Chenango Valley Home & Apartments
Making Life Blossom

January 1, 2023,

Dear Applicant,

Thank you for your interest in the Chenango Valley Home.

The Chenango Valley Home was established in 1896 on a charitable philosophy which continues today. Over the years, the ability for us to carry on this financial strategy results from the generous gifts from residents and families used to increase our endowment fund. We are a non-profit organization, and the cost of operations exceeds the amount received in rental income.

Our mission is to provide our residents with a pleasant living environment that is safe and stimulating. We assist residents to minimize the burden of daily living activities to meet their needs in a non-intrusive, respectful manner to maintain their personal dignity.

The cost for residents living in our Home is a monthly rental fee according to the schedule below. This is an inclusive price for a private room, three meals a day, snacks, medication administration assistance, assistance with daily living such as dressing, personal hygiene, etc., laundry services, housekeeping services, TV cable, entertainment, social and other activities to enrich each day.

Private room with private bath starting at $3,600.

An entrance fee of $8,000 is required for admission to the Home. This fee is refundable on a prorated basis if a resident leaves during the first year.

Please feel free to contact us if you have questions or if we may be of further service to you.

Sincerely,

Jennifer V Randall

Jennifer V. Randall

Executive Director

24 Canasawacta Street, Norwich, NY 13815 Ph:(607) 334-6598 Fax: (607)336-6625

www.chenangovalleyhome.org

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Dear Applicant,

If you are ready to formally apply for residency at the Chenango Valley Home and desire to be placed on our waiting list, please do as follows.

- Fill out the Application for Residence Part I-Biographic Information. Please be sure to date and sign the document. Our placement waiting list is prioritized by the date the application is received.

- Complete Part III-Confidential Financial Statement. This information will only be used as a guide to estimate your income. Your information will not be shared in any manner with any other party. Our goal is to minimize future potential financial hardships.

- DO NOT complete part II-Personal Information/Medical Evaluation/TB Testing until placement within 30 days is certain. The Department of Health requires the medical evaluation and the Tuberculin Skin Test to be completed within 30 days prior to placement. In addition, waiting to fill out the personal information until just before you move in ensures it is current.

Please feel free to contact me if you have any questions.

Regards,

Jennifer Randall

Jennifer Randall
Executive Director

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Application for Residence

Name of Applicant: _____ Telephone _____

Street _____

City, State and Zip _____

If this application is being completed and submitted by a person other than the applicant, please provide the following contact information:

Name _____ Telephone _____

Street _____

City, State and Zip _____

Relationship to applicant _____

Is applicant aware of this application? ☐ Yes or ☐ No

The applicant or the applicant's representative should carefully read and answer correctly every question herein and then signs the application. Neither party is under any obligation until the application has been approved by the Chenango Valley Home, Inc., the applicant has been so notified, and both parties have signed the Admissions Agreement and carried out the terms of admission.

It is a policy of the Chenango Valley Home, Inc., that an application for residence will be valid for one year from the date of the application. Then application may be renewed for successive one year periods by the applicant's communication in writing his/her desire for the application to remain active.

Every effort will be made to consider applicants chronologically according to the date of their application or their expression of continued interest in the event their application is more than one year old; however, there may be instances when a priority admission will take precedence. For example, those persons who occupy an apartment in the Chenango Valley Home complex have a right to priority admission if there is a change in their level or care.

The undersigned hereby makes application to the Chenango Valley Home, Inc., for admission and represents the following statements and information to be true and correct and agrees that this application along with : (1) Part I – Biographic Data; (2) Part II-Personal Information/Medical Evaluation/TB Testing; and, (3) Part III – Statement of Financial Assets, shall become a part of any subsequent contract of admission.

Part I – Biographic Information

1. Your full name: _____

2. Date of birth: _____ Your birthplace: _____

3. If you have been married: ☐ Yes or No Your current marital status:

4. Do you have any children? ☐ Yes or ☐ No
   If so, please provide their name, addresses and phone numbers.

   Name: _____ Name: _____
   Address: _____ Address: _____

   Phone Number: _____ Phone number: _____

   Name: _____ Name: _____
   Address: _____ Address: _____

   Phone Number: _____ Phone number: _____

5. List two living relatives, other than children.
   Name: _____ Name: _____
   Address: _____ Address: _____
   _____ _____

6. How long were you or have been a resident of Chenango County?
7. Are you related in any way to any person presently associated with the Chenango Valley Home employee or Executive Director? ☐ Yes or ☐ No
8. Where and with whom have you been living? _____
   _____

Part II – Personal Information/Medical Evaluation/TB Testing

Social Security Number: _____ **Medicare Number**: _____

Date of Birth: _____ Other Insurance: _____

Religion: _____ Policy Number: _____

Primary Physician: _____ **Area Hospital/Clinic of choice**: _____

Name: _____ Name: _____

Address: _____ Address: _____

Office Phone: _____ Office Phone: _____

Specialist – Eye

Name: _____

Address: _____

Specialist – Dentist:

Name: _____

Address: _____

Specialist – ENT

Name: _____

Address: _____

Office Phone: _____

Specialist – Optometrist

Name: _____

Address: _____

Office Phone: _____

Primary Emergency Contact

Name: _____

Address: _____

_____

Home Phone: _____

Office/Cell Phone: _____

Burial Instructions

_____

_____

_____

_____

Part III – Confidential Financial Statement

Applicant Name: _____ **Date:** _____

Regular Monthly Income

Social Security	$
Pension	$
Interest	$
Dividends	$
Mortgage/ Rental Income	$
IRA Income	$
Trust Income	$
Other Monthly Income	$
Total Monthly Income	$

Capital Assets

Cash (Savings & Checking)	$
CD's, Money Markets, Etc.	$
Stocks and Bonds	$
IRA's, Annuities, Etc.	$
House	$
Other Real Estate	$
Trust Fund	$
Life Insurance	$
Other Assets	$
Total Assets	$

Monthly Expenses

Rent	$
Medical	$
Prescription	$
Insurance(s)	$
Debt Payment(s)	$
Contracted Services	$
Personal Spending	$
Total Monthly Expenses	$

Expense Detail

Please attach to your application the following documents:

1. Copies of Federal Income Tax Return for the preceding two (2) years
2. Copies of statements for each bank account and brokerage account listed in the financial statement for the preceding two (2) years.

Declaration of Application

In completing this application for residency, I affirm that the answers to the above questions are complete and accurate to the best of my knowledge. I understand that failure to provide accurate, truthful, and complete information on this application is grounds for discharge from Chenango Valley Home. I understand that the filing of this application does not obligate me to enter The Chenango Valley Home, nor does it guarantee me admission to Chenango Valley Home.

I understand that an entrance fee of $8,000 per resident is due upon admission to Chenango Valley Home. I understand that termination of residency during the first twelve months of residency shall be accompanied by a refund of the balance of the entrance fee after deducting 1/12th for each month of residency and any outstanding charges. I agree to pay the monthly rental fee on the first day of each and every month. Chenango Valley Home agrees to give me 30 days' notice of increases to monthly fees.

_____ _____

Applicant's Signature Date

Application Terms:

As part of this application, you will need to submit the **Application for Residency - Part III;** the **Confidential Financial Statement;** Copies of your Federal Income Tax Return for the preceding two (2) years; and Copies latest monthly statement of each bank account and brokerage account listed in the financial statement.

All documents will be regarded as confidential and will be reviewed only by the Executive Director and/or members of the Admissions Committee.

New York State Department of Health
Division of Assisted Living

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: _____

Resident will receive assistance with all medications unless 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.

PHYSICIAN CERTIFICATION

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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ALCOHOL USE APPROVAL FORM

Date:

To:

Re:

DOB:

As part of the Food Service and Activity Programs at Chenango Valley Home there are times when alcohol is served at social events that our residents attend. These events are under the supervision of the facility staff. However, many of our residents are on medications that may not interact well with alcohol.

As part of our QA, we ask that you please check below the approval/choice for your patient.

_____May have alcohol when served at social events at the Chenango Valley Home.

_____May not have alcohol at any time

Thank you for helping us to provide a safe environment for our residents.

Physician Signature & Date: _____

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PRN Medications

Date:

To:

Re:

DOB:

According to New York State Department of Health regulations, we must obtain written authorization that a resident is capable of determining his/her need for PRN medications.

Is the above resident able to determine his/her need for PRN medications? _____

_____
Physician Signature & Date

Thank you for your time.

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