LOCKPORT
PRESBYTERIAN HOME

Application for Admission

Lockport Presbyterian Home
305-327 High Street
Lockport, NY 14094
(716) 434-8805
Fax: (716) 434-6059

MISSION STATEMENT

Presbyterian Senior Care enhances the life experience of aging persons in Western New York through a dedicated team who provides a range of services and residential options.

PRESBYTERIAN SENIOR CARE OF WESTERN NEW YORK

Application for Admission

Please complete all sides of this form. Presbyterian Senior Care of Western New York does not discriminate on the basis of Race, Creed, Color, National Origin, Sex, Age, Sponsorship, Marital Status, Blindness, Religion, Sexual Preference or Handicap.

A. APPLICANT'S DEMOGRAPHIC INFORMATION

1. NAME: _____
LAST FIRST MIDDLE

2. RESIDENCE: _____
NUMBER STREET COUNTY

3. PHONE: _____

4. BIRTH DATE: _____ SEX: _____ MARITAL STATUS: _____

VETERAN (Y/N): _____

5. BIRTH PLACE: _____ SOCIAL SECURITY NO.: _____

6. US CITIZEN (Y/N): _____ IF NOT, PROVIDE ALIEN REGISTRATION NO: _____

7. RELIGION: _____

CHURCH/SYNAGOGUE/TEMPLE: _____ PASTOR/RABBI: _____

8. PRESENT LOCATION OF APPLICANT: _____

9. PREVIOUS HOSPITAL STAY (Y/N): _____ FROM: _____ TO: _____

10. PREVIOUS NURSING HOME STAY? WHERE: _____ FROM: _____TO: _____

11. PRIOR TO ADMISSION STATUS ❑ HOME ALONE ❑ HOME WITH ASSISTANCE (Specify): _____

12. SERVICES OF A HOME HEALTH CARE AGENCY (Y/N): _____ NAME: _____

13. MAJOR HEALTH CONCERN: _____

14. MOST RECENT OCCUPATION: _____

15. ACCOMMODATION DESIRED:
- ☐ STUDIO W/ SHARED BATH
- ☐ STUDIO W/ PRIVATE BATH
- ☐ DELUXE STUDIO W/ PRIVATE BATH
- ☐ SINGLE SUITE
- ☐ COUPLE'S/LARGE SUITE
- ☐ SEMI-PRIVATE SUITE

16. PERSONAL PHYSICIAN: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

17. HEALTH DIRECTIVES: ☐ DO NOT RESUSCITATE ☐ HEALTH CARE PROXY ☐ LIVING WILL

B. SPOUSES INFORMATION

1. NAME: _____ VETERAN (Y/N): _____

2. SOCIAL SECURITY NO.: _____ BIRTH DATE: _____

3. STATUS ❑ LIVING ❑ DECEASED (DATE OF DEATH): _____

C. EMERGENCY CONTACT

NAME: _____ RELATIONSHIP:_____

ADDRESS: _____ HOME PHONE: _____

_____ WORK PHONE: _____

EMAIL ADDRESS: _____ CELL PHONE: _____

D. RESPONSIBLE PARTY

1. NAME: _____ RELATIONSHIP: _____

2. ADDRESS: _____ HOME PHONE: _____

_____ WORK PHONE: _____

EMAIL ADDRESS:_____ CELL PHONE: _____

3. BANK POWER OF ATTORNEY (Y/N): _____ DURABLE POWER OF ATTORNEY (Y/N): _____

4. GUARDIANSHIP (Y/N): _____

E. BILLING

NAME: _____ RELATIONSHIP:_____

ADDRESS: _____

_____

E. FUNERAL ARRANGEMENTS

PREPAID FUNERAL ARRANGEMENT (Y/N): _____ IF YES, NAME: _____

_____

NAME OF FUNERAL DIRECTOR ADDRESS PHONE

F. INSURANCE COVERAGE

1. MEDICARE NO.: _____ PART A: _____ PART B: _____ EFF DATE: _____

2. MEDICAID NO.: _____ TYPE: _____ EFF DATE: _____

CASEWORKER'S NAME: _____

3. VETERAN'S BENEFIT: _____

4. OTHER PRIVATE MEDICAL INSURANCE (Name, Identification Number, Insurance Carrier Telephone Number)

_____

_____

_____

5. PRESCRIPTION COVERAGE (Y/N): _____ POLICY NAME: _____

G. FINANCIAL INFORMATION (All information is considered confidential. Proofs are required prior to admission)

MONTHLY INCOME	**APPLICANT**	**SPOUSE**
1. SALARY:	_____	_____

2. SOCIAL SECURITY: _____ _____

3. SUPPLEMENTAL SECURITY INCOME: _____ _____

MONTHLY INCOME	**APPLICANT**	**SPOUSE**
4. RETIREMENT PENSION:	_____	_____
2. VETERAN'S PENSION:	_____	_____
3. OTHER (SPECIFY):	_____	_____

ASSETS	**YES/NO**	**APPROXIMATE VALUE**
1. OWNS REAL ESTATE:	_____	_____
2. LIFE INSURANCE (VALUE):	_____	_____
3. PREPAID FUNERAL:	_____	_____
4. OTHER ASSETS:	_____	_____
SAVINGS/CHECKING:	_____	_____
STOCK/BONDS/OTHER SECURITIES:	_____	_____
IRA's:	_____	_____
TRUSTS:	_____	_____
MISCELLANEOUS:	_____	_____

LIABILITIES

1. HOME MORTGAGE:	_____	_____
2. LOAN INSTALLMENTS:	_____	_____
3. OTHER LIABILITIES (Specify):	_____	_____

OTHER FINANCIAL INFORMATION (Specify):

_____

_____

As **Responsible Party (s)**, I (we) will be responsible for payment of all expenses incurred by the applicant not covered by Medicare, Medicaid or private health insurance, from the applicant's personal income or resources, with out incurring personal liability or expense. I (we) certify that the information provided in this application is true, correct and valid.

Applicant (if competent to sign): _____ Date: _____

Responsible Party's Name: _____ Telephone: _____

Responsible Party's Signature: **X** _____ Date: _____

Name & Signature: **X** _____ Date: _____

Person completing the application other than the Responsible Party or Applicant

Address: _____ Telephone: _____