



CONFIDENTIAL DATA APPLICATION

1 Johnsarbor Drive West ~ Rochester, NY 14620

Phone: 585-442-1300 Fax: 585-473-8856

The undersigned hereby applies for residency to The Hawthorne and agrees to comply with all current and future policies and procedures of The Hawthorne.

PERSONAL/APPLICANT INFORMATION

Last:		First:	
Address:			
City:	State/Zip:	Phone #:	
Email:	Date of Birth:	Age:	Gender: _____Male_____Female

POWER OF ATTORNEY/GUARDIAN/FAMILY INFORMATION

The following are the names, residences and phone numbers of any guardians, the holder(s) of my Power of Attorney and children. If no children, list interested relatives and friends. Note: Copy of POA is required prior to admissions if applicable.

*******Kindly list in order as to whom should be contacted first, on your behalf*******

1. Name:		Relationship:	
Address: (include city, state, zip)			
Email:	Home Phone:	Cell Phone:	
2. Name:		Relationship:	
Address: (include city, state, zip)			
Email:	Home Phone:	Cell Phone:	
3. Name:		Relationship:	
Address: (include city, state, zip)			
Email:	Home Phone:	Cell Phone:	
4. Name:		Relationship:	
Address: (include city, state, zip)			
Email:	Home Phone:	Cell Phone:	
5. *Power of Attorney Name & Email:			
6. *Health Care Proxy Name & Email:			
<p style="color: red; margin: 0;"><i>Check Answer: DNR: YES NO MOLST: YES NO *If YES copy is required prior to admission</i></p>			

INSURANCE INFORMATION

Medicare Number (Including Letters)

Medicaid Number:

Medicare Part A	Yes [] No []	Medicare Part B	Yes [] No []
Other Supplemental Insurance	Yes [] No []	Policy Number	Group Number
Long Term Care Policy	Yes [] No []	Policy Number	Contact Phone #

If yes, provide a copy of the long-term care policy for review of Assisted Living provisions and benefits.

PERSONAL FINANCIAL STATUS

MONTHLY INCOME

- 1. Social Security \$ _____
- 2. Pension/Retirement \$ _____
- 3. Interest Income \$ _____
- 4. Dividends \$ _____
- 5. Other Income: \$ _____

TOTAL INCOME \$ _____

ASSETS

- 1. Savings & CDs \$ _____
- 2. Stocks & Bonds \$ _____
- 3. Trust & Estate Equities \$ _____
- 4. *Value of Real Estate \$ _____
Address: _____

5 Other Assets: \$ _____

TOTAL ASSETS \$ _____

LIABILITIES

- 1. Mortgages \$ _____
- 2. Home Equity Lines of Credit \$ _____
- 3. Reverse Mortgages \$ _____
- 4. Current Credit Card Debt \$ _____
- 5. Outstanding Medical Bills \$ _____
- 6. Personal Loans \$ _____
- 7. Other Liabilities \$ _____

TOTAL LIABILITIES \$ _____

*Is Real Estate owned by the applicant, available for sale, and will sale proceed be applied, if necessary, to fund residency at The Hawthorne? **YES** _____ **NO** _____

MONTHLY EXPENSES	
2026 – Hawthorne Apartment Monthly Rent	\$ 8,275
Hawthorne Second Person Fee <i>(if applicable)</i>	\$ 2,075 <i>(if applicable)</i>
Pharmacy	\$
Out of Pocket Medical	\$
Health Insurance Premium	\$
Subscriptions	\$
Life Insurance Premiums	\$
Potential out of pocket home Health	\$
Laundry & Dry Cleaning	\$
Hair styling	\$
Personal toilet & commissary goods	\$
Medical/Recreational Transportation	\$
Telephone Expense	\$
OTHER:	\$
TOTAL EXPENSES:	\$

CERTIFICATION

I hereby declare that all statements made on this application are true and accurate to the best of my knowledge. I understand that failure to provide accurate and truthful information may result in termination of this agreement and my residence at St. John’s Meadows at any time. I have not withheld any information requested herein, and have read this application or had it read to me and it has been fully explained to me.

All prospective residents will complete a health and financial review to determine eligibility for residency at The Hawthorne. The decision to accept applicant for residency is at the sole discretion of sponsor. Such decisions will be consistent with applicable non-discrimination and civil rights laws.

Signature of Applicant	Date	Witness	Date
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Signature of Applicant	Date	Witness	Date
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_____ Date _____
 St. John’s Meadows
 Authorized Signature

IN COMPLIANCE WITH ALL FEDERAL AND STATE CIVIL RIGHTS LAWS AND REGULATIONS, THE HAWTHORNE DOES NOT DISCRIMINATE BASED ON RACE, CREED, COLOR, DISABILITY, NATIONAL ORIGIN, SEXUAL ORIENTATION, MILITARY STATUS, AGE, SEX, MARITAL STATUS OR FAMILIAL STATUS IN THE APPLICATION FOR RESIDENCY, RETENTION AND CARE UPON RESIDENCY. THE HAWTHORNE TREATS ALL PROSPECTIVE RESIDENTS AND RESIDENTS ON THIS NON-DISCRIMINATORY BASIS.

*The Hawthorne is a non-smoking community.



CONFIDENTIAL HEALTH STATUS REPORT

HEALTH INFORMATION

Applicants Name _____
Last Name First Name M.I.

1. Summary of Significant Medical Conditions, if any:

2. Current Listing of Medications:

3. Known Allergies: (medications, food, environmental)

4. Please briefly describe the assistance required.

5. Please list and briefly describe the reasons for any periods of hospitalization, surgeries, or *psychiatric illness, you have had in the past three years.

**requires submission of Department of Health Adult Care Facility Mental Health Evaluation form (provided by Hawthorne, should you require this – kindly advise)*

6. Please provide the name, address and telephone number of your **primary care physician.**

Primary Care Physician Name:
Address:
Phone:
Email:

7. Please list the names of any other physicians or health professionals you have seen in the last 12 months, and indicate their areas of specialty.

Physician Name:	Area of Specialty:
Address:	
Phone:	
Email:	

Physician Name:	Area of Specialty:
Address:	
Phone:	
Email:	

Physician Name:	Area of Specialty:
Address:	
Phone:	
Email:	

Physician Name:	Area of Specialty:
Address:	
Phone:	
Email:	

I acknowledge that acceptance of my application for occupancy of a residence at The Hawthorne will be determined by The Hawthorne based on the information I provide to sponsor. I further understand that, prior to approving my application for residency at The Hawthorne at St. John's Meadows, a written statement of health condition (form 3122) must be completed by a primary care physician and that the sponsor may request additional information concerning my health status. I hereby declare that all statements made herein and all other information I have provided to Sponsor in connection with my application for residency are true according to my best knowledge and belief.

Signature

Date

Resident's Name: _____
Facility Name: _____ Date of Evaluation: _____

SECTION 1: COMMUNICATION/DENTAL/VISION/HEARING

Can the individual Speak English? Yes No Read English? Yes No Write in English? Yes No

Can the individual understand instructions in English? Yes No

If no to any of the above, indicate dominant language: Speak: _____ Read: _____ Write: _____

Verbal Expression/Speech (check all that apply):

Easily Understood Yes No Difficulty finding words or expressing self Yes No

Slurred or mumbled speech Yes No Understands directions Yes No

SPEECH: Does the resident have a speech defect / impairment? Yes No

If yes, describe: _____

DENTAL Prosthetics: _____

VISION: Glasses: Yes No Glaucoma: L R Legally Blind: L R Contact Lenses: Yes No

Comments: _____

HEARING: Does the patient have a hearing deficit? Yes No Hearing Aid: L R

Comment(s): _____

SECTION 2: CUSTOMARY ROUTINE

Sleeping routine: Preferred wake up time: _____ Napping routine: _____
Preferred bedtime: _____ Nighttime sleep pattern: _____

Comments: _____

Bathing routine: Prefers Bath Shower Frequency: _____

Comments: _____

Eating routine: Food preferences (religious, cultural, other): _____
Food dislikes: _____

Comments: _____

Daily Events: (check all that apply)

<input type="checkbox"/> Goes out _____ days a week (Specify 1 – 7)	<input type="checkbox"/> Stays busy with hobbies, reading, fixed daily routine
<input type="checkbox"/> Spends most time alone	<input type="checkbox"/> Contact with relatives/close friends _____ days per week (Specify 1 – 7)
<input type="checkbox"/> Spends most time watching TV	<input type="checkbox"/> Usually attends church, synagogue, mosque, etc.
<input type="checkbox"/> Prefers small group activities	<input type="checkbox"/> Prefers large group activities

Comments: _____

Resident's Name: _____
Facility Name: _____ Date of Evaluation: _____

SECTION 3: CONTINENCE STATUS/MANAGEMENT

Is the resident continent of urinary function? Yes No

Is the resident continent of bowel function? Yes No

IF ANSWER IS "NO" TO EITHER QUESTION, COMPLETE THIS SECTION, AS APPROPRIATE.

Urinary Incontinence		Bowel Incontinence	
<input type="checkbox"/> Several times a week <input type="checkbox"/> Daily	<input type="checkbox"/> Day Only <input type="checkbox"/> Night only <input type="checkbox"/> Day and night	<input type="checkbox"/> Several times a week <input type="checkbox"/> Daily	<input type="checkbox"/> Day only <input type="checkbox"/> Night only <input type="checkbox"/> Day and night
Current management techniques		Current management techniques	
<input type="checkbox"/> Prompting/reminding defers incontinence <input type="checkbox"/> Timed voiding defers incontinence <input type="checkbox"/> Uses incontinence pads/adult diapers: <input type="checkbox"/> Day only <input type="checkbox"/> Night only <input type="checkbox"/> Day and night Catheter (specify type) _____ Comments: _____ _____ Self-manage continence? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Uses incontinence pads/adult diapers: <input type="checkbox"/> Day only <input type="checkbox"/> Night only <input type="checkbox"/> Day and night Comments: _____ _____ _____ Self-manage continence? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 4: PHYSICAL FUNCTION

TASK	LEVEL OF ASSISTANCE	COMMENTS
Eating: (Ability to feed self meals and snacks)	<input type="checkbox"/> Independent: Able to feed self independently with or without assistive device. <input type="checkbox"/> Intermittent Assistance: Requires minimal, intermittent supervision and/or assistance. <input type="checkbox"/> Continual Assistance: Requires constant assistance and/or supervision throughout meal. <input type="checkbox"/> Total Assistance: Unable to feed self, needs to be fed. Unable to take nutrients orally, requires enteral nutrition.	Dentures Upper <input type="checkbox"/> Yes <input type="checkbox"/> No Lower <input type="checkbox"/> Yes <input type="checkbox"/> No Chewing difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No Modified consistency <input type="checkbox"/> Yes <input type="checkbox"/> No Specify _____ Comments:
Ambulation: (Ability to safely walk and move about once in a standing position)	<input type="checkbox"/> Independent: Walks and climbs and descends stairs independently with or without assistive device. <input type="checkbox"/> Intermittent Assistance: Walks and climbs and descends stairs with minimal, intermittent assistance and/or supervision. <input type="checkbox"/> Continual Assistance: Walks and climbs and descends stairs with constant supervision and/or assistance. <input type="checkbox"/> Total Assistance: Chairfast or bedfast. Requires total assistance for mobility.	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Quad cane <input type="checkbox"/> Cane <input type="checkbox"/> Other: _____ Falls within the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency #: _____ Injury: _____ Comments:

Resident's Name: _____
 Facility Name: _____ Date of Evaluation: _____

TASK	LEVEL OF ASSISTANCE	COMMENTS
Transferring: (Moving from bed to chair, on/off toilet, in/out of shower or tub)	<input type="checkbox"/> Independent: Able to transfer independently with or without assistive device. <input type="checkbox"/> Intermittent Assistance: Transfers with minimal human assistance and/or supervision. <input type="checkbox"/> Continual Assistance: Unable to transfer but can bear weight and pivot when transferred by at least one other person. <input type="checkbox"/> Total Assistance: Chairfast or bedfast, unable to transfer, pivot, bear weight or turn self in bed.	Comments:

PROSTHESIS: No Yes (describe) _____

AMPUTATION: No Yes (describe) _____

PODIATRIC: Does the resident have podiatric concerns requiring treatment or which impair ability to ambulate or transfer? No Yes
 (describe) _____

TASK	LEVEL OF ASSISTANCE	COMMENTS
Toileting: (Getting to/from and on/off the toilet, cleansing self after elimination and adjusting clothing)	<input type="checkbox"/> Independent: Able to toilet independently with or without assistive device. <input type="checkbox"/> Intermittent Assistance: Able to toilet with minimal intermittent assistance and/or supervision. <input type="checkbox"/> Continual Assistance: Able to toilet with constant assistance and/or supervision. <input type="checkbox"/> Total Assistance: Unable to toilet. Requires total assistance with toileting.	Ostomy <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:
Bathing: (Getting in and out of tub or shower, washing and drying entire body)	<input type="checkbox"/> Independent: Able to bathe or shower independently with or without assistive device. <input type="checkbox"/> Intermittent Assistance: Able to bathe or shower w/minimal intermittent assistance and/or supervision. <input type="checkbox"/> Continual Assistance: Able to bathe or shower with constant assistance and/or supervision. <input type="checkbox"/> Total Assistance: Unable to use shower or tub. Bathed in bed or at bedside.	Comments:
Dressing: (Getting clothes from closets and drawers, dressing and undressing upper/lower body including buttons, snaps, zippers, socks and shoes)	<input type="checkbox"/> Independent: Able to dress and undress independently with or without assistive device. <input type="checkbox"/> Intermittent Assistance: Able to dress and undress with minimal, intermittent assistance and/or supervision. <input type="checkbox"/> Continual Assistance: Requires assistance throughout the dressing and undressing process. <input type="checkbox"/> Total Assistance: Requires another person to dress and undress upper and lower body.	Comments:

Resident's Name: _____
 Facility Name: _____ Date of Evaluation: _____

SECTION 4: PHYSICAL FUNCTION Cont.

TASK	LEVEL OF ASSISTANCE	COMMENTS
Grooming: (Washing face, hair care, shaving, teeth/denture, fingernail care, eyeglasses care)	<input type="checkbox"/> Independent: Able to groom self independently with or without assistive device. <input type="checkbox"/> Intermittent Assistance: Requires grooming utensils to be set up and placed within reach. <input type="checkbox"/> Continual Assistance: Requires assistance throughout the grooming process. <input type="checkbox"/> Total Assistance: Depends entirely upon someone else for grooming.	Comments:
Transportation: (Physical and mental ability to safely use a car, taxi, or public transportation [bus, train, subway])	<input type="checkbox"/> Independent: Able to independently drive a regular or adapted car; <i>OR</i> uses a regular or handicap accessible public bus, train or subway. <input type="checkbox"/> Independent: But requests facility perform task. <input type="checkbox"/> Intermittent Assistance: Able to ride in a car only when driven by another person; <i>AND/OR</i> due to physical, cognitive or mental limitations occasionally requires another person to accompany him/her when using a bus, train or subway. <input type="checkbox"/> Continual Assistance: Able to ride in a car only when driven by another person; <i>OR</i> able to use a bus or handicap van, train or subway only when assisted or accompanied by another person. <input type="checkbox"/> Total Assistance: Unable to ride in a car, taxi, bus or van, and requires transportation by ambulance.	Comments:
Laundry: (Ability to do own laundry – to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand)	<input type="checkbox"/> Independent: Able to independently take care of all laundry tasks. <input type="checkbox"/> Independent: But requests facility perform task. <input type="checkbox"/> Intermittent Assistance: Able to do only light laundry, such as minor hand wash or light washer loads. Needs assistance with heavy laundry, such as carrying large loads of laundry. <input type="checkbox"/> Continual Assistance: Due to physical, cognitive or mental limitations, needs continual supervision and assistance to do any laundry. <input type="checkbox"/> Total Assistance: <u>Unable</u> to do any laundry.	Comments:
Housekeeping: (Ability to safely and effectively perform light housekeeping and heavier cleaning tasks)	<input type="checkbox"/> Independent: Able to independently perform all housekeeping tasks. <input type="checkbox"/> Independent: But requests facility perform task. <input type="checkbox"/> Intermittent Assistance: Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently; <i>AND/OR</i> able to perform housekeeping tasks with intermittent assistance or supervision from another person. <input type="checkbox"/> Continual Assistance: <u>Unable</u> to consistently perform any housekeeping tasks unless assisted by another person throughout the process. <input type="checkbox"/> Total Assistance: Unable to effectively participate in any housekeeping tasks.	Comments:

Resident's Name: _____
Facility Name: _____ Date of Evaluation: _____

SECTION 4: PHYSICAL FUNCTION cont.

TASK	LEVEL OF ASSISTANCE	COMMENTS
Shopping: (Ability to plan form, select and purchase items in a store and to carry them home or arrange delivery)	<input type="checkbox"/> Independent: Able to plan for shopping needs and independently perform shopping tasks, including carrying package. <input type="checkbox"/> Independent: But requests facility perform task. <input type="checkbox"/> Intermittent Assistance: Able to do only light shopping and carry small packages, but needs someone to do occasional major shopping. <input type="checkbox"/> Continual Assistance: <u>Unable</u> to go shopping alone, but can go with someone to assist; <u>OR</u> unable to go shopping but is able to identify items needed, place orders, and arrange for home delivery. <input type="checkbox"/> Total Assistance: Needs someone to do all shopping and errands.	Comments:
Ability to use a Telephone: (Ability to answer the telephone, dial numbers, and <i>effectively</i> use the telephone to communicate)	<input type="checkbox"/> Independent: Able to dial numbers and answers calls appropriately and as desired. <input type="checkbox"/> Independent: But requests facility perform task. <input type="checkbox"/> Intermittent Assistance: Able to use a specially adapted telephone (i.e., large numbers on the dial pad, teletype phone for the deaf) and call essential numbers; able to answer the telephone and carry on a normal conversation but has difficulty with placing calls; able to answer the telephone only some of the time or is able to carry on only a limited conversation. <input type="checkbox"/> Continual Assistance: Unable to make calls or answer the telephone at all, but can listen if assisted with equipment. <input type="checkbox"/> Total Assistance: Totally unable to use the telephone. Requires someone else to make calls.	Comments:

SECTION 5: COGNITIVE IMPAIRMENT SCREEN

Cognitive Functioning: Individual's current level of alertness, orientation, comprehension, concentration and immediate memory.

Response: What is today's date? Correct Incorrect What day of the week is today: Correct Incorrect
 (correct, if within 2 days)
 How old are you? Correct Incorrect When were you born? Correct Incorrect

Behaviors of Note: (check all that apply):
 Wanders Day/Night Sleep disturbance Confused Depressive Feelings Anxious Withdrawn/Refuses to Socialize
 Agitated (repeated vocalizations, screaming, shouting, moaning, cursing, fidgeting, etc.) Other: _____

Overall Cognitive Functioning:(check all that apply):
 Is alert and oriented, comprehends verbal questions and commands and has accurate recall
 Requires prompting and redirection, on occasion, to complete tasks
 Has occasional fluctuation in orientation, memory/alertness
 Has significant memory loss and is disoriented to person, place and/or time

This screen includes indicators, which are often related to cognitive impairment. This is a screen ONLY and is intended to assist the residence in determining if an individual is appropriate for care in an ALR and/or if the individual should be referred to his/her physician for consultation and/or further evaluation or treatment.

Comments: _____

Resident's Name: _____
Facility Name: _____ Date of Evaluation: _____

SECTION 6: ADMISSION DECISION

ACCEPTED TO: ALR/AH/EHP Enhanced ALR Special Needs ALR

Upon admission, the following documents were provided to the applicant at, or prior to, the admissions interview:

- _____ Consumer Information Guide
- _____ Copy of the Residency Agreement
- _____ Copy of the statement of resident rights
- _____ Copy of any facility regulations relating to resident activities, office and visiting hours and like information
- _____ If made available to the operator by the Long-Term Care Ombudsman Program, a fact sheet about the program and the listing of legal services or advocacy agencies.
- _____ Personal Allowance Protections (SSI and Temporary Assistance (TA) recipients only)
- _____ Most recent Statement of Deficiencies (shown to applicant)

Signature(s) of ALR staff participating in this evaluation.

Name: _____ Title: _____ Date: _____
Name: _____ Title: _____ Date: _____
Name: _____ Title: _____ Date: _____

Signature of Administrator/Case Manager/or ISP Planner: _____ **Date:** _____

Signature of Individual/Resident: _____ **Date:** _____

Signature of Resident Representative: _____ **Date:** _____

Name(s) of others participating in this evaluation.

Name: _____ Relationship: _____ Date: _____
Name: _____ Relationship: _____ Date: _____