Pounder Hall, Inc.

1400 Utica Street
Oriskany, New York 13424
Phone: (315) 736-1759 Fax: (315) 768-4751

Application for Admission
Independent Living

(Please complete entire application.)

Name: _____ **Date:** _____

Present Address: _____
Street

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

Telephone: _____

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

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

Medicaid No.: _____ **Parents:** _____

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

Education: _____ **Past Occupation:** _____

Language Spoken: _____ **Religion:** _____

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: _____ **Relationship:** _____

Address: _____ **Telephone:** _____
Street

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

Name: _____ **Relationship:** _____

Address: _____ **Telephone:** _____
Street

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

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INSURANCE

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

Name of Company: _____
Address: _____
Identification #: _____
Claim #: _____
Group #: _____

Coverage:	**Hospital**	☐	**Yes**	☐	**No**
	Outpatient Services	☐	**Yes**	☐	**No**
	Physician Services	☐	**Yes**	☐	**No**
	Clinical Lab Services	☐	**Yes**	☐	**No**
	Dental Services	☐	**Yes**	☐	**No**

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: $_____

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.)**

   _____

   _____

6. **List any Disabilities:** _____

   _____

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

8. **Special Diets:** _____

9. **Medications/Dosage/Time Intervals:** _____

   _____

   _____

   _____

   _____

   _____

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

ADVANCED DIRECTIVES

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**

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MISCELLANEOUS

1. **Type of Accommodations Desired:** ☐ **One Room** ☐ **Two Rooms**

2. **List any Special Needs:** _____

_____

_____

_____

3. **List Electrical Equipment you plan on bringing with you:**

_____

_____

_____

_____

4. **Additional Comments:** _____

_____

_____

5. **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.)**

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

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

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

_____ **Date:** _____