



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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> spiritual endeavors       | <input type="checkbox"/> 1:1 companionship | <input type="checkbox"/> caring for pets   |
| <input type="checkbox"/> interacting with children | <input type="checkbox"/> caring for others | <input type="checkbox"/> 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:

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### 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:**

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**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: \_\_\_\_\_

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Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Work: \_\_\_\_\_

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Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_