Manor Hills, Inc.

Assisted Living Residence with SNALR
(Special Needs Assisted Living Residence)

4192B Bolivar Road Wellsville, NY 14895

(585) 593-9800
Fax: (585) 593-4605

APPLICATION FOR ADMISSION
ALL INFORMATION WILL BE KEPT CONFIDENTIAL
PLEASE COMPLETE ADDRESSES AND PHONE NUMBERS

1. _____ AGE _____ SEX ____
LAST NAME FIRST MIDDLE INT.

2 REFERRED BY: (ex. Friend, MD, Social Worker, Newspaper, etc.)_____

3. PRESENT ADDRESS _____

COUNTY OF RESIDENT _____ PHONE_____

4. CURRENT PHARMACY _____

5. DATE OF BIRTH _____ PLACE OF BIRTH _____

6. SOCIAL SECURITY NUMBER _____- _____- _____ MEDICARE # _____

7. HEALTH CARE INS. TYPE _____

POLICY # _____ GROUP # _____

ADDRESS_____ PHONE # _____

8. RECEIVING SSI ___YES ___NO MEDICAID # _____SEQ# _____

9. NAME OF PHYSICIAN _____PHONE#_____

ADDRESS_____

10. EYE DOCTOR _____PHONE # _____

ADDRESS _____

DENTIST _____ PHONE # _____

ADDRESS _____

PODIATRIST _____PHONE # _____

ADDRESS _____

FAMILY INFORMATION

11. CURRENT MARITAL STATUS M ___ S ____ W ____ D ____

12. SPOUSES NAME EVEN IF DECEASED _____

13. EMERGENCY CONTACT _____

ADDRESS _____ RELATIONSHIP _____

PHONE # _____

14. CHILDREN AND OTHER RELATIVES OR FRIENDS:

NAME _____RELATIONSHIP _____PHONE# _____

NAME _____RELATIONSHIP _____PHONE# _____

NAME _____RELATIONSHIP _____PHONE# _____

NAME _____RELATIONSHIP _____PHONE # _____

15. WERE YOU IN THE ARMED SERVICES? _____ YES ____ NO

DATES OF SERVICE _____ TO _____ BRANCH _____

16. EDUCATION _____
GRADE SCHOOL HIGH SCHOOL OTHER

17. PREVIOUS OCCUPATION _____RELIGION _____

18. SKILLS, INTERESTS, HOBBIES, MEMBERSHIPS, AND/OR ORGANIZATIONS
_____
_____
_____

19. ALLERGIES: _____

DNR (Do-Not-Resuscitate) ___ Y ____N HCP (Health-Care-Proxy)____Y ____N

Date of last flu vaccine? _____ Date of last pneumovax?_____

20. HAS THE APPLICANT EVER BEEN TREATED FOR A NERVOUS, EMOTIONAL, OR PSYCHIATRIC CONDITION? _____Y ____N DATE _____

NAME OF DOCTOR _____ HOSPITAL _____

21. IS APPLICANT A REGISTERED EYE / BODY DONOR _____YES _____NO

AGENCY NAME _____PHONE # _____

ADDRESS _____

SPECIAL INSTRUCTIONS _____

22. BURIAL ARRANGEMENTS (PLEASE CHOOSE A FUNERAL HOME)

NAME _____ PHONE # _____

ADDRESS _____
CITY STATE ZIP CODE

OTHER PERSONAL INFORMATION: _____
_____

23. DO YOU HAVE A POWER OF ATTORNEY? _____YES _____NO

NAME _____ ADDRESS _____

PHONE# _____ (PLEASE PROVIDE COPY OF DOCUMENT)

24. IF OTHER THEN APPLICANT, WHO WOULD BE ASSISTING THE RESIDENT TO PAY THE BILLS? NAME _____ PHONE#_____

ADDRESS _____
STREET CITY STATE ZIP

25. SOCIAL SECURITY _____ SSI _____

STOCKS AND BONDS _____SOURCE _____

CD'S _____ANNUITIES _____

PENSION _____DIVIDENDS / INTEREST _____

ASSETS TO HELP US DETERMINE ELIGIBILITY FOR FINANCIAL NEED BASED ON PROGRAMS AND PAYMENT SOURCES.

26. REAL ESTATE DESCRIPTION _____

ESTIMATED VALUE _____
(IF MORE THEN ONE PLEASE ATTACH LIST)

LIFE INSURANCE _____
COMPANY. NAME POLICY #

ADDRESS _____
STREET CITY STATE ZIP

SECURITIES: STOCKS AND BONDS (ATTACH LIST OF PORTFOLIO) IF MORE THEN ONE PLEASE ATTACH LIST.

27. BANK ACCOUNT: PLEASE LIST ALL OR ATTACH A LIST.

A. NAME OF BANK _____ACCOUNT_____

BANK ADDRESS _____ AMOUNT _____

B. NAME OF BANK _____ ACCOUNT _____

BANK ADDRESS _____ AMOUNT _____

C. NAME OF BANK _____ACCOUNT_____

BANK ADDRESS _____ AMOUNT _____

IT IS THE PURPOSE OF MANOR HILLS TO PROVIDE A COMPLETE CARE PROGRAM FOR ALL THOSE ADMITTED FOR CARE IN COMPLIANCE WITH THE NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES, TITLE 18.

MANOR HILLS COMPLIES WITH NEW YORK STATE AND FEDERAL LAWS PROHIBITING DISCRMINATION IN ANY FORM ON THE BASIS OF RACE, CREED, COLOR, NATIONAL ORGIN, SEX, BLINDNESS, SOURCE OF PAYMENT OR HANDICAP.

_____ _____
SIGNATURE OF APPLICANT DATE

_____ _____
SIGNATURE OF REPRESENTATIVE DATE