



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 _____
Cell Phone _____ E-Mail _____

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:

<i>Communication/Sensory Skills</i>		
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? _____
<i>Mobility</i>		
Walking	No concerns _____	Walking accommodated by cane or walker _____ Utilizes a wheelchair independently _____ Please note any known "falls" in the past 6 months: _____
<i>Nutrition</i>		
Eating	No concerns _____	Needs encouragement to eat _____ Needs monitoring for overeating _____ Problematic Weight loss _____ or Weight Gain _____ Concerns: _____ Favorite Foods: _____ Food Dislikes: _____
<i>Grooming/Hygiene</i>		
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? _____