Rochester Presbyterian Home

256 Thurston Road | Rochester, NY 14619 P 585.235.9100 F 585.235.1315 rph.org

"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) of Elder:_____ 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

☐ interacting with children ☐ caring for others ☐ useful work roles

Other social interest include:

_____

_____

Other interesting facts about this Elder:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Personal Care Needs:

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?

Walking

☐ No concerns
☐ Walking accommodated by cane or walker
☐ Utilizes a wheelchair independently
Please note any known "falls" in the past 6 months:

_____
_____
_____
_____
_____

Eating

☐ No concerns
☐ Needs encouragement to eat
☐ Needs monitoring for overeating
☐ Problematic Weight loss ☐ or Weight Gain
Concerns: _____
Favorite Foods: _____
Food Dislikes: _____

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?
_____
Other: _____

Admission Application

Date of Application: _____
Preferred Community: ☐ Cottage Grove ☐ The Homestead ☐ 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:	$_____	Savings:	$_____
Salary:	$_____	Investments:	$_____
Social Security:	$_____	Other Assets Estimated Value:	$_____
Pension:	$_____	Total Value of Assets:	$_____
Other Income:	$_____	Liabilities:	$_____
Total Monthly Income:	$_____	Home Mortgage:	$_____
Assets:	$_____	Loan/Installment Payments:	$_____
Owns Real Estate:	$_____	Other Liabilities:	$_____
Life Insurance (cash value):	$_____		

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: _____ E-mail: _____

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

Name: _____ Relationship: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
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