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:_____
E-Mail Address:_____

B) Name:_____
Relationship: _____
Address: _____
Phone No. Home:_____
Work:_____
E-Mail Address:_____

C) Name: _____
Relationship: _____
Address: _____
Phone No. Home:_____
Work: _____
E-Mail Address:_____

D) Name: _____
Relationship: _____
Address: _____
Phone No. Home: _____
Work: _____
E-Mail Address:_____

Previous Occupation Or Profession:_____

Kind Of Business: _____ Name & Location:_____

Current Hobbies, Interests, And Activities:_____

_____

Are You A Veteran? Yes No Is Your Spouse A Veteran? Yes No

Father's Name: _____ Mother's Maiden Name:_____

CLINICAL INFORMATION

Current Physician: _____ Hospital Preference: _____

Diagnosis, If Known: _____

Reason For Application: Rehab LTC

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 # (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)

Has There Been A Transfer Of Funds/Assets, Including But Not Limited To Real Estate, In The Past 60 Months?

□ **Yes** □ **No** If Yes, Please Explain:_____

It is the requirement of Elcor Nursing & Rehabilitation Center that the attached financial disclosure report be completed when making application to Elcor Nursing & Rehabilitation Center. 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 NURSING & REHABILITATION CENTER
APPLICANT FINANCIAL REPORT

(ALL INFORMATION IS CONSIDERED CONFIDENTIAL)

Monthly income of Applicant

Salary . . . . . $_____
Social Security . . . . . $_____
Retirement Pension . . . . . $_____
*(company*_____)
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 Nursing & Rehabilitation Center reserves the right to ask for confirmation of my source of income and assets.

_____ _____
Applicant's and/or Responsible Party's Signature Date