ERIE COUNTY CARE FACILITY

PART I
APPLICATION FOR RESIDENCY

Applicants are reviewed in a manner that does not discriminate against person on the basis of race, color, religion, national origin, disability, or age.

for office use only:
Adm. Date:_____
Time: _____
Room #: _____

Name of Applicant: _____
First Middle Last (Maiden)
Address: _____Phone: _____

Sex: _____ Age: _____ D.O.B: _____ Race: _____ Marital Status: M S W D Separated

Prior Living Arrangements: _____

Applicant's length of Residence in Erie Co._____ Place of Residence outside Erie Co._____

Prior Hospital Stay (Within Last 30 days): _____
Hospital Date admitted Date discharged

Prior Nursing Home Stay: _____
Facility Location Date admitted Date discharged

Social Sec. #_____ Medicare #: _____ Medicaid #: _____

Other Health Insurance Names and No.: _____
_____

(Please provide all cards upon admission)

Responsible Emergency Contact: _____ Relationship: _____

Address: _____ Phone:(H)_____(W)_____

Second Emergency Contact: _____ Relationship: _____

Address: _____ Phone:(H)_____(W)_____

*Guarantor: _____ *Power of Attorney: _____ *Guardian: _____

*If different than Responsible Emergency contact please provide addresses and phone numbers:
_____
_____

Does applicant have a living will or a durable power of attorney for health care? _____

(Please provide copies of all legal documents, guardianship, POA, DPOAHC, Living Will)
Physician Preference: _____ Phone: _____

Hospital Preference: _____

Funeral Home/Location/Phone: _____

PART II - MEDICAL

Primary Diagnosis: _____
Secondary Diagnosis: _____
Medications: _____
Allergies: _____
Treatments: _____

Placement: (Long-Term or Short-Term)_____
Elimination: _____

_____ Continent (bowels/bladder)

_____ Incontinent

_____ Catheter (Foley/indwelling)

_____ Colostomy

Mobility: _____

_____ Ambulatory

_____ Non-ambulatory

_____ Walks with assistance

_____ Wheelchair

_____ Up in chair

_____ Bed rest

Mental Status: _____

_____Alert

_____Oriented (time, person, and place)

_____ Disoriented

_____ Confused

_____ Forgetful

_____ Wanderer

_____ Combative

_____ Depressed

_____ Non-responsive

Level of Assistance: _____

_____ Supervision

_____ Assistance

_____ Total Care

Dietary Needs: _____

_____ Feeds self

_____ Feeding assistance

_____ N/G Tube

_____ G Tube

Rehabilitative Potential: _____

_____ Physical Therapy

_____ Occupational Therapy

_____ Speech Therapy

_____ Psychological Counseling

Approximate Height: _____

Approximate Weight: _____

History of falls in past 30 days: _____ 30 - 180 days: _____

Recent fractures in last 6 months: _____

Is applicant a smoker? _____ If smoked in the past, how long since quitting? _____

PART III SOCIAL HISTORY

Name: _____ Prefers to be called: _____

Place of Birth: _____ Where raised/Lived most of life: _____

Language spoken: _____ Language understood: _____

Name of Father: _____ Mother (Maiden): _____

Name of spouse: _____ Is spouse living? _____

If spouse is living, give address: _____

Date of marriage: _____ Place of marriage: _____

Educational Background: _____

Occupational History: _____

Retirement Date: _____ Reaction to retirement: _____

Was applicant in military service? _____ Branch:_____ Dates:_____

Church/Synagogue: _____ Minister/Priest/Rabbi: _____

Siblings names, addresses, phone numbers, and status of relationships:

_____

_____

_____

Name, addresses and phone numbers of children, and status of relationship:

_____

_____

_____

_____

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_____

PART IV. FINANCIAL

What real estate is owned by either the applicant or spouse? _____

Location of property_____

Present value of property_____

Are there any liens, mortgages, etc. on said property? _____

Does either the applicant or spouse own any personal property? (Cash, bonds, stock, etc.)_____

Holding firm: _____

Has any real estate, personal property, cash, stock, bonds, etc. been transferred to any other person within the last five years?_____

What was transferred? _____

To whom? _____

Bank accounts held by either applicant or spouse: (Savings and Checking)

Name(s) of account owner(s)_____

Name of Bank _____ Account #_____ Balance_____

_____

Does applicant have any income from Social Security, SSI, pensions, or from any other source?

List all: Soc. Sec. Amt._____ Pensions: Company_____ Amount_____

SSI Amt._____ Pensions: Company_____ Amount_____

_____

Is there a burial fund set up for this applicant? _____ Amount of fund? _____

Name and address of funeral home_____

Is this fund in the name of applicant? _____

Is there a cemetery lot available? _____

Name/address of cemetery_____

Does applicant have life insurance? _____

Company_____ Policy #_____ Cash Value_____

Company_____ Policy #_____ Cash Value_____