IROQUOIS NURSING HOME
4600 Southwood Heights Drive
Jamesville, NY 13078
Phone (315) 469-1300 Fax (315-469-5545)

APPLICATION FOR ADMISSION

Please give ALL information requested on pages 1 and 2: **Date ___/___/___**

Name of Applicant____
Last First Middle

Is placement considered Short term _____ or Long term________ (check one)
Does Applicant have wandering _____ (yes or no) or aggressive behaviors____ (yes or no)?
-Please explain

Home Address _______________________________ Telephone No. ________________
Street

____
City State County Zip Code

Birth Date______________________ Age_________ Sex _______ Citizenship ___________________
Marital Status: ☐ Single ☐Married ☐Widowed ☐Separated ☐Divorced
Name of Spouse _________________________________ Spouse SS #_________________________
Present Location of Applicant (if other than home address) ____________________________________
Address____
Street City State Zip Code
Former Residence in a Nursing Home or Adult Care Facility?: ☐Yes ☐No If so where_____________________
Do Not Resuscitate Order: ☐ Yes ☐ No Organ Donation: ☐ Yes ☐ No

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Social Security No. _________________ Veteran: ☐Yes ☐ No Spouse Veteran: ☐ Yes ☐ No
Medicare No. _____________________ ☐ Part A ☐ Part B Effective Date _____________
Medicaid Case No. ________________ CIN No. __________ County ____________________
Effective Date ______________ Pending Application/Date Submitted _________________
Medical Insurance Name and No. ___________________ Insurance Prescription Card No. __________
Attending Physician ____
Address ____ Telephone No.___________
Street City State Zip Code

Funeral Home ____
Name Address Phone #
please supply copies of all insurance cards

<u>Responsible Party:</u>

Name Address and Zip Code Home Phone Work Phone Relationship
____
____

Responsible Party: E-Mail Address _________________________Cell Phone No. _________________

<u>Power of Attorney/Guardian)s)/Conservators</u>
(Attach copies of Power of Attorney, Guardianship and Conservator Court Orders)
Name____ Telephone No.___________
Address ____
Street City State Zip Code

Applicant's Monthly Income:

Salary ………………………………………………………………$___________________/month
Social Security ……………………………………………………………$___________________/month
Retirement Pension Name (Please Specify):___________________________$___________________/month
Veteran's Pension ……………………………………………………..$___________________/month
Railroad Pension ……………………………………………………$___________________/month
Supplementary Security Income……………………………………….$___________________/month
Other Monthly Income (Please Specify):___________________________$___________________/month
Long Term Care Insurance ____
Company Policy #

Applicant's Spouse's Monthly Income:

Salary ………………………………………………………………$___________________/month
Social Security ……………………………………………………………$___________________/month
Retirement Pension Name (Please Specify):___________________________$___________________/month
Veteran's Pension ……………………………………………………..$___________________/month
Railroad Pension ……………………………………………………$___________________/month
Supplementary Security Income……………………………………….$___________________/month
Other Monthly Income (Please Specify):___________________________$___________________/month
Long Term Care Insurance ____
Company Policy #

Assets of Applicant and Applicant's Spouse:

Name of Investment/Broker Accts ____________________________________ Present Value ___________
Address of Investment/Broker Accts ____
Checking Account: Bank_________________________Account No._____________ Amount ________
Bank_________________________Account No._____________ Amount________
Savings Account: Bank_________________________Account No._____________ Amount________
Bank_________________________Account No._____________ Amount________

Real Estate: ☐ Yes ☐ No
Name/Address of Trusts _______________________________________Date Trust Established _________
Beneficiaries ____Amount _____________________
Other Assets ____

Liabilities of Applicant and Applicant's Spouse:

Mortgage ………………………………………………………………….$_______________/month
Credit Card Institution(s)_________________________________Account No(s). ___________________
Other: Specify ____$_______________/month

BY SIGNING THIS APPLICATION, I AUTHORIZE THE FACILITY TO VERIFY WITH BANKS, EMPLOYERS, VETERAN'S ADMINISTRATION, SOCIAL SECURITY, MEDICAID, INSURANCE AND/OR OTHER INSTITUTIONS ACCURACY OF INFORMATION

To the best of my knowledge all of the above information is correct and valid.

____ ________________________
Signature of Applicant or Responsible Party (***REQUIRED***) Date

Applications are accepted and considered without regard to race, creed, color, age, sex, religion, national origin, sponsor, sexual preference, blindness, or other handicap; persons under 16 years of age are not eligible for admission consideration as stated in New York State Public Health Law.