Hultquist Place Assisted Living

Application for Admission

715 Falconer St.
Jamestown, NY 14701
Phone Number: (716) 720-9610
Fax: (716) 720-9609

LUTHERAN
Life well lived. Everyday.

Tour Date: _____
Assessment Date: _____

APPLICATION FOR ADMISSION

GENERAL INFORMATION

How did you hear about our facility? _____

Name _____Social Security #: _____
Most Recent Address: _____
_____Telephone Number: _____
Medicare # _____Part A ☐ Part B ☐ Medicaid #_____
Medicare Part D Plan Name and #_____ _____
Secondary Insurance: _____
Long Term Care Insurance:_____
Age: _____Birth Date: ___/____/_____ Place of Birth: _____
Marital Status: _____Church Affiliation _____ Pastor _____

SOCIAL HISTORY

Where and with whom had the individual been living? For how long?_____
_____
_____
Veteran: YES ☐ NO ☐ Service Branch:_____ Years Served:_____
Where had the individual lived most of adult life? _____
_____
Former Occupation? _____
If foreign born, age and circumstances under which came to U.S. _____
_____
Languages spoken and understood _____
Of Children: _____
List children's names: _____
_____
Funeral Home Arrangements:_____

PERSON REPRESENTING APPLICANT

Name: _____ Relationship: _____
Address: _____
Telephone #: _____Business #: _____

NAME OF APPOINTED GUARDIAN OR POWER OF ATTORNEY

Name: _____ Relationship: _____
Address: _____
Telephone #: _____ Business #: _____

Name: _____ Relationship: _____
Address: _____
Telephone #: _____ Business #: _____

NAME OF PERSON HANDLING FINANCIAL AFFAIRS

Name: _____ Relationship: _____
Address: _____
Telephone #: _____ Business #: _____

NAME OF HEALTH CARE PROXY (S)

Name: _____ Relationship: _____
Address: _____
Telephone #: _____ Business #: _____

Name: _____ Relationship: _____
Address: _____
Telephone #: _____ Business #: _____

OTHER CONTACTS

Name: _____ Relationship: _____
Address: _____
Telephone # _____ Business #: _____

Does it appear that the individual has been provided with sufficient information to make an informed choice about the Assisted Living Program and chooses to participate? ☐ YES ☐ NO

What are your expectations with regard to how long the individual will remain at this facility?

_____

_____

In the event of discharge, what plans can be considered for other living arrangements or transfer to another type of care? _____

_____

MEDICAL INFORMATION

Physician Name: _____
Address: _____
Telephone Number: _____ Date of Last Office Visit: _____

Please check if you have had:

☐ Tuberculin skin test Date: _____ ☐ Tetanus Toxoid Date: _____
☐ Pneumovax Date: _____ ☐ Flu Vaccine Date: _____

Hospital of Choice: _____

Date of last hospitalization / cause for admission:_____ _____

_____

Has the individual had psychiatric treatment or hospitalization? ☐ YES ☐ NO
Please give details: _____

_____

Has the individual had any accidents or falls? ☐ YES ☐ NO
Please give details: _____

COPIES OF THE FOLLOWING MUST BE ATTACHED:

____ Social Security Card ____ Insurance Card ____ Health Care Proxy
____ Medicare Card ____ Epic Card ____ Living Will
____ Medicare Part D ____ Medicaid card ____ Power of Attorney

MEDICATIONS

Any allergy to medications, food, etc.? ☐ YES ☐ NO

Please give details: _____

List current medications:

_____

_____

_____

_____

_____

Can the individual self–administer medications? ☐ YES ☐ NO

PERSONAL CARE NEEDS

(Please indicate level of assistance):

Grooming	☐ minimal	☐ moderate	☐ maximum
Dressing	☐ minimal	☐ moderate	☐ maximum
Bathing	☐ minimum	☐ moderate	☐ maximum
Eating	☐ minimum	☐ moderate	☐ maximum
Transferring	☐ minimum	☐ moderate	☐ maximum
Walking	☐ minimum	☐ moderate	☐ maximum
Toileting	☐ minimum	☐ moderate	☐ maximum
	☐ continent	☐ incontinent	☐ able to self manage

Please indicate the individual's diet_____

The individual's eyesight is: ☐ Good ☐ Fair ☐ Poor

Does the individual have? ☐ Cataract ☐ Glaucoma

Does the individual wear glasses? ☐ YES ☐ NO Date of Last Exam: _____

Does the individual have dentures? ☐ YES ☐ NO Date of Last Exam: _____

Does the individual wear hearing aids? ☐ YES ☐ NO Date of Last Exam: _____

Does the individual use: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Commode
☐ Transfer rail ☐ Hospital bed ☐ Other: _____

Does the individual smoke? ☐ YES ☐ NO Amount per day:_____

Does the individual use alcohol? ☐ YES ☐ NO Amount per day:_____

FINANCIAL INFORMATION

Medicaid Application Pending: ☐ YES ☐ NO If Yes, date submitted:_____

Income	**Monthly Amount**
Social Security Check	$ _____
Retirement Pension	$ _____
Veteran's Pension	$ _____
Railroad Pension	$ _____
Annuities	$ _____
Other Income	$ _____
TOTAL MONTHLY INCOME	$ _____

Cash Assets

Checking Account:

Bank _____

Balance _____ Joint Account: ☐ YES ☐ NO

Savings Account (s)

1. Bank _____

   Balance _____ Joint Account: ☐ YES ☐ NO

2. Bank _____

   Balance _____ Joint Account: ☐ YES ☐ NO

Real Estate Assets

Does the individual own a home? ☐ YES ☐ NO Estimated Value $ _____

Joint Ownership? ☐ YES ☐ NO

Certificates of Deposit ☐ YES ☐ NO

Bank / Financial Institution _____

Securities

Does the individual have stocks and bonds? ☐ YES ☐ NO

Approximate value of all securities: $_____

Life Insurance / Cash Value

Does the individual have life insurance policies with cash value? ☐ YES ☐ NO

Approximate amount of cash value: $_____

Car ☐ YES ☐ NO

Make _____ Model Year _____ Mileage _____

Burial Fund ☐ YES ☐ NO

___ Irrevocable ___ Revocable

BANK STATEMENTS MUST BE ATTACHED FOR VERIFICATION OF THE ABOVE ASSETS

Have any assets been transferred in the last 60 months? ☐ YES ☐ NO
If yes, please describe: _____

_____

_____

Has an Estate Trust been established? ☐ YES ☐ NO
If yes, please provide copy.

In your estimation, the individual will be private pay for what length of time?

_____
_____
_____
_____
_____
_____

AUTHORIZATION

Everything stated in this application is true and correct to the best of my knowledge. I also understand that Hultquist Place considers this application as a continuing statement of financial condition and I agree to notify the facility in writing of any substantial change in the above financial condition. All of this information will be kept strictly confidential.

Signature of Applicant_____ **Date**_____

Signature of Representative _____ **Date** _____

Hultquist Place does not make admission or retention decisions based on race, color, creed, sex, sexual preference, national origin, sponsor, or disability