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

Appli.frm
6/11