Application for Admission

to

ST. MICHAEL'S HOME

3 LEHMAN TERRACE
YONKERS, NEW YORK 10705-3699
TEL: 914-476-3374
FAX: 914-476-1744

Application For Admission

General Information

Name in Full			Date	
Permanent Address				
Telephone	Citizen: ❑ US ❑ Greek ❑ Naturalized ❑ Green Card ❑ Other			
Date of Birth	Birthplace			
Mother's Maiden Name		Father's Name		
Spouse's Name	Date of Death	Divorced		

Family Information

Children and their addresses and telephone				
1. Name		Email Address		
Address	City	State	Zip Code	
Home Phone No.	Business Phone No.	Cell Phone No.		
2. Name		Email Address		
Address	City	State	Zip Code	
Home Phone No.	Business Phone No.	Cell Phone No.		

Employment Information

List any present and/or former occupations.

Place of Residence

Address and dates of legal residence during the past ten years

Address of Residence	From	To

Health Care Information

Does the applicant have any advance directives? Please check and provide photocopy with application.

Health Care Proxy ❑ Yes ❑ No		Do Not Resuscitate	❑ Yes ❑ No
Medical POA ❑ Yes ❑ No		Living Will	❑ Yes ❑ No

Previous Housings ❑ Private House ❑ Apartment ❑ Condo ❑ Co-op ❑ Other, explain:

Were home care services provided? ❑ Yes ❑ No

Power of Attorney

Do you have a person or firm with your general Power of Attorney? If so, give name, address, and provide a copy.

Burial Arrangements

Responsible Party Name			
Address		Telephone No.	
Deeded Cemetery Plot Location		Burial Pre-Arrangement	❑ Yes ❑ No
Name of Funeral Home			
Address			
Telephone No.			

Please provide photocopy of cemetery deed and burial pre-arrangement.

Background Information

Please provide a complete description of the applicant's level of functioning.

Does the applicant smoke?

Describe the applicant's daily routine prior to placement (i.e. eating, sleeping patterns, habits).

Discuss the applicant's past roles (i.e. life-long occupation, language, interests and skills).

Describe the applicant's family involvement and family relationships.

Describe the applicant's ability to communicate.

Describe the cognitive status of the applicant (i.e. alert, forgetful, confused, impaired judgement, poor short-term memory, etc.).

Describe the applicant's present social and behavioral functioning (i.e. sociable, passive, anxious, sad, gregarious, agitated, isolated, talkative, etc.) and indicate behavioral problems (i.e. wandering, agitation, combativeness).

Is the applicant taking any psychoactive medication currently or has he/she taken this type of medication in the past?

Has the applicant ever had a psychiatric hospitalization? If so, explain:

Personal Information

Member of what church?	
What provision for clothing, dentistry, eyeglasses, pin money, etc.	
State of health, past and present	
Name of Physician	
Address	Telephone No.
Name and Address of Parish Priest	

Applicant's Assets

Life Insurance Policies

Health Insurance Information

Social Security No.	Prescription Drug (Rx) Plan No.
Medicare No. (including suffix)	Medicaid No.
Medicare Supplemental Carrier	S.S.I. Recipient ❑ Yes ❑ No
Policy No.	
Major Medical Carrier	
Policy No.	

Level of Accommodation Requested (Please Check One)

❑ Private Room/Private Bathroom ❑ Private Room/Shared Bathroom ❑ Semi-Private Room/Shared Bathroom

Name of person completing application if other than applicant _____

Signature of Applicant Date

New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

ALL SPACES MUST BE FILLED OUT

Resident's Name: _____ **Date of Exam:** _____

Facility Name: _____ Date of Birth:_____ Sex:_____

Present Home Address:_____
Street City State Zip

Reason for evaluation: ☐ Pre-Admission ☐ 12 month ☐ Acute change in condition ☐ Other :_____

MEDICAL REVIEW FINDINGS

Vital Signs: BP: _____ Pulse:_____ Resp: _____ T: _____ Height: _____ft _____in. Weight: _____

Primary Diagnosis(s): _____

_____

Secondary Diagnosis(s): _____

_____

Allergies: ☐ **None** or list **Known Allergies:** _____

Diet: ☐ Regular ☐ No Added Salt ☐ No Concentrated Sweets ☐ Other: _____

Immunizations: ☐ Influenza (Date_____) ☐ Pneumococcal Vaccine (Date_____)

TB SCREENING ***(****performed* **within *30 days prior to initial admission*** *unless medically contraindicated)*

☐**Test is contraindicated** **Test:** ☐ TST1 ☐ TST2 ☐TB Blood Test (Type)_____ Date_____ Result_____

TST1: Date placed_____ Date Read_____ mm_____ TST2: Date placed_____ Date Read_____ mm_____

Based on my findings and on my knowledge of this patient, I find that the patient _____ **IS** _____ **IS NOT** exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

CONTINENCE

Bladder: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐
Bowel: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐

If no, recommendations for management:_____

LABORATORY SERVICES: ☐None

Lab Test	Reason/Frequency	Lab Test	Reason/Frequency
_____	_____	_____	_____
_____	_____	_____	_____

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ Date: _____

ACTIVITIES OF DAILY LIVING (ADL's)

Activity Restrictions: No ☐ Yes ☐ (describe):_____

Dependent on Medical Equipment: No ☐ Yes ☐ (describe):_____

Level and frequency of assistance required/needed by the resident of another person to perform the following:

1. Ambulate: Independent ☐ Intermittent ☐ Continual ☐
2. Transfer: Independent ☐ Intermittent ☐ Continual ☐
3. Feeding: Independent ☐ Intermittent ☐ Continual ☐
4. Manage Medical Equipment: Manages Independently ☐ Cannot Manage Independently ☐

ADDITIONAL SERVICES IF INDICATED BY RESIDENT NEED:

Pertinent medical/mental findings requiring follow-up by facility (e.g. skin conditions/acute or chronic pain issues) or any additional recommendations for follow-up: None ☐ or if yes, describe_____

_____

Therapies: ☐ None ☐Yes (specify): ☐ Physical Therapy ☐Speech Therapy ☐Occupational Therapy

Home Care: ☐ None ☐Yes (specify):_____ Other (Specify):_____

Is Palliative Care Appropriate/Recommended: ☐No ☐ If yes, describe services: _____

COGNITIVE IMPAIRMENT/MEMORY LOSS (including dementia)

Does the patient have/show signs of dementia or other cognitive impairment? ☐ No ☐ Yes

If yes, do you recommended testing be performed? ☐ No ☐ If yes, referral to:_____

If testing has already been performed, date/place of testing if known:_____

MENTAL HEALTH ASSESSMENT (non-dementia)

Does the patient have a history of or a current mental disability? ☐ No ☐ Yes
Has the patient ever been hospitalized for a mental health condition? ☐ No ☐ Yes

If yes, describe: _____

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral)
☐No ☐Yes Describe: _____

MEDICATIONS

Pursuant to NYCRR Title 18 487.7(f)(2), the patient is **NOT** capable of self-administration of medication if he/she needs assistance to properly carry out **ONE OR MORE** of the following tasks:

- ■ Correctly read the label on a medication container
- ■ Correctly ingest, inject or apply the medication
- ■ Open the container
- ■ Safely store the medication
- ■ Correctly follow instructions as the route, time dosage and frequency
- ■ Measure or prepare medications, including mixing, shaking and filling syringes
- ■ Correctly interpret the label

New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ **Date:** _____

Resident will receive assistance with <u>all</u> medications <u>unless</u> physician indicates that resident is capable of self-administration.

1. Does the patient/resident require assistance with medications (see criteria on page 2)? Yes ☐ No ☐
2. List all prescription, OTC medications, supplements and vitamins. Attach additional sheets if necessary or attach current discharge note, signed by the physician, listing ALL medications.

Medication	Dosage	Type	Frequency	Route	Diagnosis/Indication	Prescriber (name of MD/NP)

STATEMENT OF PURPOSE

Adult Homes (AH), Enriched Housing Programs (EHP), Residences for Adults (RFA), Assisted Living Residences (ALR), Enhanced Assisted Living Residences (EALR) and Special Needs Assisted Living Residences (SNALR):

- provide 24-hour residential care for dependent adults
- are not medical facilities
- are not appropriate for persons in need of constant medical care and medical supervision and these persons should not be admitted or retained in these settings because the facility lacks the staff and expertise to provide needed services.
- Persons who, by reason of age and/or physical and/or mental limitations who are in need of assistance with activities of daily living, can be cared for in adult residential care settings listed above, or if applicable, an EALR or SNALR.

<u>PHYSICIAN CERTIFICATION</u>

I certify that I have physically examined this patient and have accurately described the individual's medical condition, medication regimen and need for skilled and/or personal care services. Based on this examination and my knowledge of the patient, this individual (see Statement of Purpose):

☐ **Yes** ☐ **No** **Is** mentally **suited** for care in an Adult Home/Enriched Housing Program/Assisted Living Residence/ Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).

☐ **Yes** ☐ **No** **Is** medically **suited** for care in an Adult Home or Enriched Housing Program/Assisted Living Residence / Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).

☐ **Yes** ☐ **No** **Is not** in need of continual acute or long term medical or nursing care, including 24-hour skilled nursing care or supervision, which would require placement in a hospital or nursing home.

Name/Title of individual completing form:_____ **Date:**_____

Physician Signature: _____ **Date** _____

Adult Care Facility Mental Health Evaluation

Directions

In accordance with 18 NYCRR § 487.4(i), § 488.4(e)(3), and § 490.4(f), each mental health evaluation shall be a written and signed report, from a psychiatrist or other physician, physician assistant, psychologist, nurse practitioner, registered nurse, or social worker, licensed or certified and acting within their scope of practice, who has experience in the assessment and treatment of mental illness. This form must be completed prior to admission for any proposed adult care facility resident who has met established criteria (e.g., a positive pre-screen) for a mental health evaluation, or for whom the medical evaluation or resident interview suggests a psychiatric disability; for annual evaluations thereafter; and for any change in condition of a resident that would warrant such evaluation. No section of this document may be omitted or crossed out. Additional supporting documentation may be attached to this form on the professional's letterhead to clarify answers.

I. IDENTIFYING DATA

Individual's Name (Print): _____ Date of Birth (mm/dd/yyyy): _____

Current Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____

II. SERIOUS MENTAL ILLNESS

A person with serious mental illness (SMI) means an individual who meets criteria established by the Commissioner of Mental Health, which shall be persons: (1) who have a diagnosis of mental illness designated under the Diagnostic and Statistical Manual of Mental Disorders (excluding neurocognitive, substance use, and neurodevelopmental disorders); and (2) whose severity and duration of mental illness results in substantial functional disability. See guidance from the New York State Office of Mental Health (OMH) available at: https://omh.ny.gov/omhweb/guidance/serious_mental_illness.html.

A. Diagnosis of Mental Illness

1. Based upon your examination and/or review of available records, conducted within the scope of your professional practice, does this person have a diagnosis or diagnoses of mental illness designated under the Diagnostic and Statistical Manual of Mental Disorders? ☐ Yes ☐ No
2. If you answered "Yes" to Question A.1. above, list the diagnosis or diagnoses, indicate which data source(s) you used, and identify the records you reviewed:

List of Diagnosis or Diagnoses:

Indicate which data source(s) you used:

☐ a. Your examination ☐ b. A review of records ☐ c. Both your examination and a review of records

Identify the records reviewed if you checked box 2b. or 2c. above:

B. Substantial Functional Disability

1. During the five years preceding the date of this report, did the individual receive BOTH:
- Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) and
- One or more services from a provider licensed by Office of Mental Health under Article 31 of the Mental Hygiene Law (excluding services that only include an intake visit)

☐ Yes ☐ No ☐ Unknown

2. During the five years preceding the date of this report, did the individual receive any of the following? Any high-intensity Office of Mental Health ambulatory service: Health Home Plus, Home and Community Based (HCBS) Core Services, Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS), Prepaid Mental Health Plan (PMHP), or Partial Hospitalization.

☐ Yes ☐ No ☐ Unknown

3. During the five years preceding the date of this report, did the individual have EITHER of the following?
- One or more psychiatric hospitalizations for three or more days; or
- Three or more psychiatric hospitalizations.

☐ Yes ☐ No ☐ Unknown

4. At any point during the five years preceding the date of this report, was the individual hospitalized in an Office of Mental Health Psychiatric Center?

☐ Yes ☐ No ☐ Unknown

5. At any point during the five years preceding this report, was the individual a resident in Office of Mental Health-funded housing for persons with mental illness?

☐ Yes ☐ No ☐ Unknown

6. Does the individual have a current or expired Assisted Outpatient Treatment (AOT) order?

☐ Yes ☐ No ☐ Unknown

7. Does the individual have any history of mental health treatment in a county or state correctional facility, or mental health treatment in an Office of Mental Health forensic hospital, including individuals under the custody of the Office of Mental Health Commissioner (330.20 status)?

☐ Yes ☐ No ☐ Unknown

III. CURRENT PSYCHIATRIC STATUS AND SUBSTANCE USE DISORDER TREATMENT

Is the individual currently hospitalized? ☐ Yes ☐ No

If yes, please provide the following:

Name of facility: _____

Admission Date (mm/dd/yyyy): _____

Reason for Admission: _____

Clinical Course: _____

Describe any functional impairment _____

If no, name of facility and date of last in-patient psychiatric hospitalization (If applicable):

Name of facility: _____

Date of last in-patient psychiatric hospitalization (mm/dd/yyyy): _____

List primary psychiatric diagnosis first followed by remaining disorders in order of focus, attention, and treatment:

Primary Diagnosis: _____

Other Diagnosis:

Include onset of illness, in-patient and outpatient treatment, history of suicidal/homicidal behavior or ideation, violence, criminal activity, and substance use:

IV. MENTAL STATUS EXAM

Describe the individual in terms of the following characteristics:

Appearance: _____

Orientation: _____

Speech: _____

Affect: _____

Memory: _____

Intelligence: _____

Cognition: _____

Perception: _____

Suicidal/Homicidal (Ideation & Potential): _____

Judgment: _____

Insight: _____

Impulse Control: _____

V. SUMMARY OF CURRENT MEDICATION REGIMEN AND ADHERENCE

A. Describe current treatment plan and medication, including the individual's current adherence to medication, based on records reviewed:

B. Describe the frequency of treatment sessions such as therapy or counseling:

VI. TYPE OF EVALUATION AND DETERMINATION

Based upon your evaluation and your review of the Office of Mental Health guidance found at https://omh.ny.gov/omhweb/guidance/serious_mental_illness.html, indicate your determination below. Residents identified as meeting the criteria for serious mental illness must be counted within an Adult Care Facility's Serious Mental Illness census.

A. For preadmission evaluations, choose one of the following:

- ☐ The individual does not meet the criteria for serious mental illness and admission discussion may continue.
- ☐ The individual meets the criteria for serious mental illness and admission requirements per Title 18 NYCRR Subchapter D - Adult-Care Facilities apply.

B. For annual and resident change in condition evaluations, choose one of the following:

- ☐ The individual does not meet the criteria for serious mental illness.
- ☐ The individual meets the criteria for serious mental illness.
- ☐ The individual's mental health needs cannot be appropriately met in an adult care facility at this time due to the following:

VII. ATTESTATION BY PRACTITIONER

I, the undersigned, attest to the fact that I have conducted a face-to-face examination of the above-mentioned individual on _____ (enter date of face-to-face examination) and that such face-to-face examination, if conducted for an annual evaluation or due to a change in condition, was conducted no more than 30 days prior to the date of this report, which is set forth below. I further attest that the contents of this report are true and accurate to the best of my knowledge.

Practitioner's Name (printed): _____

Practitioner's Signature: _____

Title: _____ NYS License #: _____

Employer: _____

Employment Address: _____

Telephone Number: _____ Email Address: _____

Date of Report (mm/dd/yyyy): _____

VIII. ATTESTATION BY ADULT CARE FACILITY

This section must be signed by the Adult Care Facility operator, approved administrator, or case manager. Residents identified as meeting the criteria for serious mental illness must be counted within an Adult Care Facility's Serious Mental Illness census.

I, the undersigned, attest that I have reviewed the information in Sections I through VII completed by the practitioner whose signature appears in Section VII above. If conducted for the purpose of a preadmission evaluation, I attest that the date of the face-to-face examination conducted by the practitioner whose signature appears in Section VII above occurred no more than 30 days prior to the resident's admission, which occurred on _____ (enter date on which resident was admitted).

If the examination was conducted for the purpose of a preadmission evaluation, I attest to my understanding that the practitioner has determined that (check one as applicable):

☐ The individual is a person with serious mental illness because the practitioner determined that the individual has both a diagnosis or diagnoses of mental illness and a substantial functional disability as a result of mental illness.

☐ The individual is not a person with serious mental illness because the practitioner did not determine that the individual has both a diagnosis or diagnoses of mental illness and a substantial functional disability as a result of mental illness.

Name (printed): _____ Signature: _____

Title: _____

Adult Care Facility: _____

Telephone Number: _____ Email Address: _____

Date Signed: _____ (mm/dd/yyyy)

ST. MICHAEL'S HOME
Quality Care for the Elderly since 1958
3 LEHMAN TERRACE, YONKERS, NY 10705
Tel 914-476-3374 Fax 914-476-1744 www.stmichaelshome.org

Additional Information Required

Along with Medical and Mental Evaluations, which are included in the application packet, the following information will be needed to complete entry to St. Michael's Home:

1) Complete Medical History. (Medical conditions, allergies, medications, surgeries etc.)
2) Recent Lab Work. (CBC, CMP, Lipids, Hemoglobin A1c, TSH (Must be with-in 30 days)
3) PPD Test or QuantiFERON-TB Gold Blood Test for Tuberculosis. Please note if Positive for TB, Chest X-Ray results must be provided. (Must be with-in 30 days)
4) Electrocardiogram (EKG) Exam. (Must be with-in 30 days)
5) Activities of Daily Living (ADLs): Activities of daily living are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.
6) If resident is coming from a Hospital, Nursing Home or Rehab, we will need a copy of the Physical Therapy Assessment or Patient Review Instrument. (PRI)

If you have any questions please contact us at 914-476-3374 or email us at Administrator@stmichaelshome.org

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Admissions Requirement

A letter from their parish priest should be included. The letter should indicate that the applicant is a Greek Orthodox Christian in good sacramental standing (not financially). If the applicant cannot provide such a letter, kindly indicate this in the application.

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OVERVIEW

(2025)

Saint Michael's Home is a *New York State – Department of Health* certified residential adult care facility under the aegis of the Greek Orthodox Archdiocese of America. The Home is housed in a three-level brick structure which complies with the strict regulations of the local Building Department and the stringent requirements of the New York State Department of Health.

Overall, the programs and services of St. Michael's are specifically designed for those individuals who may have decreased powers of mobility and/or mental faculties (i.e., dementia & Alzheimer's). While not certified as such, the Home does offer a high level of "assisted living" in a Greek Orthodox environment and the staff assists those who need help with certain duties such as bathing, dressing, etc. At all times, every effort is made to maintain the physical and intellectual integrity of the residents, while encouraging them to preserve their independence and dignity.

Located in a bucolic residential neighborhood of Yonkers (bordering New York City to the North), the facility encompasses: furnished private and semi-private bedrooms; a beautiful dining room; a magnificent chapel where church services are conducted; a modern medical facility; a large recreation hall; an airy T.V. room; a fully equipped beauty salon; and a resplendent patio and garden, where the residents can enjoy the outdoors in warm weather.

Because of its classification as an "adult home," St. Michael's is not permitted to accept nor keep any resident who is not ambulatory, or who may require continuous medical or skilled nursing care. The Home is visited weekly by geriatric specialists and other medical technicians, and also has on duty at all times, personnel certified in first aid. Our technicians oversee distribution of all medications, and also monitor the general health of our residents.

St. Michael's is located in close proximity to several hospitals and other medical facilities for any residents in need of emergency care.

ACTIVITIES PROGRAM:
The Home offers a wide variety of activities for the benefit of the residents. Overall, this program, which is overseen by a full-time recreation coordinator' is geared to stimulate the resident both physically and intellectually to impede the aging process. It includes: arts and crafts, exercise, cooking, sewing, reading, bingo, etc. We also have volunteers spending time with our residents, visits from local Philoptochos chapters, and other groups as well.

ADMISSION:
As stated elsewhere, the strict regulations of the Department of Health mandate that all residents must be ambulatory and not require continuous skilled nursing care. While the Home is able to care for individuals who may suffer from Alzheimer's and dementia, another impediment to admission is behavior which is disruptive or violent and may compromise the safety of the individual or others. The admission process involves the completion of an application, and a medical evaluation from the applicant's physician. Once these documents have been received, an appointment will be scheduled for the applicant with the facility's physician who, after an examination, will indicate whether or not the applicant is appropriate for this type of facility.

If the resident is a Greek Orthodox Christian and we would please ask that a letter be submitted from a parish priest. It is not necessary for the candidate for admission to be Greek Orthodox or a member of a parish (i.e., someone meeting either the dues or stewardship requirement) but simply a member in good standing of the Orthodox Church.

ACCOMMODATIONS:
A non-profit institution, the Home does not receive funding from any governmental agency, or from the Archdiocese. To meet its operating budget, St. Michael's depends on two sources of income to meet its obligations. The first source is the boarding fees and the second is donations (which enable us to keep our fees at a very reasonable rate). At no time is the resident asked to turn his/her assets over to the Home, but rather on the first of every month the resident (or their representative) submits the monthly boarding fee established by the level of accommodation selected upon admission (based on their ability to meet the respective boarding fee):

Private Bedroom with private bath: $4,750 per month
Private Bedroom with use of communal bathrooms: $3,300-$3,700 per month
Semi-Private Bedroom with use of communal bathrooms: $2,700 per month

Every resident is provided with a single bed, freestanding closet, dresser and nightstand as well as all linens and towels. Common areas of the Home are open for use by all residents. Also included in the above fees are all services related to "Room and Board," i.e., daily housekeeping and laundry, three daily meals and two snacks, etc. The boarding fee does not include additional charges that may result from items such as medications not covered by insurances, or "extra" services such as a visit to the beauty salon.

For those residents requiring assistance with their daily routine above and beyond that usually provided by the Home, it may be necessary for the family to supplement the above boarding fee with an additional fee to cover the cost of this additional care. This will be determined on a case-by-case basis by the Director and the family.

Individuals unable to meet the private boarding fee may be eligible for Supplemental Security Income (SSI) from the Social Security Administration and the New York State Supplement Program (SSP). No one will be denied consideration for admission because of the inability to pay, and each case will be reviewed on an individual basis. We trust that the family of any applicant appreciates this accommodation and will not take advantage of the Home's magnanimous philanthropy, but will assist us to meet our expenses.

On occasion, time may take its toll on the overall condition of a resident and it may be necessary to transfer that individual to a Nursing Home. Before doing so, the Home (or one of the physicians serving the residents) will communicate that need to the family. At that time, either St. Michael's will make the necessary arrangements to have the resident transferred to one of the local nursing homes which offer quality care, or the family may transfer the resident to a facility of their own choosing.

Since its establishment, St. Michael's Home has offered care and comfort, both physical and spiritual, to hundreds of women and men of the Greek Orthodox community. Truly, it is a unique facility offering quality care in a loving environment where our residents are viewed as family members. The residents are accorded not only the appropriate care they need, but also the respect and love of the entire staff. One visit to the Home makes this reality very apparent to any and all visitors!

Some Often-Asked Questions about St. Michael's Home

1. How many residents are there?

The capacity of St. Michael's is 60 residents and for a number of years the Home has been operating at between 50% - 70% occupancy. While the majority of our residents are from New York, Connecticut and New Jersey, more and more individuals have been admitted from other states outside the tri-state area (because of the unique environment which the Home offers). Many residents have families but there are also a number of individuals who either never married or whose children have passed away. While in the past most residents were first generation Greek-Americans (i.e., those residents of Greek extraction who had immigrated to the U.S.), there are a growing number of American born residents of Greek extraction. **(According to the constitution of the Home, all residents must be Greek Orthodox.)**

2. What kind of staffing does the Home have?

The Home is staffed 24 hours a day, seven days a week. There is the Director (who in addition to overseeing the operation of the Home is working on the expansion of the facility), the Administrator (who is responsible for the day-to-day operation of the Home), the Assistant Administrator (who primarily coordinates the health care of the residents), a Case Manager, a Development Officer, an Administrative Assistant, a Bookkeeper, a Recreation Coordinator, a Greek Chef and two Kitchen Assistants. There are health aides who are responsible for overseeing the health of the residents as well as distributing their medications, and there are resident aides who help the residents bathe and dress and also handle the daily cleaning of the rooms, laundry, serving of meals, etc.

3. What kind of activities program does St. Michael's have?

We have a varied program of activities which not only entertains the residents but is also therapeutic. Our Recreation Coordinator overseas a full program of activities which include: arts/crafts, games, gardening, baking, bingo and exercise. Our mini-bus is used to transport the residents to the mall, plays, museums, parks and other venues outside of the Home.

During good weather, our residents are encouraged to enjoy our beautiful perennial and vegetable gardens, and the two outdoor patios which are used for activities such as horse shoes, shuffle board, etc. Important parts of the program are the group visitations to the facility by Philoptochos chapters, youth groups, societies and other organizations from the greater Greek community. During the year, hundreds of people visit this institution.

4. How much does it cost to live at St. Michael's?

The cost of living at the Home depends on the type of accommodation requested upon admission. There are three types of rooms: a private bedroom with private bathroom ($4,750 a month); a private bedroom with use of communal bathrooms in the hallway ($3,300 - $3,700 a month); and semi-private (shared) bedrooms with use of communal bathrooms in the hallway ($2,700 a month). The resident pays the appropriate boarding fee the first of each month and the cost includes room and board, all daily housekeeping & laundry services as well as assistance with daily routine (bathing, dressing, etc.).

5. What happens if an applicant cannot afford to pay?

NO applicant has been denied admission because they were unable to pay the boarding fee. As a philanthropic institution, St. Michael's has a sacred obligation to accept an individual regardless of their ability to pay. If they meet the criteria established by the Department of Health for admission, they are accepted, and may qualify for S.S.I. (Supplementary Security Income) or S.S.P. (State Supplement Program). For example, in 2025 if a person has no assets and receives a Social Security check for $800, they may apply for S.S.I. or S.S.P. If approved they will receive an additional amount of $884, for a total of $1,684. Please note this amount is set by NYS DOH. The home is entitled to the monthly boarding fee of $1,406 rather than the usual boarding fee of $2,700. As mandated by the State, the resident will receive a minimum of $255 as their personal needs allowance. Needless to say, the Home relies heavily on contributions to cover the cost of housing these individuals.

6. How much does it cost to run St. Michael's?

In 2023, our expenses related to the care of the elderly were approximately $1.6M. Of this amount, about $800,000 came from the boarding fees which the elderly were able to pay, while the balance was covered by donations. You can imagine how different life would be at the Home without these contributions, especially since St. Michael's does not receive any subsidies from outside sources such as governmental agencies or the Archdiocese.

7. What is the level of care which the Home can offer?

St. Michael's current certification from the State is that of a residential "adult Home." While not licensed as such, the Home does offer "assisted living." The primary criteria for admission in an "adult home" is that the individual must be able to ambulate (even with a walker/cane) by his/herself, i.e., cannot be permanently confined to bed or a wheelchair. In many cases, the staff also offers residents assistance with bathing, dressing, 24-hour-supervison (a number of them have some degree of dementia) and toileting (a number of residents suffer from incontinence). The Home cannot accept or keep individuals who cannot ambulate on their own or who need chronic nursing care.

During the course of a year, residents unfortunately may have to be transferred to nursing homes, because their declining health requires more care than the Home is licensed to offer. For this reason, St. Michael's is seeking to expand into a continuum care facility in Uniondale, Long Island. The Home could then offer a higher level of care, thus retaining many of those who eventually have to be transferred. We will also be able to accept others who do not meet the present criteria for admission.

8. How many facilities in the United States are there like St. Michael's?

St. Michael's is the **ONLY** institution of its kind in the entire United States and it provides the elderly with services above and beyond those mandated by the government. Licensed (and annually inspected) by the New York State Department of Health, the Home offers a unique environment where all residents are Greek Orthodox and they are afforded the opportunity to continue to practice their traditions and customs as well as to worship on a regular basis. In addition to two geriatric specialists, a podiatrist, two psychologists and a psychiatrist who all make weekly visitations, there are also a dermatologist, optometrist and audiologist who visit on a regular basis. A certified nutritionist monthly reviews the diet of the residents and the menu of the Home and arrangements have been made with the appropriate providers to be able to do blood tests, x-rays, EKG's and other tests within the facility.

9. What does the application process entail?

The application process is very simple. It entails completing an application and submitting two current photographs as well as a report from the applicant's physician regarding his/her state of health. Once these documents have been received, if there is a vacancy, an appointment will be made for the applicant with one of the Home's physicians. After this examination, the doctor will indicate whether or not the applicant is appropriate for placement in the facility. Contingent on this approval, an admission date will be set within 30 days. If there is no vacancy, the applicant's name will be placed on our waiting list once we have received **ALL** of the documentation.