New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE
RESIDENT PERSONAL DATA FORM

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: ____/____/____ (Month / Day / Year) Gender: ☐ M ☐ F 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 _____

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: _____

_____

_____

ASSISTED LIVING RESIDENCE
RESIDENT PERSONAL DATA FORM

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 _____ **DNR:** ☐ Yes ☐ No
(Name)

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

Burial Instructions: _____

_____

Resident's Name: _____
Facility Name: _____ Date of Evaluation: _____

SECTION 6: ADMISSION DECISION

ACCEPTED TO: ☐ **ALR/AH/EHP** ☐ **Enhanced ALR** ☐ **Special Needs ALR**

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

Grande Ville
Senior Living Community
555 Maiden Lane, Rochester, New York 14616-4199 Phone (585) 621-6160 Fax (585) 697-2934

Personal Worth Statement

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

Do You Receive? YES or NO	Income Source	Amount per month
_____	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)

YES or NO	Asset	Asset Value	Account #
_____	Checking Account(s)	$[ ]	[ ]
_____	Savings Account (s)	$[ ]	[ ]
_____	CDs	$[ ]	[ ]
_____	Stocks	$[ ]	[ ]
_____	Bonds	$[ ]	[ ]
_____	IRAs	$[ ]	[ ]
_____	Property	$[ ]	[ ]
_____	Money Market	$[ ]	[ ]
_____	Other [ ]	$[ ]	[ ]

Please list any other assets: _____

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Life Insurance Cash Value $ ☐ or ☐ N/A

TOTAL CURRENT ASSETS: $ ☐

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

III. LIABILITIES:

YES or NO	Liability	Monthly Payment	Total Owed
_____	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 Signature Resident Representative Signature

_____
GrandeVille Representative Signature

Dated this _____day of _____, 2 _____