THE LIVING CENTER
THE HIGHLANDS AT PITTSFORD

Dear Applicant and/or Designee,

We appreciate your interest in The Highlands Living Center. Enclosed you will find forms that will assist us in gathering the necessary information to process your application. *Please complete the following steps to facilitate the application process for **short-term rehabilitation, long-term care admission and respite care consideration.***

If the applicant is being admitted from the community, please:

1. Complete and return the enclosed *Application for Admission*. Include copies of any insurance cards, Health Care Proxy, Living Will, Power of Attorney and/or guardianship paperwork. Please include verification of Social Security, pension, or other monthly income. Documents can be faxed to the Admissions Department at (585) 381-5503 or mailed to the address provided at the bottom of this letter.

2. Forward the enclosed *Medical Information Form* to your primary care physician, asking that it be completed and returned to the Admissions Department as soon as possible.

3. Request (if you have not done so already) a *Patient Review Instrument (PRI)* and *SCREEN* to be completed by a local nursing agency. (If you are an out-of-state applicant, you must contact an agency to have these completed.)

If the applicant is being admitted from a hospital in New York State, please inform the hospital social work staff of your interest in The Highlands Living Center. **Steps 2 and 3** (see above) **can be omitted** as the social worker will forward the appropriate medical information along with the PRI and SCREEN to our facility. However, **if the applicant is hospitalized out-of-state**, you must contact a nursing agency to have a *Patient Review Instrument (PRI)* and *SCREEN* completed as required by New York State.

No application will be considered complete until **all** of the requested information has been received. When all relevant data has been collected, our Admissions Department will review it to determine whether The Highlands Living Center can meet your needs.

> **Please note that your file will remain active as long as we continue to receive updated PRI's and SCREENs, or contact is made to us at least every 90 days regarding your continued interest. If we do not receive notification every 90 days, we will assume you are no longer interested in pursuing admission and will close your file.**

We are happy to provide personal tours of The Highlands Living Center by appointment. Please contact the Admissions Department at (585) 641-6261, to schedule your tour or to discuss any questions or concerns.

Sincerely,

Amanda Keyser, RN BSN Admission Manager
Phone: 585-641-6261, Fax: 585-381-5503
Amanda_Keyser@urmc.rochester.edu

1850 MELIORA UR MEDICINE
MEDICINE of THE HIGHEST ORDER
500 Hahnemann Trail • Pittsford, NY 14534
585-383-1700 • 585-393-9074 fax • www.highlandsatpittsford.org

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Application for Admission

PERSONAL INFORMATION

Applicant's Name: _____
(Last) (First) (Middle)

Home Address: _____
(Street) (Town) (State) (Zip)

County: _____ DOB: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/widower ☐ Separated

Phone (if applicable): _____ Alternate Number(s): _____

Primary Care Physician: _____

Applying for: ☐ Long Term Care ☐ Rehabilitation ☐ Respite ☐ Memory Care

If Rehab, specify: Hospital: _____ Diagnosis: _____

If elective surgery, specify: Date: _____ Surgeon: _____

Is your condition a result of a motor vehicle accident? ☐ Yes ☐ No Compensation? ☐ Yes ☐ No
No fault insurance information (if applicable): _____

Has applicant been hospitalized within past 30 days? Dates _____ Where? _____

Has applicant had recent skilled nursing facility stay within past 60 days? ☐ Yes ☐ No
Dates: _____ Where? _____

RESPONSIBLE PARTY INFORMATION

Please attach copies of Health Care Proxy (HCP), Living Will & Power of Attorney (POA)

Contact #1: _____ Phone: _____

Address: _____ Alt. phone #: _____

Relationship: _____ Please circle all that apply: *POA* *HCP* *Guardian*

Contact #2: _____ Phone: _____

Address: _____ Alt. phone #: _____

Relationship: _____ Please circle all that apply: *POA* *HCP* *Guardian*

INSURANCE INFORMATION

(Please attach copy of insurance cards (front and back))

Medicare #_____ ☐ Part A ☐ Part B Date of Retirement: _____

Medicaid # _____ County: _____

Medicaid Case Worker: _____ Phone number: _____

Other Insurance Type & Number: _____

_____

_____

Long Term Care Insurance Carrier _____

FINANCIAL INFORMATION

MONTHLY INCOME

(For income not received monthly, estimate the monthly amount based on the annual amount.)

	First Person	Second Person
Social Security	$	$
Pensions	$	$
Dividends	$	$
Interest	$	$
Mortgage/Rental Income	$	$
IRA Income	$	$
Trust Income	$	$
Other Monthly Income Please describe:	$	$
Total Monthly Income	$	$

ASSETS

(If jointly owned, enter under First Person and check the box indicating "jointly".)

	First Person	Jointly	Second Person
Cash (savings and checking)	$		$
Primary Residence (estimated market value less mortgage payable)			
Real Estate other than Primary Residence			
CD's, Money Markets, etc.	$		$
Stocks and Bonds	$		$
Trusts & Estate Equities available for your use	$		$
Life Insurance	$		$
Other Assets Please describe:	$		$
Total Assets	$		$

Does Applicant own a house/property: ☐ Yes ☐ No Value of house/property: $_____

House/property jointly owned: ☐ Yes ☐ No

Has there been any transfer of assets in the last 60 months? ☐ Yes ☐ No If yes, please state amount & reason: _____

Does Applicant have any outstanding debts: ☐ Yes ☐ No

If yes, the amount of the total debt: $_____

Applicant/Responsible party signature: _____

Relationship to applicant: _____ **Date:** _____

State and federal laws prohibit discrimination because of age, race, creed, gender, color, marital status, disability, sexual preference, national origin, sponsor, military status or payer source.

UR MEDICINE
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Patient name: _____

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Medical Information Form

Patient name: _____ **DOB:** _____ **Date:** _____

Date Patient last seen: _____ **Hospital affiliation:** _____

Primary diagnosis: _____

Secondary diagnoses (Please list all): _____

Allergies: _____

I. Health Maintenance:

Flu vaccine	☐ Yes	☐ No	Date: _____
Pneumonia vaccine	☐ Yes	☐ No	Date: _____
Pneumococcal 13	☐ Yes	☐ No	Date: _____
Diphtheria/Tetanus vaccine	☐ Yes	☐ No	Date: _____
Tuberculin skin test	☐ Yes	☐ No	Date: _____
PPD Results ☐ Pos. ☐ Neg.			
PAP Smear	☐ Yes	☐ No	Date: _____

II. Functional Status: (Y = yes; N = no; and U = unknown) Please circle the appropriate code letter where indicated:

Mental: Please indicate any of the following traits:

Memory Loss Y N U Disorientation Y N U Impaired judgment Y N U

Agitation Y N U Depression Y N U Hallucinations Y N U

Are the abnormal traits of such severity that patient is harmful to self or others? Y N U

Explain: _____

Does patient present a management problem (tendency to wander, invade other's privacy, etc.)? Y N U

Explain: _____

Does this patient have sufficient judgment, understanding, and insight to participate in an active rehabilitation program? Y N U

Special Senses: Is impairment of the following special senses of significant severity as to contribute to patient's disability?

Eye Sight Y N U

Hearing Y N U

Speech Y N U If aphasic, indicate whether: ☐ receptive ☐ expressive ☐ mixed

Incontinence:

Does the patient have:	Urinary incontinence	Y N U	If Yes, frequency:	_____
	Fecal incontinence	Y N U	If Yes, frequency:	_____
	Foley catheter	Y N U		

Weight Bearing Status:

☐ Full ☐ Partial ☐ On left ☐ On right ☐ Non-weight bearing

Patient name: _____

Activities of Daily Living: **(check appropriate category)**

Bathing	☐ Independent	☐ Partially dependent	☐ Dependent
Dressing	☐ Independent	☐ Partially dependent	☐ Dependent
Feeding	☐ Independent	☐ Partially dependent	☐ Dependent
Toileting	☐ Independent	☐ Partially dependent	☐ Dependent

Ambulatory Status: **(Indicate present status)**

☐ Complete bed rest ☐ Bed/chair status ☐ Ambulatory with personal assistance

☐ Ambulatory with aid. Specify aid _____

☐ Independent ambulation

III. Advanced Directives:

Does the patient have a DNR order/request? ☐ Yes ☐ No

Does the patient have a Health Care Proxy? ☐ Yes ☐ No

Does the patient have a Living Will? ☐ Yes ☐ No

(If you answered "Yes" to any category, please provide copies of all documentation)

IV. Other:

Is the patient free of infectious illness? ☐ Yes ☐ No

If no, indicate problem and current treatment: _____

_____

Does the patient have an active drug or alcohol addiction? ☐ Yes ☐ No

If yes, please explain: _____

V. Rehabilitation Potential: Do you feel that this resident has good potential for rehabilitation? Y N U

VI. Lab Data: (Please enclose copies if available)

	Date	**Results**
Last chest x-ray	_____	_____
Last urinalysis	_____	_____
Last EKG	_____	_____
Abnormal x-rays	_____	_____

If demented, the following are requested if clinically indicated:

CT Scan: _____ Mental Status: _____

Cranial Nerves: _____ B12: _____

Motor function: _____ VDRL: _____

Sensory function: _____ Thyroid function tests: _____

DTR: _____ Abnormal reflexes: _____

Gait: _____

VII. Please suggest Care Plan referring to primary and past diagnosis: _____

_____

_____

VIII. Current Medical Orders:

1. Diet: _____ Allergies ☐ Yes ☐ No

Patient name: _____

A. Medication: _____
B. Dietary: _____
C. Other: _____

2. Medications:

Name of Med	Dosage	Route	Frequency	Name of Med	Dosage	Route	Frequency

3. Physical Therapy Recommendations: _____

_____

4. Occupational Therapy Recommendations: _____

_____

5. Additional Comments: _____

_____

IX. Physical Exam (must be current within six weeks):

Vital signs: T _____ P _____ R _____ BP _____ Wt. _____ Ht. _____

	NORMAL	ABNORMAL	COMMENTS
Skin & Nails	☐	☐	_____
HEENT	☐	☐	_____
Heart	☐	☐	_____
Lungs	☐	☐	_____
GI	☐	☐	_____
GU/GYN	☐	☐	_____
Musculo/Skeletal	☐	☐	_____
Neurological	☐	☐	_____

REASON FOR ADMISSION: Admission is requested because this patient is in need of (check appropriate categories):

☐ Custodial Care

☐ Skilled nursing care - Recommendations: ☐Swallowing eval ☐ Hearing eval ☐ Podiatry ☐ Rehabilitation services

☐ Other _____

☐ Short-term skilled rehabilitation: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

☐ Short-term respite stay: How long? _____

This patient is appropriate for the services provided by The Highlands Living Center.

Name of physician (printed): _____ **Physician signature:** _____

Address: _____

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