Applicant's Name: _____ **Date:** _____

Rosary Hill Home

600 Linda Avenue
Hawthorne, NY 10532
Tel: (914) 769-0114 Fax: (914) 769-3916

APPLICATION AND PRE-ADMISSION FORM

Please Read All Information Carefully

All Questions Must Be Answered Before the Application Can Be Reviewed and Processed

Our Mission: Rosary Hill Home, a licensed Roman Catholic Health Care Center, owned and operated by the Dominican Sisters of Hawthorne, provides loving, palliative care to those suffering from terminal cancer **according to the teachings of the Catholic Church and the Ethical and Religious Directives for Catholic Health Services**, 6th ed. 2018 (United States Conference of Catholic Bishops) and the HHS Conscience Rule (2019). Since its opening in 1901, Rosary Hill Home's Administration, Sisters and staff have been committed to protecting human dignity, freedom and human flourishing at the end of life and strive to meet the physical, emotional, spiritual and recreational needs of patients suffering from terminal cancer.

Palliative care provided by Rosary Hill Home is free to all who meet the admission requirements; there is no discrimination on the basis of race, creed, color, national origin, sex, handicap or HIV status. In fidelity to their Rule of Life, the Dominican Sisters of Hawthorne depend solely upon the "providence of God and the hourly mercy of the charitable public;" no payment is accepted from patients, their families, private insurance, or from the government.

Admission of patients to Rosary Hill Home follows a comprehensive review of the clinical history, diagnoses, and current treatment plan of each applicant. Following this review, a decision is made based on the ability of Rosary Hill Home to provide palliative care consistent with its Mission. In reviewing all applications for admission, and in order to assure that all the needs of the patients can be met, Rosary Hill Home reserves the right:

- to deny admission to any patient
- to facilitate transfer of current patients to other care centers when treatment and care do not fall within its Mission.

Patients who request or require clinical interventions, counseling, or services that are not consistent with the Catholic moral tradition, the Ethical and Religious Directives for Catholic Health Services, and the HHS Conscience Rule, e.g., Euthanasia; Assisted Suicide; Gender Dysphoria, etc., will not be admitted to Rosary Hill Home.

Requirements for Admission to Rosary Hill Home:

1. Documented proof of a diagnosis of incurable cancer is required. This may be:
    - Pathology Report,
    - CAT Scan,
    - Biopsy Report,
    - or other requested information.

2. Rosary Hill Home is a free home for those who are financially unable to afford nursing care elsewhere. This means:
    - the patient has no insurance coverage.
    - if the patient has insurance coverage, such coverage is not adequate to cover the cost of a stay in a nursing facility.
    - the patient does not have other assets that would cover the cost of nursing care.

    Rosary Hill Home accepts no payment of any kind, including Medicare, Medicaid, private insurance, or private pay. Financial need is a requirement for admission.

3. Patients and families must be informed that the care provided by Rosary Hill Home is palliative, not curative. The patient and family understand that:
    - All treatments must be completed before the patient is accepted.
    - Medications and all ancillary orders will be prescribed by our physicians.
    - We do not provide professional physical or occupational therapy.
    - Intravenous (I.V.'s) and blood transfusion services are not available.
    - We are a smoking-free facility.

4. **Do Not Resuscitate Order** - As only persons with incurable cancer are admitted to Rosary Hill Home and as Rosary Hill Home provides only palliative care, all patients must submit a valid "Do Not Resuscitate" (DNR) Order prior to admission.
5. All pages of the application must be fully completed.

Palliative Care is a concept of care which employs medical and nursing care as well as specific ancillary services, when indicated, whose primary objective is the comfort and overall well-being of the incurable/terminal individual. No treatment is employed which would overburden the individual, yet full support is offered for basic physical needs as well as spiritual, psychological, and emotional needs. Individuals, while experiencing similar diagnoses, may have different needs or symptoms associated with their disease and secondary diagnoses; hence personalized medical or nursing plans of care based on individual needs and symptoms are developed.

Rosary Hill Home complies with all applicable federal, state, and local civil and human rights laws with regard to employment and provision of services. Patients are welcome regardless of age, color, creed, sex, national origin, handicap, or marital state.

I AM AWARE OF AND ACCEPT THE MISSION AND POLICIES STATED ABOVE.

Signature of patient / responsible person required for admission:

Applicant's Name: _____ **Date:** _____

Patient's Signature: _____

Signature of the responsible person (Healthcare Proxy or next of kin) if patient is unable to sign:

Signature: _____ **Relationship:** _____

Name (Printed): _____ **Cell Phone:** _____

Address: _____ **Home Phone:** _____

_____ **Work Phone:** _____

Applicant's Name: _____
Last First Middle

Address: _____ Apt. No.
Number & Street

_____
City State ZIP Code

Date of Birth: _____
Month / Day / Year

Place of Birth: _____

Sex: ☐ Male ☐ Female

Telephone/Cellphone: _____

Social Security Number: _____

Highest Level of Education: _____

Previous Occupation: _____

Veteran: ☐ Yes ☐ No

Branch of Service: _____ Years: _____

Mother's Maiden Name: _____

Height: ____ ft. ____ in. Weight: _____ lbs.

Race: _____

Religion: _____

Marital Status: _____

Lived Alone: ☐ Yes ☐ No

Admitted From: ☐ Home ☐ Hospital ☐ Other (Specify): _____

Location: _____

If admitted from home, date of most recent hospitalization: _____
Month / Day / Year

Family / Responsible Person Contacts

* Please indicate if the person listed as a contact has Power of Attorney or other special legal relationship to the patient.

Primary Contact ☐ Health Care Proxy (HCP) ☐ Durable Power of Attorney

Name: _____ Relationship: _____

Address: _____
Number & Street Apt. Number City State ZIP Code

Phone Numbers: Cellphone #: _____ Home #: _____ Work #: _____

Email address: _____

Name: _____ Relationship: _____

Address: _____
Number & Street Apt. Number City State ZIP Code

Phone Numbers: Cellphone #: _____ Home #: _____ Work #: _____

Email address: _____

Name: _____ Relationship: _____

Address: _____
Number & Street Apt. Number City State ZIP Code

Phone Numbers: Cellphone #: _____ Home #: _____ Work #: _____

Email address: _____

Nursing Assessment

Applicant's Name:_____ **Age:**_____ **Sex:**_____

1. Present Mental Status

☐ Alert ☐ Disoriented ☐ Noisy ☐ Depressed ☐ Abusive

☐ Oriented ☐ Anxious ☐ Quiet ☐ Withdrawn ☐ Noncompliant

☐ Decisions Consistent & Reasonable ☐ Lethargic ☐ Suspicious ☐ Unresponsive

Comments _____

2. Activity / Mobility

	Transfers	Locomotion
☐ Dependent for all position changes	☐ Full Assist	☐ Geri chair ☐ Other _____
☐ Bedfast	☐ Limited Assist	☐ Wheelchair
☐ OOB to chair	☐ Supervision	☐ Walker
☐ Ambulatory	☐ OOB ad lib	☐ Cane

3. Diet / Nutrition

Type of Diet: ☐ Regular ☐ Soft ☐ Blended ☐ Liquid ☐ Thickened ☐ Other: _____

Chewing or Swallowing Problems: _____

NPO _____

Artificial Nutrition (PEG, TPN, PPN, etc.) or Hydration (IV) explain _____

_____

4. Communication

Language Spoken: ☐ English ☐ Other (specify) _____

☐ Aphasia ☐ Speech Slurred or Garbled ☐ Non-Communicative

5. Special Needs / Appliances / Equipment

☐ Oxygen (mode of delivery and l/min) _____ ☐ Incontinent of Urine

☐ Tracheostomy (size & make) _____ ☐ Foley Catheter (specify) _____

☐ Suction (specify) _____ ☐ Incontinent of Feces

☐ Humidifier ☐ Ostomy (specify) _____

☐ Nebulizer (specify) _____

Wound Care (explain in detail site, origin, procedure) _____

_____

_____

Other Issues / Needs _____

_____

6. Smoking: ☐ Non-Smoker ☐ History of Smoking (Years) _____ ☐ Currently Smokes - Packs per day _____

7. History of Alcohol or Drug Abuse: ☐ No ☐ Yes, (please explain) _____

_____

Nurse / Caregiver Signature _____

Print Name _____

Telephone Number _____

Medical Summary

Applicant's Name: _____ **Age:** _____ **Sex:** _____

Primary Diagnosis: _____

Secondary Diagnoses: _____

_____

Primary Site of Malignancy: _____ Date of onset: _____

A Pathology report and/or appropriate scans and lab results supporting the diagnosis MUST BE ATTACHED.

Presenting Symptoms: _____

Prognosis / Stage of Illness: _____

Brief Medical Summary and Course of Treatment: _____

_____

_____

_____

If there is a history of Mental Illness, please explain: _____

_____

List of surgical procedures and the year (please use additional paper if necessary)**:** _____

_____

_____

Drug Allergies: _____

Food or Other Allergies: _____

List Current Medications: _____

_____

_____

Medical Summary (cont.)

Applicant's Name: _____ **Age:** _____ **Sex:** _____

COVID-19 Vaccine: ☐ Unvaccinated ☐ Fully Vaccinated ☐ Boosted

Last dose date: _____ Mfg.: _____

Pneumococcal vaccine: _____ (Date) **Influenza vaccine:** _____ (Date)

Infectious Diseases over the past 90 Days: _____

TB Screen Test Required:

QuantiFERON TB Blood Test (Preferred)

Results: ☐ Negative ☐ Positive ☐ Indeterminate

Test Date: _____

OR

☐ **Skin Test (PPD)**

Results (in mm): _____ Date: _____

☐ History of BCG vaccine

If Indeterminate or Positive test results, perform an imaging test (chest x-ray or CT of Chest). Please see instructions below.

Imaging Test Results: ☐ Negative ☐ Positive Imaging Date: _____

Negative test *– The applicant can be considered for admission without additional TB testing requirements.*

Indeterminate test (QuantiFERON only) *– Repeat QuantiFERON test 3 – 7 days from the date the indeterminate test was performed OR perform an imaging test (such as chest X-ray or CT of the Chest showing no acute pathology) with physician stating no signs/symptoms of active TB.*

Positive test *– Applicants with a positive QuantiFERON or PPD test will only be considered for admission if:*

a. *Show no signs or symptoms of active TB.* ***AND***
b. *Present a negative imaging test (such as chest X-ray or CT of the Chest showing no acute pathology). Imaging test must be performed around or concurrent to the QuantiFERON or PPD test.* ***AND***
c. *A signed agreement from the patient to complete a TB therapy treatment. TB therapy should be started at admission until completion. (A TB Therapy Agreement document will be provided when needed.)*

Physician's Signature: _____ **Address:** _____

Physician's Name (printed): _____ _____

Date: **Phone Number:**

WHERE TO FIND COMPLIANCE INFORMATION

You may access information regarding
the quality and safety of Rosary Hill Home and other
residential health facilities in the State of New York by visiting:

https://profiles.health.ny.gov/nursing_home/index#5.79/42.868/-76.809.

Information regarding complaints, citations, inspections enforcement actions,
and penalties taken against this facility is maintained by
the New York State (NYS) Department of Health (DOH)
and can be accessed on its NYS Health Profiles website listed above.
Once you have looked up the facility, click the "inspections" tab to access the information