

# ONEONTA NURSING & REHABILITATION CENTER

330 Chestnut Street, Oneonta, New York 13820 • 607-432-8500 • 607-432-1061 (Fax)

## Admission application

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### General information about the applicant:

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Present Location of Applicant (if other than home address);

Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Beginning date of residence at this location: \_\_\_\_/\_\_\_\_/\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthplace: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Former Occupation: \_\_\_\_\_ Highest Level of Education Completed: \_\_\_\_\_ Smoker: Y / N

Marital Status: S M W D Spouse's Name: \_\_\_\_\_ Deceased: Y / N Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Religion: \_\_\_\_\_ Church: \_\_\_\_\_

Has the applicant ever been in another health care facility?: Y / N If yes, Name: \_\_\_\_\_

Address: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_

Telephone: \_\_\_\_\_ Does applicant have any allergies to or problems with domestic animals? Y / N

### Funeral Home

Have funeral arrangements been made? Y / N

If yes, name of funeral home: \_\_\_\_\_

Address: \_\_\_\_\_

Does the applicant own a plot: Y / N

If yes, where: \_\_\_\_\_

### Insurance Information:

*Please provide current insurance cards for photo copying.*

Social Security# \_\_\_\_\_ Veteran: Y / N

Medicare # \_\_\_\_\_ Part A \_\_\_\_\_ Part B \_\_\_\_\_

Medicaid CIN # \_\_\_\_\_ County: \_\_\_\_\_

Pending Medicaid Application: Y / N If yes, date submitted: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Additional Insurance: \_\_\_\_\_ 2. Additional Insurance: \_\_\_\_\_

Group# \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Telephone \_\_\_\_\_ Telephone \_\_\_\_\_

### Attending Physicians:

Name	Address	Telephone	Diagnosis
1. _____	_____	_____	_____
2. _____	_____	_____	_____

Will any of these physicians follow the applicant at the nursing home? \_\_\_\_\_ If yes, whom: \_\_\_\_\_

**Documentation/Notification/ Responsible Persons:**

Does the applicant have any of the following:

*If applicant has any of the following, please provide for photo copying.*

\_\_\_ DNR Order \_\_\_ Health Care Proxy \_\_\_ Living Will \_\_\_ Organ Donor \_\_\_ Body Donor

**Persons to be notified in case of emergency:**

- |  |  |
|--|--|
| 1. Name: _____                         | 2. Name: _____                         |
| Designation: _____ Relationship: _____ | Designation: _____ Relationship: _____ |
| Address: _____                         | Address: _____                         |
| City/State/Zip: _____                  | City/State/Zip: _____                  |
| Home Phone: _____ Work Phone: _____    | Home Phone: _____ Work Phone: _____    |
| 3. Name: _____                         | 4. Name: _____                         |
| Designation: _____ Relationship: _____ | Designation: _____ Relationship: _____ |
| Address: _____                         | Address: _____                         |
| City/State/Zip: _____                  | City/State/Zip: _____                  |
| Home Phone: _____ Work Phone: _____    | Home Phone: _____ Work Phone: _____    |

Indicate in space marked Designation above if the person to be notified is: -Power of Attorney-Conservator-Health Care Agent-or any other arrangement.

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## FINANCIAL STATEMENT

(use back of sheet if necessary)

Completion and submission of this data sheet is required prior to consideration for admission and an updated data sheet must be completed every six months after admission, or upon request.

### MONTHLY INCOME:

	Source	Amount
Pension/Retirement	_____	_____
Social Security	_____	_____
Other	_____	_____
	_____	_____

### ASSETS (Attach additional sheet, if necessary.)

	Location	Value
Savings Accounts	_____	_____
	_____	_____

Checking Accounts	_____	_____
	_____	_____

Certificate of Deposit	_____	_____
	_____	_____

Stocks/Bonds (Give number of shares owned, name of security, and market value.)		Value
_____		_____
_____		_____

Life Insurance Policies	Company	Value
	_____	_____
	_____	_____

Other Assets (Particularly real estate)	_____	_____
	_____	_____

To the best of my knowledge, the information provided in this application is correct.

\_\_\_\_\_  
*Signature of applicant or responsible party*

\_\_\_\_\_  
*Date*