



3333 Elmwood Avenue
Kenmore NY 14217
(716) 874-1566

Residential Health Care Facility-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. Name _____ Phone: _____

Street Address _____

City, State Zip _____ County _____

Is there a lease agreement at the applicant's current location? Yes ___ No ___

2. Where is applicant presently? (Facility name, if any): _____

3. Date of Birth: _____

4. 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.

5. Is applicant a veteran? Yes ___ No ___

6. 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): _____

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. **New York State Law requires that a funeral home be assigned prior to admission.**

- Funeral Home: _____
 Full Address and Phone Number: _____
 Is applicant an organ donor? ___ Yes ___ No If yes, a copy of donor card is required upon admission.

9. 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.

10. **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 _____

11. **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 _____

12. **Liabilities:**

Home Mortgage Amount _____
Loan/Installment Payments _____

13. **Power of Attorney**

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

14. 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.: _____

15. 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

16. 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 Date

Signature of Designated Representative Date

17. 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 Date