Longview
an Ithacare Community

Dear Friend:

We are delighted to provide you with the information you requested for our Assisted Living and/or Enhanced Living Residence. If you have not already done so, please call to make an appointment for a tour so that you can see our beautiful facility in person and meet some of our staff and residents. We would also appreciate the opportunity to meet you to get a better sense of your needs.

If you decide you would like to apply for admission, there are several pages of an application form to be completed, as well as a medical evaluation which your doctor must fill out and sign. The doctor's evaluation must be based on an exam within 30 days of admission. These forms can be downloaded from our website, we can mail or fax them to you, or you may pick them up from our offices. Completed forms should be mailed attention to:

Resident Services
Longview, an Ithacare Community
1 Bella Vista Drive
Ithaca, New York 14850

Upon admission, a community fee of $600 plus a security deposit equal to the monthly fee is required. The first month's rent is pro-rated from the date of admission.

If you have any questions after reviewing these materials, please don't hesitate to contact us at (607) 375-6320 Monday through Friday between 8:30am and 5:00pm.

We look forward to hearing from you.

Sincerely,

Resident Services Staff

Resident Services

Enclosures

Longview
an Ithacare Community

Assisted Living Residence Guidelines & Services

Residents must be essentially independent with Activities of Daily Living (ADLs) to reside in the Assisted Living Residence. This means that a resident needs to be able to feed, toilet, ambulate, transfer and dress him or herself. The Resident Aides (RAs) will assist with showers twice a week and a whirlpool bath once a week, if desired. Residents may use assistive devices or equipment (such as walkers and wheelchairs) as needed to maintain their independence.

Three meals are provided daily and 1 snack per day. The RAs remind the residents when it is time to eat, but the residents need to be able to get to the dining room on their own (staff may guide them). A RA is present while residents are dining to provide minimal assistance and to respond in an emergency. There is a nutritional consultant on staff who monitors residents' diets.

The RAs assist residents with their medication at the Medication Room. They also assist residents with laundry as needed, provide some assistance with bathing and they respond in emergencies (emergency call bells are located in each living unit and every bathroom). There are at least two RAs on duty 24 hours per day. A registered or licensed practical nurse is on duty and on-site at the residence 40 hours per week. In addition, a Registered Nurse is on-call and available for consultation seven days per week, 24 hours a day. Our staff is prohibited from performing any wound care in the assisted living unit by the NYS Department of Health.

Residents choose their own health care providers. A resident may obtain companion care services while at Longview.

Recreational/cultural programs are scheduled daily. Residents have the use of the library, greenhouse, craft room, auditorium, and chapel, as well as the pool and exercise room (under supervision). Our programming is enriched by the partnership we enjoy with Ithaca College.

A social worker is available to provide admission and discharge information, case management, counseling and assistance with problem solving.

Please contact Resident Services Staff with any questions regarding the Assisted Living Residence.

EQUAL HOUSING OPPORTUNITY

Longview
an Ithacare Community

Assisted Living Residence/ Enhanced Assisted Living Residence Items Needed for Admission

Applicant's Name: _____

The Following Items Are Needed for Admission:

- ❑ Tour and interview with case manager
- ❑ Assessment by nurse
- ❑ Completed application with documentation (bank statements)
- ❑ Completed and signed W-9 for depositing the security deposit in a bank account
- ❑ Copy of Health Care Proxy (required)
- ❑ Copy of DNR (optional)
- ❑ Copy of Power of Attorney (optional/recommended)
- ❑ Living Will (optional)
- ❑ Completed medical form signed by physician, based on exam within 30 days of admission, including test for TB (**give to nurse at least 2 days prior to admission**)
- ❑ Prescriptions from doctor at least two days prior to admission
- ❑ Check, made payable to Longview, for $600 community fee
- ❑ Check, made payable to Longview, for security deposit equal to the monthly fee and a separate check for pro-rated monthly fee
- ❑ Copies of insurance cards
- ❑ Copy of picture ID with birth certificate or passport

EQUAL HOUSING OPPORTUNITY

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Assisted Living Residence/ Enhanced Assisted Living Residence Admission Evaluation Form

Name:_____ Sex:_____ Age:_____ Date:_____

Birthdate:_____ Desired Occupancy Date:_____ Marital Status:_____

Legal Residence:_____ Phone:_____

Religion:_____ Church Affiliation:_____

Social Security Number:_____ Date of issuance:_____

Medicare #:_____ Medicaid #:_____

Other Health Insurance:_____ Policy #:_____

Prescription Drug Plan:_____ ID #:_____

Physician:_____ Address:_____ Phone:_____

Other Health Care Provider(s):_____ Phone:_____

Eye Doctor:_____ Address:_____ Phone:_____

Dentist:_____ Address:_____ Phone:_____

Psychiatrist:_____ Address:_____ Phone:_____

Medical Equipment?:_____

_____

Present diagnosis:_____

Medical History:_____

_____

Current Medications (Include non-prescription drugs):_____

_____

_____

Prescribed Diet:_____

Allergies:_____

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Permission For Release of Information

We require your voluntary written consent before disclosing any personal and/or medical information contained in your records (chart). Your consent to share this information may be withdrawn in writing at any time.

Note: Any information shared pursuant of this consent may be subject to review by physicians and other professionals or para-professional providers or clinical students or interns such as but not limited to:

- Physical and Occupational Therapists
- Psychologists
- Clinical Instructors
- Nursing students under the direction of their clinical instructors
- Home Health Aide trainees under the direction of their clinical instructors
- Other student clinicians or interns in training; i.e. Occupational or Physical Therapy, Social and Human Services; under direction of clinical instructors.
- Health Care Proxy

I,_____ DOB_____

Voluntarily agree to release information from my records (chart) so this Information may be shared with, but not limited to: professionals, para-professionals or student clinicians or interns as listed above. I understand by sharing this information it will be held in strictest confidence and under the guidance and directions of my case manager and that I may rescind my permission to release my records at any time in writing.

Signed_____
Date_____

Witness_____
Date_____

This form remains on file in your chart.

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

ALL SPACES MUST BE FILLED OUT

Resident's Name: _____ **Date of Exam:** _____

Facility Name: _____ Date of Birth:_____ Sex:_____

Present Home Address:_____
Street City State Zip

Reason for evaluation: ☐ Pre-Admission ☐ 12 month ☐ Acute change in condition ☐ Other :_____

MEDICAL REVIEW FINDINGS

Vital Signs: BP: _____ Pulse:_____ Resp: _____ T: _____ Height: _____ft _____in. Weight: _____

Primary Diagnosis(s): _____

_____

Secondary Diagnosis(s): _____

_____

Allergies: ☐ **None** or list **Known Allergies:** _____

Diet: ☐ Regular ☐ No Added Salt ☐ No Concentrated Sweets ☐ Other: _____

Immunizations: ☐ Influenza (Date_____) ☐ Pneumococcal Vaccine (Date_____)

TB SCREENING ***(****performed* **within *30 days prior to initial admission*** *unless medically contraindicated)*

☐**Test is contraindicated** **Test:** ☐ TST1 ☐ TST2 ☐TB Blood Test (Type)_____ Date_____ Result_____

TST1: Date placed_____ Date Read_____ mm_____ TST2: Date placed_____ Date Read_____ mm_____

Based on my findings and on my knowledge of this patient, I find that the patient _____ **IS** _____ **IS NOT** exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

CONTINENCE

Bladder: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐
Bowel: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐

If no, recommendations for management:_____

LABORATORY SERVICES: ☐None

Lab Test	Reason/Frequency	Lab Test	Reason/Frequency
_____	_____	_____	_____
_____	_____	_____	_____

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ Date: _____

ACTIVITIES OF DAILY LIVING (ADL's)

Activity Restrictions: No ☐ Yes ☐ (describe):_____

Dependent on Medical Equipment: No ☐ Yes ☐ (describe):_____

Level and frequency of assistance required/needed by the resident of another person to perform the following:

1. Ambulate: Independent ☐ Intermittent ☐ Continual ☐
2. Transfer: Independent ☐ Intermittent ☐ Continual ☐
3. Feeding: Independent ☐ Intermittent ☐ Continual ☐
4. Manage Medical Equipment: Manages Independently ☐ Cannot Manage Independently ☐

ADDITIONAL SERVICES IF INDICATED BY RESIDENT NEED:

Pertinent medical/mental findings requiring follow-up by facility (e.g. skin conditions/acute or chronic pain issues) or any additional recommendations for follow-up: None ☐ or if yes, describe_____

_____

Therapies: ☐ None ☐Yes (specify): ☐ Physical Therapy ☐Speech Therapy ☐Occupational Therapy

Home Care: ☐ None ☐Yes (specify):_____ Other (Specify):_____

Is Palliative Care Appropriate/Recommended: ☐No ☐ If yes, describe services: _____

COGNITIVE IMPAIRMENT/MEMORY LOSS (including dementia)

Does the patient have/show signs of dementia or other cognitive impairment? ☐ No ☐ Yes

If yes, do you recommended testing be performed? ☐ No ☐ If yes, referral to:_____

If testing has already been performed, date/place of testing if known:_____

MENTAL HEALTH ASSESSMENT (non-dementia)

Does the patient have a history of or a current mental disability? ☐ No ☐ Yes
Has the patient ever been hospitalized for a mental health condition? ☐ No ☐ Yes

If yes, describe: _____

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral)
☐No ☐Yes Describe: _____

MEDICATIONS

Pursuant to NYCRR Title 18 487.7(f)(2), the patient is **NOT** capable of self-administration of medication if he/she needs assistance to properly carry out **ONE OR MORE** of the following tasks:

- ■ Correctly read the label on a medication container
- ■ Correctly ingest, inject or apply the medication
- ■ Open the container
- ■ Safely store the medication
- ■ Correctly follow instructions as the route, time dosage and frequency
- ■ Measure or prepare medications, including mixing, shaking and filling syringes
- ■ Correctly interpret the label

New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ **Date:** _____

Resident will receive assistance with <u>all</u> medications <u>unless</u> physician indicates that resident is capable of self-administration.

1. Does the patient/resident require assistance with medications (see criteria on page 2)? Yes ☐ No ☐
2. List all prescription, OTC medications, supplements and vitamins. Attach additional sheets if necessary or attach current discharge note, signed by the physician, listing ALL medications.

Medication	Dosage	Type	Frequency	Route	Diagnosis/Indication	Prescriber (name of MD/NP)

STATEMENT OF PURPOSE

Adult Homes (AH), Enriched Housing Programs (EHP), Residences for Adults (RFA), Assisted Living Residences (ALR), Enhanced Assisted Living Residences (EALR) and Special Needs Assisted Living Residences (SNALR):

- provide 24-hour residential care for dependent adults
- are not medical facilities
- are not appropriate for persons in need of constant medical care and medical supervision and these persons should not be admitted or retained in these settings because the facility lacks the staff and expertise to provide needed services.
- Persons who, by reason of age and/or physical and/or mental limitations who are in need of assistance with activities of daily living, can be cared for in adult residential care settings listed above, or if applicable, an EALR or SNALR.

<u>PHYSICIAN CERTIFICATION</u>

I certify that I have physically examined this patient and have accurately described the individual's medical condition, medication regimen and need for skilled and/or personal care services. Based on this examination and my knowledge of the patient, this individual (see Statement of Purpose):

☐ **Yes** ☐ **No** **Is** mentally **suited** for care in an Adult Home/Enriched Housing Program/Assisted Living Residence/ Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).

☐ **Yes** ☐ **No** **Is** medically **suited** for care in an Adult Home or Enriched Housing Program/Assisted Living Residence / Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).

☐ **Yes** ☐ **No** **Is not** in need of continual acute or long term medical or nursing care, including 24-hour skilled nursing care or supervision, which would require placement in a hospital or nursing home.

Name/Title of individual completing form:_____ **Date:**_____

Physician Signature: _____ **Date** _____

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Assisted Living Residence/
Enhanced Assisted Living Residence
Mental Health Evaluation

Name: _____

Significant Mental Health History & Current Condition: _____

_____

_____

_____

_____

Medication: _____

I have completed this evaluation in the presence of the above named individual within the past 30 days and I find him/her mentally suited for the care provided at Longview's Assisted Living Residence. This individual does not evidence need for placement in a residential treatment facility licensed or operated pursuant to Article 19, 23, 29 or 31 of the Mental Hygiene Law.

Signature: _____

Name (print): _____

Title: _____

Date: _____

Check one:

Pre-Admission Evaluation _____

Annual Evaluation _____

EQUAL HOUSING OPPORTUNITY

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Longview Assisted Living/ Enhanced Assisted Living Residence Family Information

Name: _____ Date: _____

Emergency Contact:

Name: _____

Address: _____

Relationship: _____

Phone: Day: _____ Evening: _____ Cell: _____

Applicant's Significant Other/Partner/Spouse:

Name: _____

Address: _____

Phone: Day: _____ Evening: _____ Cell:_____

Children's Names:

Name: _____

Address: _____

Phone: Day: _____ Evening: _____ Cell:_____

Name: _____

Address: _____

Phone: Day: _____ Evening: _____ Cell:_____

Name: _____

Address: _____

Phone: Day_____ Evening_____ Cell_____

Are you affiliated with Cornell University? ☐ Yes ☐ No

If yes, how? _____

Are you affiliated with Ithaca College? ☐ Yes ☐ No

If yes, how? _____

Longview
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Assisted Living Residence/ Enhanced Assisted Living Residence Legal Information

Name: _____ Date: _____

Your Attorney

Name: _____

Address: _____

_____

Phone: _____ Fax #:_____

Do you have a will? ☐ Yes ☐ No

If yes; Executor of the Will:

Name: _____

Address: _____

_____

Phone: Day: _____ Evening:_____ Cell:_____

Attach copies of the following:

*Health Care Proxy: _____ ***(Required)***

*Proof of Birth: _____ ***(Required)*** ***Photo ID or Birth Certificate***

Power of Attorney: _____ ***(Optional but requested)***

Living Will: _____ ***(Optional)***

Nonhospital Do Not Resuscitate Order (if desired):_____

If you have made funeral arrangements…

Funeral Home: _____

Cemetery: _____

Who handles your finances?

Name: _____

Address: _____

_____

Phone: Day: _____ Evening:_____ Cell:_____

Longview
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Assisted Living Residence/ Enhanced Assisted Living Residence Financial Information

Applicant's Name_____ Social Security #: _____ Date_____

Primary contact for financial Information:

Name:_____ Phone Number: _____

1) **Please provide copies of filed Federal Income Tax Returns for the past three years:**

2) **Please provide income from the following:**

Please provide current statement or copies of checks received.

INCOME (Gross)	**Source**	**Monthly Amount**
Wages		
Social Security		
SSI		
Pension		
Annuity		
Life Insurance Disbursement		
IRA Disbursement		
Alimony Payments		
Rental Property		
Payments Received On An Owned Mortgage		
Interest		
Dividends		
Other:_____		

3) **ASSETS:**

Please provide current statements for the following:

	Financial Institution	**Account Number**	**Principal Balance**
Checking			
Savings			
Money Market			

ASSETS Cont'd:

Please provide current statements for the following:

	Financial Institution	Account Number	Principal Balance
CD	_____	_____	_____
Stocks	_____	_____	_____
Bonds	_____	_____	_____
Mutual Funds	_____	_____	_____
Real Estate	_____	_____	_____
Trust, Revocable or Non	_____	_____	_____
Business Assets	_____	_____	_____
Burial Fund	_____	_____	_____
Other:_____	_____	_____	_____
	_____	_____	_____

4) Monthly medical expenses and Health Insurance Premiums from the following:

	Company Name & Phone Number	Mthly Amt
Medicare Health Insurance	_____	_____
Medicaid Spend-Down	_____	_____
Prescription Plan Co-pay	_____	_____
Prescriptions (Not Covered)	_____	_____

Any other medical expenses not listed above (dentist visits, checkups, etc):

_____

_____

_____

5) Do you have long-term care insurance?:_____

6) Are you a veteran or spouse of a veteran?: ☐ **Yes** ☐ **No**

7) Please provide your Accountant's name, address and phone number:

Name _____

Address _____

Phone _____

I affirm under penalty of perjury that information provided on this form is true and accurate to the best of my knowledge and belief. Furthermore, I authorize Longview to obtain and verify information given. Longview agrees to maintain this information in Strict Confidence.

Signed: _____ Date: _____

Longview
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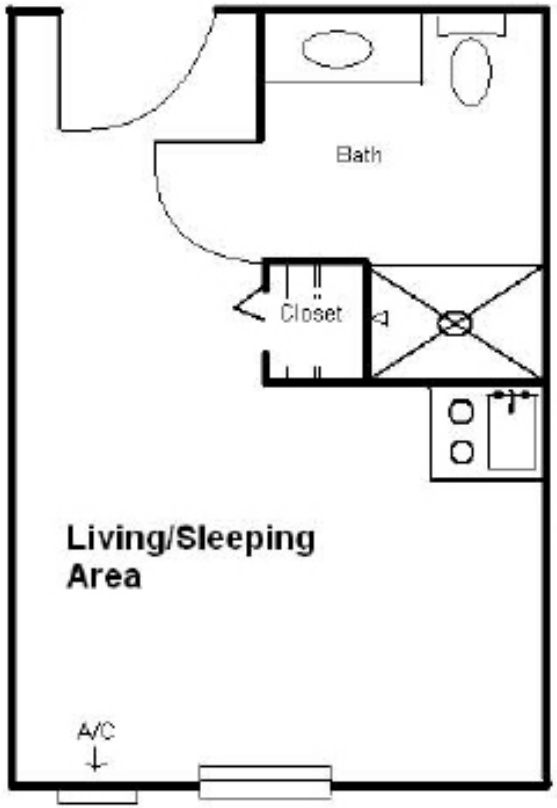
4th Floor and Garden Level Units
Floor Plans and Square Footage

Typical ***4th Floor*** Unit



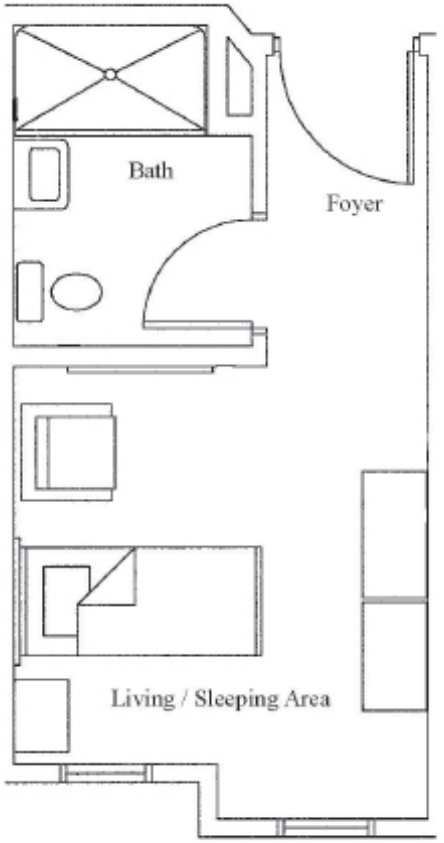
250 sq. ft.

(Approximate sizes)

Living/sleeping area	10’5” x 12’0”
Bathroom	6’8” x 10’0”
Foyer & closet(s)	5’0” x 10’0”

Drawings not to scale

Typical ***Garden Level*** Unit



220 sq. ft.

(Approximate sizes)

Living/sleeping area	11’0” x 11’0”
Bathroom	6’6” x 9’0”
Foyer & closet(s)	4’0” x 9’0”