare Schedule
SPEECH THERAPY	$ Per Medicare Schedule

PHARMACY BILLS CHARGES

ANCILLARY COSTS: Per Medicare Schedule

Application for Admission
To Residential Health Care Facilities in
St. Lawrence County

General Information

Name _____ Phone_____

Legal Address _____

Present Location _____

Date of Birth_____Social Security #_____

□ Married □ Single □ Widowed □ Separated □ Divorced

Spouse or Significant Other's Name_____

Sex □ Male □ Female Place of Birth_____ U.S. Citizen □ Yes □ No

Father and Mother's Names_____

Religion (optional)_____ Occupation:_____

Personal Physician _____

Type of Admission: □ Long Term Care □ Short Term Rehabilitation

Relatives/Friends To Be Notified In Emergency

Name _____

Address_____

City _____ State ___ Zip _____

Relationship_____

Home#_____ Work# _____

Cell# _____ Email _____

Name _____

Address _____

City_____State ___ Zip _____

Relationship _____

Home# _____ Work#_____

Cell# _____ Email,_____

Please Include Copies Of Documents Below

Health Care Proxy

Living Will

DNR Order

Body Donor ☐ Yes ☐

Organ Tissue Donor No

MOLST Form

Where Would You Like This Application Sent (Please Check)

☐ Maplewood Healthcare and Rehabilitation Center
(dba for United Helpers Canton Nursing Home, Inc.)
205 State St. Road
Canton, New York 13617

☐ St. Joseph's Home
950 Linden Street
Ogdensburg, New York 13669

☐ North Country Rehab and
Nursing Center
182 Highland Road
Massena, New York 13662

☐ Massena Rehab & Nursing Center
89 Grove Street
Massena, New York 13662

☐ Clifton Fine Hospital Long Term Care
1014 Oswegatchie Trail
PO Box 10
Star Lake, NY 13690

Funeral Arrangements

Funeral Home or Person Responsible for Funeral

Name _____ Address _____ Phone Number _____

Insurance Coverage

Medicare # _____ PDP (Prescription Drug Plan)_____

Medicaid # _____ County_____ Medicaid Applying ☐ Yes☐ No

Veteran ☐ Yes ☐ No Spouse of a Veteran ☐ Yes ☐ No VA#_____

Other Medical Coverage (Include Long Term Care Coverage or Hospice)

Insurance Company	**Address**	**Policy/Group Numbers**

Financial Resources

Monthly Income: _____

Bank Accounts

Name and Address of Bank	Type of Account (Checking, Savings, CD's, etc.)	Balance

Person responsible for payment of care_____

_____ _____

Signature of Applicant or Representative Date

FEDERAL AND STATE LAWS PROHIBIT RESIDENTIAL HEALTH CARE FACILITIES FROM DENYING ADMISSION TO ANYONE BECAUSE OF RACE, CREED, COLOR, PLACE OF BIRTH, SEX, DISABLITIY, BLINDNESS, SOURCE OF SPONSORSHIP, SOURCE OF PAYMENT, MARITAL STATUS.

Attachment A

Application for Admission To Residential Health Care Facilities in St. Lawrence County

Applicants Name: _____

Due to Medicaid's Deficit Reductions Act of 2005, there have been changes evaluating Long Term Care Medicaid Eligibility. Please respond to the following:

Has the Applicant had a transfer of any resources or real estate on/after February 8, 2006? ☐ Yes ☐ No

Has the Applicant/Spouse purchased any Life Estates in another individual's home on/after February 8, 2006? ☐ Yes ☐ No

Has the Applicant/Spouse purchased a Note, Loan, Mortgage or Annuity on/after February 8, 2006? ☐ Yes ☐ No

Does the Applicant/Spouse own real property other than their homestead? ☐ Yes ☐ No

Has the Applicant had a transfer of any resources or real estate in the last 60 months (5 years)? ☐ Yes ☐ No

Does the Applicant have a Trust Fund? ☐ Yes ☐ No If yes, was it established within the last 60 months? ☐ Yes ☐ No

Does the Applicant own their own home? ☐ Yes ☐ No

If the Applicant is the sole owner of their home, is the equity of the said home valued at $750,000 or above? ☐ Yes ☐ No

_____ _____

Signature of Applicant or Representative Date

St. Joseph's Home
Pre-Admission Study

Name: _____ Date: _____

Present Location: _____

Hospitalization Dates _____

Mental Health History: _____

_____

_____

Diagnosis of intellectual disability or history of psychiatric disorders: _____

_____

_____

List any major illnesses, hospitalizations or surgeries: _____

_____

_____

Current medications: _____

_____

_____

History of falls: Yes ____ No ____

History of fractures: Yes ____ No ____

Please check mark which is/are appropriate

Toileting:

_____ Independent

_____ Need some or occasional assistance for safety reasons – need assistance of one or more

_____ Incontinent of bowel – never / occasionally / frequently / colostomy

_____ Incontinent of bladder – never / occasionally / frequently / undergarment / catheter

_____ Waken to toilet at night

_____ Irregular bowel movement

Grooming and hygiene:

_____ Independent

_____ Needs supervision / assistance – sometimes / partial / always / complete

_____ Applicant in bed clothes much of the day

Bathing:

_____ Independent

_____ Needs supervision – sometimes / partial / always / complete

_____ Prefer – tub / shower / sink bath

_____ Prefer bathing AM / PM

Routine:

_____ Stay up late at night

_____ Nap during the day

_____ Leave for outings one or more times

_____ Stays busy with hobbies

_____ Spends time alone

_____ Able to move independently

_____ Use of tobacco (we are a smoke free facility)

_____ Sleep patterns –

get up: _____ bed time: _____

Ambulation:

_____ Transferring

_____Wheelchair

_____ Cane

_____ Assist of one / two

_____ Walker

_____ Quad cane

Dietary Habits:

_____ Consume small portions

_____ Moderate or large

_____ Distinct food preferences

_____ Does applicant eat between meals all or most days

_____ History of weight loss

_____ Swallowing difficulties

_____ Use of alcoholic beverages

Sensory:

_____ Good vision

_____ Difficulty reading

_____ Poor vision

_____ Legally blind

_____ Nearly blind

_____ Blind

_____ Cataracts

_____ Hearing adequate

_____ Somewhat hard of hearing

_____ Profoundly hard of hearing

_____ Deaf

Communication:

_____ Speech clear and distinct

_____ Speech somewhat impaired

_____ Speech profoundly impaired

_____ Speak foreign language (please specify) _____

Behavior:

_____ Generally content and cooperative

_____ Confused and/or disoriented

_____ Anxious or restless

_____ Depressed or cries frequently

_____ Paranoid

_____ Wanders

_____ Some memory loss

_____ Significant memory loss

_____ History of assaultive behavior

_____ History of alcohol or drug abuse

_____ Socially inappropriate behavior, please describe: _____

_____

Social Patterns:

_____ Daily contact with relatives or close friends

_____ Daily animal companion / presence

_____ Involved in group activities

Social Patterns (continued):

_____ Usually attends church, temple, synagogue

_____ Finds strength in faith

_____ None of the above

How would you describe yourself:

_____ At ease with others

_____ At ease with planned or structured activities

_____ At ease with self initiated activities

_____ Established own goals

_____ Active with community friends or neighbors

_____ Able to adjust easily to change in routine

_____ None of the above

List hobbies or interests: _____

_____

_____

_____ _____

Signature of Applicant Date

St. Joseph's Home since 1886...

Skilled Nursing Care

Date: _____

Doctor: _____

RE: _____

Dear Doctor:

An application for admission to St. Joseph's Home has been received for the above named.

A pre-admission physical form is required, and it would be very much appreciated if you would send the last 1 year of office visits to our social services department.

Thank you in advance for your assistance with this aspect of the admission process.

Sincerely,

Admissions Office

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315-393-3780 . Fax: 315-393-3847
Web Site: www.stjh.org