



County of Schenectady

NEW YORK

Todd M. Zbytniewski
Administrator

Glendale Home
59 Hetcheltown Road
Scotia New York 12302
Tel: (518) 384-3600 Fax: (518) 384-1615
Website: www.schenectadycounty.com

Dear Applicant;

Thank you for your interest in Glendale Home. I have attached an application for admission. Please answer all questions to the best of your ability and be sure to sign and date the application.

To complete the application process, you will need to have a Patient Review Instrument (PRI) and SCREEN completed and sent to Glendale Home. The PRI should be updated every 90 days to keep your application current.

If you are admitted from home, in addition to the PRI and SCREEN, we require the following information:

1. Medical History and Physical Examination form completed within the past two months from your Primary Care Physician,
2. Universal Application,
3. We also require the following information from your Primary Care Physician:
 - a. Labs required prior to admission:
 - SMA 18 test panel/CMP
 - Urinalysis
 - TB Screening (PPD and chest x-ray as indicated)
 - b. Immunization Records:
 - Pneumonia Vaccine (date)
 - Influenza Vaccine (date)
 - COVID vaccines (date)

Please feel free to contact Glendale Home if you would like a tour or if we can assist you in any way.

I can be reached Monday through Friday, 8:00 am – 4:00 pm at 518-414-0680.

Sincerely,

Jackie Cancelliere
Admissions Coordinator



PRE-ADMISSION UNIVERSAL APPLICATION

I. PATIENT INFORMATION

DATE: _____

SSN: _____

Last: _____

First: _____

Initial: _____

Address: _____

City: _____

State / Zip: _____

Patient's Marital Status: Single Married Widowed Separated Divorced

U.S. Citizen: Yes No

Date of Birth (MM/DD/YYYY): _____

II. INSURANCE INFORMATION

Medicare: _____

Other Insurance: _____

Medicaid Application Pending: Yes No If Yes, Date Submitted: _____ County: _____

Name and Relationship of Individual Representing Patient: _____

Address: _____

City: _____

State/Zip: _____

Telephone: _____

Work/Cell: _____

Status (Please Check) Power of Attorney Legal Guardian Health Care Proxy

Person Responsible for Handling Financial Transactions

Primary Physician: Name: _____ Phone: _____

Are you or your spouse a veteran? Yes No

Are you or your spouse a volunteer firefighter? Yes No

III. FINANCIAL DISCLOSURE (All information is kept confidential)

INCOME

MONTHLY AMOUNT

Social Security \$ _____

Retirement Pension \$ _____

Veteran's Pension \$ _____

Railroad Pension \$ _____

Supplementary Security Income \$ _____

Annuities \$ _____

Other Income \$ _____

Total Monthly Income \$ _____

ASSETS

CHECKING ACCOUNTS:

Bank Name: _____

Account Balance: \$ _____ Joint Account: Yes No

SAVINGS ACCOUNTS:

Bank Name: _____

Account Balance: \$ _____ Joint Account: Yes No

OTHER ACCOUNTS:

Bank Name: _____

Account Balance: \$ _____ Joint Account: Yes No

CERTIFICATES OF DEPOSIT:

Bank Institution: _____ Balance: \$ _____

Does the patient own a home? Yes No Estimated Value: \$ _____

If yes, is the home jointly owned with anyone? _____

Does the patient have Long Term Care Insurance? Yes No

If yes, with Insurance Company _____

OTHER ASSETS (e.g. stocks, bonds, other) (Please list)

AMOUNT

1. _____ \$ _____

2. _____ \$ _____

3. _____ \$ _____

Have any assets been transferred in the last 60 months: Yes No

If yes, please describe: _____

Has an estate trust been established: Yes No Date established: _____ if yes, please provide copy

Has burial been arranged? Yes No If yes, where: _____ Paid for? Yes No

To the best of my knowledge, all the information provided is correct and valid. I understand that the information contained in this form will be shared with nursing homes.

X _____
Signature of Patient or Responsible Party

Date

The information provided shall remain confidential and shall be made available only to authorized hospital and nursing home personnel involved in the placement process and to any governmental officials authorized access by law to such records. The facilities having access to the information do so without regard to race, creed, color, age, sex, religion, national origin, sponsor, sexual preference, disability or marital status. Persons under 18 years of age are not eligible for admission consideration unless special approval has been received from the Department of Health.