Rochester
Presbyterian Home

Leading The Way In Memory Care Since 1925

Admissions Application

Rochester Presbyterian Home

Application Part 1/3

Personal Data Form

This form essential for gathering critical information about a resident's medical history, current medications, personal preferences, and emergency contacts. It ensures that our staff can provide personalized care, respond effectively to emergencies, and respect the resident's lifestyle choices.

This form also covers legal and financial details, streamlining communication with family and handling administrative tasks. All information is kept confidential and helps ensure a smooth transition into assisted living with the necessary support in place. Please complete this form to ensure we have accurate information for records and communication purposes.

Below are some Frequently Asked Questions:

1. **Resident's Name:** Please write their legal name.
2. **Facility Name:** Please write what RPH Community you are applying to (Cottage Grove, Creekstone or Homestead).
3. **Room Number:** Can be left blank until admission.
4. **Date of Admission and County:** Can be left blank until admission.
5. **Address Admitted From:** Please write the current address of their home, hospital or current facility.
6. **Discharge Date, To, and Reason for Discharge:** Can be left blank.
7. **Podiatry Services at RPH:** Please note if you would are approving or declining podiatry services at our community.
8. **Hospital/Clinic of Choice:** If you have no preference, RPH recommends Highland Hospital located at 1000 South Ave, Rochester, NY 14620.

For assistance completing this form, please call our Admissions Office at (585) 235-9100 ext. 104 or email admissions@rph.org.

RESIDENT PERSONAL DATA FORM / FACE SHEET

Resident's Name: _____

Facility: _____ Room #: _____

ADMISSION / DISCHARGE INFORMATION

Date of Admission: _____ **County:**_____

Admitted from: ☐ **Own Home** ☐ **Hospital** ☐ **NH** ☐ **OMH** ☐ **Other (specify):** _____

Address Admitted from (Street, City, State, Zip): _____

Discharge Date: _____ **Discharge to:** ☐ **Own Home** ☐ **Hospital** ☐ **NH** ☐ **OMH**

☐ **Other (Specify):** _____

Address Discharged to (Street, City, State, Zip Code): _____

Reason for Discharge:_____

Are you a veteran? ☐ **Yes** ☐ **No** **Are you the spouse of a veteran?** ☐ **Yes** ☐ **No**

SECTION 1: PERSONAL DATA

Date of Birth: _____/_____/_____ Gender: ☐ M ☐ F Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Partner
Month Day Year

NOTIFY IN CASE OF EMERGENCY

Name _____

Relationship _____

Home: _____ Cell:_____

Email:_____ Other:_____

Address _____

City _____ State _____ Zip _____

ATTENDING PHYSICIAN

Name _____

Address _____

City/State/Zip _____ Email: _____

Phone:_____ Fax:_____

OTHER HEALTH CARE PROVIDERS

Name _____

Specialty _____ Email: _____

Phone: _____ Fax:_____

Address _____

City _____ State _____ Zip _____

Name _____

Specialty _____ Email: _____

Phone: _____ Fax:_____

Address _____

City _____ State _____ Zip _____

OTHER HEALTH CARE PROVIDERS

Name _____

Specialty _____ Email: _____

Phone: _____ Fax:_____

Address _____

City _____ State _____ Zip _____

Name _____

Specialty _____ Email: _____

Phone: _____ Fax:_____

Address _____

City _____ State _____ Zip _____

Podiatry Services at RPH? ☐ Approved ☐ Declined

AREA HOSPITAL / CLINIC OF CHOICE

Name _____

Address_____

Additional Information:_____

_____

New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE
RESIDENT PERSONAL DATA FORM

Resident's Name: _____ Facility Name: _____

Room Number: _____

SECTION 1: PERSONAL DATA Cont.: HEALTH INSURANCE

Insurer _____ ID # _____

Medicaid No. _____

Medicare No. _____

Prescription Drug Plan (if any) _____

Plan ID # _____

Other Health Care Coverage _____

_____

PHARMACY

Pharmacy(ies) _____

_____

Phone _____ Email _____

Address(es) _____

_____

City _____ State _____ Zip_____

SECTION 2: PERSONAL BACKGROUND

Wishes to be addressed as: _____

Address (if different from ALR): _____

Resident's Financial Rep: _____

Relationship: _____

Address: _____

_____

Phone: Home _____

Cell _____

Email: _____

Significant Other: _____

Relationship: _____

Address: _____

_____

Phone: Home _____

Cell _____

Email: _____

Resident's Representative: _____

Relationship: _____

Address: _____

_____

Phone: Home _____

Cell _____

Email: _____

Significant Other: _____

Relationship: _____

Address: _____

_____

Phone: Home _____

Cell _____

Email: _____

Residential Background (born/raised, lived most of life): _____

_____

Occupational/Educational Background: _____

_____

Religious Affiliation (if any): _____ **Place of Worship:** _____ **Phone:** _____

Health Care Proxy: ☐ Yes ☐ No _____ **(Name)**

Power of Attorney: ☐ Yes ☐ No _____ **(Name)**

DNR: ☐ Yes ☐ No

MOLST: ☐ Yes ☐ No

Living Will: ☐ Yes ☐ No

Burial Instructions: _____

_____

****This is a double-sided form. Please complete BOTH sides!**

Rochester Presbyterian Home

Application Part 2/3

Financial Eligibility Form

Thank you for your interest in admission to RPH. To financially qualify for any of our communities, we kindly ask that you complete the following form and provide supporting documentation with your application.

1. **Qualifications:** In order to financially qualify, applicants must demonstrate that their income/assets can cover at least 3 years of rent.
2. **Documentation:** For each income or asset listed, please submit 3 recent statements that verify the amounts reported. For example, if you list $1,500/month in Social Security, please provide 3 recent statements that reflect that being deposited.
3. **Accuracy:** All financial information you provide must match the documentation you submit. Discrepancies and incomplete information could delay your application.

Monthly Income	Resident's	Spouse's	
Earned Income	$_____	$_____	Institution Name: _____
Social Security	$_____	$_____	Institution Name: _____
Pension	$_____	$_____	Institution Name: _____
Veteran's Benefits	$_____	$_____	Institution Name: _____
Disability	$_____	$_____	Institution Name: _____
Retirement Plans	$_____	$_____	Institution Name: _____
Other Income	$_____	$_____	Institution Name: _____
Total Monthly Income	$_____	$_____	Institution Name: _____

Assets	Resident's	Spouse's	
Life Insurance (cash value)	$_____	$_____	Institution Name: _____
Checking Account	$_____	$_____	Institution Name: _____
Savings Account	$_____	$_____	Institution Name: _____
IRA/TDA/TSA	$_____	$_____	Institution Name: _____
Other Assets (approx. value)	$_____	$_____	Institution Name: _____
Real Estate (approx. value)	$_____	$_____	Address: _____
☐ *Selling to cover monthly rent*			
Total Value of Assets	$_____	$_____	Institution Name: _____

Investments	Resident's	Spouse's	
Total Value of Investments	$_____	$_____	Institution Name: _____

Monthly Expenses & Liabilities	Resident's	Spouse's	
Home Mortgage	$_____	$_____	Institution Name: _____
Loans	$_____	$_____	Institution Name: _____
Installment Payments	$_____	$_____	Institution Name: _____
Other Liabilities	$_____	$_____	Institution Name: _____
Total Liabilities	$_____	$_____	Institution Name: _____

LTC Insurance _____ Policy # _____ Effective _____

Do you have a trust fund? ☐ YES or ☐ NO **Can principal of the trust be used if needed?* ☐ YES or ☐ NO
Is the trust: ☐ Revocable ☐ Irrevocable ☐ Special Needs/Pooled Trust
Are assets held jointly? ☐ YES or ☐ NO If so, with whom? _____

List information below regarding expiration dates on the above listed sources of income… pension and annuity plans survivor benefits… if amounts are reduced and to what level… etc. If married, indicate any assets that will not be available to your spouse after death.

_____
_____
_____
_____

Has there been a transfer of funds/assets/real estate in the past 5 years? ☐ YES or ☐ NO
If yes, please explain here _____

Do you expect any significant financial changes in the next 3-5 years? ☐ YES or ☐ NO
If yes, please explain here _____

Disclosure Statement

☐ I hereby declare that all statements made in this application are true and complete according to the best of my knowledge and belief. I understand that the sponsor is relying on my representations herein determining whether to enter into a residency agreement.

In witness whereof, the applicant or applicant's representative, has read and understands this statement.

Signature _____ **Date** _____

Rochester Presbyterian Home

Application Part 3/3

Sharing is Caring Form

Please complete this form to help us get to know you or your loved one better and provide personalized care and support.

Personal Information

Legal Name of Applicant (Elder) _____

Preferred Name _____ Date of Birth _____

Geographical Background

Birthplace _____ Hometown _____

Other Cities Lived (and approx. time spent) _____

Family & Relationships

Father's Name _____ Mother's Name _____

Occupation _____ Occupation _____

Siblings? YES or NO

Names of Siblings _____

_____

_____

Marital Status

☐ Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partnership

Spouse's Name _____ If widowed, approx. how long? _____

Children? YES or NO

Number of Children? _____

Names of Children _____

_____

_____

Significant Persons in Elder's Life _____

Spiritual & Service Background

Religion _____ Church _____

Active Since _____

Military Service _____ Branch _____

Active Since _____

Education & Employment

High School _____ College/University _____

Degree _____ Former Occupation _____

Other Information _____

Lifestyle

Social Preferences (please check all that apply)

☐ Prefers to be alone ☐ One-on-one interaction ☐ Small groups ☐ Large gatherings

Emotional Support (how is Elder comforted during challenging times) _____

_____

Describe how the Elder currently spends their day _____

_____

_____

Does the Elder find fulfillment/happiness through any of the following?

☐ Spiritual Endeavors
☐ Pets and Animals
☐ Interacting with Children
☐ Caring for Others
☐ 1:1 Companionship
☐ Plants and Gardens
☐ Work-Related Roles
☐ Other _____

Activities & Hobbies

☐ Reading
☐ Drawing
☐ Painting
☐ Dancing
☐ Music
☐ Writing
☐ Theatre
☐ Photography
☐ Crafts
☐ Bingo
☐ Board & Card Games
☐ Television & Movies
☐ Culinary
☐ Exercise
☐ Walking
☐ Yoga
☐ Outdoors
☐ Fashion
☐ Sports
☐ Gardening
☐ Birdwatching
☐ Knitting & Crocheting
☐ Sewing & Quilting
☐ Sports
☐ Fishing
☐ Woodworking
☐ Model Building

Hobbies or Interests Outside of the Listed Activities _____

_____

_____

Category	No Concerns	Care Assessment
Speech & Hearing	☐	Difficulty with word finding? YES or NO Difficulty speaking? YES or NO Slight hearing deficit? YES or NO Significant hearing deficit? YES or NO Uses a hearing aid? YES or NO Language(s) other than English? _____ Other (dementia diagnosis, processing delay, word loss? _____
Vision	☐	Legally blind? YES or NO Visual deficit? YES or NO Wears glasses? YES or NO or READING ONLY Other (cataracts, glaucoma, macular degeneration)? _____
Walking	☐	Falls within the past 6 months? YES or NO Please note when _____ Uses cane or walker? YES or NO Uses wheelchair? YES or NO Needs assistance? YES or NO
Eating	☐	Forgets to eat? YES or NO Monitor for overeating? YES or NO Problematic weight loss? YES or NO Problematic weight gain? YES or NO Favorite foods? _____ Food dislikes? _____ Other concerns? _____
Bathing	☐	Preferred method? SHOWER or BATH Needs reminders to bathe? YES or NO Needs 1:1 assistance with bathing? YES or NO How often do they bathe/shower? _____ Preferred time of day? _____
Restroom	☐	Assistance needed? PARTIAL or FULL Incontinence related to… BLADDER or BOWEL Needs reminders to use restroom? YES or NO Wears incontinence briefs? YES or NO Needs help changing briefs? YES or NO Type of protective wear? _____
Sleeping	☐	Preferred wake-up time? _____ Bedtime? _____ Any routine “napping preferences”? _____ Any concerns regarding nighttime sleep patterns? _____
Grooming & Dressing	☐	Assistance needed dressing? FULL or PARTIAL Needs assistance brushing teeth? YES or NO Needs assistance brushing hair? YES or NO Needs assistance shaving? YES or NO Needs assistance with socks and shoes? YES or NO Owns teeth, dentures or partials? YES or NO Needs reminders to change clothing? YES or NO Needs assistance washing in AM/PM? YES or NO Wears makeup and needs help applying? YES or NO Wears support stockings? YES or NO

Personal Preferences

Ideal Atmosphere or Environment _____
Favorite Books, TV Shows, Movies, Music _____
Preferred Forms of Relaxation _____
Favorite Colors, Clothing, Items _____
Any Specific Cultural Preferences _____
Favorite Holiday or Celebration _____
Any Specific Travel Destinations or Memories _____
_____
Any Special Requests or Considerations _____
_____

We Want To Know!

Share with us anything you want our care team to know about your loved one! We are eager to learn every detail so that we can offer the most compassionate care possible. Your notes will help our devoted care team create a nurturing and personalized environment for them.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____