

Application for Admission

Rochester Presbyterian Home

Thank you for considering Rochester Presbyterian Home as a potential new home for your loved one. For more than 100 years, we have provided a loving home for elders, offering compassionate memory care in a warm, person-centered environment.

Our three memory care residences support elders living with dementia, Alzheimer's disease, and other memory impairments. At Rochester Presbyterian Home, we believe every individual deserves dignity, purpose, and meaningful relationships. Through specialized dementia training and a deep commitment to person-centered care, our team helps each elder maintain the highest possible level of independence, comfort, and well-being while honoring their unique abilities, preferences, and life experiences.

The information in this application will help us learn more about your loved one, their care needs, preferences, and personal history. This information is essential in determining whether we can safely and appropriately meet their needs and develop an individualized plan of care.

We understand that choosing a memory care community is an important decision. Our Admissions Team is available to answer your questions and guide you through the application process. We appreciate the opportunity to learn more about your loved one and look forward to exploring whether Rochester Presbyterian Home is the right fit for your family.

The RPH Admissions Application consists of four sections:

1. Personal Data Form (NYS DOH Form 4397-A).
2. Financial Eligibility Worksheet and three months of financial statements.
3. Sharing is Caring Form.
4. Email the POA legal documentation.

Email completed forms, POA documents and financial statements to admissions@rph.org
It is not necessary to email this cover page.

Instructions for Part 1 - Personal Data Form:

Resident's Name: Please write residents full legal name.

Facility Name: Please write what RPH Community you are applying to (Cottage Grove, Creekstone or Homestead).

Admission / Discharge Section: Please complete the information on where elder is being admitted from and address.

Section 1. Personal Data: Fill in each line or write N/A if no other names to be provided.

Section 2. Hospital/Clinic of Choice: If you have no preference, reference the following:

Highland Hospital located at 1000 South Ave, Rochester, NY 14620

Rochester General Hospital located at 1425 Portland Ave, Rochester, NY 14621

Unity Hospital located at 1555 Long Pond Rd, Rochester, NY 14626

Thompson Health located at 350 Parrish Street, Canandaigua, NY 14424

Burial Instructions: Complete each section or write N/A.

Please complete each part and section fully. Do not leave any section blank. Write NA if a section or question does not have an answer so that we know it was intentionally left blank.

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

Resident's Name: _____ Facility Name: _____

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: _____

SECTION 1: PERSONAL DATA

Date of Birth: ____/____/____ Gender: M F
 Month Day Year

Status: Married Single Divorced Widowed Partner

NOTIFY IN CASE OF EMERGENCY

Name _____
 Relationship _____
 Home: _____ Work: _____
 Cell Phone: _____ Other: _____
 Address _____
 City _____ State _____ Zip _____

ATTENDING PHYSICIAN

Name _____
 Address _____
 City _____ State _____ Zip _____
Phone: _____ **Fax:** _____

OTHER HEALTH CARE PROVIDERS

Name _____
 Specialty _____
 Phone: _____ Fax: _____
 Address _____
 City _____ State _____ Zip _____
Name _____
 Specialty _____
 Phone: _____ Fax: _____
 Address _____
 City _____ State _____ Zip _____

OTHER HEALTH CARE PROVIDERS

Name _____
 Specialty _____
 Phone: _____ Fax: _____
 Address _____
 City _____ State _____ Zip _____

Name _____
 Specialty _____
 Phone: _____ Fax: _____
 Address _____
 City _____ State _____ Zip _____
Name _____
 Specialty _____
 Phone: _____ Fax: _____
 Address _____
 City _____ State _____ Zip _____

AREA HOSPITAL / CLINIC OF CHOICE

Name _____
 Address _____
Additional Information: _____

Resident's Name: _____ Facility Name: _____

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 _____ Phone _____

Address(es) _____

City _____ State _____ Zip _____

SECTION 2: PERSONAL BACKGROUND

Wishes to be addressed as: _____

Address (if different from ALR): _____

Resident's Representative: _____

Relationship: _____

Address: _____

Phone: Home _____

Work _____

Cell _____

Significant Other: _____

Relationship: _____

Address: _____

Phone: Home _____

Work _____

Cell _____

Resident's Representative: _____

Relationship: _____

Address: _____

Phone: Home _____

Work _____

Cell _____

Significant Other: _____

Relationship: _____

Address: _____

Phone: Home _____

Work _____

Cell _____

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)

DNR: Yes No

Power of Attorney: Yes No _____

(Name)

Living Will: Yes No

Burial Instructions: _____

Financial Eligibility Form

APPLICANT'S NAME _____

RPH COMMUNITY _____

Please provide a copy of the POA legal documentation with the Application.

In order to be eligible for admission to RPH, applicants must demonstrate that the resident's monthly income and assets can cover at least three to five years of care.

Please submit three months of financial statements to support your application.

The financial statements should must match the information you submit. Discrepancies and incomplete information could delay your application. For example, if you list \$1,500/month in Social Security, please provide 3 recent bank statements that reflect that amount being deposited.

Do not include assets that do not belong to the resident or assets that are not available to support their care.

Monthly Income

Earned Income	\$ _____	Institution Name: _____
Social Security	\$ _____	Institution Name: _____
Pension/Retirement Plans	\$ _____	Institution Name: _____
Veteran's Benefits	\$ _____	Institution Name: _____
Disability	\$ _____	Institution Name: _____
_____	\$ _____	Institution Name: _____
_____	\$ _____	Institution Name: _____
Total Monthly Income	\$ _____	

Assets

Checking Account	\$ _____	Institution Name: _____
Savings Account	\$ _____	Institution Name: _____
IRA/TDA/TSA	\$ _____	Institution Name: _____
Life Insurance (cash value)	\$ _____	Institution Name: _____
_____	\$ _____	Institution Name: _____
_____	\$ _____	Institution Name: _____
Real Estate (approx. value)	\$ _____	Address: _____
☐ Home WILL be sold ☐ Home WILL NOT be sold ☐ Home will be sold IF NEEDED to support care expenses		

Total Value of Assets **\$ _____**

Montly Expenses & Liabilities of Resident

List any expenses that the resident will continue to be liable for.

Home Mortgage	\$ _____	Institution/End Date: _____
Loans	\$ _____	Institution/End Date: _____
Installment Payments	\$ _____	Institution/End Date: _____
Other Liabilities	\$ _____	Institution/End Date: _____
Total Liabilities	\$ _____	Institution/End Date: _____

General:

Are assets held jointly? ☐ Yes ☐ No If so, what and with whom? _____

Are any of the assets listed unavailable to the resident to support care?

Explain: _____

Provide any other information regarding expiration dates on the above listed sourced 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.

Do you expect any significant financial changes in the next 3-5 years? ☐ Yes ☐ No

If yes, please explain _____

Long Term Care Insurance:

Company _____ Policy # _____ Effective _____

Is there a waiting/elimination period? ☐ Yes ☐ No # of days _____

Has LTC Insurance previously been accessed? ☐ Yes ☐ No

What is the current available benefit? _____

Trust Fund:

Do you have a trust fund? ☐ Yes ☐ No Can principal of the trust be used if needed? ☐ Yes ☐ No

Is the trust: ☐ Revocable ☐ Irrevocable ☐ Special Needs/Pooled Trust

What are the terms of the trust? _____

Is the resident the owner/sole beneficiary of the trust? ☐ Yes ☐ No Explain _____

Who are the beneficiaries of the trust? _____

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 RPH is relying on my representations herein to determine whether to enter into a residency agreement.

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

Signature _____ Date _____

Sharing is Caring Form

We want to know who your loved one is and how we can best meet their needs. Please complete this form to the best of your ability so we can provide personalized care and support.

Personal Information

Legal Name of Applicant (Elder) _____

Preferred Name _____ Date of Birth _____

Advanced Directives

☐ HCP ☐ MOLST ☐ Living Will ☐ DNR ☐ Conservatorship/Guardian

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 (Indicate if living or deceased)

Marital Status

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

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

Children? YES or NO

Number of Children? _____ Number of Grandchildren _____

Names of Children _____ Names of Grandchildren _____

Other Important People in Elder's Life _____

Spiritual & Service Background

Religion _____ Church _____

☐ Practicing ☐ Not Practicing

Military Service _____ Branch _____ Years of Service _____

Education & Employment

High School _____ College/University _____

Degree _____ Former Occupation _____

Career Information _____

Lifestyle

Social Preferences (please check ALL that apply)

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

Describe how the Elder currently spends their day _____

How is Elder comforted during challenging times? _____

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

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

Specific Activities & Hobbies

Past / Present

- ☐ ☐ Reading
- ☐ ☐ Drawing
- ☐ ☐ Painting
- ☐ ☐ Dancing
- ☐ ☐ Music
- ☐ ☐ Writing
- ☐ ☐ Theatre
- ☐ ☐ Photography
- ☐ ☐ Crafts

Past / Present

- ☐ ☐ Bingo
- ☐ ☐ Board & Card Games
- ☐ ☐ Television & Movies
- ☐ ☐ Cooking
- ☐ ☐ Exercise (see other)
- ☐ ☐ Walking
- ☐ ☐ Yoga
- ☐ ☐ Outdoors
- ☐ ☐ Fashion

Past / Present

- ☐ ☐ Sports
- ☐ ☐ Gardening
- ☐ ☐ Birdwatching
- ☐ ☐ Knitting & Crocheting
- ☐ ☐ Sewing & Quilting
- ☐ ☐ Sports
- ☐ ☐ Fishing
- ☐ ☐ Woodworking
- ☐ ☐ Model Building

Other (please describe) _____

Category	No Concerns	Care Assessment	Applicant's Name _____
Speech & Hearing	☐	Difficulty with word finding? YES or NO Difficulty speaking? YES or NO Slight 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 If YES, please note when _____ Uses cane or walker? YES or NO Uses wheelchair? YES or NO Needs assistance? YES or NO	
Eating	☐	Special Diet? YES or NO 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 _____ Allergies _____	
Bathing	☐	Preferred method BATH or SHOWER 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? Morning or Evening	
Restroom	☐	Assistance needed? PARTIAL or FULL Incontinence related to... BLADDER or BOWEL or BOTH Needs reminders to use restroom? YES or NO Wears incontinence briefs? YES or NO Needs help changing incontinence 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	☐	Needs assistance 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 Authors, TV Shows, Movies, Music _____

Preferred Forms of Relaxation _____

Favorite Colors, Clothing, Items _____

Any Cultural Preferences _____

Favorite Holiday or Celebration _____

Interests _____

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.

This image shows a single sheet of white paper with horizontal black lines, resembling notebook paper. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Admissions Checklist

Use this checklist to ensure you have everything YOU need to submit a complete application to RPH.

Required at Application:

- ☐ Personal Data Form (Part 1 of the Application)
- ☐ Financial Eligibility Form and Detailed Supporting Documentation (Part 2 of the Application)
Include: three months of financial statements for each line item/asset listed
- ☐ Sharing is Caring Form (Part 3 of the Application)
- ☐ 3122 DOH Form from PCP, Hospital or Current Facility with Medications List, Diagnosis, PT/OT/Medical Notes, DME and Vaccination History sent to RPH by Doctor's Office or Social Worker
- ☐ Power of Attorney Documentation (POA) (Part 4 of the Application)

Required Before Move-In:

- ☐ Vaccination Records (Including COVID - needed for Department of Health records, whether vaccinated or not vaccinated)
- ☐ Copy of Resident Identification Card
- ☐ Copies of Insurance Cards (Health, Prescription, Long-term Care)
- ☐ Medicare Card
- ☐ Health Care Proxy (HCP) *Optional but Highly Recommended*
- ☐ Anatomical Donor Card *Optional but Highly Recommended*
- ☐ Living Will *Optional but Highly Recommended*
- ☐ DNR Authorization Form *Optional but Highly Recommended*
- ☐ MOLST Form *Optional but Highly Recommended*



