

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 Status: Married Single Divorced Widowed Partner
Month Day Year

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 _____

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 _____

Resident's Representative: _____
Relationship: _____
Address: _____
Phone: Home _____
Work _____
Cell _____

Significant Other: _____
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: _____

Resident's Name: _____ Facility Name: _____ Date of Evaluation: _____
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SECTION 6: ADMISSION DECISION

ACCEPTED TO: <input type="checkbox"/> ALR/AH/EHP <input type="checkbox"/> Enhanced ALR <input type="checkbox"/> Special Needs ALR
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Upon admission, the following documents were provided to the applicant at, or prior to, the admissions interview:

- _____ Consumer Information Guide
- _____ Copy of the Residency Agreement
- _____ Copy of the statement of resident rights
- _____ Copy of any facility regulations relating to resident activities, office and visiting hours and like information
- _____ If made available to the operator by the Long-Term Care Ombudsman Program, a fact sheet about the program and the listing of legal services or advocacy agencies.
- _____ Personal Allowance Protections (SSI and Temporary Assistance (TA) recipients only)
- _____ Most recent Statement of Deficiencies (shown to applicant)

Signature(s) of ALR staff participating in this evaluation.

Name: _____	Title: _____	Date: _____
Name: _____	Title: _____	Date: _____
Name: _____	Title: _____	Date: _____

Signature of Administrator/Case Manager/or ISP Planner: _____ **Date:** _____

Signature of Individual/Resident: _____ **Date:** _____

Signature of Resident Representative: _____ **Date:** _____

Name(s) of others participating in this evaluation.

Name: _____	Relationship: _____	Date: _____
Name: _____	Relationship: _____	Date: _____

Grande Ville

Senior Living Community

555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 697-2934

E-Mail Information

In an effort to reduce the use of paper we are asking for the email address of the Resident Representative so we are able to send electronic communications. This will provide us an efficient way to keep you informed of upcoming events as well as any other important news at GrandeVille.

Thank you for your cooperation.

Resident Representative

Email Address



555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 697-2934

Personal Worth Statement

Name: _____
 Address: _____
 Social Security Number: _____

I. INCOME (Please write YES or NO in every space provided below. Fill in monthly amounts as applicable)

Do You Receive?

<u>YES or NO</u>	<u>Income Source</u>	<u>Amount per month</u>
_____	Social Security	\$ _____
_____	VA Pension	\$ _____
_____	Retirement/Pension	\$ _____
_____	Alimony	\$ _____
_____	SSI	\$ _____
_____	Rental Property	\$ _____
_____	Other _____	\$ _____

Please list any other sources of income: _____

TOTAL MONTHLY INCOME: \$ _____

II. ASSETS (Please write YES or NO in every space provided below. List amount of asset where applicable)

<u>YES or NO</u>	<u>Asset</u>	<u>Asset Value</u>	<u>Account #</u>
_____	Checking Account(s)	\$ _____	_____
_____	Savings Account (s)	\$ _____	_____
_____	CDs	\$ _____	_____
_____	Stocks	\$ _____	_____
_____	Bonds	\$ _____	_____
_____	IRAs	\$ _____	_____
_____	Notes	\$ _____	_____
_____	Property	\$ _____	_____
_____	Money Market	\$ _____	_____
_____	Other _____	\$ _____	_____

Please list any other assets: _____

Life Insurance Cash Value \$ _____ or _____ N/A

TOTAL CURRENT ASSETS: \$ _____

Do you have Long Term Care Insurance? _____ yes _____ no

III. LIABILITIES:

<u>YES or NO</u>	<u>Liability</u>	<u>Monthly Payment</u>	<u>Total Owed</u>
_____	Bank Loans	\$ _____	\$ _____
_____	Taxes Due	\$ _____	\$ _____
_____	Mortgage	\$ _____	_____/Value _____
_____	Health Insurance	\$ _____	N/A
_____	Prescriptions	\$ _____	N/A
_____	Phone	\$ _____	N/A
_____	Cable	\$ _____	N/A
_____	Auto Loan	\$ _____	_____/Value _____
_____	Auto Insurance	\$ _____	\$ _____
_____	Other: _____	\$ _____	\$ _____
TOTAL LIABILITIES:		Monthly: \$ _____	TOTAL \$ _____

IV. PERSONAL NET WORTH (Total Assets minus Total Liabilities): \$ _____

Please submit proof of income source and assets with this application.

Resident Name (Please Print)

Resident Signature

Resident Representative Name (Please Print)

Resident Representative Signature

GrandeVille Representative (Please Print)

GrandeVille Representative

Dated this _____ day of _____, 2_____.