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: _____
RELATIONSHIP:_____
ADDRESS: _____
PHONE NO. HOME:_____
WORK:_____

B) NAME:_____
RELATIONSHIP: _____
ADDRESS: _____
PHONE NO. HOME:_____
WORK:_____

C) NAME: _____
RELATIONSHIP: _____
ADDRESS: _____
PHONE NO. HOME:_____
WORK: _____

D) NAME: _____
RELATIONSHIP: _____
ADDRESS: _____
PHONE NO. HOME: _____
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