# Bethany Gardens Skilled Living Center

800 W. Chestnut St.
Rome, NY 13440
PH: (315) 339-3210
Fax: (315) 339-6927


Bethany Gardens strives to minister to the needs of members of the Rome region – those who cannot maintain their own independent household or to continue living with other family members. A complete range of personal, social and medical services are offered by an efficient, skilled staff.

Bethany Gardens provides its residents with a complete and satisfying community environment – one of warmth – responsive to both physical and emotional needs. Concern for individuals instills in our residents a sense of security and well-being.

Particular effort is made to assist new residents in the difficult adjustment to their new surroundings and altered pattern of living. They are encouraged to draw on past experiences, to use their talents and continue interests and associations in pursuing a new but interesting and vital way of life at Bethany Gardens.

Bethany Gardens has facilities to accommodate 100 residents in their own private room with bath.

Location – Bethany Gardens occupies a one-acre tract between Chestnut Street and Cypress Street near the Walsh Complex.

Admission Policy – As a Residential Health Care Facility, Bethany Gardens will admit any individual whose social, psychological or medical needs cannot be met by the community.

To be considered for admission, the applicant must be free from any contagious disease or psychiatric disorder that would pose a danger to his or her welfare or that of other residents.

Complete information regarding admission procedures can be obtained from the Bethany Gardens Social Work Department at 800 W. Chestnut St., Rome, N.Y. 13440.

Living Accommodations – All residents will occupy a single room comfortable furnished and adequately sized. Each room has its own bathroom and shower.

Relatives and friends of residents are welcome to visit Bethany Gardens any day between 7:30 a.m. and 9 p.m. Indeed, such visits are among the happiest moments in the lives of the residents and are encouraged by the staff.

In the same spirit, those residents physically and mentally able to come and go independently are encouraged to do so. They need only report to the Nursing Office when they plan to be absent from a meal, overnight, or for even a longer period. Here, too, an outing with a relative or friend can represent a pleasant and beneficial experience for the resident. These are encouraged whenever feasible.

Religious activity is encouraged and every effort will be made to help the resident attend services of his or her choice.

Activities – For the individual, the need to continue doing, making or learning something useful each day can be far more important than for a younger person who takes such activities for granted. Idle hands and minds cannot contribute to a zest for living. Bethany Gardens thus offers a wide variety of activity programs in which residents are encouraged to continue old skills, develop new skills and pursue new interests.

At all times, social work staff at Bethany Gardens is available to both residents and families for counseling, assistance and sympathetic understanding.

Residence Fees – Rates at Bethany Gardens are based on operating costs. Those applicants who are able to pay the full fee are required to do so. Government assistance is available for those who require assistance to meet the cost of care. In no case is a resident required to surrender his personal resources.

The assessed monthly rate covers the cost of room and board, linen, personal care, social work and services, occupational and recreational therapy and special diets.

The resident's family is responsible for supplying clothing and spending money and must assume the cost of extraordinary services. See attached policy or further information regarding resident property.

State and Federal Law prohibit discrimination based on race, creed, color, national origin, sexual preference, sponsor or handicap.

Policy Regarding Resident Property

If accepted and admitted, items can be moved into the facility Monday through Friday between the hours of 9 a.m. to 11 a.m. and 1 p.m. to 3 p.m. If these hours are inconvenient, you must make prior arrangements with the Maintenance Department. There will be no moving in on weekends unless prior arrangements are made.

Due to our limited storage space and the New York State Safety and Fire Regulations Code, we request that clothing brought in is limited to the closet space provided in residents' rooms. We are unable to provide storage for off-seasonal clothing.

Large pieces of furniture are prohibited. The condition of furniture must not present a safety hazard to residents or staff. Residents are allowed their own television (with stand if needed), a lounge chair and pictures and mementos from home. Swivel rockers are prohibited. The facility can and will provide a dresser, lockable nightstand, lamp and chair. You must discuss with the social worker or maintenance department any furniture you are considering bringing in. Facility hospital beds must be used.

Due to New York State Safety and Fire Regulations, the following items will not be allowed for use by residents in their room. If found in room, they will be disposed of.

1) Extension cords of any type
2) Electric blankets
3) Heating pads
4) Irons and ironing boards
5) Microwave units
6) Refrigerators
7) Hot plates
8) Rugs of any kind
9) Halogen lamps
10) Hairdryers and curling irons
11) Space heaters
12) Toasters
13) Coffee makers
14) Knives, scissors and nail clippers
15) Cleaning supplies of any kind

All electrical appliances allowed for residents' use must be inspected and tagged by the Maintenance Department before they may be used. We thank you in advance for your cooperation in making Bethany Gardens a safe place to reside.

State and Federal Law prohibit discrimination
Based on race, creed, color, national origin,
Sexual preference, sponsor or handicap.

Application for Admission to
**Bethany Gardens Skilled Living Center**
**800 W. Chestnut St.**
**Rome, NY 13440**

## Section I

Date Applied: _____

Soc. Sec. Number: _____

Medicare Number: _____

Medicaid Number: _____
** Please provide copies of cards

Name: _____

Address: _____ Phone Number: _____

Present Location (if not at home): _____

Present Living Arrangements: _____

Date of Birth: _____ Age: _____

Country of Birth: _____ If not US, Date of Citizenship: _____

Marital Status: Single // Married // Divorced // Separated // Widowed

Spouse's Name: _____

Address: _____

## Section II

Children: Number: _____ Sons _____ Daughters _____

| Name: | Address: | Telephone: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Person(s) to be notified in case of emergency (please provide name, address, telephone number and relation to applicant).

1. _____
2. _____

## Section III

Financial Information
Income:

O.A.S.O. (Social Security Grant) _____ Per Month

Public Assistance Grant _____ Per Month

Trust Fund _____ Per Month

Government Pension _____ Per Month

Private Pensions _____ Per Month

Veterans Benefits _____ Per Month

Other _____ Per Month

## Section III Con't

Resources:

Bank Accounts

| Bank: | Acct. Number: | Amt.: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Stocks and Bonds

_____

_____

_____

Property Owned:

| Location: | Value: | Mortgages: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## Section IV

Name and Address of the following:

Physician(s): _____

Dentist: _____

Eye Doctor: _____

Podiatrist: _____

## Section IV Con't

Provide carrier name, policy number(s), ID#, Group # and location of Hospitalization Insurance (other than Medicare/Medicaid). Provide photocopy of card(s).

_____

_____

_____

Do you have prescription coverage: Yes // No (If yes, provide copy of card)

Burial Arrangements:

Funeral Director _____

Are services already paid for or do you have a burial fund? Yes // No

Cemetery and Location: _____

Religious Affiliation:

Denomination _____

Parish/Church/Synagogue _____

## Section V

Please give a brief description of reason for application and type of assistance required.

_____

_____

_____

Please describe briefly applicant's daily routine and include sleeping pattern, leisure time activities, meal pattern, appetite, food intolerances/allergies, diet restrictions.

_____

_____

_____

_____

## Section V Con't

Please advice if applicant utilizes any of the following assistive devices.

Eye Glasses: Yes // No (If yes, optician used: _____)
Hearing Aid(s): Yes // No (If yes, H/A Service used: _____)
Dentures: Upper // Lower // Both // None
Ambulatory Device(s): Cane // Walker // Wheelchair // Brace Crutches
Home Health Care Services: Yes // No (If yes, hours provided: _____)

Please complete if any of the following are applicable:

A) Is the applicant an organ donor? Yes // No
B) Does the applicant have a Living Will? Yes // No
C) Is there a designated Power-of-Attorney for applicant? Yes // No

If yes, name and address: _____

_____

_____

Phone Number: _____

D) Is there a designated Health Care Proxy? Yes // No

If yes, name and address: _____

_____

_____

Phone Number: _____

I hereby consent to comply with all the rules and regulations of H.R.F. and Nursing Home Company of Rome (hereafter referred to as Bethany Gardens), and all the medical regulations and procedures of Bethany Gardens now in force of that may, from time to time, be established by it, that I will apply for financial assistance (Medicaid), which may be available to the undersigned and for which the undersigned is eligible upon request of Bethany Gardens.

I do also hereby authorize the said Bethany Gardens to furnish reports of its findings to my physician or to physician clinic or hospital that I designate or to which I apply for examination or treatment and hereby give permission to obtain such reports from my physicians and any hospitals in which I have been treated.

I agree that this application shall be subject to the acceptance of Bethany Gardens, I understand that Bethany Gardens does not, by the acceptance of this application, assume any responsibility for medicines, medical supplies, hospitalization or burial expenses, and that my residence may be terminated at any time by Bethany Gardens for good and sufficient reason, such as non-payment of stay or non-compliance with facility policy.

I understand that Bethany Gardens will admit and retain only those persons it can adequately care for. If, at any time, my condition warrants more care than Bethany Gardens can provide, I agree to allow Bethany Gardens to seek alternate placement in a facility that can best meet my needs.

Signed: _____

Relationship to Applicant: _____

Date: _____

**Bethany Gardens**
800 W. Chestnut St.
Rome, NY 13440

**Medical Report**
Must be Completed by Attending Physician

Name: _____

Address: _____

Age: _____

History (Sources) _____
Present Illness
_____
_____
_____

Past History
a) Significant Illnesses (and hospitalizations)
_____
_____
_____
_____
_____
_____

b) Operations (Kind, date)
_____
_____
_____
_____
_____
_____

c) Allergies _____

d) Transfusions _____

e) Immunizations _____

f) Drug allergies

_____

_____

_____

Review of Systems

Eyes _____

ENT _____

Glandular _____

Cardio Respiratory _____

Gastrointestinal _____

Gentourinary _____

Musculoskeletal _____

Physical Examination: T_____ P_____ R_____ BP_____ WT_____

General Appearance & Medical Status:

_____

_____

Skin: _____

Nodes: _____

Head: _____

Eyes: _____

Ears: _____

Nose: _____

Mouth-Pharynx: _____

Neck: _____

Back: _____

Breasts: _____

Lungs: _____

Heart: _____

Abdomen: _____

Genetalia (Pelvic): _____

Rectal: _____

Extremities: _____

Neurological: _____

_____

_____

Diagnosis: 1) _____

2) _____

3) _____

4) _____

5) _____

Can he or she: Walk stairs unaided? _____ Dress self? _____

Walk on level unaided? _____ Feed self? _____

List medications applicant is currently taking:

| | | |
|---|---|---|
| 1) _____ | 5) _____ | 9)_____ |
| 2) _____ | 6) _____ | 10)_____ |
| 3) _____ | 7) _____ | 11)_____ |
| 4) _____ | 8) _____ | 12)_____ |

List Physical Therapy or Nursing treatment applicant is currently receiving:

_____

_____

_____

List any dietary restrictions, special diets, etc.:

_____

_____

_____

List appliances (hearing aid, glasses, prosthesis, etc.) applicant uses and/or needs:

_____

_____

_____

List any restrictions on applicant's full participation in programs and activities:

_____
_____
_____

List any precautions to be taken by the applicant on or in his/her behalf:

_____
_____
_____

Evaluation of mental and emotional status of applicant:

_____
_____
_____
_____
_____

Date and nature of last acute illness treated by physician completing report:

_____
_____
_____
_____
_____

_____ _____

Signed Date

**Please attach a copy of a radiologists' report of a chest x-ray taken within the past three months.

**What are your Patient Care goals for the applicant?**