



425 Michigan Avenue
Buffalo NY 14203
(716) 819-9200

Adult Day Health Care Program-Application for Admission

All questions must be answered in full either by or on behalf of the Applicant desiring admission. No application for admission will be considered unless it is complete. Submission of an application does not guarantee admission, nor does it create entitlement to admission or placement on any waiting list. State and Federal laws prohibit discrimination on the basis of race, color, creed, sex, sexual preference, national origin, sponsor, blindness, handicap or method of payment on the acceptance, retention or care of residents. All information given is considered confidential.

Personal Data

1. Applicant's Name _____ Phone: _____
2. Where is applicant presently? _____
Facility name, if any): _____
3. How long has applicant lived at the above address? _____
4. Home address if different from above: _____
5. Date of Birth: _____ 6. Name of Parents: Father _____ Mother _____
7. Is applicant a citizen of the United States? Yes _____ No _____*
(*If not a citizen of the U.S., a copy of applicant's Green Card is required.)
8. Is applicant a veteran? Yes _____ No _____
9. Name of spouse and/or nearest living blood relatives:
Name: _____ Relationship _____
Address _____ City/State/Zip _____
Phone Number(s): Home _____ Business _____ Cell _____
E-mail Address (optional): _____

Name: _____ Relationship _____
Address: _____ City/State/Zip _____
Phone Number(s): Home _____ Business _____ Cell _____
E-mail Address (optional): _____

Name: _____ Relationship _____
Address: _____ City/State/Zip _____

Phone Number(s): Home _____ Business _____ Cell _____

E-mail Address (optional): _____

9. Attending Physician: _____
 Address and Phone No _____

Statistical Section

7. Social Security Number: _____ (copy of card is required)

Medicare Claim Number: _____ (copy of card is required)

Is entitled to Hospital Insurance: Effective Date _____

Is entitled to Medical Insurance: Effective Date _____

Is applicant approved for nursing home care under the **New York State Medical Assistance Program?**
(Medicaid) ___ Yes ___ No If yes, Medicaid No.: _____

Access No.: _____ If pending, interview date: _____

Does applicant have health insurance? Yes _____ No _____

If yes, give company name and policy number: _____

Does applicant's policy have prescription coverage? Yes _____ No _____

Medicare Part D-name of PDP (Prescription Drug Plan) _____

If no PDP, please provide a copy of letter indicating credible coverage exists.

Does applicant have long term care insurance? Yes _____ No _____

If yes, give company name and policy number: _____

Please submit a copy of all applicable insurance cards along with this application.

___ Social Security ___ Medicaid ___ Medicare ___ Health Insurance(s) ___ Long Term Insurance

8. Does applicant have a Health Care Proxy? ___ Yes ___ No If yes, please bring a copy upon admission.

Does applicant have a Living Will? ___ Yes ___ No

Does applicant have a Do Not Resuscitate Order (DNR)? ___ Yes ___ No

If yes, please bring copy upon admission.

Financial Section (All Information is Considered Confidential)

No application for admission will be considered unless all requested financial information is provided.

9. **Monthly Income**

	Applicant	Spouse
Salary		
Social Security		
Retirement Pension		
Veteran's Pension		
Railroad Pension		
Supplementary Security Income		

Other Monthly Income _____ Source _____

Have you transferred any money within the past 5 years? _____ If so, amount \$ _____

To Whom _____

10. **Assets**

Checking Account: Bank _____ Amount _____
Savings Account: Bank _____ Amount _____
CD's, Stocks, Bonds, Mutual Funds _____ Amount _____
Real Estate _____ Jointly Owned? Yes ____ No ____
Insurance Policies _____ Cash Value _____
Other Assets _____

11. **Liabilities:**

Home Mortgage Amount _____
Loan/Installment Payments _____

12. **Power of Attorney**

Name _____ Telephone No. _____
Address _____
Street City State Zip

13. Designated Representative or Power of Attorney who will take full responsibility in insuring that payment will be made from resources of the applicant for all expenses incurred while at the Schofield Residence, which are not covered by Medicare, Medicaid or other Health Insurance.

Name: _____
Full Address and Phone No.: _____

14. A copy of one of the following should be returned with the application. Please check the one that applies:
 Power of Attorney Bank Power of Attorney Order Appointed Guardian, Conservator or Committee

15. To be completed by both applicant (if able) and designated representative.
I, _____, do solemnly swear or affirm that the information contained on this form is true, complete and accurate to the best of my knowledge.

Signature of Applicant

Signature of Designated Representative

16. To be completed by Power of Attorney, if different from designated representative.
I, _____, do solemnly swear or affirm that the information contained on this form is true, complete and accurate to the best of my knowledge.

Signature of POA, if different from Designated Representative