Dear Applicant and Family,

Thank you for considering the New Jersey Firemen's Home located in Boonton, NJ.

The New Jersey Firemen's Home was established by an act of the New Jersey Legislature and given as a gift from the Lathrop family. The New Jersey Firemen's Home is a reliable life care choice for those who have faithfully served as firefighters in N.J.

We are licensed and regularly inspected by the New Jersey Department of Health and Senior Service to operate as a long-term care facility and residential healthcare facility. State regulations help formulate and dictate facility policy and procedures.

The Home is governed by a twenty-one-member Board of Managers in conjunction with a full time Administrator/Superintendent.

Our guests receive the best of care by our licensed and certified nursing staff, certified social worker, certified recreation director, certified dietary manager, and licensed dietician. Our Housekeeping and Maintenance Departments ensure that our guests enjoy a safe and clean environment.

Our nursing units are staffed twenty-four hours a day, seven days a week.

The New Jersey Firemen's Home is the only nursing home in the country dedicated exclusively to the care of both career and volunteer firefighters. This is an incredible benefit to firefighters, and we are honored to in turn continue the mission of service and dedication now directed at New Jersey's bravest.

Our Mission

Our mission is to provide care for aged and indigent Firefighters. The home where aged and indigent firefighters, who have freely given their services and the best years of their lives to the saving lives and property, may rest and be secured in the comforts of life for their remaining years.

Eligibility

The following persons are eligible to submit an Admission Application to our Home:

- Must have been a member of a NJ Fire Department for at least 1 year.
- Must be of good moral character.
- Must be in good standing as a Firefighter.

Contact

For more information, you may contact the following individuals. The staff and county representatives of The New Jersey Firemen's Home are always glad to answer any questions or concerns that you may have during the application process.

Facility Information

John Veras, Superintendent
(973) 334-0024, extension 11

Social Services:

Ursula Baumgartner, Social Services Director
(973) 334-0024, extension 22

Nursing Information:

Amberlee Bundrick, Director of Nursing
(973) 334-0024, extension 20

Finance:

Cindy Humen, Finance Administrator
(973) 334-0024, extension 36

Application Requests:

Melissa Humen, Administrative Assistant
(973) 334-0024, extension 10

What Forms are Required?

Below is a checklist of information required during the application process. <u>These forms must be filled out in their entirety to be eligible for review</u>.

For further assistance, please refer to the Contact and County Representative pages.

General Information

☐ Personal Data
☐ Agreement to Reimburse
Witness signature required.
☐ Limited Durable Power of Attorney
Must be sealed and witnessed by notary.
☐ Responsibilities of the Resident
☐ Report of Local Fire Company
☐ Acknowledgement of Receipt of General Information
☐ Authentication of Signatures
☐ Manager's Certification

Medical Information

Please note that the following forms must be submitted within a timeframe of no more than <u>six months</u> after physician's evaluation.

☐ Medical Evaluation
☐ Psychiatric Evaluation
☐ Front and back copies of Medicare, health insurance, and prescription cards

Legal Information

☐ Copy of Healthcare Power of Attorney
If a <u>Healthcare</u> Power of Attorney is not included, we at the very least, require a designated Health Care Proxy/Agent.
☐ Copy of Living Will

LTC:____ RC____ MC____

Application for Admission

Upon completion of application, please contact your respective County Manager. The application is considered completed by the standards of the checklist preceding this form. Incomplete applications are not eligible to be reviewed by the Application Committee staff.

TO THE BOARD OF MANAGERS DATE: _____

Application is hereby respectfully made for admittance to the New Jersey Firemen's Home.

Name of Applicant: _____

General Information Concerning Prospective Applicant

Home Address_____
City _____State_____Zip_____
Telephone Number(s) _____
Social Security Number_____Age_____
Date of Birth _____Birthplace_____ Citizen of_____
Applicant's marital status_____Does applicant have children? ____Yes ___No
Applicant is now at ____Home _____Hospital*____Nursing Home*____Other*
Please identify location *Name_____
Contact Person @ facility_____
Address_____
Tele #_____How Long? _____

Have you ever made a previous application for admittance to the New Jersey Firemen's Home?
____Yes ____No If yes, when_____state reason for wishing to enter now.
_____
_____

Applicant's primary language____English___Other, please specify _____
Education _____ Former Occupation _____
Religion _____ Church _____
Pastor _____ Tele # _____
Military Status: ___Yes ___No if yes, Branch of Service _____
Dates of Service_____Service Serial Number_____
Type of Discharge _____

Please identify person(s) to be notified in case of emergency:

1. Name_____Address_____
City_____State_____Zip_____
Tele # Home _____Business _____Cell _____
Email_____ FAX _____
Occupation_____Relationship_____
Will this person(s) help defray cost of Health Care/Nursing Home Care? ___Yes ____NO

2. Name_____Address_____
City_____State_____Zip_____
Tele # Home _____Business _____Cell _____
Email_____ FAX _____
Occupation_____Relationship_____
Will this person(s) help defray cost of Health Care/Nursing Home Care? ___Yes ____NO

3. Name_____Address_____
City_____State_____Zip_____
Tele # Home _____Business _____Cell _____
Email_____ FAX _____
Occupation_____Relationship_____
Will this person(s) help defray cost of Health Care/Nursing Home Care? ___Yes ____NO

Medical Information Concerning Applicant

A. Current problems, if any _____
How long has this problem existed? _____
Please list current medications _____
Applicant's last hospitalization _____
For What? _____
How long? _____
Has the applicant ever been in a Nursing Home? ___Yes ___No
Where _____ How long? _____
Why did resident leave Nursing Home? _____
Any problems there? _____

B. Applicant's special needs:
Grooms self ____Yes ___No Special diet ____Yes ___No

Dresses self ____Yes ___No Please specify _____
Bathes self ____Yes ___No
Other _____
Please list applicant's current clothing sizes: waist: _____ inseam: _____ shirt: _____ shoe: _____
Applicant's physical mobility:
____Walks unassisted ____uses wheelchair ____Walks only with assistance
____Uses walker ____Bed-Bound
Is applicant incontinent?
____Yes ___No ____Bowel ____Bladder ____Both
Does applicant wear glasses? ____Yes ___No
When was last eye exam? _____
Does applicant wear dentures? ____Yes ___No
When was last dental/gum exam? _____
Oxygen needed _____ Catheter _____
Does applicant have any physical deformities that require special care and attention?
____Yes ___No If yes, please describe_____

C. Applicant's Mental Status
Does the applicant usually desire to be dressed and groomed properly? ____Yes ___No
If no, please explain _____
Does the applicant manifest any signs of unusual or bizarre behavior?
____Yes ___No ___Occasionally

Is the applicant alert? ____Yes ___No Cooperative? ____Yes ___No

Is the applicant quiet and controlled? ____Yes ___No

Is the applicant combative? ____Yes ___No

Does the applicant have episodes of crying, screaming, yelling? ____Yes ___No

Does the applicant tend to wander? ____Yes ___No

Does the applicant have violent outbursts of temper? ____Yes ___No

Does the applicant generally get along well with others? ____Yes ___No

Does the applicant like to converse and socialize with others? ____Yes ___No

Does the applicant enjoy/appreciate the opportunity for external activities? ____Yes ___No

Does the applicant tend to be depressed and withdrawn? ____Yes ___No

State any other significant event or occurrence you recall about the applicant's mental condition:

_____

_____

_____

_____

Health Insurance Information Concerning Applicant

Primary Insurance Company: _____

Policy # _____ Group# _____

Policy Holder _____ DOB _____

Relationship to Patient _____

Secondary Insurance Company: _____

Policy # _____ Group# _____

Policy Holder _____ DOB _____

Relationship to Patient _____

Prescription Insurance Company:

Policy # _____ Group# _____

Policy Holder _____ DOB _____

Relationship to Patient _____

PLEASE DO NOT REFILL/ORDER PRESCRIPTIONS PRIOR TO ADMISSION. ON ADMISSION, OUR MEDICAL DIRECTOR WILL ASSESS ALL MEDICATIONS CURRENTLY IN USE BY THE APPLICANT.

AS PART OF THE ADMISSION AGREEMENT, THIS FACILITY DOES NOT PERMIT PHARMACEUTICALS FROM OUTSIDE PHARMACIES. THIS IS IN THE BEST INTEREST OF SAFETY AND ECONOMIC CONSIDERATIONS FOR EACH RESIDENT. FOR FURTHER QUESTIONS, PLEASE CONTACT OUR SOCIAL WORKER OR DIRECTOR OF NURSING.

Financial Information Concerning Applicant

(This information is required to verify ability to cover expenses)

A. Cash Assets

Bank _____ Location _____
Checking Account # _____ Savings Account #_____
Balance in Account $ _____ Balance in Account $_____
Certificates of Deposit? ____Yes ___No If Yes, approx.. amt. $ _____
Safe Deposit Box? ____Yes ___No
If Yes, please indicate bank and location _____
_____

B. Monthly Income

Social Security $_____ Railroad $ _____ Interest $_____
Private Pension $_____ Civil Service $_____ Dividends $_____
Veterans Benefits $_____ Other $_____

C. Real Estate Assets

Does applicant own home? ____Yes ___No Approx. Value $_____
Does applicant own any other property? ____Yes ___No
If yes, where is property located? _____
Does applicant receive any "rental" income? ____Yes ___No
If yes, how much per month $ _____ Per year $ _____

D. Life Insurance Cash Value

Does applicant have life insurance policies with cash values? ____Yes ___No
Approx. amount of cash value $_____ Annuities $_____
Company Name _____
Agent's Name _____Agent's Tele # _____

E. Securities

Does the applicant own stocks and bonds? ____Yes ___No
Approx. value of all securities $_____
Agent handling securities: Name _____ Tele # _____
Address_____

Representative of the Applicant

REQUIRED

Power of Attorney: ____Yes (PLEASE ATTACH COPY) _____NO
A **Power of Attorney (POA)** is a document that allows you to appoint a person or organization to manage your affairs if you become unable to do so.

Name _____Tele # _____

Living Will */Advance Directive*: ___Yes (PLEASE ATTACH COPY) _____NO
Health Care Proxy/Agent: ____Yes (PLEASE ATTACH COPY) _____NO

A health care proxy is a document (legal instrument) with which a patient (primary individual) appoints an agent to legally make health care decisions on behalf of the patient, when he or she is incapable of making and executing the health care decisions stipulated in the proxy.

Name _____Tele # _____

Funeral/Burial Arrangements

1. Name of Funeral Home_____
Address_____
Tele # _____Prepaid ___Yes ___No

2. Cemetery Plot:
Name of Cemetery _____
Address_____
Tele # _____Prepaid ___Yes ___No

3. Donation of Body Parts: ____Yes ___No
If Yes, what and to whom? _____
Cremation: ____Yes ____No

According to the best of my knowledge, the foregoing information is accurate and true in all respects. I agree, if admitted, to abide by the regulations of the New Jersey Firemen's Home.

_____

Signature of Applicant and/or Signature of Person Acting for Applicant

_____

Date Address Tele # Relationship

APPLICANT'S NAME:_____

MANAGER'S CERIFICATION

I, _____, a member of the Board of Managers representing _____ County, hereby certify that the application is in order, propose the applicant for admission.

_____ _____

Date *Manager Signature*

RECOMMENDATION OF APPLICATION COMMITTEE

Date: _____

We find the application is in order as of this date and recommend the admission of the applicant.

_____

Signature- Chairman Application Committee

ORDER OF ADMISSION

Date of Board Action: _____

The foregoing application is hereby approved, and the formal admission is recommended by the Board of Managers _____ Executive Committee _____

All applications will be approved or disapproved at any regular or special meeting of the Board of Managers or the Executive Committee and signed by at least six (6) members of the Board of Managers.

Managers: _____ _____

_____ _____

_____ _____

_____ _____

Register No: _____ Book _____ Page _____

Approved: _____ Admitted: _____ Rejected: _____

MEDICAL CERTIFICATION OF HOME PHYSICIAN

For use of Home Physician only

I have examined the within applicant and (DO) _____ (DO NOT) _____ recommend applicant's admission.

Date: _____ _____M.D.

Signature- Home Physician

Comments/Remarks: _____

_____

PREPARED BY:
THOMAS H. WARD, ESQUIRE
Solicitor, New Jersey Firemen's Home

THIS AGREEMENT made this____day _____in the year of our Lord Two Thousand and _____ between _____ hereinafter called the applicant and _____ spouse and/or family of said applicant, part(y)(ies) of the first part, and the Board of Managers of the New Jersey Firemen's Home. The following is an agreement concerning the reimbursement of the Firemen's Home for all services and boarding provided by the Home for the benefit of its Guest.

A. By execution of this document and admission to the Home, the Guest and his/her estate agree to be obligated to pay all sums due the Firemen's home for the care of the Guest.
B. All income which the Guest may entrust to the Home by means of Power of Attorney or assignment may be used for payment or reimbursement of any costs incurred or advanced by the Home on behalf of the Guest.
C. The Guest shall be responsible for the maintenance fee as may from time to time be established by the Board of Managers of the New Jersey Firemen's Home
D. Execution of this document shall constitute permission to the Home physician to obtain all medical information respecting the Guest from any source.
E. The Guest or his/her estate shall be responsible for all costs incurred by the Home on behalf of the Guest. This responsibility shall be present regardless of Medicare eligibility or other medical reimbursement plans.
F. A quarterly statement will be issued for each quarter which shall show all deposits to and withdrawals from the Guest's account.
G. The present monthly maintenance fee is $850.00 and is payable upon entry into the Home and then monthly thereafter.
H. If sufficient or excess funds remain in the Guest's medical account, the interest accrued from the invested monies will be transferred to the General Account and used to operate the Home. STATE STATUE- 30:4-67- I Eff. June 14, 1938.

I, _____, say that all facts, matters, and things set forth in the foregoing application are true to the best of my knowledge and belief.

Witness:

_____

Date: _____

_____
Applicant's Signature

_____
Signature of Spouse/Family

_____
Relationship to Applicant

Limited Durable Power of Attorney

KNOW ALL MEN BY THESE PRESENTS:

That I, _____, referred to herein as principal, now a Guest of the New Jersey Firemen's Home, 565 Lathrop Avenue, Boonton, New Jersey, 07005, designated the Superintendent or Treasurer of the New Jersey Firemen's Home as my attorney in fact and agent (thereinafter called "Agent") in my name and for my benefit.

1. Limited Grant of Power. To do each and every act which I could personally do for the following limited uses and purposes:
   a. to endorse and negotiate all checks, drafts, pension payments, Social Security checks, supplemental Social Security income or other income payments received by Guest at the New Jersey Firemen's Home.
   b. to review and approve quarterly accounting reports of the Guest as issued by the New Jersey Firemen's Home.
   c. to complete, endorse, execute and take all steps necessary for the processing of all medical insurance or reimbursements claims to Medicaid, Medicare, Blue Cross Blue Shield of New Jersey or any private or public health insurance plan in which the Guest is participating.
   d. to manage and distribute a personal allowance to the Guest from any funds entrusted to the Home on behalf of the Guest in such amounts as determined by the appropriate officers of the Home.
   e. to apply for assistance to the Local Firemen's Relief Association in the fire district or municipality where the Guest resided. This assistance shall be applied to the Guest account held by the Home and be utilized for medical expenses of the Guest.

THIS POWER SHALL SPECIFICALLY NOT APPLY TO PROPERTY, REAL OR PERSONAL, POSSESSED OR MAINTAINED BY THE GUEST OUTSIDE THE HOME.

2. Interpretation and Governing Law. This instrument is to be construed and interpreted as a durable power of attorney. The enumeration of specific powers herein is intended to limit and restrict the powers herein granted to my Agent. This instrument is executed and delivered in the State of New Jersey and the laws of the State of New Jersey shall govern all questions as to the validity of this power and the construction of its provisions.
3. Third-Party Reliance. Third parties may rely upon the representatives of my Agent as to all matters relating to my power granted to my Agent, and no person who may act in reliance upon the representations of my Agent or the authority granted to my Agent shall incur any liability to me or my estate as a result of permitting my Agent to exercise any power. Any third party may rely on a duty executed counterpart of this instrument, or a copy certified by my Agent to be a true copy of this original hereof, as fully and completely as if such third party had received the original of this agreement.
4. Disability of Principal. *N.J.S.A.* 46:2B-8 authorizes me to provide that this power of attorney shall not be affected by my disability as principal and I declare this power of attorney shall not terminate upon my disability. The power(s) conferred by this document shall be exercisable from this date notwithstanding a later disability or incapacity on my part and shall be valid until such time as I shall die or revoke this power.

IN WITNESS WHEREOF, I have herein set my hand and seal this day of _____, 20__.

Sworn to and Subscribed

before me this _____ day

of _____, 20___.

_____

Notary Public, State of _____

_____

Signature of Guest

Medical Certification of Local Physician

Name: _____ **Age:**_____ **Date**: _____
Medical Diagnosis: _____
Height: _____ **Weight:**_____

Physical Examination

Eyes: (Visual Diagnosis, i.e., Glaucoma, Macular Degeneration, lens replacements)
_____
_____

Ears:
(Hearing conditions, hearing aides):_____
Mouth, Nose, & Throat: _____
Neck:
Thyroid _____Glands _____

Lungs:
_____

Cardiovascular:
BP _____ Pulse _____ Heart _____
Murmurs_____ Rhythm _____ Size _____
Varicose Veins _____ Peripheral Circulation _____

Abdomen:
General _____
Hernia _____ Varicocele _____
Hydrocele _____

Extremities:
Amputations _____ Edema _____ Gait _____
Statis Dermatitis _____ Ambulatory _____
Weight Bearing _____

Spine and Joints: _____
Skin _____ Rashes _____ Good _____ Bed Sores_____

Food:
Independent Eating: _____ Assistance: _____
Diet: _____

Allergies:

Medication: _____

Food & Environmental: _____

Vaccinations: (Please list dates of the following)

Flu _____ Pneumonia _____ Shingles _____ COVID 19 _____

Habits:

Alcohol _____ Tobacco _____ Drugs _____

Have you been hospitalized within the last year:

Yes ____ No ____

If YES, when _____ to _____

Where: _____

What for: _____

Medications: (Presently taking and why)

_____

_____

_____

Additional Information: (Past Medical & Surgical History)

_____

_____

_____

Review of Systems

Cardiovascular:

RHD _____ CHF _____ Hypertension _____

Myocardial Infarction _____ Other _____

Respiratory:

Asthmas _____ Emphysema _____ Chronic Bronchitis _____

Previous TB _____ Date of last chest x-ray _____ Result: _____

Gastro:

GB Disease _____ Ulcer _____ Ostomy _____

Intestinal:

Recurrent or chronic _____ Hemorrhoids _____

Bowl Habits, regular _____ Constipated _____

Genito:

Pyelonephritis _____ Calculi _____ Cystitis _____

Urinary:

Foley _____ Suprapubic_____

Musculo-Skeletal:

Rheumatoid Arthritis _____ Osteoarthritis _____ Osteoporosis _____

Significant Injuries:

_____
_____
_____

Previous Vascular Accident:

Thrombotic _____ Hemorrhage ____ Undetermined _____

Other Disorder:

_____
_____
_____

Additional Information:

_____
_____
_____
_____

_____ _____

Date *Signature of Physician*

REMINDER TO THE APPLICANT

In addition to these Medical Certification of Local Physician Forms it is mandatory that a Psychiatric Evaluation be performed by a professional Psychiatrist. The evaluations are to be typed and submitted on the professional's Evaluation Form (the New Jersey Firemen's Home does not supply the evaluation forms).

NOTE: ALL EVALUATIONS MUST BE TYPED OR THEY WILL NOT BE ACCEPTED

Month/Day/Year

New Jersey Firemen's Home
Attn: Superintendent
565 Lathrop Avenue
Boonton, NJ 07005

RE:

Dear Sir:

This is an elderly white widowed male, who was first seen by me on *Month/Day/Year*, as the patient was depressed.

The patient is a resident of _____ and he was referred from the nursing home as the patient was expressing depression and suicidal comments.

HISTORY OF PRESENT ILLNESS: This elderly white gentlemen's wife had died in December of 1993 and in March of 1994 the patient underwent a right below knee amputation. After the surgery the patient started getting depressed. He was not doing well, he was withdrawn, would not take care of his ADL's and hence he was referred to me.

The patient, however, denied suicidal ideations to me at that time. He was started on Paxil 20mg orally at bedtime and Xanax was discontinued and he was started also on Ativan 0.25mg orally three times a day.

On subsequent evaluations, on 6-15-94, the patient apparently was doing well, responding well to Paxil. The patient since then has been subsequently followed by me. His last evaluation was on 4-24-95, at the time of evaluation the patient appeared to be doing fairly well. He was, in a way, hyper-talkative, a good historian and related well. Casually groomed. Mood appeared to be euthymic. Affect appeared to be appropriate. I did not detect any signs of psychosis. He was alert and oriented times three. No suicidal or homicidal ideations. He knew the year, month, date. I did not detect any paranoia or any guardedness. Memory and cognitively he remained unchanged since the first evaluation, he was doing fairly well. Insight and judgment of his problems appeared to be fair.

IMPRESSION:	AXIS I:	MAJOR DEPRESSION, MODERATE, WITHOUT PSYCHOTIC FEATURES.
	AXIS II:	NONE.
	AXIS III:	RIGHT BELOW KNEE AMPUTATION.

PLAN: At this time, I consider the patient to be pretty stable. He is apparently responding very well to Paxil, on 40mg of Paxil and Ativan 0.25mg orally twice a day. The patient was given an appointment to see me in 6 weeks' time. I do not detect that there can be any problems with the patient at the nursing home.

If there are any questions regarding this, please contact me at my office.

Sincerely yours,

(Signature)

Responsibilities of the Resident

In reference to pages 7 – 9 in ***Part B: General Information***

I, _____, a resident of this facility, certify that I have received a written copy of my obligations and responsibilities of the resident. I further certify that my rights and responsibilities were reviewed with me and that I understand them and agree to abide by them to the best of my ability.

_____ _____

Date *(Signature- Resident)*

Or

_____ _____

Date *(Signature- Agent/Power of Attorney for Resident)*

A COPY OF THIS DOCUMENT MUST BE FILED IN THE RESIDENT'S MEDICAL RECORD

Report of the Local Fire Company and/or Relief Association

Date of Report: _____

The _____Fire Company
(Name of Fire Company)
of the _____ Fire Department of _____
at a meeting held _____does hereby certify_____
(Name of Applicant)
that the Fire Department is under municipal control, and that the records have been examined and show that the Applicant was an active member of said Fire Department for a minimum of one (1) year, having been admitted as an active member on _____, and retiring from active service through _____ on _____; and that said Applicant is a proper person to
(Resignation or Suspension) *(Date)*
be admitted to the New Jersey Firemen's Home, and of good moral character and in good standing as a fireman.

Certified by the Local Fire Company

President (Print Name): _____ (Signature): _____
Phone: (_____) _____

Or

Secretary (Print Name): _____ (Signature): _____
Phone: (_____) _____

Or

Chief (Print Name): _____ (Signature): _____
Phone: (_____) _____

Acknowledgement of Receipt of General Information

Please initial to the right of each of the line items below to signify that the information has been read and understood by the applicant and/or his representative:

	Initials
1. Notice of Monthly Rent/Room and Board/ Description of Charges	_____
2. General Information on NJFH Operation	_____
3. Responsibilities of NJFH Resident with Covered/Non-Covered Charges	_____
4. List of Suggested Clothing	_____
5. NJFH Privacy Practices	_____

Date: _____ _____ _____

(Print Name) *(Signature)*

WITNESS: _____ _____

(Print Name) *(Signature)*

Authentication of Signatures in Admission Applications

I, _____, certify the signatures placed on the pages to this application herein are true and authentic. I am aware that if any part of this representation is willfully false, I am subject to punishment by law.

Witness:

_____ _____

Applicant's Signature or Representative

Date: _____