APPLICATION FOR ADMISSION

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Penn Yan, New York 14527
Phone (315) 536-8800
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Clintoncrestmanor.com

PROMOTING THE HIGHEST LEVEL OF WELL BEING

Date of Application_____ Desired admission date_____

Please answer all questions as completely and as accurately as possible.

This information is for the use of Clinton Crest Manor in determining your eligibility for admission and will be held in confidence.

NAME IN FULL

_____

(First) (Middle Initial) (Last)

Address_____ Phone #_____

City_____ County_____ State_____ Zip_____

With whom do you now reside?_____Relationship_____

Birthdate_____ Sex_____ Citizenship_____

City of Birth_____ State of Birth_____

Social Security No._____

MARITAL AND SOCIAL:

Marital Status: Widow/Widower (date of death:_____) Single Divorced Married

If married spouse's name:_____

Hobbies, interests, and/or activities you enjoy: _____

_____

Organizations to which you belong?_____

_____

Licensed to drive a car? Yes No

If yes, driver's license number _____ Expiration Date _____

Would you bring a car? Yes No

If yes, year_____ make_____ color_____ plate no._____

Veteran Status Yes No Spouse of Veteran Yes No

Do you have a religious affiliation? If so what is your faith and what church (if any) do you attend?_____

_____

CONTACT PERSONS (nearest relatives or significant others). Please list in order of contact. In completing this application, it is recommended that every resident appoint a Power of Attorney (POA) and Health Care Proxy (HCP).

1. Name_____
Relationship_____
POA HCP
Street_____
City_____
State & Zip_____
Phone: Home_____
Cell:_____
E-Mail_____

2. Name_____
Relationship_____
POA HCP
Street_____
City_____
State & Zip_____
Phone: Home_____
Cell:_____
E-Mail_____

3. Name_____
Relationship_____
POA HCP
Street_____
City_____
State & Zip_____
Phone: Home_____
Cell:_____
E-Mail_____

4. Name_____
Relationship_____
POA HCP
Street_____
City_____
State & Zip_____
Phone: Home_____
Cell:_____
E-Mail_____

Please enclose **copies** of any of the following which pertain to you:

Social Security Card
Medicare Card
Medicaid Card
Major Medical Insurance Card
Medicare D Prescription Card
Body Organ Donor Card
Long Term Care Insurance Card
Power of Attorney Form
Living Will/Health Care Proxy
Non-Hospital DNR
Medical Orders for Life-Sustaining Treatment (MOLST)

HEALTH SECTION

Personal Care Physician's Full Name:_____

Address:_____Phone:_____

Last office visit:_____Reason for visit:_____

General Diagnoses:_____

Other than your Primary Care Physician, have you been seen by a Physician/Specialist in the past year? Yes No

List any other Physicians/Specialists whom you have been seeing: (i.e., Surgeon, Dentist, Optometrist, Dermatologist, Psychiatrist)

Name_____

Address_____

Phone:_____Speciality:_____

Name_____

Address_____

Phone:_____Speciality:_____

Name_____

Address_____

Phone:_____Speciality:_____

Please check if you experience any of the following impairments:

__ Hearing __Vision __Cognition __Speech __Walking __Transferring
Physical Disabilities:_____

Past Surgeries:_____

Allergies:_____

Do you have allergies to specific animals Yes No Do you have any fear of animals? Yes No

Do you need assistance with your medications? Yes No

Do you currently receive any home services (meals, aides)? Yes No

If yes, which agency do you utilize?_____

The following questions are to help the staff at Clinton Crest Manor know you a little better. Please answer them as completely as possible. If you are not comfortable answering a particular question, please feel free to leave it blank.

FAMILY HISTORY

Father's Name_____ Occupation:_____

Mother's Name:_____ Occupation:_____

Sibling's name(s):_____

_____

_____

Where are you in your sibling's birth order?_____

Please tell us about any significant childhood events:_____

_____

_____

_____

_____

Please list children (names/location, etc.):_____

_____

_____

_____

Other significant relationships:_____

_____

_____

Describe relation(s) with family:_____

_____

_____

Special life events:_____

_____

_____

What are you most proud of?_____

_____

_____

What would you like to be remembered for?_____

_____

_____

EDUCATION AND EMPLOYMENT

Education (where/grade level/ degree, etc.)_____

_____

Employment (former or present)_____

Last Employer?_____

Answering these questions about your daily routine and preferences will also help us to provide you with the best possible, specialized care. Please place a check mark in front of all items that best describe your abilities. Leave blank those items that don't apply to you.

DRESSING:

___ can get own clothing from closet/dresser
___ can put clothing on without assistance
___ can put shoes on without assistance
___ can manage buttons/zippers without assistance

DRESSING COMMENTS:

_____
_____
_____
_____

BATHING: How many times a week?_____

___ can shower independently
___ need assistance with washing certain areas of the body
___ can comb hair independently
___ can brush teeth/perform dental care independently
___ can shave independently
___ can put on make-up/jewelry independently

BATHING COMMENTS:

_____
_____
_____
_____
_____
_____

EATING: special diets, allergies _____

_____

___ can open container without assistance
___ need adaptive equipment (special utensils, dishes, etc.)
___ need food cut
___ have difficulty swallowing

EATING COMMENTS:

_____
_____
_____
_____
_____

AMBULATION:

___ can walk without assistive devices
___ can walk independently with: CANE WALKER
___ can walk if someone is with me to ensure safety
___ can walk short distance (50 feet)
___ without assistance ___ with assistance
___ can walk long distance
___without assistance ___with assistance
___ enjoy taking regular walks
___ independent in a wheelchair (transferring, entering/exiting building,etc.)

AMBULATION COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____
_____

TRANSFERRING:

___ can get out of bed with no assistance
___ can go from the bed to chair and vice versa without assistance
___ can use a lift chair
___ need assistance to get out of bed or chair

TRANSFERRING COMMENTS:

_____
_____
_____
_____
_____

TOILETING:

___ can get on/off toilet without assistance
___ can get on/off independently with raised seat
___ can clean self without assistance
___ incontinent, but use protective undergarments and can change them myself
___ incontinent, but need assistance with incontinence products

If Incontinent:

Are you incontinent during the day night both?
How often are you incontinent?_____
Incontinent of? bladder bowel both

TOILETING COMMENTS:

_____
_____
_____
_____
_____
_____
_____

Additional Comments:_____

_____

_____

APPLICANTS FINANCIAL INFORMATION

Clinton Crest Manor requires the following personal financial information. This information is used for admission determinations and for determinations regarding our obligation to provide a resident centered environment and service continuum. Please complete the financial information below. It will be held in confidence and not released to any person, agency, or party unless so directed by the resident.

Please indicate below the approximate market value or actual value of each of the following ASSETS you own.

ASSETS	APPROXIMATE VALUE	TOTAL VALUE
BANK ACCOUNTS	BANK	BALANCE
Checking Accounts		
Savings Accounts		
Total Banking Assets		
REAL ESTATE ASSETS		
Residential Home		
Other Property or Land		
Total Real Estate Value		
INVESTMENTS		CURRENT VALUE
Stocks/Bonds		
CD's		
Mutual Funds		
Other		
Total Investments		
LIFE INSURANCE	CASH VALUE	FACE VALUE
Paid Up Life Policies		
TOTAL OF ALL ASSETS LISTED		
HAS A BURIAL FUND BEEN ESTABLISHED?	Yes (provide details below)	No
FUNERAL HOME		
ADDRESS		
PHONE NO.		

MONTHLY INCOME	AMOUNT
Social Security	
Supplemental Security	
Veteran Benefits	
Interest Income	
Dividend Income	
Pension	
Annuity	
Support From Relatives	
TOTAL MONTHLY INCOME	

LIABILITIES	AMOUNT
Medical Liabilities	
Other Liabilities	
TOTAL LIABILITIES	

The financial information on this form is a true and correct statement of my current financial position to the best of my knowledge and belief. I further attest that I have not transferred, nor donated, to other persons assets not reflected on this form within the past five years and will not transfer or donate assets to other persons in the future which would preclude my ability to meet my financial obligation to Clinton Crest Manor.

Signed_____ Date_____

I will be able to pay the self-pay room and board rate for a minimum of six (6) months.

Signed_____ Date_____

Clinton Crest Manor, in compliance with New York State and Federal laws which prohibit discrimination based on race, creed, color, national origin, age, gender, marital status, sexual preference, disability, blindness, source of payment or sponsorship, admits and treats all residents on a non-discriminatory basis.