Vista on 5th
Individual care. Together.

1261 Fifth Avenue
New York, NY 10029
vistaon5th.org

Phone: 212.534.6464
Fax: 212.534.8279

Dear Admissions Candidate:

Thank you for your interest in Vista on 5th. As a licensed assisted living program (ALP), Vista on 5th provides a safe environment for residents who require assistance with the activities of daily living (i.e. bathing, dressing, toileting, etc.) but wish to maintain their independence.

Enclosed is the admission package. Please return the Application for admission with the Financial Questionnaire in order to be considered for admission.

- ☐ Application for Admission
- ☐ Medical Evaluation, completed by your doctor
- ☐ Mental Health Evaluation, completed by your doctor
- ☐ PPD Report, completed by your doctor
- ☐ Financial Questionnaire with documents (see Admissions Check List)

Your doctor must complete every section of the Medical Evaluation form and provide a clear description of the assistance you will need with activities of daily living, such as; transferring, toileting, dressing, grooming, housekeeping, incontinence care and medication management. Your doctor must print his/her name, address, license number, and telephone number on the medical evaluation form.

After your completed application has been submitted, the Admissions Supervisor will review the application and, if appropriate schedule an interview. All attached documents must be completed prior to admission. The application and financial questionnaire must be submitted in order to be considered for admission.

Please submit the required documents to Kyle Pirez, at the above address. He also can be contacted at Kyle.Pirez@vistaon5th.org 212-534-6464, ext. 5569, if you require additional information.

Yours truly,

Nicole Atanasio

Nicole F. Atanasio, MS, RN-BC
President and CEO

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Application for Admission

This Application must be filled out completely in order to be considered for admission.

Thank you

Date: _____

Applicant Name: _____ Social Security #:_____

☐ Male ☐ Female Age: _____ Date of Birth: _____

Referred by: _____

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single (never married)

Number of Children: _____

Current Residence: _____ Phone: _____

_____

☐Own Home ☐Hospital ☐Nursing Home ☐Other: _____

Nursing Home _____ Date of Admission: _____

Are you currently receiving home health services? ☐ Yes ☐ No

If yes: ☐ Visiting Nurse ☐ Private Hired Help ☐ PCA/HHA

How many hours/days/week? _____ How long? _____

What services are provided? _____

Most Recent Hospitalization/Rehab? _____ Where? _____

Reason: _____

Primary Contacts/Support Persons:

Name:_____ Name: _____

Relationship:_____ Relationship:_____

Address:_____ Address:_____

_____ _____

Home:_____ Home: _____

Work:_____ Work: _____

EQUAL HOUSING OPPORTUNITY

revised 11/23 JH

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Cell:_____ Cell: _____

Email:_____ Email: _____

Attending Physician:

Name: _____

Address: _____

_____

Phone:_____

Other Health Care Providers:

Name:_____

Specialty:_____

Address: _____

Health Insurance:

Medicaid No.: _____

Medicare No.: _____

Prescription Drug Plan/Medicare Part D Plan

Name: _____

Prescription Drug Plan/Medicare Part D

Number:_____

HMO Plan Name: _____

Any other insurance:_____

Hospital of Choice: _____

If Applicant has any Mental Health or Psychiatric history, this section must be filled out. If not, please indicate with N/A.

Mental Health: _____

Psychiatric hospitalizations? ____ Where? _____Date:_____

Please explain: _____

_____

_____

Personal Background

Wishes to be addressed as: _____

Where were you born/raised/lived most of your life? _____

Highest Grade Completed: _____ Former Occupation: _____

Religious Affiliation (if any): _____ Place of Worship: _____

Have you ever been a client of Adult Protective Services? ☐ Yes ☐ No

If yes, when? _____

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Health Care Proxy: ☐ Yes ☐ No Name: _____

Power of Attorney: ☐ Yes ☐ No Name: _____

Financial Resources: SSA: $_____ SSI: $_____

Pension: _____ Any other annuities_____

DNR: ☐ Yes ☐ No Living Will: ☐ Yes ☐ No

Burial Instructions: _____

Can Applicant speak, read, and/or write in English: ☐ Yes ☐ No

If no, indicate primary language: _____

Daily Habits

How often do you drink alcohol? _____ How often do you smoke tobacco? _____

Preferred wake-up time: _____ Preferred bedtime: _____

Eating Habits

Do you have any dietary restrictions? _____

Food Allergies (List all): _____

Food preferences: _____

Food dislikes: _____

Daily Events:

(Check all that apply)

- ☐ Goes out _____ days a week
- ☐ Stays busy with hobbies; fixed daily routine
- ☐ Spends most time alone
- ☐ Contact with relatives/close friends _____ days per week
- ☐ Spends most time watching TV
- ☐ Prefers small group activities

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☐ Usually attends church, synagogue, etc.

Name and Location of House of Worship: _____

☐ Prefers large group activities

Assistive Device Used:

☐ Cane ☐Walker ☐Rollator ☐Wheelchair

CONTINENCE STATUS/MANAGEMENT

Is the resident continent of urinary function? Yes ☐ No ☐
Is the resident continent of bowel function? Yes ☐ No ☐
IF ANSWER IS "NO" TO EITHER QUESTION, COMPLETE THIS SECTION, AS APPROPRIATE.

Why does applicant require assisted living at this time?

_____
_____
_____
_____
_____
_____

Applicant's statement of own needs, desires, fears, expectations, etc.

_____
_____
_____
_____
_____
_____

_____ _____
Applicant Signature Date

Application Completed by:_____ _____ _____
Relationship to Applicant Date

EQUAL HOUSING OPPORTUNITY

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Vista on 5th Financial Questionnaire

Please answer all questions and attach the required documents.

Name:	Address:
Telephone:	Marital Status: (Circle one): Married – Widowed – Single, never married Legally Separated – Other – Explain
Monthly Income:	Resources – Give Current Month's Balance:
□ Social Security	□ Checking
□ Pension (1):	□ Statement Savings:
□ Pension (2):	□ Passbook Savings:
□ SSI	□ Money Market
□ Annuity:	□ C.D.'s
□ V.A. Pension:	□ Life Insurance:
□ Public Assistance:	□ Annuities, IRAs
□ Other Income:	□ Trusts
	□ Mutual Funds
Health Insurance Premium:	□ Brokerage Accts.
	□ Other:
Contact_____ Relationship_____ Name: _____ Address: _____ Address Continued: _____	Home Tel: _____ Work Tel: _____ Cell: _____ Email: _____
Date Completed:	

DSS-4449C (Rev. 4/97, 05/13, 9/13)

ALP MEDICAL EVALUATION

Check all that apply: ❑ AH ❑ EHP ☒ ALP ❑ Initial ❑ Rug Category Change ❑ 12 month ❑ Other

❑ **UAS-NY Summary Report is attached for RUG Category Change, 12 month and other assessments**

This form may be used to verify that an individual's health/safety needs can appropriately be met in an adult home, enriched housing program or residence for adults. It may also be used to verify that an applicant/resident of an Assisted Living Program (ALP) is medically eligible to reside in a nursing facility but does not require continual nursing or skilled care and the individual's needs can be met in an ALP.

Resident/Patient Name: _____ Date of Birth: _____

Facility Name: _____ Address: _____

Sex: Male ❑ Female ❑ **Weight:** _____ **Blood Pressure:** _____

Primary Diagnosis/Prognosis:

Secondary Diagnoses/Prognosis:

Significant medical history & current conditions:	**Continence:** Bladder: ❑ Yes ❑ No Bowel: ❑ Yes ❑ No	**Allergies: NKA** ❑
Needs assistance with self-administration of medications? ❑Yes ❑No	**Type of Diet:** Regular ❑ NSA ❑ NCS ❑ Other: (Explain) ❑	

List all current medications (prescription and OTC, including dosage, type, frequency and method of administration and note special instructions: (attach additional sheets if necessary signed and dated by Physician)

MEDICATION	DOSAGE	TYPE	FREQUENCY	METHOD

Resident/Patient Name: _____

Is the individual free of communicable disease? ❑Yes ❑No If no, describe: _____

Does the individual require supervision and/or assistance by aide with:

bathing: ❑No If yes, is it?: intermittent: ❑ constant ❑

grooming: ❑No If yes, is it?: intermittent: ❑ constant ❑

dressing: ❑No If yes, is it?: intermittent: ❑ constant ❑

eating: ❑No If yes, is it?: intermittent: ❑ constant ❑

transferring: ❑No If yes, is it?: intermittent: ❑ constant ❑

ambulation: ❑No If yes, is it?: intermittent: ❑ constant ❑

toileting: ❑No If yes, is it?: intermittent: ❑ constant ❑ *Such that it requires toileting program 24 hours/7 days per week to maintain continence?

Describe any additional activity restrictions/needs: _____

Describe Current Treatment Plan (e.g., nursing, therapies, etc.): _____

Is Palliative Care appropriate/recommended?: ❑Yes ❑ No If yes, describe services: _____

Is the individual's condition stable? ❑Yes ❑No If no, describe: _____

Cognitive Impairment/Memory Loss (including dementia)

Does the individual have/show signs of dementia or other cognitive impairment? ❑Yes ❑No If yes, describe: _____

If yes, do you recommend testing be performed? ❑Yes ❑No If yes, describe: _____

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

Mental Health Assessment (non-dementia)

Does the individual have a history, current condition or recent hospitalization for mental disability?

❑Yes ❑No If yes, describe: _____

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

Date of Today's Examination _____ **Recommended frequency of Medical Exams** _____

I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regimens, and that the individual is medically appropriate to be cared for in an Adult Home, Enriched Housing Program or an ALP.

_____

Physician Signature (required) Date

_____

Nurse Practitioner, Physician or Specialist's Assistant Signature Date

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Vaccination Record

MD Name: _____

Date Signed:_____ MD Signature: _____

PPD- Date placed:	
Date: Result Brand:	
If Positive, Chest x-ray date: mm.	
Quantiferon result:	
COVID-19 Initial Vaccination	COVID-19 Booster
Date: Brand:	Date: Brand:
Date Read: Results: mm.	Date: Read: mm.
If Positive, Chest x-ray date:	Results
Influenza Vaccine Date:	Influenza Vaccine Date:
Influenza Vaccine Date:	Influenza Vaccine Date:
Pneumovax Date:	Others:
	Date:
	Date:
Comments:	

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Due to the nature of our facility, we can accept only the following diet orders for residents:

1) REGULAR

   No restrictions

2) NO CONCENTRATED SWEETS

   Diabetic: We cannot accept a calorie restricted diet such as; 1600 &/or 1800 ADA

3) REDUCED FAT AND CHOLESTEROL

   We cannot accept low fat/low cholesterol

4) NO ADDED SALT

   We cannot accept a lower sodium restriction such as; 2 or 3 gm sodium

(No specialty diets that require medical monitoring)

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MEDICAID REQUIREMENTS

Vista On 5th is licensed by the NYS Department of Health as an Assisted Living Program (ALP). Medicaid reimbursement for residents entering ALP facilities requires Community based long-term care Medicaid or Institutional (Nursing Home) Medicaid.

Community Based Long –Term Medicaid

To obtain Community Based Long-Term Care through Medicaid the applicant must file an application for (a) Coverage with a long-term care or (b) coverage for all covered care services at the local Human Resources Office (Telephone: 1-877-472-8411; see instruction sheet attached). The Long-Term Care Medicaid application requires documentation of the applicant's finances for the prior 36 month period. Once the applicant has obtained approval of the Community Based Long-Term Care Medicaid the following documents from the Human Resource Office must be submitted with the Vista On 5th application.

1. MAP-2087 – Notice of Decision of your Medicaid Assistance Application
2. MAP – 2060 – Budget Explanation or
3. MAP – 2120B –Notice of Eligibility for Medicaid Assistance & Home Care Services

The following documents must also be submitted with the Vista On 5th application for SSI purposes:

1. Birth Certificate
2. Social Security Card
3. Current Resources Information

Any client that is in a nursing home or has been a resident in a nursing home should already have Institutional Nursing Home Medicaid. The following documents obtained from the nursing home finance office must be submitted with the Vista On 5th application:

1. MAP – 2087 – Notice of Acceptance of Medicaid Assistance Application (Institutional Care/Nursing Home) Approval and Budget Letter
2. MPT – 1124 – Discharge Notice
3. Birth Certificate, Social Security Card, & Current Resources Information will be required for Supplemental Security Income Application

If you require further information please call: Gail Johnson, Patient Accounts Manager
(212) 534-6464 Ext. 5152

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MEDICAID INFORMATION HELPLINE
(Available in several languages)
1-877-472-8411

To assist you with the Medicaid Application Process we have provided you with the above Medicaid information phone number. In addition, we have also given you a guide to follow to help your collection of documentation to be submitted with the Medicaid Application at your local Human Resources Administration.

A) Identity	State Issued Identification Driver's License U.S. Passport Social Security Card
B) Marital Status	Marriage Certificate Separation Agreement Divorce Decree Death Certificate
C) Residence	Landlord Statement Current Rent Statement Mortgage Records
D) Citizenship	Birth Certificate Naturalization Certificate U.S. Passport
E) Bank Accounts Checking Savings IRA, etc.	Current Statement & 3 months prior
F) Medical Expenses	All Receipts
G) Household	All Receipts
H) Income	SSA Benefits SSD or SSI Benefits Pension = Retirement or VA Annuities

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I) Proof of Life Insurance/Burial Assets/Burial Contracts

J) Proof of Home of Land Ownership

K) Proof of Health Insurance

L) Copy of Medicare Card

As a guide to assist with obtaining mandatory documents for Medicaid see the following:

Document	**Contact Agency**
Social Security Card Social Security Award Letter	Social Security Administration www.socialsecurity.gov www.socialsecurity.gov
State Issued Identification	Department of Motor Vehicles www.dmv.gov
Driver's License	Department of Motor Vehicles www.dmv.gov
Birth Certificate Death Certificate	Department of Vital Statistics (New York State) 125 Worth Street New York, NY 10013 New York City: www.nyc.gov/vitalrecords
Marriage Certificate Divorce Decree	Department of Vital Statistics (New York State) New York City: www.nyc.gov/vitalrecords
U.S. Passport	Department of Homeland Security www.dhs.gov

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ADMISSIONS CHECKLIST

All Admission candidates must provide Vista on 5th with the following documents requested below. Please note that the application will not be processed unless all mandatory documents are attached upon receipt.

Identification of applicant:

- ☐ Application for Admission, completed in full.
- ☐ Verification of Citizenship or permanent legal residence in the U.S.A. including a copy of one of the following: Birth Certificate, Naturalization Certificate, or current U.S. Passport.
- ☐ Current New York State ID

Financial Information:

- ☐ Verification of Income: Social Security, Pension, SSI, SSP Annuities, Royalties
- ☐ Verification of Resources: Bank and Money Market statements, Life Insurance cash value, annuities, CD's
- ☐ Insurance Cards: Medicare, Medicaid, Social Security, other health insurance or prescription coverage
- ☐ Medicaid Documents: Nursing Home Budget/Approval, other verification of coverage (if applicable)
- ☐ Divorce Decree or Death Certificate of Spouse (if applicable)
- ☐ Pooled Trust Binder Agreement & Deposit Ledger (if applicable)

Medical Clearance:

- ☐ Attached Medical Evaluation (DSS-449C) and Mental Health Evaluation signed by a physician, within 30 days of admission
- ☐ PPD form signed by a physician, within 30 days of admission
- ☐ Current Psychiatry notes (if applicable)

Please be advised a check covering the first month of rent is due upon admission.

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☐ Financial Review & Approval: Signature: _____ Date: _____

☐ Medicaid #_____ DOB _____

☐ Medicare #_____

☐ Private Pay

☐ SS # _____

☐ Age: _____ Financial Questionnaire: _____

☐ Apartment assigned: _____

☐ Date of prescreen: _____

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Vista on 5th at a Glance

- Private Studio Apartment and use of all Common Areas
- Restaurant-Style service of three (3) delicious, healthful meals a day
- All utilities (**excluding** phone and cable)
- 24-hour Emergency Response Security System
- Activities Center and
- Social, Educational, Recreational, Religious, and Cultural Programs
- Scheduled Transportation for Activities/Outings
- Maintenance of the Building Outdoor Area
- Library and Music Rooms
- Concierge Services
- Quality Furnishings and Artwork Throughout Common Areas
- Elegant Dining Room
- Private Dining available for Family/Guests
- Media/TV Lounge Room areas
- Trash Removal
- Weekly linen and towel service
- Housekeeping
- Personal attention by designated Care Managers
- Physician on-premises
- Communication with resident's personal physician
- LPN assistance with medication management and other health related assistance
- Scheduling and reminding of medical appointments
- Fireproof Construction with sprinkler system throughout the Residence
- General Resident monitoring
- Exercise programs with Coaching

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SECTION: ALP SERVICES **PAGE**: 1 of 2

DATE ISSUED:9/22 **SUPERSEDES:** **NUMBER:**

SUBJECT: Banned Items

Responsibility	**Superintendent or Superintendents Assistant/Case Manager/Admissions Coordinator**
Attached Documents	**None**
Issue/QA Approval Date	**PENDING**
Regulatory Reference(s)	**None**

Policy:
To maintain the safety and wellbeing of all Vista Residents and staff, Vista has implemented a ban on any item with an independent heating element that will not automatically shut itself off.

This includes, but is not limited to;

1. Iron
2. Hot Plate
3. Electric Grills
4. Cooktops (gas or electric)
5. Portable Heaters
6. Ornate Fireplaces
7. No Relay Extension cords
8. Heating Pads
9. Electric Blankets
10. Crock Pots
11. Pressure Cooker/s
12. Toaster Oven
13. Deep Fryer/Air Fryer
14. Rice Pots
15. Candles
16. Incense
17. Oil Burners
18. Kettles
19. Curling Irons
20. Flat Irons

Process:

1. Upon admission the **Superintendent or Superintendents Assistant** will;
   a. Assess all appliances and electronics moved in by a resident and will appropriately tag items as needed.
   b. Identify any appliances and/or electronics that qualify as banned items, confiscate them, and provide them to a case manager with a label indicating the residents apartment number and date of confiscation.
   c. If the resident refuses to relinquish the banned item will coordinate with a member of the case management team.
2. A **Case Manager** will be responsible for;
   a. Review of the banned items policy at the time of;
      i. Pre-screen Interview
      ii. Execution of Admission Agreement
   b. Intervention in the event that a resident refuse to relinquish a banned item and will coordinate with the resident's primary care giver/next of kin as needed.
   c. Will dispose of (with consent from the resident) a banned relinquish item.

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Responsibility	**Superintendent or Superintendents Assistant/Case Manager/Admissions Coordinator**
Attached Documents	**None**
Issue/QA Approval Date	**PENDING**
Regulatory Reference(s)	**None**

   d. Will coordinate a pickup from a friend, family member, care giver, or other next of kin with the resident's consent of the banned item.
   e. Will maintain the banned items in their office labeled with the resident's name, apartment number, and date of confiscation until such time the item is picked up by an identified party.
3. The **Admissions Coordinator** will provide a copy of this policy within the facility's admissions application.