



Hultquist Place

Assisted Living Program

***715 Falconer St.
Jamestown, NY 14701***

***(716) 665-8166
Fax (716) 665-7795***

Application for Admission



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: _____

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? _____

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: _____

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: _____



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	<input type="checkbox"/> minimal	<input type="checkbox"/> moderate	<input type="checkbox"/> maximum
Dressing	<input type="checkbox"/> minimal	<input type="checkbox"/> moderate	<input type="checkbox"/> maximum
Bathing	<input type="checkbox"/> minimum	<input type="checkbox"/> moderate	<input type="checkbox"/> maximum
Eating	<input type="checkbox"/> minimum	<input type="checkbox"/> moderate	<input type="checkbox"/> maximum
Transferring	<input type="checkbox"/> minimum	<input type="checkbox"/> moderate	<input type="checkbox"/> maximum
Walking	<input type="checkbox"/> minimum	<input type="checkbox"/> moderate	<input type="checkbox"/> maximum
Toileting	<input type="checkbox"/> minimum	<input type="checkbox"/> moderate	<input type="checkbox"/> maximum
	<input type="checkbox"/> continent	<input type="checkbox"/> incontinent	<input type="checkbox"/> 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	\$ _____
<u>TOTAL MONTHLY INCOME</u>	\$ _____

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: \$ _____

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** _____