

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 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 address provided at the bottom of this letter.
2. Request, if you have not already done so, 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.)
3. A 30-day deposit is required for all private rooms. All assets will be verified during the admission process.

**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 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 30 days regarding your continued interest. If we do not receive notification every 30 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 Highland Living Center by appointment. Please contact the Admissions Department at (585) 641-6261, to schedule your tour to discuss any questions or concerns.

Sincerely,

Latoya Singleton, LPN, IPC, Admissions Manager  
Phone: 585-641-6261, Fax: 585-381-5503  
Latoya\_Singleton@urmc.rochester.edu



MEDICINE of THE HIGHEST ORDER

500 Hahnemann Trail · Pittsford, NY 14534  
585-383-1700 · 585-393-9074 fax · www.highlandspittsford.org

THE LIVING CENTER  
THE HIGHLANDS  
AT PITTSFORD

**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  Respite  Memory Care

Is your condition a result of a motor vehicle accident?  Yes  No

Worker's 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

Medicaid # \_\_\_\_\_ County: \_\_\_\_\_

Medicaid Case Worker: \_\_\_\_\_ Phone number: \_\_\_\_\_

Other Insurance Type & Number: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Long Term Care Insurance Carrier \_\_\_\_\_

Policy # \_\_\_\_\_

---

## FINANCIAL INFORMATION

### MONTHLY INCOME

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

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

**ASSETS**

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

	<b>First Person</b>	<b>Jointly</b>	<b>Second Person</b>
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:	\$		\$
<b>Total Assets</b>	\$		\$

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.



MEDICINE of THE HIGHEST ORDER

500 Hahnemann Trail · Pittsford, NY 14534  
585-383-1700 · 585-393-9074 fax · www.highlandsatpittsford.org