Fairport Baptist Homes
— ASSISTED LIVING —

APPLICATION FOR ADMISSION

Fairport Baptist Homes Adult Care Facility/Assisted Living Program

Fairport Baptist Homes (FBH) is very pleased to be able to offer an Adult Care Facility (ACF) and Assisted Living Program (ALP) in addition to our Rehabilitation Center and Long-Term care (Skilled Nursing). Fairport Baptist Homes has been helping our community for over 100 years. Attached, please find an application for potential admission to our program.

Most of the Adult Care and Assisted Living units are designed for occupancy by one person, however, a limited number, due to their size, can accommodate two. If you are planning on sharing a unit please give us the name of your co-resident and their relationship to you. Each applicant needs to complete an application with detailed demographic and health information, along with individual financial details. If your co-resident is a spouse, and you maintain joint assets/accounts, you can complete one of the "Other Assets" listing in the financial portion of this application.

All prospective residents will complete a health and financial review to determine eligibility for residency. The decision to accept an applicant for residency is at the sole discretion of Fairport Baptist Homes. Such decisions will be consistent with applicable non-discrimination and civil rights laws and in compliance with all Federal and State civil rights laws and regulations. Fairport Baptist Homes does not discriminate based on race, religion, creed, color, national origin, handicap, disability, blindness, gender, sexual preference, or marital status in the application for residency, retention and care upon residency. Fairport Baptist Homes treats all prospective residents on this non-discriminatory basis.

Please enclose copies of any of the following which pertain to you.

Social Security Card	Prescription Plan
Medicare Card	Body Organ Donor Card
Medicaid Card	Long Term Care Insurance Card
Major Medical Insurance Card	Power of Attorney
Medicare D	Living Will/Health Care Proxy

Please complete all questions as fully as possible:

Applicant Name: _____

Co-Resident Name:_____Relationship: _____

Address: _____

Present housing: (apartment, private house, condo, etc) _____

Phone: _____

Email: _____

Demographic Information:

Date of Birth: _____Birth place: _____

If you were NOT born in the USA, please provide copies of your permanent Visa/Naturalization papers or Green card.

Social Security Number: _____

Funeral Home/Burial Instructions: Funeral Home Name: _____

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Address: _____
Phone: _____Cemetery:_____

Do you plan on bringing a car? Yes: _____ No: _____
Please provide year, make, color, plate#_____
Insurance Information: _____

Medicare # _____
Medicaid#_____County_____CaseWorker_____
Medicare D (prescription plan) _____
Other Supplemental Insurance _____yes _____no
Policy Number Group Number: _____
Long Term Care Policy _____yes _____no
Policy Number:_____Contact Phone Number:_____

Contact Persons: (Nearest Relatives or Significant Others). Please list in order of contact; attach another sheet(s) if necessary. In completing this application, it is recommended that every resident appoint a Power of Attorney (POA) and Health Care Proxy (HCP).

Name: _____ Relationship: _____
Address:_____
_____
Home Phone:_____ Cell Phone: _____
Work Phone:_____Email: _____
POA _____ HCP _____

Name: _____ Relationship: _____
Address:_____
_____
Home Phone:_____ Cell Phone: _____
Work Phone:_____ Email:_____
POA _____ HCP _____

Name: _____ Relationship: _____
Address:_____
_____
Home Phone:_____ Cell Phone: _____
Work Phone:_____ Email: _____
POA _____ HCP _____

HEALTH SECTION:
Primary Care Physician
Name: _____
Address:_____ Phone:_____
Fax: _____

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Please list other Physicians or health professionals you have seen in the last 12 months (i.e., Surgeon, Dentist, Optometrist, Dermatologist, Psychiatrist):

Name:_____
Address:_____ Phone:_____
Specialty:_____

Name:_____
Address:_____ Phone:_____
Specialty:_____

Name:_____
Address:_____ Phone:_____
Specialty:_____

Summary of significant medical conditions (if any):
_____
_____
_____

Please briefly describe the assistance you would require:
_____
_____
_____

Please list and describe the reasons for any periods of hospitalization, surgeries, or psychiatric illnesses you have had in the past three years:
_____
_____
_____

Allergies?
Do you have any allergies specific to animals? †Yes †No Do you have any fear of animals? †Yes †No

FINANCIAL DISCLOSURE INFORMATION:
YOUR MONTHLY INCOME:

Social Security: _____
Private Pension: _____
Veteran Pension: _____
Interest Income: _____
Dividend Income: _____
Mortgage/Rental Income: _____
IRA Income: _____
Trust Income: _____
Other Monthly Income: _____
Source of other income: _____

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TOTAL MONTHLY INCOME _____

FINANCIAL DISCLOSURE FORM "OTHER ASSETS"BANK ACCOUNTS:

SAVINGS:
Ownership: _____Self_____Joint
Name of Account _____
Balance: _____as of (date) _____

CHECKING:
Ownership: _____Self_____Joint
Name of Account _____
Balance: _____as of (date) _____

CERTIFICATES OF DEPOSIT
Ownership: _____Self_____Joint
Name of Account _____
Balance: _____as of (date) _____

STOCKS AND BONDS
Current Value: _____

HOUSE: Please list: _____
Current Value: _____

OTHER PROPERTY: Please list: _____
Current Value: _____

OTHER ASSETS: (i.e. IRA)
Current Value: _____

LIFE INSURANCE: _____
Cash Value: _____
Face Value: _____

TOTAL ASSETS: _____Value Date:_____Total Current Value:_____

Have you established a Trust? _____Yes_____No
If yes, date this was established: _____
Revocable or Irrevocable? _____
List which assets are in numerated in your trust: _____

Present Medicaid/Supplemental Security Income (SSI) guidelines require that no asset fund transfers take place within sixty (60) months (five (5) years) prior to a Medicaid/SSI application submission. Transfers to a trust are subject to a sixty (60) month prior review. Please indicate all funds/assets given as gifts and/or transferred from the applicant, to another individual, within the last five (5) years.

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In preparation of anticipated admission to the Assisted Living Community at Fairport Baptist Homes, medical information from your Primary Care will be helpful. We need to have each applicant sign this release form so that we are able to obtain information such as your current medication listing, diagnosis and recent office visits notes to add to your application file. As we progress and get closer to admitting you to our Assisted Living Community, the New York State Department of Health will require FBH to obtain additional current (which is within thirty (30) days of admission) medical information.

Additional request for information and forms may be sent to your Primary Care Physician directly, from the ACF/ALP admissions team.

RELEASE OF INFORMATION CONSENT FORM

I,_____, an applicant for admission to the Assisted Living Community at Fairport Baptist Homes of Fairport, New York, or its accredited representatives, has my permission to obtain full and detailed information from any doctor, hospital or clinic to whom I am or have been known regarding any consultations I have had with them, including the reason, the diagnosis and the nature and result of the treatment.

_____ _____

Signed Date

(May be signed by Applicant or Legal Representative) Relationship to Applicant

Applicants to the Assisted Living Community at Fairport Baptist Homes are accepted and considered without regard to race, religion, creed, color, age, sex, national origin, sponsor, advance directive, sexual orientation, blindness or other handicap.

This application and any related documents can be mailed to Fairport Baptist Homes at:
4646 Nine Mile Point Road, Fairport, NY, 14450. You can also return via e-mail to ltoomey@fbhcm.org, or via fax at (585) 388 2388.

Please note, Fairport Baptist Homes is a completely smoke-free facility. Admission to Fairport Baptist Homes is made regardless of age, race, creed, color, national origin, sex, disability, sexual orientation, marital status, or source of payment.