PAZ HEALTHCARE MANAGEMENT, INC.

Assisted Living Facilities

1 Main Street
Highland, New York NY 12528
Telephone: (845) 691-9692 (x14)
Fax: (845) 691-8460

APPLICATION FOR ADMISSION

In compliance with federal and New York State laws, this facility does not discriminate based upon race, age, creed, color, national origin, sex, sexual preference, disability, handicap, marital status, sponsorship, or source of payment in the admission, retention or care of any individual.

GENERAL INFORMATION

Applicant's Name____
SS#__________________________

Most recent
address____

Telephone________________________

Medicaid #_______________________ Medicare #________________________

Age ___________ Date of Birth ______________ Place of Birth
____

Marital Status __________________ Date married ________________ Religion
____

If widowed, name and date of death of spouse

____

Parents' names _____________________________________ Mother's maiden name
____

Referred by: Self __________________ Doctor__________________ Social Worker
__________________ Source Name
Name
RN __________________ Other (please specify)________________________
Name
Applicant is now at (circle one)

Home Hospital Nursing Home Adult Home Other
____

If currently in hospital or other facility, please specify the following:

Hospital/Facility Name ____ Date of admission______________

Address ____Telephone ______________________

Name of discharge planner ____

APPOINTED GUARDIAN OR POWER OF ATTORNEY (IF APPLICABLE)

Name ______________________________ Address ____

Relationship _________________ Home Telephone _________________ Work Telephone _______________

NEXT OF KIN

Name ______________________________________

Address____________________________________

Telephone______________Relationship__________

Name ______________________________________

Address____________________________________

Telephone______________Relationship__________

Name ______________________________________

Address____________________________________

Telephone ______________Relationship__________

Name ______________________________________

Address____________________________________

Telephone ______________Relationship__________

PERSONAL HISTORY

A. Education____

B. Last significant employment____

C. Hobbies____

____

D. Past and present club affiliations____

____

E. Language(s) spoken

____

MEDICAL HISTORY

A. Current medical conditions and limitations (please indicate length of each condition)_______________

____

____

B. Name, address and telephone of primary physician______________________________

____

C. Name, address and telephone of other specialist(s) seen on a regular basis_________________

____

D. Date of last hospitalization ____________ Length of stay ____________

Cause of admission____

E. Known food and medical allergies______________________________________

____

F. Use of medical devises, such as a walker, wheelchair, cane, ears, eyeglasses, dental, etc. __________

____

G. Known immunizations and vaccinations: (i.e. PPD, flu vaccination, etc.)_________________

____

H. Current medications: (If more space is required, please attach a separate sheet.)

Name ____ Dose___________________ Frequency ____________

Name ____ Dose___________________ Frequency ____________

Name ____ Dose___________________ Frequency ____________

Name ____ Dose___________________ Frequency ____________

FINANCIAL INFORMATION (Optional)

Since funding from governmental sources may be available to cover some of the fees for our services, the information below will be helpful in advising you of your eligibility.

A. APPLICANT'S MONTHLY INCOME (Please circle)

Income under $937/month Or Income over $937/month

B. APPLICANT'S PERSONAL EQUITY (total value of cash on hand and in the bank, net value of personally owned property, car, investments and life insurance cash value)

Please circle:

0	to	$2,500
$2,501	to	$5,000
$5,001	to	$10,000
$10,000 or more		

C. BURIAL ACCOUNT

Is money set aside for burial purposes? Yes No

If yes, specify amount $_____________________

D. LONG TERM HEALTH INSURANCE

Do you have long term health insurance Yes No

If yes, please specify company name and daily agreed allowance
____
____

_______________________________________ _________________ __________________________

Name of person completing this application Relationship Telephone (Day and Evening)

____

Date