Kaleida Health

LONG TERM CARE
APPLICATION FOR ADMISSION 1 of 3

Patient ID Area

This application must be submitted in full before an individual is considered for admission. Submission of an application does not create any entitlement to admission or mean that the applicant will be placed in the applicant waiting pool.

Applicant's Name (Last, First MI.)_____

Maiden Name_____

Social Security Number_____

Present Location/ Address of Applicant (Street, City, State, Zip Code)

_____

_____

_____

_____

Phone Number of Applicant or Representative_____

Date of Birth_____

Place of Birth_____

Religion_____

Marital Status: ☐ Single/Never Married ☐ Divorced ☐ Widowed ☐ Separated

Former Occupation and Employer_____

Is the applicant a Veteran? ☐ Yes ☐ No

Highest Education Level Completed_____

Name of Spouse_____

Spouses Address (Street, City, Sate, Zip Code)

_____

_____

_____

_____

Spouses Phone Number_____

Please list individuals to be notified in the event of an emergency

1. Name_____
   Relationship to applicant_____
   Street Address_____
   City, State, Zip Code_____
   Phone Number_____
2. Name_____
   Relationship to applicant_____
   Street Address_____
   City, State, Zip Code_____
   Phone Number_____
3. Name_____
   Relationship to applicant_____
   Street Address_____
   City, State, Zip Code_____
   Phone Number_____

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LONG TERM CARE
APPLICATION FOR ADMISSION 2 of 3

Patient ID Area

MEDICAL HISTORY:
Primary Physician_____
Physicians Address and Phone _____
_____
_____
_____

Does the applicant smoke? ☐ Yes ☐ No

HEALTH INSURANCE (Provide the numbers for the following):
Medicare_____
Does the applicant have Medicare Part B? ☐ Yes ☐ No
Medicaid_____
Univera_____
Encompass 65_____
Blue Cross Blue Shield_____
Other (list)_____
Other (list)_____
Other (list)_____

MONTHLY INCOME:

Source	Monthly Amount
Social Security	
Pension	
Veteran's Benefits	
Railroad Retirement	
Dividends	
Interest	
SSI	
Other (list)	
Other (list)	
Other (list)	

BANK ACCOUNTS:

Institution	Type of Account	Current Balance

POWER OF ATTORNEY:
Name_____
Address_____
City, State, Zip Code_____
Phone Number_____

Kaleida Health

LONG TERM CARE
APPLICATION FOR ADMISSION 3 of 3

Patient ID Area

Have any of the applicant's assets been disposed of within the last 5 years? ☐ Yes ☐ No
If yes, state the amount and reason for the disposition:

_____
_____
_____
_____

I acknowledge that Advance Directives and Do Not Resuscitate (DNR) have been reviewed verbally and written materials have been provided.

☐ I have chosen to remain in full code

☐ I have a Health Care Proxy or DNR (copies provided ☐ YES ☐ NO)

☐ I decline any Advance Directives or DNR discussion at this time and understand that I will remain a full code. Advance Directives/DNR will again be discussed at the Quarterly RCPC meeting.

FUNERAL ARRANGEMENTS:
Name of the person responsible for funeral arrangements_____
Relationship_____
Address _____
_____
_____
_____
Home Phone_____
Work Phone_____
Pager/Cell Phone_____
Is applicant donating body or body parts? ☐ Yes ☐ No
If yes, to whom?_____
Cremation ☐ Yes ☐ No

To the best of my knowledge and information, all the foregoing information is accurate and true.

_____
Signature of Applicant

_____ _____
Signature of Person Acting for Applicant Printed Name of Person Acting for Applicant

_____
Date of Application Completion

KALEIDA Health Long Term Care Facilities do not discriminate in admission, retention, or care of its residents because of race, creed, color, national origin, sex, disability, age, source of payment, marital status, or sexual preference.