Residential Health Care FacilityAdmission Application

Applicant NameFirs			Middle		Last			
Where is the applicant pre	sently?							
Home Address								
Home Address Stree	t# A	xpt #	City	State	Zip			
Phone #(Sez	x: Male	_ Female	Marital Sta	itus			
Birth Date	Birth	Place		Spouse's	Name			
Admitting Physician	Admitting Physician			Religion				
Advanced Directives: He (A copy will be requested			N Molst/DNR	R Y N	Living Will Y	_ N_		
Previous Occupation			Veterai	n Affairs Ben	efits Y N			
Funeral Home & Phone #								
Person(s) to Notify in Ti								
Name			Relationship_					
Address								
Street #	A	pt#	City	State	Zip			
Home Phone # ()			Work Phone #	()				
Name			Relationship _					
Address								
Street #	A	pt#	City	State	Zip			
Home Phone # ()			Work Phone #	()				
Name			Relationship_					
AddressStreet #	A	pt#	City	State	Zip			
Home Phone # ()	-		Work Phone #	()	-			

Financial Information

Insurance Information

Medicare #		Effective Date _		
Medicare Part B: Y N	Social Secu	rity #		
Medicare Part D: Y N	Insurer			
Medicaid #	County _		_ Social Worker	
Other Insurance Name				
Address				
Group #		Group Name:		
Policy #				
Other Insurance Name				
Address				
Other Insurance Name				
Address				
Group #		Group Name:		
Policy #				
Long Term Care Insurance				
Address				
Group #		Group Name:		
Policy #				
		Accounts		
Bank Name	Checkin	ng Balance \$	Savings \$	
Name(s) on accounts				
Authorized Signatures on account				
Bank Name	Checkir	ng Balance \$	Savings \$	
Name(s) on accounts				
Authorized Signatures on account				

Bank Name	Checking Balance	Savings \$		
Name(s) on accounts				
Authorized Signatures on	account			
	<u>Assets</u>			
Real Estate Location of Property				
		Balance Owed		
Titleholder				
I anotion of Duomantes				
		Balance Owed		
Titleholder				
Investments		** 1		
_				
~ .		** •		
Other		Volue		
Life Insurance				
Other Assets				
	Income-Per Mo			
Social Security	Pension	n		
Veterans Benefits	ment Funds			
Other				
	Outstanding De	<u>ebts</u>		
Please List		Value		
	lease List Value			

Person Managing Applicant's Funds

Name	Relationship					
Address						
	Street #	Apt #	City	State	Zip Code	
Home Phone (()		Work Phone (
Power of Atto	rney Y	N	Name			
(Please provi	de a copy of	f the Power o	of Attorney document	t)		
Name	Relationship					
Address						
	Street #	Apt #	City	State	Zip Code	
Home Phone (()		Work Phone (
			Executor of Estat	<u>te</u>		
Name		Relationship				
Address						
	Street #	Apt #	City	State	Zip Code	
Home Phone (()		Work Phone (
Attorney Name			Phone			
Address						
	Street #	Apt #	City	State	Zip Code	
According to respects.	the best of m	ny knowledge	and belief, the above	information is a	ccurate and true in a	
	Date		Signature of App	ignature of Applicant		
	Date		Signature of Designated Representative			

In compliance with New York State and Federal Laws, which prohibit discrimination based on race, creed, color, national origin, sex, age, sexual preference, disability, blindness, marital status, sponsorship, employment or source of payment, this facility admits and treats all patients on a nondiscriminatory basis.