Eastern Star Campus
8290 State Route 69
Oriskany, New York 13424
Phone: (315) 736-9311 Fax: (315) 736-3047

Application for Admission

LEVEL OF CARE IN WHICH APPLICANT IS APPLYING FOR: ***(please check one)***

ALP _____ MEMORY CARE _____

Name: _____ **Date:** _____

Present Address: _____
Street

_____
City **State** **Zip Code** **County**

Telephone: _____

Date of Birth: _____ **Place of Birth:** _____

Social Security No: _____ **Medicare No.:** _____

Medicaid No.: _____ **Medicaid County:** _____

Citizen of USA? Yes _____ No _____ Veteran Status: _____ **Branch:** _____

Education: _____ **Past Occupation:** _____

Language Spoken: _____ **Religion:** _____

Parents: _____

Marital Status: _____ **Date of Marriage:** _____ **Date of Termination:** _____

Spouse Name: _____ **Date of Birth:** _____

Spouse Date of Death: _____ **Social Security No.:** _____

Spouse Veteran Status: _____ **Branch:** _____

Emergency Contacts/Designated Representative/POA:

Name: _____

Address: _____

Relationship: _____ **Power of Attorney: Yes _____ No _____**

Email: _____ **Health Care Proxy: Yes _____ No _____**

Phone: Home _____ **Cell** _____ **Work** _____

Secondary Contact Person(s)

Name: _____

Address: _____

Relationship: _____ **Power of Attorney: Yes _____ No _____**

Email: _____ **Health Care Proxy: Yes _____ No _____**

Phone: Home _____ **Cell** _____ **Work** _____

FINANCIAL

1. **Checking Account:**
   Name of Bank: _____
   Address: _____
   Account #: _____ **Current Balance:** $ _____

2. **Savings Account:**
   Name of Bank: _____
   Address: _____
   Account #: _____ **Current Balance:** $ _____

3. **C.D.'s/Money Market Funds:**
   Name of Bank: _____
   Address: _____
   Account #: _____ **Issue Amount:** $ _____
   Cash Surrender Value: $_____

4. **Stocks, Bonds, Certificates: (If needed, please list additional information on separate sheet)**
   Company Name: _____
   Address: _____
   Number of Shares: _____ **Market Value:** $ _____
   Date of Purchase: _____

5. **Within the past five (5) years have you sold, transferred or given away any property, assets, stocks, bonds, and/or cash with a cumulative total of $6,000 or more? Yes _____ No _____ (If yes, please list on a separate page)**

6. **Cash on Hand:** $_____

7. **Do you own property? Yes _____ No _____ If yes, Location: _____**

   In your name? Yes _____ No _____ Co-Ownership? Yes _____ No _____

   If co-ownership, name and address of co-ownership: _____

   _____

8. **Do you own a motor vehicle? Yes _____ No _____ If yes, make and year: _____**

9. **Income:**

	Amount:	Direct Deposit:
Social Security	$_____	**Yes _____ No _____**
Supplemental Social Security	$_____	**Yes _____ No _____**
Pension	$_____	**Yes _____ No _____**
Dividends	$_____	**Yes _____ No _____**
Support from Relatives	$_____	**Yes _____ No _____**

Name of Bank or Credit Union: _____

Address: _____

INSURANCE

1. Health Insurance: (Please list additional policies on separate sheet)

Name of Company: _____

Address: _____

Identification #: _____

Claim #: _____

Group #: _____

2. Long Term Care Insurance: (Identify if a New York State Partnership Policy)

Name of Company: _____

Address: _____

Policy #: _____

Date Purchased: _____

Amount of Coverage: $_____

3. Other Insurance Coverage:

Name of Company: _____

Address: _____

Policy #: _____

Date Purchased: _____

Face Value: $_____

Cash Surrender Value: $_____

FINANCIAL ARRANGEMENTS

1. Private Pay Arrangements: (Please check one)

____ Control Own Assets

____ Appoint Individual to Pay Bills: _____

Name of Appointed Individual

_____

Complete Mailing Address

____ Power of Attorney to Pay Bills (Upon moving in, a copy of Current Power of Attorney will need to be provided.)

The financial information on this form is a true and correct statement of my financial position to the best of my knowledge.

_____ **OR** _____

Signature of Applicant **Signature of responsible party**

HEALTH STATUS

1. **Primary Care Physician's Name:** _____

   Address: _____
   Street **City/State** **Zip Code**

   Telephone: _____ **Date of Last Visit:** _____

2. **Dentist's Name:** _____

   Address: _____
   Street **City/State** **Zip Code**

   Telephone: _____ **Date of Last Visit:** _____

3. **Optometrist's Name:** _____

   Address: _____
   Street **City/State** **Zip Code**

   Telephone: _____ **Date of Last Visit:** _____

4. **Other Physician's Name:** _____

   Address: _____
   Street **City/State** **Zip Code**

   Telephone: _____ **Date of Last Visit:** _____

5. **Past Hospitalizations and/or Surgeries: (Please include dates and reasons, last five years)**

   _____

   _____

6. **List any Disabilities:** _____

   _____

7. **List any Known Allergies:** _____

8. **Special Diets:** _____

   Food Likes _____ **Food Dislikes** _____

9. **Medications/Dosage/Time Intervals (Please attach current list):** _____

   _____

   _____

10. **Hospital of Choice:** _____ **Pacemaker: Yes** _____ **No** _____

11. **Do you have an up-to-date will? Yes** _____ **No** _____ **If yes, date of will:** _____

ADVANCED DIRECTIVES
(Please provide copy)

1. Do you have Advanced Directives: Yes _____ No _____

If yes, please check which ones from list below: (Upon moving in, a current copy of each will need to be provided.)

_____ Do Not Resuscitate (DNR) _____ Living Will

_____ Healthcare Proxy (HCP) _____ Durable Power of Attorney

2. Are you in the Body Organ Donor Program? Yes _____ No _____

FUNERAL ARRANGEMENTS

1. Name of Funeral Home: _____

Address: _____
Street City/State Zip Code

Telephone: _____

2. Do you have pre-planned arrangements? Yes _____ No _____

If yes, are these arrangements paid in full? Yes _____ No _____

3. Do you have a burial plot? Yes _____ No _____

If yes, location: _____

Is deed available? Yes _____ No _____

If this application is accepted, I agree that for and in consideration of admission, I shall conform to all the rules and regulations as set forth by the Trustees of the Eastern Star Hall and Home.

Applicant's Signature: _____ **Date:** _____

Signature/Title of Person Completing Application (if other than applicant):

_____ **Date:** _____