LAKESIDE BEIKIRCH CARE CENTER

170 WEST AVENUE
BROCKPORT, NY 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: _____ Date of Birth: _____

Birthplace: _____ Race/Ethnicity: _____

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

Veteran ☐ Yes ☐ No Name of Spouse: _____

Spouse of Veteran ☐ Yes ☐ No

Previous Occupation: _____ Education: _____

Physician: _____ Phone Number: _____

Preferred Hospital: _____ Currently At: _____

PRIMARY CONTACT

(Also known as the Designated Representative)

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

_____ Other Phone: _____

City *State* *Zip* ☐ **Power of Attorney** ☐ **Healthcare Agent**

OTHER CONTACTS

(Please list names in the order of who you would like contacted after the primary contact)

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

_____ Other Phone: _____

City *State* *Zip* ☐ **Power of Attorney** ☐ **Healthcare Agent**

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

_____ Other Phone: _____

City *State* *Zip* ☐ **Power of Attorney** ☐ **Healthcare Agent**

INSURANCE INFORMATION (Please attach copies of all insurance cards)

Social Security Number: _____

Medicare Number: _____ Part A Effective Date: _____

Part B Effective Date: _____

Medicaid Number: _____ Effective Date: _____

County: _____ Caseworker: _____

Health Insurance: _____ ID Number: _____

Long Term Care Insurance: _____ ID Number: _____

Prescription Insurance: _____ ID Number: _____

FINANCIAL INFORMATION

Monthly Income: Social Security Benefit $ _____

Pension: $ _____ Source: _____

Address: _____

Other Income: $ _____ Source: _____

Address: _____

Checking Account: Bank: _____

Address: _____

Name on Account: _____

Balance: $ _____

Savings Account: Bank: _____

Address: _____

Name on Account: _____

Balance: $ _____

Other Accounts: Bank: _____

Address: _____

Name on Account: _____

Balance: $ _____

Bank: _____

Address: _____

Name on Account: _____

Balance: $ _____

List any real estate, stocks, bonds, etc. that are financial assets of the applicant. Include address of property and contact information for investments.

1. _____ Value: _____

_____

_____

In whose name is this asset? _____

2. _____ Value: _____

_____

_____

In whose name is this asset? _____

3. _____ Value: _____

_____

_____

In whose name is this asset?

Attorney: _____

Address: _____

_____

Financial Advisor: _____

Address: _____

_____

House? ☐ Yes ☐ No

Spouse, Disabled Adult, Child in Home? ☐ Yes ☐ No

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? _____

Has applicant had any relatives or friends of Lakeside Beikirch ☐ Yes ☐ No

If Yes, who? _____

RELIGION

Religious Denomination: _____ Local Affiliation: _____

Clergy Name: _____ Phone: _____

FUNERAL ARRANGEMENTS

Funeral Home: _____

Address: _____

Phone: _____

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

Is this account irrevocable? ☐ Yes ☐ No

ORGAN DONOR OR ANATOMICAL GIFT

Organ Donor ☐ Yes ☐ No | Anatomical Gift Program ☐ Yes ☐ No

NOTE: If either of the above options are checked yes, please provide a copy of the program card.

DISCHARGE PLANS

☐ Expected long term care

☐ Return home, if condition permits

☐ Transfer to lower level of care, if condition permits

Does the applicant smoke?
☐ Yes ☐ No

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

OTHER ITEMS NEEDED (To be submitted with Application.)

Copies can be made of these items in the Nursing Home Administration Office if needed.

- Birth Certificate
- Photo Identification (license)
- Insurance Cards
- Social Security Card
- Power of Attorney
- Living Will and/or Health Care Proxy
- Other items may be requested if the applicant is admitted to the facility.

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.