

THE FRIENDLY HOME APPLICATION

Name: _____ Social Security Number: _____

Address: _____

Telephone #: _____ County of Residence: _____

DOB: _____ Marital Status: M W D S Sex: M F

Religion: _____ Place of Worship: _____

U. S. Citizen: Y N If naturalized citizen, date: _____

Occupation: _____ Employer: _____

Are you currently working: Y N Is your spouse currently working? Y N

Are you a veteran: Y N Is your spouse a veteran? Y N

Current location of Applicant: _____

If applicant is currently hospitalized or has been hospitalized within the past 30 days, please complete the following:

Name of Hospital: _____ Dates of Stay: _____

Reason for Hospitalization: _____

Has the applicant had a previous nursing facility stay? Y N

If yes, please give the name of the facility and dates of stay: _____

Please list names of Physicians including specialists and dentist (use separate sheet, if necessary)

Name	Specialty	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have Advanced Directives been established (MOLST, Living Will, DNR, Health Care Proxy)?

Please list: _____

Please provide a copy of the Advanced Directives at the time of admission.

*Name of Funeral Home: _____ Telephone Number: _____

**Long Term Care applicants only*

Insurance Coverage for Applicant: Please provide a copy of all cards (both sides)

Medicare: _____ Part A: Y N Part B: Y N
Excellus: _____ MVP Gold: _____
Medicaid: _____ County: _____
Case Worker Name: _____ Telephone Number: _____
Other Insurance: _____
Medicare D Plan (prescription plan): _____
Long Term Care Insurance: _____

Primary Contacts: Please list in order to be contacted (Use a separate sheet, if necessary)

Name: _____ Relationship: _____
Address: _____
Home phone: _____ Cell phone: _____ Work phone: _____
Email address: _____
Name: _____ Relationship: _____
Address: _____
Home phone: _____ Cell phone: _____ Work phone: _____
Email address: _____

Financial Representative: (manages financial obligations for applicant)

Name of Power of Attorney/Guarantor: _____
Relationship: _____
Address: _____
Home phone: _____ Cell phone: _____ Work phone: _____
Email address: _____

Do you have a current Power of Attorney for Applicant? Y N *(Please provide a copy)*

Is a Trust Fund involved? Y N *(Please provide a copy)*

Has a conservator/guardian been appointed? Y N *(Please provide a copy)*

Has there been a transfer of funds/assets including but not limited to real estate in the past 60 months? Y N If yes, please explain: _____

Have you consulted with an attorney or financial advisor regarding payment for nursing home care? If yes, please provide name and telephone number: _____

Financial Information – If married, please include financial information for spouse

Monthly	Applicant	Spouse
Salary	_____	_____
Social Security	_____	_____
Retirement Pension	_____	_____
Veteran's Benefits	_____	_____
Interest/Dividends	_____	_____
Other	_____	_____
Total Monthly Income	\$ _____	\$ _____

Assets		Amount
Does the Applicant own a home?	Y N	_____
Life Insurance (cash value)	Y N	_____
Checking Account	Y N	_____
Name of Bank:	_____	
Savings Account	Y N	_____
Name of Bank:	_____	

	Amount
Other financial assets such as stocks, bonds, CDs, annuities, etc	
_____	_____
_____	_____
_____	_____
_____	_____

Total Assets: \$ _____

Liabilities (example: mortgage, credit cards, loans)	Amount
_____	_____
_____	_____
_____	_____
_____	_____

Total Liabilities: \$ _____

Please provide additional financial information that may be pertinent to this application:

Additional information/comments, which may be helpful in processing this application: _____

Why did you choose The Friendly Home? _____

I, _____, certify that this information is accurate and true to the best of my knowledge.

Signature of Applicant

Date

(OR)

Signature of Responsible Party

Date

Relationship

Please note that New York State requires a Patient Review Instrument (PRI) and Screen to accompany the application.

The Friendly Home respects the rights of all people and applications are considered without regard to race, creed, color, age, gender, marital status, disability, sexual orientation, national origin, or sponsor. The Friendly Home is also a smoke-free facility and campus.

CONSENT FOR RELEASE OF INFORMATION TO THE FRIENDLY HOME

NAME: _____

DOB: _____

I hereby give permission to release confidential medical information from any physicians, dentists, social workers, psychologists, nurses, technicians, clinics, hospitals and psychiatric facilities where I have been a patient.

Signature of Applicant

Date

(OR)

Signature of Responsible Party

Date

Relationship to Applicant