RENSSELAER COUNTY

VAN RENSSELAER MANOR NURSING & REHABILITATION FACILITY

85 Bloomingrove Drive, Troy, New York 12180

Phone: 518-283-2000; Fax: 518-283-4390

Steven F. McLaughlin
County Executive

Kenyatta Walker, RN, BSN, LNHA
Executive Director

Hello,

Enclosed you will find the application for admission to Van Rensselaer Manor. After you submit the completed application with all the required information (see page 2), the Admissions team will review the information and determine if the applicant is appropriate for the facility. If the applicant is appropriate, admissions staff will notify the applicant or designated representative when beds become available. Once your completed information is received, it will be kept in an active file as long as the PRI is updated every 90 days.

The facility is not a participating provider with all insurance plans, such as: MVP, GHI, Wellcare. If you have an insurance company that manages your health care, please determine what providers participate with your insurance plan prior to applying. This could include Medicare plans, Medicaid plans or private HMO plans.

Van Rensselaer Manor is the Rensselaer County Nursing and Rehab facility and gives preference to Rensselaer County residents.

If you have any related questions, please contact anyone on our admissions team: Nancy Casey, RN; Tara Gregory, LPN; or Marianne Hunter, LCSW.

Thank you for your interest in Van Rensselaer Manor Nursing & Rehabilitation Facility,

Nancy at extension 426 Tara at extension 467 Marianne at extension 483

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Thank you for your interest in admission to the Van Rensselaer Manor Nursing & Rehabilitation Facility. In order to consider an applicant for admission, the following information is required:

1) A completed VRM application.
2) A physical exam completed by your physician within the last 3 months, along with a complete medical history, including immunization records.
3) Medical reports from any specialist (ie. Neurologist) you have seen in the last two years.
4) A tuberculin skin test (PPD) within the last 3 months.
5) Copies of all insurance cards and Advance Directives (ie. Health Care Proxy, Power of Attorney).
6) A New York State PRI/Screen completed within the last 90 days. You may arrange to have this completed by a local assessor, a local home care agency or assistance from the applicant's primary care clinic.
7) A copy of the applicant's COVID-19 vaccination status. Additional information may be required based on CDC and DOH guidance.

Once the above is completed, the application may be submitted to the Van Rensselaer Manor Admissions Office. Applications are kept in an active file as long as the information is kept up to date.

At time of admission, a completed Admission Agreement will need to be reviewed and signed. For more information regarding the Admission Agreement please call and speak to the VRM Director of Social Work, Katherine Agard, LMSW at 518-283-2000, extension 410.

If you are interested in exploring county benefits to assist with long term (chronic) care services, please contact the Medicaid office in the county the applicant resides in for information and assistance.

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APPLICATION FOR ADMISSION

APPLICANT'S NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ TELEPHONE: _____

APPLICANT'S CURRENT LOCATION: _____

APPLICANT'S DESIGNATED REPRESENTATIVE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

PERSONAL DATA OF APPLICANT

APPLICANT'S DATE OF BIRTH _____ BIRTHPLACE _____

US CITIZEN _____ MARITAL STATUS _____ IF WIDOWED, HOW LONG _____

DATE OF MARRIAGE _____ SPOUSE'S NAME _____

ADDRESS OF SPOUSE _____

RELIGION _____ ACTIVE RELIGIOUS OBSERVER? _____

US MILITARY SERVICE _____ BRANCH OF SERVICE _____ YEARS _____

LANGUAGE(S) SPOKEN AND UNDERSTOOD _____

VOTER STATUS: ARE YOU REGISTERED? _____ INTERESTED IN VOTING? _____

***PLEASE INCLUDE COPIES OF ANY ADVANCE DIRECTIVES YOU MAY HAVE: HEALTH CARE PROXY, LIVING WILL, MOLST, POWER OF ATTORNEY.**

APPLICANT'S CHILDREN

NAMES: _____

_____

OTHER RELATIVES: _____

_____

PARENT'S NAMES: _____

IS APPLICANT ACCEPTING OF NURSING HOME PLACEMENT? _____

FAMILY'S REACTION TO PLACEMENT? _____

EDUCATIONAL BACKGROUND (HIGHEST LEVEL ACHIEVED): _____

SCHOOLS/ COLLEGE ATTENDED: _____

LIFETIME OCCUPATION: _____YEAR OF RETIREMENT: _____

HOBBIES/LEISURE INTERESTES/COMMUNITY ACTIVITIES: _____

_____

_____

DESCRIBE MOST RECENT LIVING ARRANGEMENTS:

_____

DID APPLICANT RECEIVE HOME CARE SERVICES? _____ NAME OF AGENCY: _____

IMPAIRMENTS (CHECK ALL THAT APPLY):

_____ MEMORY

_____ JUDGEMENT

_____ VISION

_____ HEARING

_____PHYSICAL – DESCRIBE: _____

_____EMOTIONAL- DESCRIBE: _____

CURRENT BEHAVIOR (CHECK ALL THAT APPLY):

__SAD	__QUIET	__NOISY	__DEMANDING
__FEARFUL	__FRIENDLY	__VERBALLY ABUSIVE	__PARTICULAR
__ANXIOUS	__CONFUSED	__PHYSICALLY AGGRESSIVE	_____
__AGITATED	__WITHDRAWN	__WANDERS	_____

HAS APPLICANT BEEN TREATED FOR A MENTAL ILLNESS OR ADDICTION- IF YES, PLEASE DESCRIBE:

_____

_____

CUSTOMARY ROUTINE (PRIOR TO ADMISSION- CHECK ALL THAT APPLY):

__LIKES TO STAY UP LATE AT NIGHT

__NAPS REGULARLY DURING THE DAY

__GOES OUT 1+ DAYS/WEEK

__STAYS BUSY WITH HOBBIES, READING OR FIXED DAILY ROUTINE

__SPENDS MOST OF TIME ALONE OR WATCHING TV

__USE OF TOBACCO PRODUCTS AT LEAST DAILY

__DISTINCT FOOD PREFERENCES

__EATS BETWEEN MEALS ON ALL OR MOST DAYS

__USE OF ALCOHOLIC BEVERAGES AT LEAST WEEKLY

__IN PAJAMAS MOST OF THE DAY

__WAKENS TO TOILET ALL OR MOST NIGHTS

__HAS IRRECGULAR BOWEL MOVEMENT PATTERN

__PREFERS SHOWERS

__PREFERS BATHS

__DAILY CONTACT WITH RELATIVES/ CLOSE FRIENDS

__USUALLY ATTENDS RELIGIOUS SERVICES

__FINDS STRENGTH IN FAITH

__DAILY ANIMAL COMPANION/PRESENCE- IF YES, WHAT TYPE OF ANIMAL _____

__ENJOYS INVOLVEMENT IN GROUP ACTIVITIES

HEALTH INSURANCE INFORMATION

****PLEASE PROVIDE COPIES OF ALL CARDS****

SOCIAL SECURITY NUMBER: _____

MEDICARE NUMBER: PART A _____

PART B _____

MEDICAID NUMBER _____ COUNTY _____

SUPPLEMENTAL MEDICAL INSURANCE

NAME_____

POLICY # _____

PRESCRIPTION DRUG PLAN (MEDICARE PART D)

NAME _____

POLICY # _____

LONG TERM INSURANCE

NAME _____

POLICY NUMBER _____

NAME OF PRIMARY CARE PHYSICIAN _____

CHOICE OF HOSPITAL _____

BURIAL ARRANGEMENTS:

FUNERAL HOME _____ TELEPHONE NUMBER _____

IS APPLICANT AN ORGAN DONOR? _____

PLEASE SPECIFY ANY OTHER BURIAL PLANS _____

_____

FINANCIAL SUMMARY

CURRENT MONTHLY INCOME:

SOCIAL SECURITY $ _____/ MONTH

INTEREST FROM BANK ACCOUNTS $ _____/ MONTH

DIVIDENDS FROM SECURITIES $ _____/ MONTH

PENSION BENEFITS $ _____/ MONTH

VETERANS BENEFITS $ _____/ MONTH

RAILROAD RETIREMENT $ _____/ MONTH

INCOME FROM ANNUITIES $ _____/ MONTH

RENT FROM REAL PROPERTY $ _____/ MONTH

OTHER $ _____/ MONTH

BANK ACCOUNTS:

NAME OF BANK	**ACCOUNT BALANCE**	**JOINT ACCOUNT**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

STOCKS/ BONDS/ OTHER SECURITIES:

NAME OF SECURITY	**MARKET VALUE**	**JOINT ACCOUNT**
_____	_____	_____
_____	_____	_____
_____	_____	_____

REAL ESTATE:

DESCRIPTION OF PROPERTY	**APPRAISED VALUE**	**OUTSTANDING MORTGAGE**
_____	_____	_____
_____	_____	_____

LIFE INSURANCE:

NAME OF COMPANY _____

POLICY NUMBER _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO ASSIST WITH MEDICAID ASSESSMENT:

HAVE YOU APPLIED FOR MEDICAID? _____ WHAT COUNTY? _____

HAS THE APPLICANT DISPOSED OF ANY ASSETS WITHIN THE 60 MONTHS PRIOR TO THE DATE OF THIS APPLICATION ? _____ PLEASE DESCRIBE: _____

HAS THE APPLICANT SET UP A TRUST? _____

DOES THE APPLICANT MAINTAIN A SAFE DEPOSIT BOX? _____

NOTE: THIS APPLICATION MUST BE SUBMITTED BEFORE ANY PERSON CAN BE CONSIDERED FOR ADMISSION. SUBMISSION OF THIS APPLICATION DOES NOT CREATE ANY GUARANTEE TO ADMISSION OR MEAN THAT AN APPLICANT WILL BE ACCEPTED AS A CANDIDATE FOR ADMISSION. SUBMITTED FINANCIAL DOCUMENTATION IS SUBJECT TO REVIEW AND VERIFICATION BY VAN RENSSELAER MANOR.

ADMISSION AND ACCESS TO VAN RENSSELAER MANOR WILL BE AVAILABLE TO ALL APPLICANTS REGARDLESS OF RACE, CREED, COLOR, HANDICAP, AGE, SEX PAYOR SOURCE, MARITAL STATUS, SEXUAL PREFERENCE, BLINDNESS, VETERAN STATUS OR RELIGION.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL THE INFORMATION CONTAINED HERIN IS ACCURATE AND TRUE.

_____ _____

SIGNATURE OF APPLICANT **DATE**

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PRE-ADMISSION HISTORY AND PHYSICAL

PATIENT NAME _____ DOB_____ DATE OF EXAM _____

CURRENT MEDICAL DX: _____

_____

_____

_____

PAST MEDICAL HX (INCLUDING SURGICAL HX): _____

_____

_____

_____

MENTAL HEALTH DX: _____

HX OF DEMENTIA (SUPPORTING DOCUMENTATION FOR WORK UP): _____

_____

ALLERGIES (FOOD & DRUG) SYMPTOMS

_____

HEIGHT _____ WEIGHT _____ BP _____ PULSE _____ RESP _____

OTHER PHYSICIANS APPLICANT IS FOLLOWED BY:

DENTIST _____

OPTHAMOLOGIST _____

PODIATRIST _____

OTHER _____

_____

REVIEW OF SYSTEMS:

ENT _____

NEURO _____

RESPIRATORY _____

CARDIAC _____

GI _____

ENDOCRINOLOGY _____

GU _____

SKIN/WOUNDS _____

IMMUNIZATIONS WITH DATE RECEIVED:

INFLUENZA _____ PNEUMOCOCCAL _____

TETANUS _____ HAPATITIS B _____

COVID VACCINATIONS _____

RECENT MEDICAL TESTS/ EXAMS- REQUIRED FOR ADMISSION

CBC/BMP

PPD/ MANTOUX: DATE GIVEN _____ DATE READ _____ RESULTS _____
SIGNTURE / LICENSE OF PROVIDER READING PPD RESULT _____

*IF HX OF +PPD, CHEST XRAY W/IN THE LAST 3 MONTHS IS NEEDED. IF HX OF TB, PROVIDE DOCUMENTATION OF TREATMENT RECEIVED.

HEPATITIS C SCREENING TEST OFFERED _____

(INDIVIDUALS BORN BETWEEN 1945 AND 1965 RECEIVING INPT HOSPITAL CARE OR PRIMARY CARE)

MEDICATIONS	**DOSE**	**FREQUENCY**	**ROUTE**

DO YOU RECOMMEND NURSING HOME PLACEMENT FOR THIS PERSON? _____

_____

PHYSICIAN SIGNATURE DATE

_____

PHYSICIAN NAME (PLEASE PRINT)

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____ DOB _____

I hereby authorize the use r disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a covered health plan, health care provider or clearinghouse (ie. Thy perform certain transactions electronically), the released information may no longer be protected by federal privacy regulations, except that a recipient may be prohibited from re-disclosing substance abuse information under the federal substance abuse confidentiality requirements. State law governs the release of HIV information and you may request a list of persons authorized to re-release such information.

Persons/organizations providing the information: Persons/ organizations receiving the information:

_____ _____

_____ _____

1. Description of information including date (s). I consent to the release of any HIV/AIDS information and alcohol and substance abuse information unless a box is checked.
   ☐ Do NOT disclose HIV information ☐ NOT disclose drug & alcohol information
2. Purpose of the use/ disclosure: _____
3. Will the person/program requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes ____ No ____
4. I understand that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for payment, enrollment, etc.
5. I understand that I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
6. I may revoke this authorization at any time by notifying the Rensselaer County Manor Nursing Home in writing, but if I do it will not have any affect on any actions they took before they received the revocation.
   This authorization will expire on _____

_____ _____
Signature of patient or legal representative Date

Printed Name of Patient's Legal Representative _____
Relationship to the Patient _____

HIV specific information:
For questions/complaints regarding HIV discrimination, call the NYS Division of Human Rights at 518-474-2705 or the NYC Commission on Human Rights at 212-306-7450.
Federally protected substance abuse information:
I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

(HIPAA Authorization for Release of Information 164-508) (Last Revised 3/18/03)