Fairport Baptist Homes caring.vibrant.vital

APPLICATION FOR ADMISSION

Adult Care Facility/Assisted Living Program

The Fairport Baptist Homes (FBH) is very pleased to be able to offer an Adult Care Facility (ACF) and Assisted Living Program (ALP) in addition to our Rehabilitation Center and Long-Term care (Skilled Nursing). Fairport Baptist Homes has been helping our community for over 100 years. Attached please find an application for potential admission to our program.

Most of the Adult Care and Assisted Living units are designed for occupancy by one person, however, a limited number, due to their size, can accommodate two. If you are planning on sharing a unit please give us the name of your co-resident and their relationship to you. Each applicant needs to complete an application with detailed demographic and health information, along with individual financial details. If your co-resident is a spouse, and you maintain joint assets/accounts, you can complete one of the "Other Assets" listing in the financial portion of this application.

Applicant Name:_____

Co-Resident Name:_____**Relationship**_____

Please enclose **copies** of any of the following which pertain to you.

Social Security Card
Medicare Card
Medicaid Card
Major Medical Insurance Card
Medicare D Prescription Plan
Body Organ Donor Card
Long Term Care Insurance Card
Power of Attorney Form
Living Will/Health Care Proxy

You will also find attached an Application Addendum. Completing this form, and returning it with your application, will be helpful to our staff. It will allow us to know more about your personal history, special interests and daily routine. It will also be instrumental in developing the care plans which are needed for each admission to our Adult Care Facility/Assisted Living Program.

Applicants are accepted and considered without regard to race, creed, color, age, sex, national origin, sponsor, advance directive, sexual orientation, or handicap.

Fairport Baptist Homes caring.vibrant.vital

APPLICATION FOR ADMISSION – FBH ACF/ALP

Full Name (please print)	Date Mailed	Date Received

DEMOGRAPHIC SECTION: All questions must be answered; incomplete applications will not be accepted

1. Present Address _____
   _____ Phone _____ How long at this address?
   Describe this residence: (i.e. Home, apt, etc) _____
2. Circle: Widow Widower Single Divorced Married Spouse's Name _____
3. Contact Persons (Nearest Relatives or Significant Others). Please list in order of contact; attach another sheet(s) if necessary. In completing this application, it is recommended that every resident appoint a Power of Attorney (POA) and Health Care Proxy (HCP).

a. Name _____ Relationship _____ POA HCP
   Address _____
   Home Phone _____ Business Phone _____ Cell: _____

b. Name _____ Relationship _____ POA HCP
   Address
   Home Phone _____ Business Phone _____ Cell: _____

c. Name _____ Relationship _____ POA HCP
   Address
   Home Phone _____ Business Phone _____ Cell: _____

d. Name _____ Relationship _____ POA HCP
   Address
   Home Phone _____ Business Phone _____ Cell: _____

4. Social Security # _____ Medicare # _____
   Medicaid # _____ County _____ Case Worker _____
5. Birth date _____ Birthplace _____
   If you were NOT born in the USA, you will need to provide copies of your permanent Visa/Naturalization papers or green card.
6. Occupation (former or present) _____
7. Funeral Home/Burial Instructions: Name
   Address _____ Phone _____
8. Do you plan on bringing a car? ☐ Yes ☐ No Please provide year, make, color and plate# _____
9. Please describe some of your interests and activities you enjoy _____

HEALTH SECTION:

1. Personal Care Physician's Full Name _____

   Address _____ Phone: _____

List other Physicians/Specialists whom you have been seeing:

(i.e., Surgeon, Dentist, Optometrist, Dermatologist, Psychiatrist)

a. Name _____

   Address _____

   Phone _____ Specialty _____

b. Name _____

   Address _____

   Phone _____ Specialty _____

2. Have you been under a Physician's care during the past year? _____

   General Diagnosis _____

   _____

   _____

a. Please check if you experience any of the following impairments:

   ☐ Hearing ☐ Vision ☐ Cognition ☐ Speech ☐ Walking ☐ Transferring

b. Physical Disabilities _____

c. Past Surgeries _____

3. Allergies _____

4. Do you have any allergies specific to animals? ☐ Yes ☐ No Do you have any fear of animals? ☐ Yes ☐ No

5. Special Diet _____

6. Do you need assistance with your medications? ☐ Yes ☐ No

7. Do you need assistance with your ADL's (activities of daily living)? ☐ Yes ☐ No

8. Do you currently receive any home services (meals, aides)? ☐ Yes ☐ No

   If yes, which agency do you utilize? _____

FINANCIAL INFORMATION

YOUR MONTHLY INCOME	
Social Security	
Private Pension	
Veteran Pension	
Interest Income	
Dividend Income	
Mortgage/Rental Income	
IRA Income	
Trust Income	
Other Monthly Income	
Other Monthly Income	
TOTAL MONTHLY INCOME	

FINANCIAL DISCLOSURE FORM – "OTHER ASSETS"

BANK ACCOUNTS – ***Savings***

Ownership: ☐ Self ☐ Joint (Account Names:) Balance: as of:

Ownership: ☐ Self ☐ Joint (Account Names:) Balance: as of:

BANK ACCOUNTS – ***Checking***

Ownership: ☐ Self ☐ Joint (Account Names:) Balance: as of:

Ownership: ☐ Self ☐ Joint (Account Names:) Balance: as of:

CERTIFICATES OF DEPOSIT (Account Names:) Balance: as of:

(Account Names:) Balance: as of:

STOCKS AND BONDS Current Value:

Current Value:

Current Value:

Current Value:

Current Value:

HOUSE: Please list Current Value:

PROPERTY: Please list Current Value:

OTHER ASSETS: (i.e. IRA) Current Value:

Current Value:

LIFE INSURANCE: Cash Value: Face Value:

TOTAL ASSETS: Value Date Total Current Value:

Have you established a Trust? ☐ Yes ☐ No If yes, date this was established ☐Revocable or ☐Irrevocable?

List which assets are in numerated in your trust:

Has a Burial Fund been established? Funeral Home

Address

Present Medicaid/Supplemental Security Income (SSI) guidelines require that no asset fund transfers take place within sixty (60) months (five (5) years) prior to a Medicaid/SSI application submission. Transfers to a trust are subject to a sixty (60) month prior review. Please indicate all funds/assets given as gifts and/or transferred from the applicant, to another individual, within the last five (5) years.

LIABILITIES Home Mortgage

Loans and Installment Payments

Other Medical Liabilities

Other Liabilities Explain

Other Liabilities Explain

TOTAL LIABILITIES

It is understood that submission of an application does not create any entitlement to admission or mean that the applicant will be accepted or admitted.

SIGNATURE: DATE:

Fairport Baptist Homes caring.vibrant.vital

ADULT CARE FACILITY/ASSISTED LIVING PROGRAM

In preparation of anticipated admission to the Fairport Baptist Homes Assisted Living Community, medical information from your Primary Care will be helpful.

We need to have each applicant sign this release form so that we are able to obtain information such as your current medication listing, diagnosis and recent office visits notes to add to your application file.

As we progress and get closer to admitting you to our Assisted Living Community, the New York State Department of Health will require FBH to obtain additional current (which is within thirty (30) days of admission) medical information.

Additional request for information and forms may be sent to your Primary Care Physician directly, from the ACF/ALP admissions team.

RELEASE OF INFORMATION CONSENT FORM

I, _____, an applicant for admission to the Fairport Baptist Homes Assisted Living Community of Fairport, New York, or its accredited representatives, has my permission to obtain full and detailed information from any doctor, hospital or clinic to whom I am or have been known regarding any consultations I have had with them, including the reason, the diagnosis and the nature and result of the treatment.

Signed_____Date_____

(May be signed by Applicant or Legal Representative)

Relationship to Applicant_____

Applicants to the Fairport Baptist Homes Assisted Living Community are accepted and considered without regard to race, creed, color, age, sex, national origin, sponsor, advance directive, sexual orientation, blindness or other handicap.

Fairport Baptist Homes caring.vibrant.vital

APPLICATION ADDENDUM

The Fairport Baptist Homes Assisted Living Community staff value you as an individual. Help us to know who you are by telling us about yourself. Please be as complete as possible in answering these questions. If there is something you do not feel comfortable in completing, you may leave it blank. If you find there isn't enough room to answer a specific question, please feel free to expand your answer on the last page. Any and all input would be helpful.

Name:_____ Date of Completion_____

FAMILY HISTORY:

Birthplace:

Father's name and occupation:

Mother's name and occupation:

Sibling's name(s):_____

Where are you in your sibling's birth order?_____

Please tell us about any significant childhood events:_____

EDUCATION AND EMPLOYMENT:

Schooling (where/grade level/degree, etc.)_____

Employment_____

Organizations_____

MARITAL AND SOCIAL:

Marital Status: Married Widow Widower Divorced Separated

Spouse Name:_____

Current Residence:_____ or date of death:_____

Please list children (names/location, etc.):

Other significant relationships:

Describe relation(s) with family:

Do you have a religious affiliation? If so, what is your faith, what church do you attend (please give address of church and/or name of clergy) or how is your faith expressed?

Special interests:

Special life events:

What are you most proud of?

What would you like to be remembered for?

What do you have the most fun doing?

Do you like animals? Do you have any allergies or concerns with pets?

Answering these following questions about your daily routine and preferences will also help us to provide you with the best possible care. Please place a check mark in front of all items that best describe your abilities, and leave blank those items that do not apply to you.

DRESSING:

_____ can get own clothing from closet/dresser

_____ can put clothing on without assistance

_____ can put shoes on without assistance

_____ can manage buttons/zippers without assistance

DRESSING COMMENTS:

BATHING: How many times a week? _____

What time of day? _____

_____ can shower independently

_____ need assistance with washing

certain areas of the body

_____ can comb hair independently

_____ can brush teeth/perform dental care independently

_____ can shave independently

_____ can put on makeup/jewelry independently

BATHING COMMENTS:

EATING:

_____ can open container without assistance

_____ do you use adaptive equipment (special utensils, dishes, etc.) Please describe _____

EATING COMMENTS: (special diets, allergies)

AMBULATION:

_____ can walk without assistive devices

_____ can walk independently with: CANE WALKER

_____ can walk if someone is with me to ensure safety

_____ can walk short distance (50 feet)

_____without assistance _____with assistance

_____ can walk long distance

_____without assistance _____with assistance

_____ enjoy taking regular walks

_____without assistance _____with assistance

_____ independent in a wheelchair

_____ need to be pushed in a wheelchair

AMBULATION COMMENTS:

TRANSFERRING:

_____ can get out of bed with no assistance

_____ can go from the bed to chair and vice versa, with no assistance

_____ use a lift chair

_____ need assistance to get out of bed or a chair

TRANSFERRING COMMENTS:

TOILETING:

_____ can get on and off toilet without assistance

_____ can get on and off independently with raised seat

_____ can clean myself without assistance

_____ incontinent, but use protective padding and can change them myself

_____ incontinent, but need assistance with incontinent products

If Incontinent:

Are you incontinent during the day, night, both?

How often are you incontinent?

Incontinent of? bladder bowel both

What brand or type of incontinence product(s) do you use?

TOILETING COMMENTS:

Additional Comments:

Please tell us about your customary routine:

What time do you get up in the morning?_____ What time do you get dressed?_____

Do you nap during the day? YES NO if yes, what time? _____ For how long? _____

What time do you go to bed at night?_____ Do you generally sleep through the night?_____

If no, do you: _____ awaken to go to the bathroom? (how many times at night?_____)

_____ have trouble falling back to sleep? _____ stay awake more than 4 hours most nights?

In your present bedroom, is one side of your bed against a wall? YES NO

If yes, which side (as you are lying on the bed) is it against the wall LEFT RIGHT

Do you have someone come in during the day or night to assist with meal preparation, household chores, personal care, etc.? YES NO if yes, please describe

Which of the following would you do on a typical day:

_____ go out (shopping, visiting) _____ watch TV _____ read _____ craft work

_____ hobbies (specify)

_____ other (specify)

Do you smoke? YES NO if yes, how many cigarettes do you smoke per day?_____

Do you drink alcoholic beverages? YES NO if yes, how many per day_____ week?_____

Time you usually eat breakfast_____ your typical breakfast is_____

Time you usually eat lunch _____ your typical lunch is _____

Time you usually eat supper_____ your typical supper is_____

Which is your most substantial meal of the day? BREAKFAST LUNCH SUPPER

Do you have a good appetite? YES NO What is your current weight?_____

Have you had recent weight loss? YES NO Who prepares your meals?_____

Do you prefer to eat: ALONE WITH OTHERS

Do you prefer to socialize in: SMALL GROUPS LARGE GROUPS

Do you spend time with family/friends?

DAILY 2-3 TIMES PER WEEK WEEKLY MONTHLY LESS THAN MONTHLY

When was the last time you were hospitalized? (Please list reason(s) and date(s))

Do you see a psychiatrist or a psychologist on a regular basis?

Please explain why you are seeking counseling:

Do you have any difficulties with your memory?

Do you have any difficulties finding your way around your house or neighborhood?

Do you wear a hearing aid? RIGHT LEFT BOTH Battery type:

SAVE FORM