Application for The Terrace at Newark

208 Route 88 South
Newark, New York 14513

LEVEL OF CARE IN WHICH APPLICANT IS APPLYING FOR:

(please check one)

Adult Care_____ ALP_____ Memory Care Neighborhood_____

Name of applicant_____
Last First Middle Initial

Address: _____

Phone_____ County_____ Sex_____ Marital Status _____

Date of Birth_____ Age_____ Religion_____ SS#_____

Medicare Number_____ (A)_____ (B)_____ Medicaid Number _____

Long Term Care Insurance: Name_____ Policy #_____

Veteran _____yes _____no Funeral Arrangements _____

Other Insurance Coverage *(please specify company and policy numbers):*

1) _____

2) _____

Hospital of Choice _____

Primary Physician _____

Address _____

Phone Number_____ Fax Number _____

Primary Contact Person/Person to Contact in Case of Emergency

Name _____

Address _____

Relationship_____ Power of Attorney _____Yes _____ No

Health Care Proxy _____Yes _____ No

Phone: Home _____ Cell _____ Work _____

Secondary Contact Person(s)

Name _____

Address _____

Relationship_____ Power of Attorney _____Yes _____ No

Health Care Proxy _____Yes _____ No

Phone: Home _____ Cell _____ Work _____

CONFIDENTIAL FINANCIAL DISCLOSURE

Monthly Income: **Total Income**

Social Security _____

Supplemental Social Security _____

Interest Income _____

Dividend Income _____

Pension _____

Annuity _____

Support from relatives _____

Banking Assets: **Total Value**

Savings Accounts (bank names):

_____ _____

_____ _____

Checking Accounts (bank names):

_____ _____

_____ _____

Investments:

Certificates of Deposit (bank names):

_____ _____

_____ _____

Stocks/Bonds (name and number of shares):

_____ _____

_____ _____

Mutual Funds:

_____ _____

_____ _____

Life Insurance:

Paid Up Life Insurance Policies:

_____ _____

Revocable_____ Irrevocable_____

Real Estate:

Property Address:

_____ _____

_____ _____

Other Assets: **Total Value:**

_____ _____

_____ _____

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 Date Signature of Responsible Party Date

MEDICAL CONDITION

Applicant's Diagnosis: _____

_____

_____

Does the applicant smoke? _____Yes _____No; if yes, how much:_____

If Diabetic, can the applicant self-inject? _____Yes _____No

Does the applicant require the following:

Oxygen _____ Catheter _____ Prostheses _____ Ileostomy _____ Colostomy _____

Please check yes or no for the following questions:

Incontinent: _____ yes _____ no

(bowel_____ bladder_____ or both_____)

Walks unassisted: _____ yes _____ no

Uses walker: _____ yes _____ no

Uses cane: _____ yes _____ no

Uses wheelchair: _____ yes _____ no

Dentures: _____ yes _____ no

Glasses: _____ yes _____ no

Does the applicant require assistance with any of the following needs?

Eating: _____ yes _____ no

Dressing: _____ yes _____ no

Bathing: _____ yes _____ no

Special Diet: _____ yes _____ no

(if yes, please specify diet: _____)

_____

Has the applicant exhibited the following behavior:

Memory Loss: _____ yes _____ no

Confusion: _____ yes _____ no

Verbal Disruption: _____ yes _____ no

Physical Disruption: _____ yes _____ no

Hallucination: _____ yes _____ no

Delusions: _____ yes _____ no

Depression: _____ yes _____ no

MEDICATIONS

(please list the applicant's medications)

_____

_____

_____

_____

_____

_____

PERSONAL/SOCIAL INFORMATION

Please complete the following:

Hobbies: _____

_____

_____

Significant Lifetime Events/Contributions: _____

_____

_____

Present Interests: _____

_____

_____

Food Likes: _____

_____

Food Dislikes: _____

_____

Additional Comments or Information (optional):

_____

_____

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Acknowledgement Statement:

I acknowledge that the above information furnished on this application is true and as accurate to the best of my knowledge.

Applicant Signature_____ Date _____

Responsible Party_____ Date _____