County of Schenectady

NEW YORK

Edmond Marchi
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. You may contact the Visiting Nurse Service at 518-382-7932 to arrange for a PRI and Screen.

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 (Attachment -1),
2. Universal Application (Attachment -2),
3. We also require the following information from your Primary Care Physician:
   a. Labs required prior to admission:

   - SMA 18/CMP
   - Urinalysis
   - TB Screening (PPD and chest x-ray as indicated)

   b. Immunization Records:

   - Pneumonia Vaccine (date)
   - Influenza Vaccine (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, 7:00 am – 3:00 pm at 518-384-3624.

Sincerely,

Patricia Stevens BSN RN, CCM

Admission 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

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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.

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GLENDALE HOME

Medical History and Physical Examination

To be completed by your Primary Care Physician

Patient Name:_____ Age:_____ DOB:_____

Diagnosis:_____
_____
_____

Pertinent Medical History:
_____
_____
_____

Allergies:_____
_____

Current Medications:_____
_____
_____

PHYSICAL EXAMINATION

HT:_____WT:_____B/P_____P_____

Normal/Abnormal, Explain

Head:

Eyes:_____
Ears:_____
Nose:_____
Mouth:_____
Throat:_____
Neck:_____

Thorax:

Lungs:_____
Heart:_____
Breasts:_____
Abdomen:_____
Rectal:_____
Pelvic: _____
Extremities:_____
Neurological: _____

Pertinent Lab, X-RAY, ECG, Please attach:_____

Mantoux PPD:_____Results:_____Chest X-RAY:_____

Pneumovac:_____ Date:_____Flu Vaccine:_____Date:_____

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MEDICAL CARE PLAN

A. Mental Status: Alert & Oriented YES_____ NO_____
Co-Operative YES_____ NO_____
Independent in ADL's YES_____ NO_____

B. Physical Limitations and/or Disabilities: YES_____NO_____(Specific)
Amputation_____Speech_____Vision_____Incontinence: Bowel_____
Paralysis_____Hearing_____Sensation_____Bladder_____

Additional Comments:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Attending MD:_____Date:_____