The Arc
Monroe
New York

The Arc of Monroe
Financial Intake Checklist

Name: Arc Address:

Please attach each of the following:

☐ **Copy of Birth Certificate (with Mother's Maiden name)**
☐ **Rep Payee Approval Form**
☐ **Medicaid/Food Stamp Authorization**
☐ **Authorization to Release Information**
☐ **Benefit Eligibility Questionnaire**

For each applicable item below, please attach documentation needed

☐ **Wages, last 4 pay stubs**
☐ **SSI, award letter**
☐ **SSD, award letter**
☐ **SSP, award letter**
☐ **SSA, award letter**
☐ **SNAP/Food Stamps, award letter**
☐ **Insurance Beneficiary Income, recent statement**
☐ **Trust Account, recent statement and agreement**
☐ **Burial Account, recent statement and agreement**

Resident Accounts Approval

☐ Documentation packet is complete

Approved by: Date:

☐ Documentation is incomplete

Still need:

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Rep Payee Approval Form

Name of wage earner, self-employed person or SSI claimant:

Social Security Number:

The Social Security Administration has decided that I need someone to manage my benefits. Because of this, SSA will send my benefits to a representative payee. It is the duty of the representative payee to use my benefits for my best interests.

I do not object to The Arc of Monroe becoming my representative payee.

Signature:

Date:

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New York

MEDICAID/FOOD STAMP AUTHORIZATION TO COMPLETE AND SIGN APPLICATION

I, _____, hereby authorize and designate The Arc of Monroe to complete and sign my application for assistance. I understand that The Arc of Monroe will represent me in the application process and I authorize them to give any and all information necessary to complete my application.

I further understand that this designation does not relieve me of my obligation to cooperate with all aspects of initial and continuing eligibility for public assistance and care and to provide timely and accurate information to the Monroe County Division of Social Services (MCDSS). By authorizing and designating The Arc of Monroe to complete and sign my application for assistance, I am agreeing to any investigation made by **MCDSS** to verify or to confirm the information submitted in the application or any other investigation made by **MCDSS.** If additional information is requested, I will provide it. I will also cooperate fully with State and Federal personnel in a Quality Control Review.

I understand that I may revoke this authorization at any time by notifying **MCDSS** in writing, but if I do it will not have any effect on any actions that MCDSS took before they received the revocation.

Signature of applicant: Date:

CERTIFICATION BY DESIGNATED AUTHORITY

I hereby swear and affirm that I have met with the applicant _____ and have explained to them that I will be completing and signing an application for assistance on their behalf as their designated representative, that _____ has agreed to this designation and that he/she understands that I will have to verify the accuracy of the information I will give to MCDSS in support of this application.

Signature: Date:

Name:

Address: The Arc of Monroe
PO Box 23438
Rochester, NY 14692
(585) 271-0660 x1363

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New York

AUTHORIZATION TO RELEASE INFORMATION

I,_____, hereby authorize and request that the:

- Social Security Administration
- Department of Social Services
- Health Care providers holding medical
- Financial Institutions
- Pension Plan Administrators
- Trustees, Executors
- Immediate Family Member

Give full, detailed and relevant information regarding me to The Arc of Monroe, for the purpose of applying for and/or maintaining Medicaid, Financial Assistance Programs, and/or other Entitlement and Community Based Programs to which I may be entitled.

In addition I authorize The Arc of Monroe to act as my representative in applying for, and/or maintaining Medicaid, Financial Assistance Programs and/or other Entitlement and Community Based Programs to which I may be entitled; and to act as my representative at any conference and/or fair hearing until they become my Rep Payee.

Signature of Applicant/Guardian:

Date:

Relationship to Applicant:

Print Name:

BENEFIT ELIGIBILITY QUESTIONNAIRE

A. INFORMATION ABOUT THE INDIVIDUAL

Full Name at Birth	Date of Birth	Social Security Number

Place of Birth (City, State) (attach a copy of the individual's birth certificate)	U.S. Veteran? ☐ YES ☐ NO

Marital Status	Spouse's Name	Date and Place of Marriage/Divorce

U.S. Citizen ☐ YES ☐ NO
If NO, please provide the individual's alien registration number, the date of entry, and the port of entry. Please attach a copy of both sides of the individual's Alien Registration Card or Permanent Resident Card and any other proof of lawful residence.

Is there a **court appointed** legal guardian, alternate or standby guardian, conservator, or committee for the individual?
☐ YES ☐ NO If YES, give the name and address (attach copies of the legal papers):

If the individual is under age 21, does he/she live with his/her parents? ☐ YES ☐ NO

Is the individual covered by Medicaid? ☐ YES ☐ NO

If YES: Client Identification Number (CIN):_____ Date approved:_____

If NO: Was a Medicaid application filed? ☐ YES ☐ NO If YES, complete the following:

Date of application: _____ Date of denial: _____

Reason for denial: _____

Is the individual enrolled in the HCBS Waiver? ☐ YES ☐ NO Enrollment Date:_____

If NO: Has a HCBS Waiver application been filed for the individual? ☐ YES ☐ NO

Date of application: _____ Date of denial: _____

Reason for denial: _____

What services is the individual receiving? *Include **all services** provided by your agency and any other agency:*

B. INFORMATION ABOUT THE INDIVIDUAL'S INCOME

Does the individual receive income from any source? ☐ YES ☐ NO
If YES, complete the following regarding all sources of income the individual received during the last 3 months:

Income Source	Who is Payee?	Claim Number	Monthly Amount
SOCIAL SECURITY			$
SUPPLEMENTAL SECURITY INCOME (SSI)			$
Other Benefits			$
			$

Was the individual ever employed or did he or she receive wages (including wages from a workshop)? ☐ YES ☐ NO
If YES, is the individual currently employed? ☐ YES ☐ NO
If YES, complete the following about the current employer(s), other employers, and monthly gross wages during the last 3 months.

Employer(s)	Address	Gross Wages

C. INFORMATION ABOUT THE INDIVIDUAL'S ASSETS

Answer the following question only if the individual will be residing in an ICF:
Has the individual sold, given away or transferred any cash, real estate, or other asset(s) during the last 60 months?
☐ YES ☐NO
If YES, attach a sheet with details, including the type of asset, value, to whom the asset was sold/given/transferred, the date of the transaction and the amount for which the asset was sold.

Has the individual placed any asset(s) into a trust or have any disbursements been made from a trust established for the individual's benefit?
☐ YES ☐ NO
If YES, attach a photocopy of the trust document or a sheet with details about the trust, including the source of the money, the name of the trustee, location of the trust, account number and the value of the trust.

Does the individual have any bank account(s), credit union account(s), certificates of deposit, annuity, 401(k), other retirement account, stocks, bonds, securities, or interest in real property?
☐ YES ☐ NO
If YES, attach copies (attach an additional sheet if needed for additional assets or details):

	Asset 1	**Asset 2**
Type of Asset		
Name of Person Receiving Bank Statements or Holding Records		
Current Asset Value		

Is there a burial fund for the individual? ☐ YES ☐ NO If YES, attach a sheet with details.

Does the individual have a pre-need funeral contract, a burial trust, a burial plot or other burial space items?
☐ YES ☐ NO If YES, provide details (attach a photocopy of the contract):

D. FUTURE INCOME OR ASSETS FOR THE INDIVIDUAL

Does the individual have an interest in, possible interest in, or expect to receive an inheritance, lawsuit settlement, trust fund or other asset? ☐ YES ☐ NO
If YES, describe the asset below (attach a sheet with details).

E. INFORMATION ABOUT THE INDIVIDUAL'S LIFE INSURANCE

Is there Life Insurance on the individual? ☐ YES ☐ NO If YES, complete the following:

Insurance Company Name and Address

Policy Number(s)	Face Value $

Name and Address of the Person Holding the Policy

F. INFORMATION ABOUT THE INDIVIDUAL'S HEALTH INSURANCE

Does the individual have Medicare? ☐ YES ☐ NO	**Effective Date**	**Claim Number**
Part A Hospital Insurance ☐ YES ☐ NO		
Part B Medical Insurance ☐ YES ☐ NO		
Part D Prescription Drug Plan ☐ YES ☐ NO		
Medicare Advantage Plan ☐ YES ☐ NO		

Medicare Advantage Plan Name, Address and Phone Number		
Is the individual covered by other health insurance? ☐ YES ☐ NO If YES, please enclose a copy of the insurance certificate, policy, booklet or card (front and back) and complete the following:		
Insurance Company Name and Address		
Policy Number	Group Number	Other Identifier(s)
Effective Date of Coverage	Subscriber's Name	
Name and Address of Group/Employer		

G. IDENTIFYING INFORMATION ABOUT THE INDIVIDUAL'S PARENTS and SPOUSE

	FATHER	MOTHER	SPOUSE
Full Name at Birth/Maiden Name			
Date of Birth			
Place of Birth (City, State)			
Social Security Number			
U. S. Citizen	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
U. S. Veteran If YES, provide:	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Serial Number			
Claim Number			
Receiving Disability/Retirement Benefit	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Date of Disability/Retirement			
Date and Place of Death, if applicable			

H. FINANCIAL REPRESENTATIVES FOR THE INDIVIDUAL

Is there any other person(s) who has financial information about the individual? ☐ YES ☐ NO
If YES, provide the information below or attach a sheet with a detailed list:

NAME	ADDRESS AND PHONE NUMBER	RELATIONSHIP

I. THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE

Signature of Person Completing Form	Print Name	
Relationship to Individual	Telephone	Date

The Arc of Monroe
Intake Checklist

Name: Arc Address:

Please attach each of the following:

☐ **Station MD consent form**
☐ **Health Care Proxy paperwork**
☐ **Legal Guardian paperwork**
☐ **DNI/DNR paperwork**

Staff Approval

☐ Documentation packet is complete

Approved by: Date:

☐ Documentation is incomplete

Still need:

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Dear Resident & Family:

We are pleased to announce a new program that has been implemented in collaboration with all of the NYS Arc facilities.

The program is called StationMD. StationMD is a tele-health medical initiative that will be available 24 hours a day to act as resource for all staff and nurses to call if they have a concern about any of our residents. It allows the physician to assess a resident and even allows the physician to check heart and lung sounds, etc.

The goal of the program is to expedite medical care and hopefully reduce unnecessary hospital visit so residents can be treated in the comfort of their usual surroundings. The physicians will have access to our medical records and will place their consultations in the medical record. Their consultations will be available to all our private physicians and nurses. Other medical orders and follow-up care will be communicated with the nursing staff. The nurses and staff will execute the doctors' orders and coordinate the care.

The program is HIPAA compliant. There is no recording of the session other than a log of the call. The physicians affiliated with StationMD are board certified in Emergency Medicine and licensed in New York State.

The program is an adjunct to the current medical care offered by each individual's primary care physician. *The StationMD program is being offered at no additional cost to the resident.*

Please review the attached StationMD consent to evaluate and treat form. Please sign and return the form to us. If you have any questions, please contact our Director of Nursing, Susan Sproule, RN.

Very truly yours,

Susan Sproule, MPA, RN

585-271-0660 ext. 1373

Consent for Evaluation & Treatment

Patient Name: _____ DOB: _____

I, the patient, legal guardian, or authorized representative of the named patient, hereby authorize and request StationMD, PC and its doctors, to provide such medical care and administer such diagnostic, and therapeutic measures which may include but not limited to performing a history and physical exam, ordering labs, urine, and radiographic diagnostic studies, as deemed necessary and advisable. I understand that StationMD, PC is a provider of emergency telemedicine services. I also give StationMD, PC access to my medical records. I understand that my medical records are kept in both hard copy and electronic form and that doctors and persons involved in my care may have access to both forms of record. This will include remote access to electronic records. I consent to the release of my medical information for purposes of assessment, treatment, payment, operations, and discharge planning as outlined in the StationMD, PC privacy notice. The StationMD, PC privacy notice is available at the time of this acknowledgement and is always available at https://www.stationmd.com/wdpr/wp-content/uploads/2018/08/notice-of-privacy-practice-082018.pdf.

_____

Patient/Legal Guardian/Authorized Representative

_____

Relationship Date Time