



Manor Hills, Inc.

Assisted Living Residence with SNALR

4192B Bolivar Road
Wellsville, NY 14895

(585) 593-9800
Fax: (585) 593-4605

APPLICATION FOR ADMISSION
ALL INFORMATION WILL BE KEPT CONFIDENTIAL
PLEASE COMPLETE ADDRESSES AND PHONE NUMBERS

1. _____ AGE _____ SEX _____
LAST NAME FIRST MIDDLE INT.
PHONE NUMBER _____
2. PRESENT ADDRESS _____
COUNTY OF RESIDENT _____
3. PREVIOUS HOME ADDRESS _____
4. DATE OF BIRTH _____ PLACE OF BIRTH _____
5. SOCIAL SECURITY NUMBER ____ - ____ - ____ MEDICARE # _____
6. HEALTH CARE INS. TYPE _____
POLICY # _____ GROUP # _____
ADDRESS _____ PHONE # _____
7. RECEIVING SSI ___ YES ___ NO MEDICAID # _____ SEQ# _____
8. NAME OF PHYSICIAN _____ PHONE# _____
ADDRESS _____
9. EYE DOCTOR _____ PHONE # _____

ADDRESS _____

DENTIST _____ PHONE # _____

ADDRESS _____

PODIATRIST _____ PHONE # _____

ADDRESS _____

FAMILY INFORMATION

10. CURRENT MARITAL STATUS M ___ S ___ W ___ D ___

11. SPOUSES NAME EVEN IF DECEASED _____

12. EMERGENCY CONTACT _____

ADDRESS _____ RELATIONSHIP _____

PHONE # _____

13. CHILDREN AND OTHER RELATIVES OR FRIENDS:

NAME _____ RELATIONSHIP _____ PHONE# _____

NAME _____ RELATIONSHIP _____ PHONE# _____

NAME _____ RELATIONSHIP _____ PHONE # _____

14. WHO WOULD BE ASSISTING RESIDENT WITH BRING PERSONAL ITEMS?
.

15. WERE YOU IN THE ARMED SERVICES? ___ YES ___ NO

DATES OF SERVICE _____ TO _____ BRANCH _____

16. EDUCATION _____
GRADE SCHOOL HIGH SCHOOL OTHER

17. PREVIOUS OCCUPATION _____ RELIGION _____

18. SKILLS, INTERESTS, HOBBIES, MEMBERSHIPS, AND/OR ORGANIZATIONS

19. ALLERGIES: _____

DNR ___Y___N HCP ___Y___N DATE OF LAST FLU SHOT? _____

DATE OF LAST PNEUMOVAX? _____

20. HAS THE APPLICANT EVER BEEN TREATED FOR A NERVOUS,
EMOTIONAL, OR PSYCHIATRIC CONDITION? ___Y___N DATE _____

NAME OF DOCTOR _____ HOSPITAL _____

21. HAS APPLICANT EVER BEEN A RESIDENT IN AN ADULT CARE FACILITY
OR ANOTHER HOME FOR THE AGED? _____ YES _____ NO

22. IS APPLICANT A REGISTERED EYE / BODY DONOR ___Y___ YES _____ NO

AGENCY NAME _____ PHONE # _____

ADDRESS _____

SPECIAL INSTRUCTIONS _____

23. BURIAL ARRANGEMENTS (PLEASE CHOOSE A FUNERAL HOME)

NAME _____ PHONE # _____

ADDRESS _____

CITY

STATE

ZIP CODE

OTHER PERSONAL INFORMATION: _____

24. DO YOU HAVE A POWER OF ATTORNEY? _____ YES _____ NO

NAME _____ ADDRESS _____

PHONE# _____ (PLEASE PROVIDE COPY OF DOCUMENT)

25. IF OTHER THEN APPLICANT, WHO WOULD BE RESPONSIBLE TO PAY

THE BILLS? NAME _____ PHONE# _____

ADDRESS _____

STREET CITY STATE ZIP

26. SOCIAL SECURITY _____ SSI _____

STOCKS AND BONDS _____ SOURCE _____

CD'S _____ ANNUITIES _____

PENSION _____ DIVIDENDS / INTEREST _____

ASSETS TO HELP US DETERMINE ELIGIBILITY FOR FINANCIAL NEED
BASED ON PROGRAMS AND PAYMENT SOURCES.

27. REAL ESTATE DESCRIPTION _____

ESTIMATED VALUE _____

(IF MORE THEN ONE PLEASE ATTACH LIST)

LIFE INSURANCE _____

COMPANY. NAME POLICY #

ADDRESS _____

STREET CITY STATE ZIP

SECURITIES: STOCKS AND BONDS (ATTACH LIST OF PORTFOLIO) IF
MORE THEN ONE PLEASE ATTACH LIST.

28. BANK ACCOUNT: PLEASE LIST ALL OR ATTACH A LIST.

A. NAME OF BANK _____ ACCOUNT: _____

