

MANOR HILLS ARCF
4192-B BOLIVAR RD
WELLSVILLE, NY 14895

PHONE# 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 ____ 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: _____

BANK ADDRESS _____ AMOUNT _____

B. NAME OF BANK _____ ACCOUNT _____

BANK ADDRESS _____ AMOUNT _____

C. NAME OF BANK _____ ACCOUNT _____

BANK ADDRESS _____ AMOUNT _____

IT IS THE PURPOSE OF MANOR HILLS TO PROVIDE A COMPLETE CARE PROGRAM FOR
ALL THOSE ADMITTED FOR CARE IN COMPLIANCE WITH THE NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES, TITLE 18.

MANOR HILLS COMLIES WITH NEW YORK STATE AND FEDERAL LAWS PROHIBITING
DISCRMINATION IN ANY FORM ON THE BASIS OF RACE, CREED, COLOR, NATIONAL
ORGIN, SEX, BLINDNESS, SOURCE OF PAYMENT OR HANDICAP.

SIGNATURE OF APPLICANT DATE

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