8 Bushey Boulevard
Plattsburgh, New York 12901
Tel.(518)563-3261
Fax.(518)563-3294

Hassett Adult Day Services
Restorative Care
Skilled Nursing Care

APPLICATION FOR ADMISSION

STATE AND FEDERAL LAW PROHIBIT DISCRIMINATION BASED ON RACE, CREED, COLOR, AGE, SEX, RELIGION, NATIONAL ORIGIN, SPONSOR, SEXUAL PREFERENCE, DISABILITY, OR MARITAL STATUS, BLINDNESS, SOURCE OF PAYMENT IN ADMISSION, RETENTION AND CARE OF RESIDENTS. PERSONS UNDER 16 YEARS OF AGE ARE NOT ELIGIBLE FOR ADMISSION CONSIDERATION, UNLESS SPECIAL APPROVAL HAS BEEN RECEIVED FROM THE DEPARTMENT OF HEALTH.

THE INFORMATION PROVIDED SHALL REMAIN CONFIDENTIAL AND SHALL BE MADE AVAILABLE ONLY TO AUTHORIZED HOSPITAL AND NURSING HOME PERSONNEL INVOLVED IN THE PLACEMENT PROCESS AND TO ANY GOVERNMENTAL OFFICIALS AUTHORIZED ACCESS BY LAW TO SUCH RECORDS.

Full Name: _____

Current address: _____

County: _____Telephone No.:_____U.S. Citizen: Yes____ No____

I have been residing at this address since: _____

Date of birth: _____ Place of birth: _____

Name of father: _____ Name of mother: _____

U.S. Military service: Yes____ No____ Spouse of veteran: Yes____ No____

Occupation or trade: _____

Marital status: _____ Name of spouse: _____

Date of marriage: _____ Is spouse deceased: Yes____ No____

Does anyone have Power of Attorney: Yes____ No____ IF YES, PLEASE ATTACH

Name of POA: _____ Relationship:_____

Who is the Executor of your estate: _____

Personal Contacts:

Name Address Relationship Phone

_____

_____

_____

Name of Primary Physician: _____

Funeral Home: _____

Prepaid funeral: Yes____ No____ Prepaid burial plot: Yes____ No____

Do you have a Health Care Proxy or other Advance Directives: Yes____ No____

IF YES, PLEASE ATTACH

Financial Information: Monthly amount:

Social Security $_____

Retirement Pension $_____

Veteran's Pension $_____

SSI $_____

Other $_____

Insurance:

Medicare: A B C #_____

Medicaid: Yes____ No____ #_____

Prescription Plan: _____

Other: Yes____ No____ Plan: _____

ID#: _____

Assets:

Checking: Amount: _____ Bank: _____

Savings: Amount: _____ Bank: _____

CDs: Amount: _____ Stocks/bonds: Amount: _____

Have you sold or transferred any real property or other assets within the last five years?

Yes____ No____ If yes, please provide details: _____

Do you own any property or real estate: Yes____ No____

Location: _____ Value: _____

Are you working with an attorney? If yes, who: _____

To the best of my knowledge all the information provided herein is correct and valid. I hereby apply for admission to the Evergreen Valley Nursing Home.

_____ _____

SIGNATURE OF APPLICANT OR RESPONSIBLE PARTY DATE

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EVERGREEN VALLEY NURSING HOME

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, hereby authorize Evergreen Valley Nursing Home to request and receive all identifying and medical information from the records of:

Resident Name: _____

Address: _____

_____

_____

Date of Birth: _____

Social Security Number: _____ - _____ - _____

This information is required for the purposes of:

- **Evaluation for admission to Evergreen Valley Nursing Home**
- **Continuation of services and care following admission to Evergreen Valley Nursing Home**

_____
Resident or Designated Representatives Signature

_____
Date

_____
Witness

_____
Date