

LAKESIDE BEIKIRCH CARE CENTER
170 WEST AVENUE
BROCKPORT, NEW YORK 14420
Phone: (585) 395-6052
Fax: (585) 395-6007

APPLICATION FOR ADMISSION

This application must be submitted before any individual can be considered for admission. Submission of an application does not create any entitlement to admission or imply that the applicant will be placed in our admission pool.

Name of Applicant: _____

Address of Applicant: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Currently At: _____

Date of Birth: _____ Birthplace: _____

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

Maiden Name: _____

Has applicant had any relatives or friends as residents of Lakeside Beikirch? Yes No

If Yes, who? _____

Is applicant a veteran or the widow of a veteran? _____ Yes _____ No

Occupation (present or former): _____ Education: _____

Religion: _____ Church: _____

Clergy Name: _____ Phone: _____

Physician: _____ Dentist: _____

Physician Phone#: _____

PERSON TO CONTACT REGARDING ADMISSION

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

DURABLE POWER OF ATTORNEY

Name: _____ Has this been executed? Yes No

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

HEALTH CARE PROXY

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

DESIGNATED REPRESENTATIVE**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

** Defined as the individual designated to receive information and to assist and/or act on behalf of a particular resident.

EMERGENCY INFORMATION

Person(s) to contact in an emergency (please list in the order you wish to be contacted):

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

INSURANCE INFORMATION

Social Security Number: _____

Medicare Number: _____ Part A Effective Date: _____
Part B Effective Date: _____
Part D Plan Name: _____
Part D ID Number: _____

Medicaid Number: _____ Effective Date: _____

County: _____ Caseworker: _____

Health Insurance: _____ ID Number: _____

Long Term Care Insurance: _____ ID Number: _____

Pharmacy Coverage: Yes No

FINANCIAL INFORMATION

Monthly Income: Social Security Benefit: \$ _____

Pension: \$ _____ Source: _____

Other Income: \$ _____ Source: _____

Checking Account: Bank: _____

Name on Account: _____

Balance: \$ _____

Savings Account: Bank: _____

Name on Account: _____

Balance: \$ _____

Other: Bank: _____

Name on Account: _____

Balance: \$ _____

List any real estate, stocks, bonds, etc. that are financial assets for use of the applicant:

1. _____ Value: _____

In whose name is this asset? _____

2. _____ Value: _____

In whose name is this asset? _____

3. _____ Value: _____

In whose name is this asset? _____

Have you given away any cash, or sold/transferred any real estate, income or personal property
In the past 60 months or created a trust in the past 60 months? Yes No

If yes, please provide date(s) and amount(s): _____

Have there been any hospital stays in the past 60 days? Yes No

If yes, when and where? _____

Have there been any nursing home stays in the past year? Yes No

If yes, when and where? _____

MEDICAL HISTORY

Brief overview of medical issues: _____

Does the applicant smoke? Yes No

Allergies: _____

DISCHARGE PLANS

_____ Expected long term care

_____ Return home, if condition permits

_____ Transfer to lower level of care, if condition permits

FUNERAL ARRANGEMENTS

Funeral Home: _____ Phone: _____

Address: _____

Has a pre-need burial account been established? Yes No

Is this account irrevocable? Yes No

To the best of my knowledge and belief, all of the foregoing information is accurate and true.

Signature of person completing this form: _____

Relationship to applicant: _____

Date: _____

FEDERAL AND STATE LAW PROHIBIT THIS FACILITY FROM DENYING ADMISSION TO ANYONE BECAUSE OF RACE, CREED, COLOR, NATIONAL ORIGIN, SEX, HANDICAP, BLINDNESS, SPONSOR OR SEXUAL PREFERENCE. THIS FACILITY ADMITS AND TREATS ALL RESIDENTS ON A NON-DISCRIMINATORY BASIS.

Please include a copy of insurance cards, Durable Power of Attorney and any self-determination forms, such as Living Will and/or Health Care Proxy.

NOTE: LAKESIDE BEIKIRCH CARE CENTER IS A SMOKE-FREE FACILITY.