Jennings

Jennings at Brecksville is located at 8736 Brecksville Road Brecksville, OH 44141

www.jenningsohio.org

216-581-2900

Jennings at Brecksville

Jennings Assisted Living suites are ideal for individuals who seek an independent lifestyle in a community with the convenience of amenities and services.

Jennings at Brecksville offers a distinctive new assisted living residence in the exceptional Brecksville community. Opened in 2017, the residence is a place where modern comforts meet traditional Western Reserve architecture for premier living.

With more than 75 years of experience, Jennings offers choices for individuals to live independently while accessing amenities and services. We respect each individual's unique preferences so you can enjoy the lifestyle you expect. Bringing together the traditions of neighborhood and home, Jennings offers you the opportunity to enjoy the everyday elements of community life while providing the extra support you may need.

Make it Home

Comfortable private suites need only your personal touch with your furniture and home furnishings. Residential options and upgrades enable you to tailor your home to make it your own. Social areas, activities and amenities invite friendships and enable the spirit of community to flourish.

Catered Living

From lifestyle choices to health and personal care, our staff provides a wide range of support to ensure your comfort and well-being. The varying service levels enable individuals to live comfortably now as well as plan for any temporary or changing needs. Service options allow for individual preferences and independence. You can choose to participate in the varied opportunities for socializing, outings and enjoying the plentiful amenities.

From catered independence to all-inclusive services, Jennings provides a number of lifestyle options. Three home-cooked meals per day and convenience services afford you more free time for socialization and enjoying daily activities. Our dedication to quality care, which we uphold through our mission and values, is demonstrated by our commitment to supporting your needs and choices.

Wellness Services

In addition to the regular health care support of licensed nursing staff, specialty physicians (such as podiatry and audiology) will be on-site to support residents. Each individual has the choice to keep his/her community physician or take advantage of Jennings' physician and wellness services. This unique addition offers the convenience of excellent health care without the worry about transportation issues.

Celebration of Life

A balance of privacy and social activity enables residents to make their own individualized choices. Cable television and internet access are provided in each assisted living suite. Celebrations, life-enriching recreational programs, amenities and lifelong learning activities provide the channel for virtually all interests.

Services and Amenities

Key Features

- Choice of spacious apartment-style suite floor plans:
  - Studio/1 bathroom
  - 1 bedroom/1 bathroom
  - 2 bedroom/1 bathroom
  - 2 bedroom/2 bathroom
- Suites feature kitchenette with refrigerator/freezer, microwave, sink, pantry and cabinets
- Secured entrance from outside; suite entry features private lock
- Three homestyle meals each day, featuring choices and anytime menu
- Cable TV and wi-fi included
- Includes electricity, gas heat, air conditioning and water. Connection for private telephone and Internet in suite (resident must choose and authorize service)
- Emergency call system
- Individual thermostat for heating and air conditioning
- Reserved parking space near building (includes snow removal)

Amenities

- Open pantry with snacks available 24 hours each day
- Free laundry facilities on each floor
- Trash chute on each floor
- Daily activities, as well as special events and regular group trips
- Transportation to daily Mass at St. Basil the Great
- Local transportation and shopping trips
- Pub with gathering space
- Beauty/barber services
- Banking services
- Spiritual programs and meditative space
- Wellness services on-site
- Fitness equipment and exercise programs
- 24-hour nursing staff support
- Routine care & service planning
- Outdoor patio and gardens
- Community rooms for private family gatherings
- Computer desk with Internet access
- Private mailbox

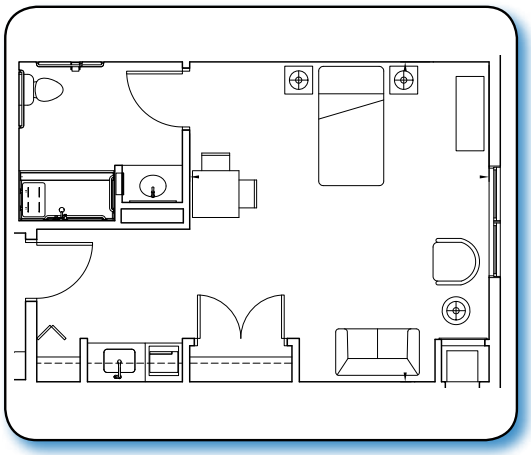
Individual Plan Highlights

In addition to the features and amenities, an individual may enrich his/her lifestyle with a supportive service plan:

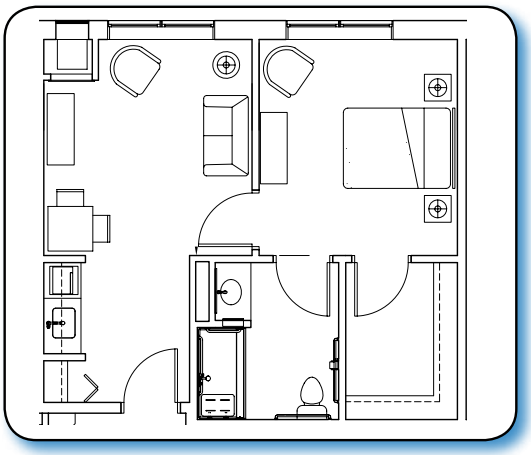
	Premier Plan	Catered Plan	Support Plan	Enhanced Plan	All-inclusive Plan
Culinary Services					
• Three (3) meals per day served restaurant style	✓	✓	✓	✓	✓
• Specialized dietary considerations	✓	✓	✓	✓	✓
• Snacks and meals available 24 hours/day	✓	✓	✓	✓	✓
Housekeeping					
• Full suite cleaning frequency	weekly	weekly	weekly	weekly	weekly or as needed
• Bed making				daily	daily
• Linen changes	weekly	weekly	weekly	weekly	weekly
• Trash removal	daily	daily	daily	daily	daily
• Laundry service provided by staff		2 loads/week		4 loads/week	full service
Health and Wellness Services					
• Check of vital signs, weight, etc.	monthly	monthly	as needed	as needed	as needed
• Assistance with arranging medical appointments			✓	✓	✓
Medication Administration					
• Administering, coordinating, ordering medications			✓	✓	✓
• Blood glucose monitoring			✓	✓	✓
Personal Care Services					
• Assistance with compression stockings, shoes, socks		✓		✓	✓
• Bathing assistance		2x per week		3x per week	as needed
• Reminders for meals		✓		✓	✓
• Regularly family requests to check on resident		✓		✓	✓
Additional Support					
• Case management and service coordination	✓	✓	✓	✓	✓
• Pastoral care services	✓	✓	✓	✓	✓
• Cueing, reminders, support, and other situational assistance					✓

Jennings

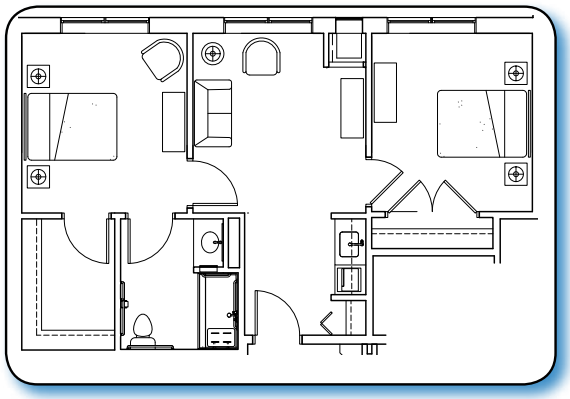
Jennings at Brecksville Suite Layouts



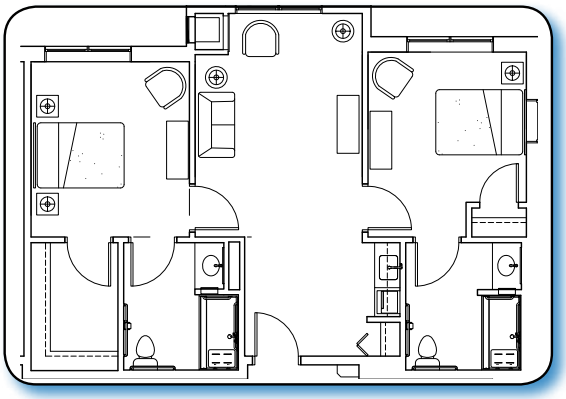
Studio/One Bath
(approximately 427 sq. ft.)



1 Bedroom/1 Bath Suite
(approximately 485 sq. ft.)



2 Bedroom/1 Bath Suite
(approximately 642 sq. ft.)



2 Bedroom/2 Bath Suite
(approximately 765 sq. ft.)

About Jennings

For more than 75 years, Jennings has nurtured the body, mind and spirit of adults over 55. Jennings is a local, vibrant, non-profit organization, rooted in its Catholic foundation and serving people of all faiths. As a continuum of care, Jennings offers a residences and services through a continuum of care in Northeast Ohio.

Our Mission

Rooted in Catholic values, Jennings celebrates and nurtures individuals as they age, through exceptional choices and continuous innovation.

We commit ourselves to our mission through:
Respect | Compassion | Community
Discovery of Potential | Celebration of Life

Brecksville
Chardon
Garfield Heights
Shaker Heights

www.jenningsohio.org

216-581-2900

Information subject to change without notice.

PUB135542FS_01012020

Jennings

Jennings at Brecksville

8736 Brecksville Road, Brecksville, OH 44141 · 216-581-2900 · www.jenningsohio.org

Monthly Rates*

Effective January 1, 2023

Application	No charge
Assessment	No charge

Residential Rates

Studio (one person)

Premier Plan	$ 3,060/month
Catered Plan	$ 3,600/month
Support Plan	$ 3,990/month
Enhanced Plan	$ 4,680/month
All-Inclusive Plan	$ 5,340/month

1 bedroom/1 bath suite

	One person	Two People
Premier Plan	$ 3,960 /month	$ 5,460 /month
Catered Plan	$ 4,680 /month	$ 6,210 /month
Support Plan	$ 5,280 /month	$ 6,840 /month
Enhanced Plan	$ 6,270 /month	$ 7,830 /month
All-Inclusive Plan	$ 7,080 /month	$ 8,670 /month

2 bedroom/1 bath suite (one or two persons)

Premier Plan	$ 6,360 /month
Catered Plan	$ 6,630 /month
Support Plan	$ 7,260 /month
Enhanced Plan	$ 7,920 /month
All-Inclusive Plan	$ 8,700 /month

2 bedroom/2 bath suite (one or two persons)

Premier Plan	$ 7,590 /month
Catered Plan	$ 7,920 /month
Support Plan	$ 8,670 /month
Enhanced Plan	$ 9,450 /month
All-Inclusive Plan	$ 10,110 /month

*Monthly rates estimated based on month with 30 days. Lease will reflect charges as daily rate.

Security Deposit (See Section II C of Residency Agreement) $1,000.00

Thank you for your interest in Jennings. Attached you will find an application to apply for an assisted living or long-term care residence at Jennings. Please complete this application, sign, and return it to us. The addresses for our Garfield Heights and Brecksville residences are listed below. Jennings does not discriminate against applicants or residents in the provision of services or in any other manner on the grounds of race, color, creed, religion, sex or national origin. **Please note that Jennings is a non-smoking campus.**

INSTRUCTIONS

The information requested in this application is required to help determine that your ability to pay for the services you are requesting. Please answer each question truthfully and completely. Incomplete or inaccurate answers to questions may delay the processing of the application, and untruthful answers may result in a denial of the application.

The application will proceed when this form (along with supporting documentation) has been completed, signed, and returned to Jennings. Please send the completed application to:

GARFIELD HEIGHTS:
Jennings
10204 Granger Road
Garfield Heights, OH 44125
ATTN: Admissions

OR

BRECKSVILLE:
Jennings at Brecksville
8736 Brecksville Road
Brecksville, OH 44141
ATTN: Admissions

The information provided will be reviewed by Jennings and is subject to independent verification by third parties. Jennings will take reasonable steps to ensure the confidentiality of the information provided; however, we cannot guarantee that the information will be kept confidential.

If a decision is made for you to become a resident of Jennings, then you will need to sign various documents, including an admission agreement. In addition, Jennings requires that another person besides the resident also sign the admission agreement. This other person is referred to as the “Representative.” The Representative will act on the resident’s behalf to satisfy his/her financial obligations under the admission agreement if the resident chooses not to, or is unable to, meet those obligations. Thus, the Representative has legal access to the resident’s income, assets or resources, including, but not limited to, social security, pension or retirement funds, annuities, insurance, bank accounts, and mutual funds.

If you have any questions or concerns, please contact us at (216) 581-2900.

Jennings

Brecksville: 8736 Brecksville Road; Brecksville, OH 44141
Garfield Heights: 10204 Granger Road, Garfield Heights, Ohio 44125
Phone: (216) 581-2900 | Fax: (216) 472-2693 | Web: jenningsohio.org

Application for Residence

Today's Date: _____ Requested Date of Residence: _____

Interest (check all that apply) ____ Assisted Living Garfield Heights ____ Assisted Living Jennings at Brecksville ____ Long-term Care ____ Respite

APPLICANT(S) INFORMATION

APPLICANT 1

Full Name

Address

Address line 2

City State Zip

Phone

Email

Sex Birthdate Age

Single Married Divorced Separated Widowed

Marital Status (circle one)

Religious Preference Parish

Are you a U.S. Citizen? □ Yes □ No

Are you a veteran? □ Yes □ No
If yes, please list branch of service: _____

Physician

Physician phone number

Health System

APPLICANT 2 (If applicable)

Full Name

Address

Address line 2

City State Zip

Phone

Email

Sex Birthdate Age

Single Married Divorced Separated Widowed

Marital Status (circle one)

Religious Preference Parish

Are you a U.S. Citizen? □ Yes □ No

Are you a veteran? □ Yes □ No
If yes, please list branch of service: _____

Physician

Physician phone number

Health System

Applicant Information

Please complete the following information. If any question does not apply, please mark "N/A"

		Applicant #1	Applicant #2
Social Security Number		_____	_____
Medicare Number		_____	_____
Private Insurance	Insurer Name	_____	_____
	Policy number	_____	_____
	Member ID#	_____	_____
Have you ever applied for Medicaid?		□ Yes □ No	□ Yes □ No
	If Yes, When?	_____	_____
	State and County	_____	_____
Please list any additional services from other sources (i.e., PASSPORT)		_____	_____

Health Information

Applicant #1

Last hospital stay approximate date(s):_____

Hospital: _____

Describe surgical history:

Describe any health conditions or challenges:

Any confusion, memory loss or wandering at night?

Applicant #2

Last hospital stay approximate date(s):_____

Hospital:_____

Describe surgical history:

Describe any health conditions or challenges:

Any confusion, memory loss or wandering at night?

Advance Directives

Have you prepared and signed any of the following advance directives?

	Applicant #1	Applicant #2
Financial Power of Attorney	□ Yes □ No	□ Yes □ No
Print Name of first FPOA	_____	_____
Print Name of second FPOA	_____	_____
Durable Power of Attorney for Health Care	□ Yes □ No	□ Yes □ No
Print Name of first HPOA	_____	_____
Print Name of second HPOA	_____	_____
Living Will	□ Yes □ No	□ Yes □ No
Provision for Do Not Resuscitate (DNR) order	□ Yes □ No	□ Yes □ No
Do you have a court appointed guardian:?	□ Yes □ No	□ Yes □ No
Print Guardian Name	_____	_____

Upon lease signing, please include copies of any documents that support your answers.

Financial Information

Monthly Income.
For each income source below, indicate the monthly amount and in whose name the account is listed.
Please provide copies of supporting documents.

Social Security	Applicant 1 $ _____	Applicant 2 $ _____	Joint $_____
Veterans Benefits	Applicant 1 $ _____	Applicant 2 $ _____	Joint $_____
Pension and/or Annuities	Applicant 1 $ _____	Applicant 2 $ _____	Joint $_____
Dividends and Interest	Applicant 1 $ _____	Applicant 2 $ _____	Joint $_____
Other _____	Applicant 1 $ _____	Applicant 2 $ _____	Joint $_____
Other _____	Applicant 1 $ _____	Applicant 2 $ _____	Joint $_____

Current Monthly Expenses.
For each expense below, indicate the monthly amount.

Home Mortgage/Rent (circle one)	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Home Maintenance Fee	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Credit Cards/Charges	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Loans	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Prescription Expenses	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Health Insurance Premium	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Household Expenses	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Homeowner's Insurance	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____

Other (for example student loans, child support, etc.)

specify $_____ ❑Applicant 1 ❑Applicant 2 ❑Joint

specify $_____ ❑Applicant 1 ❑Applicant 2 ❑Joint

Real Estate Taxes $ _____ ❑Per Year ❑Per Half-year

Asset Transfers and Trusts

Have you transferred any assets (i.e., gifts, real estate, bank accounts, money, cars, houses, jewelry, bonds, stocks, etc.) to anyone in the last five (5) years? ❑**No** ❑**Yes**
If yes, please provide the name of the person to whom you made the transfer, what was transferred, the amount/value of what was transferred and when the transfer was made (attach any additional pages if necessary):

Name	Asset Transferred	Amount/Value	Date of Transfer

Have you created any trusts in the last five (5) years? ❑No ❑Yes If yes, please provide the name of the trustee, type of trust, amount/value of the trust and the date the trust was created (attach any additional pages if necessary):

Name	Asset Transferred	Amount/Value	Date of Transfer

Financial Information

Type	Account Holder	Financial Institution	Value/Amount	Name(s) on Account in addition to Applicant	Is account held in trust?
Savings	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Savings	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Checking	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Checking	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Certificate	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Certificate	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Stock	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Bond	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Mutual Fund	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Life Insurance	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Real Estate	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Other	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Other	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No

Financial Responsibility

Applicant and/or Financial Power of Attorney please sign below:

I hereby affirm that, to the best of my knowledge, the information provided is true. I understand that Jennings will rely upon the accuracy and completeness of the above financial information in making a decision. Applicant and/or Financial Power of Attorney shall be responsible for insuring the cost of care from the applicant's funds. I/We will provide copies of legal documents (such as Financial or Durable Power of Attorney or Guardianship) upon admission.

Applicant (print name) _____ Signature _____ Date _____

Applicant 2 (print name) _____ Signature _____ Date _____

Representative _____ Signature _____ Date _____

Representative Social Security Number: _____

Required for those who have access to the applicant(s) funds.

Family Information: Contact in Case of Emergency

Name _______________ Relationship _______________ Phone: _______________
Address _______________ Cell: _______________
Email _______________ Other: _______________

Check all that apply: □ Responsible Party: Financial □ Responsible Party: Health Care □ Emergency Contact 1 □ Emergency Contact

Name _______________ Relationship _______________ Phone: _______________
Address _______________ Cell: _______________
Email _______________ Other: _______________

Check all that apply: □ Responsible Party: Financial □ Responsible Party: Health Care □ Emergency Contact 1 □ Emergency Contact

Name _______________ Relationship _______________ Phone: _______________
Address _______________ Cell: _______________
Email _______________ Other: _______________

Check all that apply: □ Responsible Party: Financial □ Responsible Party: Health Care □ Emergency Contact 1 □ Emergency Contact

Name _______________ Relationship _______________ Phone: _______________
Address _______________ Cell: _______________
Email _______________ Other: _______________

Check all that apply: □ Responsible Party: Financial □ Responsible Party: Health Care □ Emergency Contact 1 □ Emergency Contact

CERTIFICATION & SUBMISSION OF APPLICATION

The undersigned persons represent(s) that the information contained on this application form and any attached documents are true to the best of his/her/their knowledge and belief. The undersigned persons understand that Jennings will rely upon such information, and agree that any misrepresentation or material omission made by the undersigned persons in connection with this application may result in the denial of the application, the future discharge of the resident, or possible legal action against the undersigned persons.

The undersigned person(s) grant Jennings, its employees and representatives permission and authority to consult with any health care institutions, government agencies, or other entities or persons that may have information concerning the applicant's qualifications for admission and/or the information provided in this admission application. The undersigned person(s) further authorize and request all persons and entities possibly having information relevant to the applicant's qualifications for admission or the material in this application to supply such information to Jennings.

The undersigned person(s) extend immunity to and hereby release Jennings and any persons or entities from any and all liability arising out of the release of information, including otherwise privileged or confidential information. Photocopies of this release will be as binding as the original. The undersigned person(s) warrant that they can legally give the consent and authorizations made above.

Applicant 1 Signature _______________ Date _______________

Applicant 2 Signature _______________ Date _______________

If individual other than applicant is completing the application, please sign below:

Print Name _______________ Relationship to applicant(s) _______________

Signature _______________ Date _______________

Please use this blank page for any additional notes.

Jennings

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Phone: (216) 581-2900 | Fax: (216) 472-2693

PHYSICAL FORM

Patient's Last Name	First Name	MI	Sex: ☐ M ☐ F	Age	Date of Birth

Patient's Address	Phone No.

Relative/Guardian Name	Address	Phone No.
1.		
2.		

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Medical Diagnosis

Height: _____ Weight: _____

History of weight changes, please explain:

MEDICATIONS (drug, dose, frequency, route)

TREATMENTS

Dressings: _____

Aerosols/O2: _____

Foley Catheter: Size: _____ Irrigation: _____

G-Tube: _____

PROGNOSIS (circle one): Good Fair Poor Terminal

Therapy Needs: Physical_____ Occupational_____ Speech_____

REHABILITATION POTENTIAL:_____ Good _____ Fair _____Poor

PAST HISTORY

Medical:_____

_____

_____

Surgical: _____ Date: _____

_____ Date: _____

Fracture: _____ Date: _____ How Repaired?_____

PHYSICAL FINDINGS Date: _____

Eyes: _____ Nose & Throat:_____

Hearing: _____ Extremities:_____ Decubiti: _____

Teeth: _____ Dentures: _____ Skin:_____

Heart: _____ Pulse: _____ Lungs: _____ Pelvic:_____ Hernia: _____

Blood Pressure:_____ Temp.: _____ Abdomen: _____ Rectal:_____

Bowel & Bladder Condition:_____

Known Allergies:_____

DATE	PERTINENT LABORATORY RESULTS	DATE	PERTINENT LABORATORY RESULTS
_____	CBC:_____	_____	TOTAL PROTEIN:_____
_____	HCT & HGB:_____	_____	BUN:_____
_____	URINALYSIS: _____	_____	EKG: _____
_____	FASTING BL. SUGAR:_____	_____	EEG: _____

Date of Last Chest X-Ray: _____ Results:_____

History of T.B. ☐ Yes ☐ No Date: _____ Treatment: _____

Immunization Dates: Tetanus:_____ Flu: _____ Pneumovax: _____ Shingles:_____

Other(s), please note: _____

PATIENT INFORMATION

Self Care Status: (Check 1 level of ability.) Key: **I** - independent, **A** - needs assistance, **U** - unable to do. Write **S** if needs supervision only.
Draw line across if inapplicable.

ACTIVITY	I	A	U	
Bed Activity				Turns Sits
Personal Hygiene				Face, Hair, Arms Trunk, Perineum Lower Extremities Bladder Program Bowel Program
Dressing				Upper Extremities Trunk Lower Extremities Appliance, Splint
Transfer				Sitting Standing Tub Toilet
Locomotion				Wheelchair Walking Stairs

ADDITIONAL PERTINENT INFORMATION

(Explain necessary details of care, diagnosis, medication, treatments, prognosis, teaching, habits, preferences, etc.)

Glasses _____ Hearing Aid _____
Dentures _____ Contact Lenses _____

Colostomy_____ Cane_____ Wheelchair _____
Prosthesis _____ Walker _____ Recliner Chair_____

BED

Pressure Relieving Mattress ☐Yes ☐No
Other: _____
Transfer Aide?: ☐Yes ☐No

BEHAVIOR

_____ Cooperative _____Agitated
_____ Noisy _____Suspicious
_____ Withdrawn _____Wanders
_____ Aggression

MENTAL STATUS

_____ Alert_____Forgetful _____ Confused
Psychiatric Evaluation ☐ Yes ☐No

COMMUNICATION ABILITY

☐ Yes ☐No Can speak
☐ Yes ☐No Can write
☐ Yes ☐No Understands speaking
☐ Yes ☐No Understands writing
☐ Yes ☐No Understands gestures
☐ Yes ☐No Understands English
If no, state language spoken:_____

DIET

Regular:_____Soft:_____Pureed: _____
Liquids _____

No Conc. Sweets: _____Diabetic I: _____

Diabetic II:_____Supplements:_____

_____

Feeds Self:_____Needs Help: _____
Part:_____All:_____

TUBE FEEDING

Product: _____
Amount: _____Frequency: _____
Type of Tube:_____
Date of Insertion_____
Other: _____
_____
_____

SOCIAL INFORMATION

(Adjustment to disability, emotional support from family, motivation for self care, socializing ability, financial plan, family health problem, etc.)

Is the patient able to safely self-medicate? ☐Yes ☐No

I have assessed and determined that this patient **has cognitive challenges such that he/she would be best served in a secured neighborhood** and would benefit from the specialized dementia programming on the memory care area. ☐Yes ☐No

To the best of my knowledge, the applicant is not suffering from a contagious disease. ☐True ☐See notes

PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S NAME _____ PHONE _____ FAX _____
(please print)

CONTINUATION OF CARE: I will continue care at Jennings ☐Yes ☐No If yes, alternate physician:_____ Phone _____

PATIENT REFERRED TO DOCTOR_____I REQUEST CONSULTATION WITH DOCTOR_____