

**ELCOR NURING AND REHABILITATION CENTER
48 COLONIAL DRIVE
HORSEHEADS, NY 14845
(607) 739-0304**

ADMISSION APPLICATION

DATE: _____ NAME: _____ MAIDEN NAME: _____

CURRENT LOCATION: _____ MARITAL STATUS: _____

USUAL ADDRESS: _____ TELEPHONE #: _____

SEX: ___ DATE OF BIRTH: _____ PRESENT AGE: _____ U.S. CITIZEN: _____

PLACE OF BIRTH: _____ CURRENT COUNTY OF RESIDENCE: _____

NAMES OF CLOSE LIVING RELATIVES OR CLOSE FRIENDS/SPONSORS: *(STAR OR CIRCLE TWO TO BE NOTIFIED IN CASE OF EMERGENCY):*

A) NAME: _____ B) NAME: _____

RELATIONSHIP: _____

RELATIONSHIP: _____

ADDRESS: _____

ADDRESS: _____

PHONE NO. HOME: _____

PHONE NO. HOME: _____

WORK: _____

WORK: _____

C) NAME: _____

D) NAME: _____

RELATIONSHIP: _____

RELATIONSHIP: _____

ADDRESS: _____

ADDRESS: _____

PHONE NO. HOME: _____

PHONE NO. HOME: _____

WORK: _____

WORK: _____

PREVIOUS OCCUPATION OR PROFESSION: _____

KIND OF BUSINESS: _____ NAME & LOCATION: _____

CURRENT HOBBIES, INTERESTS, AND ACTIVITIES: _____

SERVED IN THE U.S. ARMED FORCES: YES OR NO EDUCATION: *(GRADE COMPLETED)*: _____

FATHER'S NAME: _____ MOTHER'S MAIDEN NAME: _____

CLINICAL INFORMATION

CURRENT PHYSICIAN: _____ HOSPITAL PREFERENCE: _____

DIAGNOSIS, IF KNOWN: _____

REASON FOR APPLICATION: _____

HAS AN ASSESSMENT BEEN DONE BY A PRI NURSE/SCREENER: YES _____ NO _____

IF YES, WHO: _____

PRI SCORE, IF KNOWN: _____ *(PLEASE ATTACH A COPY OF THIS PRI/SCREEN).*

GENERAL INFORMATION

SOCIAL SECURITY NO.: _____ MEDICARE NO.: _____

MEDICAID NO.: _____ MEDICARE PART A & B DATES: _____

BLUE CROSS/BLUE SHIELD NO.: _____ GROUP NOS.: _____

ADDRESS OF BC/BS: _____

OTHER INSURANCE NAME & NO.: _____

ADDRESS OF OTHER INSURANCE: _____

PRESCRIPTION CARD NO (IF ANY): _____

RELIGION: _____ CHURCH IF ANY. _____

DO YOU HAVE BURIAL ARRANGEMENTS MADE: YES: _____ NO: _____

FUNERAL HOME: _____ ADDRESS: _____

PERSON RESPONSIBLE FOR FUNERAL ARRANGEMENTS:
NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

FINANCIAL INFORMATION

DO YOU HAVE A POWER OF ATTORNEY: YES: _____ NO: _____

IF YES, NAME OF P.O.A.: _____

ADDRESS: _____ PHONE NO.: _____

(NOTE: A COPY OF THIS POWER OF ATTORNEY MUST BE PRESENTED AT TIME OF ADMISSION)

IF NO POWER OF ATTORNEY, DOES ANYONE OTHER THAN YOURSELF HANDLE YOUR AFFAIRS? _____

IF YES, WHO: NAME: _____ PHONE NO. _____

ADDRESS: _____ RELATIONSHIP: _____

DO YOU HAVE A CONSERVATOR? YES _____ NO _____

IF YES, WHO: NAME: _____ PHONE NO. _____

ADDRESS: _____ RELATIONSHIP: _____

(NOTE: A COPY OF THIS CONSERVATOR MUST BE PRESENTED AT TIME OF ADMISSION)

IT IS THE REQUIREMENT OF ELCOR HEALTH SERVICES THAT THE ATTACHED FINANCIAL DISCLOSURE REPORT BE COMPLETED WHEN MAKING APPLICATION TO ELCOR HEALTH SERVICES. THIS REPORT MUST BE COMPLETED AND ATTACHED IN ORDER TO ACTIVELY BE PLACED ON OUR ADMISSION WAITING LIST.

IN COMPLIANCE WITH NEW YORK STATE AND FEDERAL LAWS WHICH PROHIBIT DISCRIMINATION BASED ON RACE, CREED, COLOR, NATIONAL ORIGIN, AGE, SEX, SEXUAL PREFERENCE, HANDICAP, MARITAL STATUS, SPONSORSHIP, THIS FACILITY ADMITS AND TREATS ALL RESIDENTS ON A NON-DISCRIMINATORY BASIS.

According to my best knowledge and belief, the foregoing information is accurate and true in all respects. I agree, if admitted, to abide by the regulations of the facility.

_____ Date

_____ Signature of Applicant

or

_____ Date

_____ Signature of Person Applying for Applicant

**ELCOR HEALTH SERVICES
APPLICANT FINANCIAL REPORT**

(ALL INFORMATION IS CONSIDERED CONFIDENTIAL)

Monthly income of Applicant

Salary\$ _____
 Social Security\$ _____
 Retirement Pension\$ _____
 Veteran's Pension\$ _____
 Railroad Pension\$ _____
 Supplementary Security Income\$ _____
 Other Monthly Income\$ _____

Please explain _____

Assets

Bank Accounts:

Name & Address Bank	Account No.	Type of Account	Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Other\$ _____

Market Securities

Stocks, Current Value\$ _____
 Bonds, Current Value\$ _____
 Funds in Trust\$ _____
 Real Estate (Current Market Value)\$ _____
 Life Insurance (cash value)\$ _____
 Life Insurance (face value)\$ _____
 Other Assets\$ _____

LIABILITIES

Home Mortgage\$ _____
 Loans & Installment Payments\$ _____
 Other\$ _____

TOTAL LIABILITIES\$ _____

NET BALANCE\$ _____

To the best of my knowledge all of the above information is correct and valid and is a complete accurate accounting of all assets and liabilities. I acknowledge that Elcor Health Services reserves the right to ask for confirmation of my source of income and assets.

Applicant's and/or Responsible Party's Signature

Date