KALEIDA HEALTH

☐ DeGraff Memorial Hospital
☐ HighPointe on Michigan

LONG TERM CARE APPLICATION FOR ADMISSION 1 of 3

Patient ID Area

This application must be submitted in full before an individual is considered for admission. Submission of an application does not create any entitlement to admission or mean that the applicant will be placed in the applicant waiting pool.

Applicant's Name (Last, First MI.): _____
Maiden Name: _____
Social Security Number: _____
Present Location/ Address of Applicant (Street, City, State, Zip Code):
_____
_____
_____
_____
Phone Number of Applicant or Representative: _____
Date of Birth: _____
Place of Birth: _____
Religion: _____
Marital Status: ☐ Single/Never Married ☐Divorced ☐Widowed ☐Separated
Former Occupation and Employer: _____
Is the applicant a Veteran? ☐Yes ☐No
Highest Education Level Completed: _____
Name of Spouse: _____
Spouses Address (Street, City, Sate, Zip Code):
_____
_____
_____
_____
Spouses Phone Number: _____

Please list individuals to be notified in the event of an emergency

1. Name: _____
   Relationship to applicant: _____
   Street Address: _____
   City, State, Zip Code: _____
   Phone Number: _____
2. Name: _____
   Relationship to applicant: _____
   Street Address: _____
   City, State, Zip Code: _____
   Phone Number: _____
3. Name: _____
   Relationship to applicant: _____
   Street Address: _____
   City, State, Zip Code: _____
   Phone Number: _____

KALEIDA HEALTH

LONG TERM CARE APPLICATION FOR ADMISSION 2 of 3

Patient ID Area

MEDICAL HISTORY:
Primary Physician: _____
Physicians Address and Phone: _____
_____
_____
_____

Does the applicant smoke? ☐ Yes ☐ No

HEALTH INSURANCE (Provide the numbers for the following):
Medicare: _____
Does the applicant have Medicare Part B? ☐ Yes ☐ No
Medicaid: _____
Univera: _____
Encompass 65: _____
Blue Cross Blue Shield: _____
Other (list): _____
Other (list): _____
Other (list): _____

MONTHLY INCOME:

Source	Monthly Amount
Social Security	
Pension	
Veteran's Benefits	
Railroad Retirement	
Dividends	
Interest	
SSI	
Other (list):	
Other (list):	
Other (list):	

BANK ACCOUNTS:

Institution	Type of Account	Current Balance

POWER OF ATTORNEY:
Name: _____
Address: _____
City, State, Zip Code: _____
Phone Number: _____

KALEIDA HEALTH

LONG TERM CARE APPLICATION FOR ADMISSION 3 of 3

Patient ID Area

Have any of the applicant's assets been disposed of within the last 3 years? ☐ Yes ☐ No

If yes, state the amount and reason for the disposition:

_____

_____

_____

_____

I acknowledge that Advance Directives and Do Not Resuscitate (DNR) have been reviewed verbally and written materials have been provided.

☐ I have chosen to remain in full code

☐ I have a Health Care Proxy or DNR (copies provided ☐ YES ☐ NO)

☐ I decline any Advance Directives or DNR discussion at this time and understand that I will remain a full code. Advance Directives/DNR will again be discussed at the Quarterly RCPC meeting.

FUNERAL ARRANGEMENTS:

Name of the person responsible for funeral arrangements: _____

Relationship: _____

Address: _____

_____

_____

_____

Home Phone: _____

Work Phone: _____

Pager/Cell Phone: _____

Is applicant donating body or body parts? ☐ Yes ☐ No

If yes, to whom? _____

Cremation: ☐ Yes ☐ No

To the best of my knowledge and information, all the foregoing information is accurate and true.

_____

Signature of Applicant

_____ _____

Signature of Person Acting for Applicant Printed Name of Person Acting for Applicant

_____

Date of Application Completion

KALEIDA Health Long Term Care Facilities do not discriminate in admission, retention, or care of its residents because of race, creed, color, national origin, sex, disability, age, source of payment, marital status, or sexual preference.