



Ontario County Health Facility

3062 COUNTY COMPLEX DRIVE
CANANDAIGUA, NEW YORK 14424-9502

TELEPHONE (585) 396-4340
FACSIMILE (585) 396-4838

E-MAIL ADDRESS: healthfacilityadm@co.ontario.ny.us

APPLICATION FOR ADMISSION

Return this application and a completed Patient Review Instrument (PRI) and Screen to the Social Work Department at the above address.

THE ONTARIO COUNTY HEALTH FACILITY WILL NOT DENY ADMISSION TO ANYONE BECAUSE OF RACE, CREED, COLOR, NATIONAL ORIGIN, AGE, SEX, DISABILITY, MARITAL STATUS, SEXUAL ORIENTATION OR SOURCE OF PAYMENT.

APPLICANT INFORMATION

Name: _____
Last First Middle

Street Address: _____

City: _____ State: _____ Zip: _____

County: _____ Telephone Number: (____) _____

Date of Birth: _____ Age: _____ Sex: ___ Male ___ Female

Social Security Number: _____

Religious Preference: _____ Church: _____

Marital Status: _____ U.S. Veteran: _____ U.S. Citizen: _____
Yes or No Yes or No

Spouse: _____ Date of Marriage: _____ Date of Death: _____

Father: _____ Mother: _____
Maiden name

Place of Birth: _____

Occupation: _____ Type of Business: _____

Retired from: _____ Date: _____

MEDICAL INFORMATION

Physician Name: _____

Physician Address: _____

Physician Telephone Number: (_____) _____ Fax Number: (_____) _____

Dentist Name: _____

Dentist Address: _____

Dentist Telephone Number: (_____) _____ Fax Number: (_____) _____

INSURANCE COVERAGE

(PLEASE PROVIDE COPIES OF MEDICAID AND MEDICARE CARDS)

Medicare #: _____ Part A: _____ Part B: _____
Effective Date Effective Date

Medicaid #: _____ Date Applied: _____ County: _____

Effective Date: _____

OTHER HEALTH CARE INSURANCE (Include health, hospitalization, long term health)

(PLEASE PROVIDE COPIES OF INSURANCE CARDS)

- Company: _____ Telephone Number: (_____) _____

Address: _____

Subscriber Number: _____

- Company: _____ Telephone Number: (_____) _____

Address: _____

Subscriber Number: _____

- Company: _____ Telephone Number: (_____) _____

Address: _____

Subscriber Number: _____

PRESCRIPTION COVERAGE

(PLEASE PROVIDE COPY OF PRESCRIPTION DRUG CARD)

- Company: _____ Telephone Number: (_____) _____

Address: _____

Subscriber Number: _____

CONTACT PERSONS

- Primary person to contact regarding Admission: _____

Address: _____

City: _____ State: _____ Zip: _____ Relationship: _____

Telephone Numbers: Home: (_____) _____

Work: (_____) _____

Cell: (_____) _____

- Secondary Person to Contact Regarding Admission (if primary is not available):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Relationship: _____

Telephone Numbers: Home: _____

Work: _____

Cell: _____

Power of Attorney: _____ Type: _____

Address: _____

City: _____ State: _____ Zip: _____ Relationship: _____

Telephone Numbers: Home: (_____) _____

Work: (_____) _____

Cell: (_____) _____

Conservator/Guardian: _____ Yes _____ No Name: _____

Telephone Numbers: Home: (_____) _____

Work: (_____) _____

Cell: (_____) _____

Health Care Proxy: _____ Yes _____ No Health Care Agent: _____

Do Not Resuscitate Documentation Completed: _____ Yes _____ No

Other Advanced Directives: _____

(PLEASE ATTACH COPIES OF POWER OF ATTORNEY, GUARDIANSHIP COURT ORDER, CONSERVATORSHIP OR COMMITTEE COURT ORDER, HEALTH CARE PROXY, DNR DOCUMENTS)

Relatives Names:

- Name: _____ Relationship: _____

Address: _____

Telephone Numbers: _____

- Name: _____ Relationship: _____

Address: _____

Telephone Numbers: _____

- Name: _____ Relationship: _____

Address: _____

Telephone Numbers: _____

- Name: _____ Relationship: _____

Address: _____

Telephone Numbers: _____

Other Person(s) to Notify:

- Name: _____ Relationship: _____

Address: _____

Telephone Numbers: _____

- Name: _____ Relationship: _____

Address: _____

Telephone Numbers: _____

- Name: _____ Relationship: _____

Address: _____

Telephone Numbers: _____

Legal Counsel:

Attorney Name: _____

Address: _____

Telephone Numbers: Work: (_____) _____ Cell: (_____) _____

MISCELLANEOUS DOCUMENTS

Living Will? ___ Yes ___ No

Existing DNR Order? ___ Yes ___ No

Does resident have a Will? ___ Yes ___ No

Location of Will: _____

Executor of Will: _____

Address of Executor: _____

Telephone Number of Executor: (_____) _____

***NOTE: PLEASE PROVIDE COPIES OF ANY DOCUMENTS RELATED TO THE ABOVE.**

BURIAL INSTRUCTIONS/ORGAN DONATION

Mortuary (This must be on file with at least a preference if arrangements have not been made.)

Name: _____

Address: _____

Telephone Number: (_____) _____

Arrangements Made? ___ Yes ___ No

Burial Plot, Cemetary: _____

Have you donated your organs? ___ Yes ___ No Where? _____

Which organs? _____

Who has donation card? _____

(PLEASE BRING YOUR CARD WITH YOU FOR US TO COPY)

FINANCIAL INFORMATION

Person Handling Applicant's Funds:

Name: _____ Telephone Number: (_____) _____

Address: _____

Relationship: _____

MONTHLY INCOME (If married, record joint assets)

	Applicant	Spouse
Social Security_____	\$_____	\$_____
Supplemental Security Income_____	\$_____	\$_____
Pension/Retirement_____	\$_____	\$_____
Interest Annuity Income_____	\$_____	\$_____
Other_____	\$_____	\$_____
Total Monthly Income	\$_____	\$_____

MONTHLY EXPENSES

Health Insurance Premiums_____	\$_____	\$_____
Mortgage _____	\$_____	\$_____
Other_____	\$_____	\$_____
Total Monthly Expense	\$_____	\$_____

ASSETS (Attach additional sheet, if necessary. If married, record joint assets)

SAVINGS/CHECKING ACCOUNTS (Include Bank Name, Address, City, State, Zip Code)

-Bank Name: _____

Address: _____

Name(s) on Account: _____

Account Number:_____ Current Value: \$_____

-Bank Name: _____

Address: _____

Name(s) on Account: _____

Account Number:_____ Current Value: \$_____

-Bank Name: _____

Address: _____

Name(s) on Account: _____

Account Number:_____ Current Value: \$_____

SAVINGS/CHECKING ACCOUNTS (continued)

-Bank Name: _____

Address: _____

Name(s) on Account: _____

Account Number: _____ Current Value: \$ _____

CERTIFICATES OF DEPOSIT

- Name: _____

Address: _____

Name(s) on Account: _____

Account Number: _____ Current Value: \$ _____

- Name: _____

Address: _____

Name(s) on Account: _____

Account Number: _____ Current Value: \$ _____

STOCKS/BONDS (Give number of shares owned, name of security, market value, and name and address of funds manager, if applicable)

- Name: _____

Address: _____

Name(s) on Account: _____

Account Number: _____ Current Value: \$ _____

- Name: _____

Address: _____

Name(s) on Account: _____

Account Number: _____ Current Value: \$ _____

- Name: _____

Address: _____

Name(s) on Account: _____

Account Number: _____ Current Value: \$ _____

LIFE INSURANCE POLICIES (Company, address, agent and nature of policy)

- Company: _____

Address: _____

Agent: _____ Nature of Policy: _____

- Company: _____

Address: _____

Agent: _____ Nature of Policy: _____

- Company: _____

Address: _____

Agent: _____ Nature of Policy: _____

REAL PROPERTY (Location, Name(s) of Owner, Market Value)

- Location: _____

Name(s) of Owner: _____ Market Value: \$ _____

- Location: _____

Name(s) of Owner: _____ Market Value: \$ _____

- Location: _____

Name(s) of Owner: _____ Market Value: \$ _____

- Location: _____

Name(s) of Owner: _____ Market Value: \$ _____

MISCELLANEOUS RESOURCES (List type, location and value) (ex: automobile, IRAs, etc.)

- Type of Resource: _____

Location: _____ Value: \$ _____

- Type of Resource: _____

Location: _____ Value: \$ _____

- Type of Resource: _____

Location: _____ Value: \$ _____

Have you transferred any assets or created any trusts within the past 6 years? If so, provide details here.

SUMMARY OF HOME/FAMILY SITUATION

COMPREHENSIVE LIVING CONDITION SUMMARY: (Include Home, Family, Friends, Interests, Possibility of Returning Home, Possible Alternative Plans of Care, Reasons Care cannot be provided at home and other comments)

ORGANIZATIONS OR LODGE MEMBERSHIPS

OFFICE HELD OR HONORS

OTHER COMMENTS

The information provided above is true and accurate to the best of my knowledge.

Date

Signature of Applicant

Date

Signature of Referring Person

Relationship