





H o m e f o r A d u l t s

Pineview Commons

An Assisted Living Facility

Dear Applicant;

Enclosed is the admission application that you requested for our facility. Please complete and return the first section of the application in order to be placed on our waiting list. Returning the application does not obligate the applicant in any way to become a resident of our facility. It will be kept on file and in the event that a room opens that we feel may be of interest to you, a member of our administrative staff will contact you. Again, at this time you are not obligated to accept the room being offered. If you decline because you feel that the applicant is not yet ready to move, we will simply contact you the next time a similar room becomes available.

In order for the application to be reviewed and/or approved, it must be completed in its entirety. If something on the application does not apply to you, please write "N/A" in the space. Please do not leave any blank spaces. The application will not be processed if any space is left blank.

The second section of the application must be filled out by the applicant's primary care physician (or the attending MD if in a hospital or rehab center). Please do not worry about this section until you have been offered and accepted a bed at our facility as this portion of the paperwork is only valid for 30 days prior to the admission date. If it is completed more than 30 days prior to admission, it will have to be completed again. Please submit a copy of all insurance cards and advance directives with the application to the business office.

Per the New York State Department of Health, all residents must also have a PPD (TB test) done by their primary care physician within 30 days prior to admission.

If you have any questions at all or would like a tour of our home; please feel free to contact our facility at the above phone number Monday-Friday 9am-4pm. The following is a directory of our Administrative staff:

Kara Vollmer – RN, Administrator – Extension 101 or kvollmer@pineviewcommons.com
Jenifer Prouty – Coordinator of Resident and Family Services – Extension 102 or jprouty@pineviewcommons.com
Bobette Shirley – RN, Director of Resident Care – Extension 108 or bshirley@pineviewcommons.com
Jeannie Burton – Coordinator of Medical Services – Extension 100 or jburton@pineviewcommons.com
Amy Ouellette – Financial Manager – Extension 106 or aouellette@pineviewcommons.com

We look forward to meeting you.

Sincerely,
Jenifer Prouty

I am the owner of the following property:

1. Real Estate: (Describe and List Value) _____

2. Car: (Describe and List Value) _____

3. Stocks/Bonds: (Describe and List Value) _____

If I should exhaust my private funds and apply for assistance, (S.S.I.), I understand the S.S.I assistance rate paid to the Adult Home is a Room and Board rate and is below the Home's private rate. I further understand the Home will not accept this S.S.I. rate without a third party contributor supplementing the Home up to the Home's private rate.

THIRD PARTY CONTRIBUTOR'S INFORMATION

Name: _____ Phone Number: _____

Address: _____ Relation to Applicant: _____

I will have my relative (s) or representative take care of my financial affairs while I am at Pineview Commons LLC.

REPRESENTATIVE'S/EMERGENCY CONTACT INFORMATION

Name: _____ Relation to Applicant: _____

Address: _____

Email Address: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

*****ADDITIONAL FAMILY CONTACTS - IF REPRESENTATIVE ABOVE CANNOT BE REACHED.**

Name Address Phone Relation to Applicant

Name Address Phone Relation to Applicant

Name Address Phone Relation to Applicant

MEDICAL INFORMATION

Resident's Primary Physician: _____

Address: _____ Phone: _____

Hospital of Choice: _____

Social Security #: _____ Medicare #: _____

Medicaid #: _____ County of Medicaid: _____

Other Health Insurance: _____

Policy #: _____ Group #: _____

Other Physicians:

Physician: _____ Type of Physician: _____

Address: _____ Phone: _____

Physician: _____ Type of Physician: _____

Address: _____ Phone: _____

PERSONAL ASSISTANCE INFORMATION

I understand this is an **ADULT HOME** providing room and board with laundry and housekeeping services. There will be adequate staff to assist me with personal care services such as: personal hygiene, medication management, and functions of daily living. A recreation and social program will be provided. There will be personal care staff available to me on a 24-hour basis.

Options for transportation to medical appointments

1. Family will take and/or make arrangements
2. Pineview Commons to arrange/provide transportation.

We need to know how you would like us to handle doctor appointment transportation. Pineview Commons can provide this transportation at an additional cost unless Medicaid is in effect.

Pineview Commons **Family Transportation**

I will be needing assistance with personal services as listed below:

1. _____
2. _____
3. _____
4. _____

If I am admitted to the Home, I request that my personal mail be given to me and that my business mail be handled by ___me, or ___my representative. (Please check one)

Date of Application: _____

Applicant's Signature: _____

RESIDENT'S REPRESENTATIVE INFORMATION

I understand if the resident should require a higher level of care due to physical or mental impairment, it will be my responsibility to make arrangements for the proper placement and transfer.

This will be done by me, after proper evaluation, assistance, and notice by the Home.

Resident Representative Signature: _____

Date: _____

HOW DID YOU HEAR ABOUT PINEVIEW COMMONS? _____

*****AFTER COMPLETING PLEASE REVIEW ENTIRE APPLICATION TO
BE SURE IT IS COMPLETED IN FULL*****

**PINEVIEW COMMONS ASSISTED LIVING FACILITY/
PINEVIEW COMMONS ASSISTED LIVING PROGRAM**

FINANCIAL DISCLOSURE

*****This form to be completed with the Application for Admission.**

It is important that this information is procured upon admission. We have found that to get it later can be very difficult. Documents may be lost, misplaced or the people who have them cannot be located. This is the information that is needed to apply for Medicaid and/or S.S.I. Or VA benefits.

Name: _____

Date of Birth: _____ Social Security Number: _____

MEANS OF SUPPORT - FINANCIAL INCOME

Social Security Check Amount: \$ _____

Payee - Where does check go? : _____

Supplemental Security Check (SSI) Amount (if applicable): \$ _____

Payee - Where does check go?: _____

Veterans Check Amount (if applicable): \$ _____

Payee - Where does check go?: _____

Pension checks: From Whom?: _____

Amount of Pension Check: \$ _____

Payee - Where does check go?: _____

Other Income: _____

RESOURCES - BANK ACCOUNTS, CD'S

Name of Bank and Address: _____

Savings: \$ _____ Checking: \$ _____

Who has authority to deposit and withdraw from these accounts--:

Name: _____

Relationship to Applicant: _____

Address: _____

Phone Number: _____

REAL ESTATE

Do you own any real estate: _____ If so, appraised value: _____

Do you have any assets held by other parties? _____ If so, please describe: _____

Power of Attorney: _____

Applicant Signature: _____

Date: _____

PINEVIEW COMMONS HOME FOR ADULTS - ALP

ADVANCE DIRECTIVE INFORMATION

****This form to be completed with the Application for Admission.**

Name: _____

BURIAL ARRANGEMENTS

Funeral Home: _____

Address: _____

Contact Person: _____ Phone #: _____

ADVANCE DIRECTIVES
(health care proxy, DNR, living will, etc.)

Please list what directives have been obtained.

1. _____

2. _____

3. _____

4. _____

POWER OF ATTORNEY

Name: _____ Phone #: _____

Address: _____

****The facility must have copies of all above documents.

PINEVIEW COMMONS HOME FOR ADULTS

PRE-ADMISSION QUESTIONNAIRE

Name: _____

Please complete

Do you wear glasses ? Yes ____ No ____ Only for Reading ____

Do you have dentures? Yes ____ No ____

Partials ____ Full ____ Upper Plate Only ____ Lower Plate Only ____

Do you wearing hearing aides? Yes ____ No ____

Both Ears ____ Left Ear Only ____ Right Ear Only ____

Do you use a device to assist you with walking? Yes ____ No ____

Walker ____ Cane ____ A wheelchair for long distances? Yes ____ No ____

Comments: _____

Please make sure all clothing is marked upon admission.

Please submit a copy of all insurance cards with this application.

Please submit a copy of all advance directives with this application.

THE FOLLOWING IS THE MEDICAL PAPERWORK

This paperwork needs to go with the applicant to the doctor's appointment to be completed before admission

MEDICAL EVALUATION

Check all that apply: AH EHP ALP Initial RUG Category Change 12 Month

This form may be used to verify that an individual's health/safety needs can appropriately be met in an adult home, enriched housing program or residence for adults. It may also be used to verify that an applicant/resident of an Assisted Living Program (ALP) is medically eligible to reside in a nursing facility but does not require continual nursing or skilled care and the individual's needs can be met in an ALP.	Name:		
	Facility Name:		
	Pineview Commons LLC		
	Address:		
	201 South Melcher Street Johnstown, NY 12095		
Sex	Date of Birth	Weight	B/P
M() F()	/ /		

Primary Diagnosis:

Secondary Diagnosis:

Significant medical history and current conditions:	Continenence: Bladder: <input type="checkbox"/> Yes <input type="checkbox"/> No Bowel: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Diet: <input type="checkbox"/> Regular, CAT <input type="checkbox"/> NAS, CAT <input type="checkbox"/> Consistent Carbohydrate, CAT
Needs assistance with self-administration of meds? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Allergies:

List all current medications (prescription and OTC), including dosage, type, frequency, and method of administration, and note any special instructions:(attach additional sheet if necessary).

MEDICATION	DOSAGE	TYPE	FREQUENCY	METHOD

MEDICAL EVALUATION (page 2)

Name: _____

Is the Individual:

Free of communicable disease? Yes No If no describe: _____

Able to transfer without Assistance? Yes No If no, describe: _____

Ambulatory without assistance? Yes No If no, describe: _____

Describe Activity Restrictions/Assistance Needed with ADLs (e.g., eating, transferring, toileting):

Describe Current Treatment Plan (e.g., nursing, therapies, labs, etc.):

Is the individual's condition stable? Yes No If no describe: _____

Does the individual have a history, current condition or recent or current hospitalization for mental disability?
 Yes No If yes describe: _____

Is a Mental Health Evaluation recommended? Yes No

Date of Today's Examination: _____ Recommended Frequency of Medical Exams: As ordered by MD

I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regimens, and that the individual is medically appropriate to be cared in an Adult Home enriched housing program or an ALP

Signature: _____ Date: _____

Nurse Practitioner, Physician's or Specialist Assistant

Signature: _____ Date: _____

Physician (required)

ATTACHMENT TO MEDICAL EVALUATION

STANDING/PRN ORDERS - OVER THE COUNTER MEDICATIONS

Resident: _____

Acetaminophen 325 mg

- 2 tablets po every 4-6 hours as needed (not to exceed more than 12 tablets in 24 hours)
- May be used for relief of Headache, Minor aches and pains, Minor Arthritis Pain,
 For the reduction of Fever

Maalox (or generic equivalent)

- 10-20 ml po up to 4 times daily (not to exceed 80 ml in a 24 hour period)
- May be used for the relief of: Upset Stomach/Indigestion

Milk of Magnesia (or generic equivalent)

- 5-15 ml po with water up to 4 times daily - Not to exceed more than 60 ml in 24 hours)
- May be used as a Laxative to relieve constipation

Immodium AD tablets (or generic equivalent)

- 2 tablets po after the first loose stool; 1 caplet after each subsequent loose stool
- Not to exceed more than 4 tablets in 24 hours

Immodium AD Liquid (or generic equivalent)

- 20 ml po after the first loose stool; 10 ml after each subsequent loose stool
- Not to exceed 40 ml in 24 hours

Robitussin DM (or generic equivalent) Regular _____ Sugar Free _____ (check one)

- 10 ml po every four hours - Not to exceed 60 ml in 24 hours
- To be used to relieve cough and to help loosen secretions

Cough Drops Regular _____ Sugar Free _____ (check one)

- 1 drop dissolved in mouth for minor cough - Repeat every 2 hours as needed

*Physician Signature verifies order and that resident is capable of requesting any of the above.

Physician's Signature: _____ Date: _____

Pineview Commons Home for Adults

Record of TB Screening

Must be completed in full

Per New York State Department of Health Regulations, (NYS DOH), all residents must be screened for TB before being admitted into the Adult Home. One or Two Step Tuberculin Skin Tests, (TST) are acceptable to the NYS DOH. Please note that NYS DOH does prefer the Two Step TST. However: The decision to use the One or Two Step TST is up to each individual physician.

Resident: _____ **Physician:** _____

Date PPD Given: _____ Manufacturer: _____ Lot # _____ Site: _____

Given by: _____

Date Read: _____ Read by: _____

Results of Test: Negative _____ Positive _____ Induration (mm): _____

IF POSITIVE: Date of CXR: _____ Results: _____

*****If date of first TST is negative do you want a second TST? Yes _____ No _____**

Physician Signature: _____ Date: _____

****Submit copy of written CXR report.

Date of 2nd TST

Given: _____ Manufacturer: _____ Lot # _____ Site: _____

Date Read: _____ Read by: _____

Results of Test: Negative _____ Positive _____ Induration (mm): _____

Physician Signature: _____ Date: _____

Pineview Commons Home for Adults

Record of Vaccinations/Influenza/Tetanus/Pneumonia

*****Must be completed in full*****

Resident: _____

Physician (please print): _____

Has your patient received:

1. A tetanus shot - in the past five years? Yes____ No____

If yes: Date: _____

2. Pneumonia Vaccination: Yes____ No____

If yes: Date: _____

*****If no, do you want facility to arrange for administration of vaccine(s) Yes ____ No ____**

3. Influenza Vaccination: Yes____ No____

If yes: Date: _____

*****If no, do you want facility to arrange for administration of vaccine Yes ____ No ____**

MD Comments: _____

Physician's Signature: _____

Date: _____

Pineview Commons Home for Adults
201 South Melcher Street
Johnstown, NY 12095
762-5488
Fax# 762-5583

PRIMARY MD AUTHORIZATION FOR PODIATRY CARE

Resident: _____

Primary Physician: _____

Date: _____

Dr. Lam, DPM comes to the facility on a scheduled basis to provide podiatry care for the residents.

Please verify below with signature that your patient may see Dr. Lam for an initial consult, every 2-3 months, and PRN for one of the reasons listed below.

PLEASE CHECK ONE OR MORE OF THESE

- _____ **DIABETES MELLITIS**
- _____ **PVD**
- _____ **NEUROPATHY**
- _____ **FUNGAL NAILS**
- _____ **INGROWN NAILS**
- _____ **THICK MYCOTIC NAILS**

Physician's Signature: _____ Date: _____

PINEVIEW COMMONS HOME FOR ADULTS
201 SOUTH MELCHER STREET
JOHNSTOWN, NEW YORK 12095
518-762-5488
FAX 762-5583

Resident: _____

Physician: _____

Date: _____

PLEASE CHECK ONE OF THE FOLLOWING AND VERIFY WITH YOUR SIGNATURE
BELOW THAT YOU WISH TO BE NOTIFIED ON A

DAILY BASIS_____

WEEKLY BASIS_____

MONTHLY BASIS_____

NOT AT ALL_____

OF ANY MEDICATION REFUSALS BY THE ABOVE MENTIONED RESIDENT
WHO RESIDES AT PINEVIEW COMMONS.

MD COMMENTS: _____

*****IF MONTHLY NOTIFICATION IS REQUESTED IT WILL BE SENT TO YOU AT THE
BEGINNING OF THE FOLLOWING MONTH.**

Physician's Signature: _____

Date: _____

MENTAL HEALTH EVALUATION

NAME: _____

FACILITY: PINEVIEW COMMONS HOME FOR ADULTS

SIGNIFICANT MENTAL HEALTH HISTORY AND CURRENT CONDITION:

Date discharged to: PINEVIEW COMMONS HOME FOR ADULTS from:

(Name of Facility/Hospital)

I have completed this evaluation in the presence of the above named within the past thirty (30) days, and I find him/her mentally suited for the care provided at PINEVIEW COMMONS HOME FOR ADULTS. This person does not show evident need for placement in a residential treatment facility licensed or operated pursuant to article nineteen, twenty-three, twenty-nine, or thirty-one of the mental hygiene law.

MD SIGNATURE: _____

TITLE: _____

DATE: _____

CHECK ONE:

- _____ PREADMISSION EVALUATION
- _____ ANNUAL EVALUATION
- _____ HOSPITAL DISCHARGE EVALUATION-(Mental Health Admit)
- _____ ER EVALUATION

State of New York Department of Health

Non hospital Order Not to Resuscitate (DNR Order)

Person's Name: _____

Date of Birth: ____/____/____

Do not resuscitate the person named above.

Physician's Signature: _____

Print Physician's Name: _____

License Number: _____

Date: ____/____/____

It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is **NOT** required, and under the law this order should be considered valid if it has not been reviewed within the 90 day period.