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

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.)

	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.