ROCHESTER PRESBYTERIAN HOME
Assisted Living & Memory Care Residences
Extend your family

256 Thurston Road • Rochester, NY 14619 • P (585) 235.9100 • F (585) 235.1315 • www.rph.org

Admission Application

Date of Application: _____

Preferred Community: ____Cottage Grove ____ Presbyterian Home ____ Creekstone

Application Demographics:

Name of Applicant: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____
Current Location of Applicant: (please check)
___ Own Home/Apartment ___ With Family Member
___ Hospital ___ Other Care Provider

Social Security Number: _____ Birth Date: _____
Sex: ____ Female ____ Male
Marital Status: ____ Single ____ Married ____ Widowed ____ Divorced
Religious Affiliation: _____ Church: _____

Life Time Occupation:
_____
_____
Veteran (self or spouse): _____ Branch: _____

Primary Care Physician's Name: _____
Phone: _____Address:_____
Local Hospital of choice, (If hospitalization is ever needed): _____
Other Physicians that the Applicant is known to,
(Example: Dentist, Cardiologist, Neurologist, Psychiatrist, Ophthalmologist, Orthopedist, etc…)

*****Please provide a Physician Names, Addresses, Specialty and Telephone Numbers:**

_____
_____
_____
_____

Applicant's Insurance Information:
Medicare Number: _____
Other Health Insurance: _____
Policy Number: _____
Long Term Care Insurance: _____
Policy Number: _____
Prescription Coverage: _____

Applicant's Representative for Health Care Decisions:

_____ Check here if Rep same as Financial representative or complete below

Name: _____ Relationship: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: _____ Work: _____ Cell: _____ Pager: _____

Health Care Proxy: _____ Yes _____ No
Living Will/Advance Directives in Place: _____ Yes _____ No
Memorial Arrangements in Place: _____ Yes _____ No
Arrangements planned with: _____
Anatomical Gift Program: _____ Yes _____ No

Copies of the following documentation will be requested,

- Medicare Card
- Insurance Cards (Health Insurance, Prescription Insurance &/or Long term care insurance)
- Power of Attorney
- Health Care Proxy &/or any Advance Directives, (MOLST, Living Will, etc…)
- Social Security Card
- Anatomical Gift Donor Card (If indicated)

Please bring applicable items to the Pre Admission Appointment for copies to be made or feel free to attach copies to our application.

The Rochester Presbyterian Home is a not for profit Adult Home. We respect the rights of all people and applications are considered without regard to race, creed, color, age, gender, marital status, disability, sexual orientation, national origin or sponsor.

Applicant's Representative for Financial Decisions:
Name: _____ Relationship: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____ Home Telephone: _____ Work: _____ Cell: _____ E-mail: _____

Bank Power of Attorney: _____ Yes _____ No
Durable Power of Attorney: _____ Yes _____ No
Conservatorship/Guardian: _____ Yes _____ No
Does the Applicant have a trust? _____ Yes _____ No

Has there been a transfer of funds/assets/real estate in the past 36 months?
_____ Yes _____ No

Applicant's Financial Information:
Monthly Income:
Salary: $_____
Social Security: $_____
Pension: $_____
Other Income: $_____
Total Monthly Income: $_____
Assets:
Owns Real Estate: $_____
Life Insurance (cash value): $_____
Savings: $_____
Investments: $_____
Other Assets Estimated Value: $_____
Total Value of Assets: $_____
Liabilities:

Home Mortgage: $_____
Loan/Installment Payments: $_____
Other Liabilities: $_____

Additional Financial Information:
_____
_____
_____

Signature of Applicant's Financial Representative _____

_____
Date

Please list**, in order of preference,** the four family members/friends whom you would like us to contact in the event of an emergency:

Name: _____ Relationship: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone:_____ Work _____
Cell Phone _____ E-Mail _____

Name: _____ Relationship: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone:_____ Work _____
Cell Phone _____ E-Mail _____

Name: _____ Relationship: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone:_____ Work _____
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Name: _____ Relationship: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone:_____ Work _____
Cell Phone _____ E-Mail _____

ROCHESTER PRESBYTERIAN HOME
Adult Living & Dementia Care Communities
Extend your family.

"Sharing the Caring"

Please complete this form to the best of your knowledge. This will be utilized to develop a wellness plan that will address your loved one's unique needs and interests.
Thank you!

Elder's Name:_____
Prefers to be called: _____

Social History:
Elder's Date of Birth: _____
Elder's Birthplace: _____
Elder's Religion: _____
Elder's Church: _____

Childhood:
Father's Name: _____Mother's Name:_____
Parent's Occupation: _____
Siblings:_____
_____
Where Elder was raised: _____
Elder's Education: _____
(note College/University and type of degree ('s)
Other Information related to Childhood:
_____
_____ _____

Adulthood:
Marital Status: _____ (if widowed, approximately how long? _____)
Spouse's Name: _____
Names of Children:
_____
_____
_____
_____
_____
Occupation, ('s): _____
Hobbies and Interests:_____
Service in Armed Forces:_____
Place('s) of residence and approximate length of time:
_____
_____

Elder hood:
Interests pursued over the last 5 years:

Daily activities:

Persons of significance in the elder's current life:

Does this elder suffer from loneliness, helplessness or boredom?
What alleviates this suffering?

Does this elder find fulfillment through:
_____spiritual endeavors _____1:1 companionship _____caring for pets
_____caring for plants/gardens _____interacting with children ____caring for others _____useful work roles

Other social interest include:

Other interesting facts about this elder:

Personal Care Needs:

Communication/Sensory Skills		
Speech	No concerns_____	Difficulty with word finding_____ Difficulty Speaking_____ Speaks a language other than English_____ Other, (processing delay, word loss, impediment): _____
Hearing	No concerns_____	Slight hearing deficit_____ Significant hearing deficit but will not use hearing aid_____ Hearing deficit well accommodated by hearing aid _____ Hearing deficit despite use of hearing aid _____
Vision	No concerns_____	Visual deficit accommodated by glasses_____ Legally Blind_____ Glasses only for reading _____ Other history, (Cataracts, Glaucoma, Macular Degeneration), other? _____
Mobility		
Walking	No concerns_____	Walking accommodated by cane or walker _____ Utilizes a wheelchair independently_____ Please note any known "falls" in the past 6 months: _____
Nutrition		
Eating	No concerns____	Needs encouragement to eat _____ Needs monitoring for overeating _____ Problematic Weight loss_____ or Weight Gain_____ Concerns:_____ Favorite Foods:_____ Food Dislikes:_____
Grooming/Hygiene		
Bathing	Independent_____	Needs Reminders but physically independent _____ Needs 1:1 assistance with bathing/showers _____ Prefers shower_____ or bath_____ Frequency and time of day preferred:_____
Grooming	No concerns_____	Needs assistance with brushing teeth_____ Own teeth, dentures or partials? _____ Needs assistance with brushing hair _____ Needs assistance with washing in am and pm _____ Needs assistance with shaving _____ Likes to wear make up and needs assistance applying _____
Dressing	Independent ____	Needs reminders to change clothing _____ Needs assistance in dressing _____ Needs assistance with socks and shoes _____ Wears support stockings? _____
Toileting	Independent ____	Needs reminders to use the bathroom _____ Wears protective wear_____ (any type?)_____ Needs assistance changing protective wear _____
Sleeping Habits and Routines		Preferred wake up time? _____ Preferred bed time? _____ Any routine "napping preferences"? _____ _____ Any concerns regarding night time sleep patterns? _____