

ST. JOHNSVILLE NURSING HOME
7 TIMMERMAN AVENUE
ST. JOHNSVILLE, NEW YORK 13452

APPLICATION FOR ADMISSION

APPLICANT'S NAME _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

DOB _____ MARITAL STATUS _____ NAME OF SPOUSE _____

RELIGIOUS PREFERENCE _____ PREVIOUS OCCUPATION _____

APPLICANT IS AT _____ (HOME) _____ (HOSPITAL) _____ NURSING HOME _____

APPLICANT'S DIAGNOSIS _____

DOES THE APPLICANT HAVE ANY OF THE FOLLOWING ADVANCE DIRECTIVES?

_____ DNR _____ HEALTH CARE PROXY _____ LIVING WILL _____

HAS ANYONE BEEN APPOINTED POWER OF ATTORNEY OR GUARDIAN _____

IF SO, WHO? _____

INDIVIDUAL RESPONSIBLE FOR PAYING BILL:

NAME _____ RELATIONSHIP _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE (HOME) _____ BUSINESS _____

IS APPLICANT OR SPOUSE A VETERAN? _____ YES _____ NO

RELATIVES OR SIGNIFICANT OTHERS:

NAME _____ RELATIONSHIP _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE (HOME) _____ BUSINESS _____

FINANCIAL INFORMATION:

SOCIAL SECURITY NUMBER _____ MEDICARE # _____

MEDICAID # _____ COUNTY _____ PRIVATE INS. _____

MONTHLY INCOME:

TYPE _____ AMOUNT \$ _____

IS PROPERTY OWNED JOINTLY OR INDIVIDUALLY? (CIRCLE ONE)

NAME OF CO-OWNER (IF APPLICABLE) _____

CASH ASSETS IN BANKS, CREDIT UNIONS, SAVINGS OR OTHER:

INSTITUTION NAME _____ LOCATION _____ BA _____

BALANCE IN ACCOUNT \$ _____ NAME ON ACCOUNT _____

INSTITUTION NAME _____ LOCATION _____ BA _____

BALANCE IN ACCOUNT \$ _____ NAME ON ACCOUNT _____

OTHER ASSETS/INVESTMENTS (STOCKS, BONDS, IRA'S) _____

HAS THE APPLICANT APPLIED, OR WILL THE APPLICANT SHORTLY BE
APPLYING FOR MEDICAL ASSISTANCE? _____ YES _____ NO

DATE OF APPLICATION _____ COUNTY _____

I hereby certify that to the best of my knowledge and belief, the above stated information is true, correct and complete. I understand that if any information has been falsely represented, this will be sufficient cause for voiding my application for admission. All of the information will be kept confidential by the nursing home.

SIGNATURE OF APPLICANT _____ DATE _____

SIGNATURE OF SPONSOR _____ DATE _____

It is the policy of St. Johnsville Nursing Home that no person shall be denied admission based on race, creed, color, age, sex, national origin, sponsor, handicap, marital status, or sexual preference.