SARATOGA COUNTY MAPLEWOOD MANOR
149 BALLSTON AVENUE
BALLSTON SPA, NEW YORK 12020
PHONE (518) 885-2233 FAX (518) 885-2226

Thank you for your interest in Maplewood Manor.

The staff of Saratoga County Maplewood Manor are dedicated to providing superb physical care, while preserving human dignity and meeting the total needs of every resident. Quality care is extended to all residents regardless of race, creed, color, national origin, sex, disability, marital status, source of payment, or sexual preference.

This packet has been compiled to provide some basic information on Maplewood Manor, and to answer some of the most frequently asked questions. As you will see in review of this material, Maplewood Manor is a public 277 bed nursing facility that provides 24 hour skilled nursing care, specialized dietary services, individualized social work services, physical therapy, occupational therapy, speech therapy, a variety of activity programs, and housekeeping/laundry services.

Please be advised that this application, in its completed form, is a necessary prerequisite in obtaining placement in the facility. The **Physician's Order for Nursing Home Placement** (copy enclosed) must also be completed and submitted along with any pertinent documentation. We also require a **current PRI** (Patient Review Instrument), which can be supplied by a hospital (should an applicant be there) or other health care personnel. After appropriate application paperwork has been submitted, a member of Maplewood Manor's staff may visit the prospective applicant to assure proper placement.

Application information should be submitted to **Greer Hotaling, Admissions Coordinator,** at the above address. If you have any questions regarding the admissions process, please feel free to contact Greer at 885-2233. If you are unable to reach Greer, please contact **Erica O'Brien, Director of Social Work** at 885-2288.

Again, thank you for considering Maplewood Manor.

COMMITMENT:

SARATOGA COUNTY MAPLEWOOD MANOR

Residents do not live in our facility; we work in their home

Saratoga County Maplewood Manor is committed to providing the highest quality nursing home care to our residents. We serve our residents with compassion, diligence, and professionalism. We strive to provide a safe, comfortable home-like environment.

Recognizing the innate dignity and personal worth of each resident, we identify the residents' medical and psychosocial needs as they relate to their current experience and, through care, counseling, education, and advocacy, we strive to empower the resident to utilize their individual strengths to reach their optimum level of physical, psychosocial, and intellectual functioning.

The staff of Maplewood Manor recognizes the importance of personal relationships, and work hard to provide for the emotional well being of our residents as well as their family and friends. The clinicians, in all departments, are not only well versed in their areas of expertise, but also understand the importance of kindness, compassion and empathy.

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PHYSICIAN'S ORDER FOR NURSING HOME PLACEMENT

PT'S NAME: ____
ADDRESS: ____
____

PROBLEM PRECIPITATING NURSING HOME PLACEMENT: ______________________
____

DIAGNOSES: ____
____

CURRENT MEDICATIONS:

____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

BRIEF MEDICAL HISTORY, INCLUDING ANY RECENT HOSPITALIZATIONS: __________
____

PAST SURGICAL HISTORY: ____
____

IMMUNIZATIONS & TESTS:

Adult D/T	Yes/No	Date: ____________
Fluogen	Yes/No	Date: ____________
Tetanus	Yes/No	Date: ____________
Pneumovax	Yes/No	Date: ____________
Mantoux	Yes/No	Date: ____________

Mantoux prior to admission is preferred. If there is a history of a positive Mantoux, the results of a chest x-ray must be submitted.

PHYSICIAN'S NAME AND ADDRESS:

____
____

____
Physician's Signature and Date

SUBMIT COPY OF MOST RECENT H&P AND ANY PERTINENT X-RAYS OR LAB WORK.

PLEASE RETURN TO GREER HOTALING AT ABOVE ADDRESS OR FAX NUMBER

SARATOGA COUNTY MAPLEWOOD MANOR
FAMILY, NEXT-OF-KIN, OR DESIGNATED REPRESENTATIVE BILL OF RIGHTS

It is the intention of the Saratoga County Maplewood Nursing Home (SCMM) to provide "visitors" with opportunity to exercise those human rights that contribute to the individuality and dignity of the resident. In addition, both SCMM and visitors have rights and responsibilities to one another. To promote more effective car, contribute to residents' physical and mental well- being, to offer opportunities for continued personal and family growth, to protect the rights of the residents and to guide staff, residents and families, SCMM adheres to the following principles:

FAMILY, NEXT-OF-KIN, OR DESIGNATED REPRESENTATIVE RIGHTS

To be treated with courtesy and respect;
To associate and communicate privately with residents of my choice with the consent of the resident;
To meet with, and participate in activities of social, religious and community groups with my relatives;
To not be required to perform services for the facility;
To be encouraged and assisted to voice grievances and recommend changes to either staff or to outside representatives of my choice, free from restraint, interference, coercion, discrimination or reprisal;
To be fully informed of the facility's rules and regulations;
To be informed, in writing, prior to or upon admission of the services that will be rendered, the rate, and the method for notice of a change in the rate, and to be informed of those services not covered by the basic rate;
To be informed, with resident consent, of my relative's/friend's medical condition, diagnosis, prescribed medications and treatments;
To be informed of any projects in which the resident will be participating and which includes his/her specific treatment or personal interview;
To be given advance notice of anticipated resident transfers within the facility and to be informed of options;
To be notified of the resident care plan review and to be given the opportunity to provide input into this plan of care.

FAMILY, NEXT-OF-KIN, OR DESIGNATED REPRESENTATIVE RESPONSIBILITIES

To provide accurate and complete information about the resident's past and present illnesses, hospitalizations, medications and physical and emotional needs;
To promptly report to staff any changes in the resident's physical and emotional condition;
To make it known if I do not understand the care plan of the resident;
To cooperate with the implementation of the care plan;
To accept responsibility for consequences of my actions if the resident refuses treatment or does not follow staff recommendations because of my influence;
To abide by facility rules and regulation;
To be considerate of all others and to control my behavior particularly in relation to noise and abide by SCMM's no smoking policy;
To be respectful of the regulations regarding property of resident's, the staff and the facility;
To promptly report any changes in my address and/or telephone number to the Social Service Department and/or Nursing Department;
To notify the Social Services Department and/or Nursing Department when I will be unavailable in an emergency.

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APPLICATION FOR ADMISSION

PERSONAL INFORMATION

Last Name:______________________First Name:___________________M.I.:________

Maiden Name:___________________Prefers to be Called: ________________________

Social Security Number:__________________ Citizenship:_________ Race:__________

Present Address:____

Current Location:______________________________Date Admitted:_______________

Marital Status:__________ # of Years in Current Marital Status: ___________________

Date of Birth:____________________Birthplace:_________________________________

Primary Language: ________________ Additional Languages:_____________________

Education (highest grade completed/special training):______________________________

Previous Occupation: _____________________________Age at Retirement:__________

Adjustment to Retirement:____

Religion:__________________________ Church: _______________________________

Father's Name:___________________Mother's Maiden Name:____________________

Veteran? YES/NO Spouse of Veteran? YES/NO

Who holds Power of Attorney for the applicant?__________________________________

EMERGENCY CONTACTS

Name:__________________________________Relationship:______________________

Address:____

Home Phone:____________________________Work Phone:______________________

Name:________________________________Relationship:____________________

Address:____

Home Phone:__________________________Work Phone:_____________________

Name:________________________________Relationship:____________________

Address:____

Home Phone:__________________________Work Phone:_____________________

FAMILY HISTORY

Place Raised: ____

Number of Siblings: # Male:_______________ #Still Living:__________________

#Female:_____________ #Still Living:_________________

Spouse's Name:____________________________ Date of Marriage:_____________

Number of Children: #Male:_______________ #Still Living:_________________

#Female:______________#Still Living:_________________

Important Family Dynamics (close family, estranged family members, primary caregivers, etc): ____

____

____

____

MEDICAL INFORMATION

Past Illnesses/Surgeries:____

____

List Hospitalizations in the Last 5 years:____________________________________

____

History of Mental Illness, Suicide Attempts, or Alcohol/Drug Abuse: ________________

____

____

History of Verbal, Sexual or Physical Aggression; History of Wandering:_____________

____

____

Primary Physician:____

Communication:

Speech (clear/garbled):____

Communicates Needs: Yes/No

Makes Choices: Yes/No

Establishes Own Goals: Yes/No

RESIDENTIAL HISTORY FOR THE PAST 5 YEARS

Home Setting: _ Apartment _ House _ Assisted Living/Adult Home _ Nursing Home

____

____

Were any Family Members/Community Agencies Assisting Resident With Needs?

(i.e.; meals on wheels, visiting nurses, housekeeper, transportation, medication, etc)

____

____

____

____

____

Is the Applicant Aware/Accepting of Possible Placement in a Nursing Home? _________

How Does the Family Feel About Placement?___________________________________

Is Placement Expected to be Permanent or Temporary?___________________________

____

How Often Do Family Members Expect to Visit? ________________________________

Applicant's **Former** and Previous Interests/Hobbies: ______________________________

____

Does or **Did** Applicant Belong To Any Clubs or Organizations? ____________________

____

____

Applicant's Life Long Personality Traits (i.e.: easy going, outgoing, shy, kept to self, stubborn, etc.) ____

____

____

ADVANCE DIRECTIVES

Which directives have been completed by the applicant?

____ Health Care Proxy ______ Do Not Resuscitate ____ Living Will

BURIAL ARRANGEMENTS

Funeral Home: (name) ____

(address) ____

(phone) ____

Are arrangements prepaid? YES/NO

CUSTOMARY ROUTINE

Cycle of Daily events	Yes	No	Comments
Stays up late at night (i.e. after 9PM)			
Naps regularly during day (at least 1 hour)			
Goes out 1+ days a week			
Stays busy with hobbies, reading, or fixed routine			
Spends most time alone or watching T.V.			
Moves independently indoors			
Uses tobacco products at least daily			
Eating Patterns	**Yes**	**No**	**Comments**
Distinct food preferences			
Eats between meals all or most days			
Use of alcoholic beverages at least weekly			
ADL Patterns	**Yes**	**No**	**Comments**
In bed clothes much of the day			
Wakens to toilet all or most nights			
Has irregular bowel movement pattern			
Prefers showers for bathing			
Bathing in the PM			
Involvement Patterns	**Yes**	**No**	**Comments**
Daily contact with relatives or close friends.			
Usually attends church, temple, etc.			
Finds strength in faith			
Daily animal companionship			
Involved in group activities			

INSURANCE

Medicare #:__________________________Does applicant have Part B?_____________

Medicaid # and County:____

Medicaid Application Pending? YES/NO   If yes, date submitted:______

HMO Insurance (please provide name and #):__________________________________

Is HMO in place of Medicare? YES/NO

Other Health Insurance (please name and #):____________________________________

____

FINANCIAL INFORMATION

Current Monthly Income:

Social Security: $______________   SSI or SSD: $_______________

Retirement: $______________   Annuities: $_______________

Veteran's Pension: $______________   Other: $_______________

Railroad Pension: $______________

Checking Account (bank & balance)____

Joint Account?   YES/NO   If yes, with whom?____________________

Savings Account (bank & balance)____

Joint Account?   YES/NO   If yes, with whom?___________________

Stocks and Bonds (Name and # of shares):_____________________________________

____

Certificates of Deposit:____

Does the Applicant Own a Home? YES/NO Estimated Value:____________________

Is the Home Jointly Owned? YES/NO With Whom?________________

Other Assets:____

Have any assets been transferred in the last 60 months? YES/NO

If yes, please describe:____

____

To the best of my knowledge and belief, all the information provided herein is accurate and true and will be held confidential:

Signature of Person Completing Application:

____

*Relationship to Applicant:*____

*Date:*____

**This nursing home is a non-smoking facility. Admission priority is given to applicants who do not smoke.*
Smoker? YES/NO

**This facility does not discriminate in admission, retention or care of its residents because of race, creed, color, nationality, national origin, sex, disability, age, religion, source of payment, marital status or sexual preference.*

**The information provided shall remain confidential and shall be made available only to authorized hospital and nursing home personnel involved in the placement process and to any governmental officials authorized access by law to such records.*

**The facilities having access to this information do so without regard to race, creed, color, age, sex, religion, national origin, sponsor, sexual preference, disability, marital status, or upon any other ground prohibited by the law of the State of New York or the United States of America; persons 16 years of age or younger are not eligible for admission consideration, unless special approval has been received from the Department of Health.*

1/07 - EOB

CONTACT NUMBERS FOR SARATOGA COUNTY

Local Social Security Office
For information concerning application for and use of Medicare benefits

530 Franklin Street
Schenectady, NY 12305
(518) 383-1001

Local Department of Social Services
For information concerning application for and use of Medicaid benefits

152 West High Street
Ballston Spa, NY 12020
(518) 884-4148

Saratoga County Public Health Nursing
To request a nurse to complete a PRI for applicant

31 Woodlawn Avenue
Saratoga Springs, NY 12866
(518) 584-7460

Saratoga County Office for the Aging
For information on services available to the elderly in Saratoga County

152 West High Street
Ballston Spa, NY 12020
(518) 884-4100

NYS Dept. of Health – Office of Health Systems Management
For facility licensing and certification and for filing resident complaints

Frear Building – 2nd Floor
Fulton and Third Street
Troy, NY 12180
(518) 271-2680
after hours (518) 445-9989