Home Sweet Home of Athens, Inc
71 Second Street
Athens, NY 12015
Phone (518) 945-1673
Fax (518) 945-2082

APPLICANT'S NAME ____
LAST FIRST M.I

HOME ADDRESS ____

CITY______________________ COUNTY____________ STATE_______ ZIP _________

MARITAL STATUS______________ NAME OF SPOUSE______________________

IS THE APPLICANT OR SPOUSE A VETERAN ________YES_____________NO

RELIGIOUS PREFERENCE__________________________ ACTIVE MEMBER_______

DATE OF BIRTH_______________ PLACE OF BIRTH___________________________

PREVIOUS OCCUPATION____

LEVEL OF EDUCATION COMPLETED____

APPLICANT IS AT _______ (HOME) ______ (HOSPITAL) _______ (NURSING HOME)

PREFERRED HOSPITAL ____

MEDICARE NUMBER__________________________ MEDICAID_________________

DOES THE APPLICANT HAVE ANY OF THE FOLLOWING ADVANCE

DIRECTIVES? _____ (DNR) _____ (HEALTH CARE PROXY) _____ (LIVING WILL)

(PLEASE ATTACH COPY OF ANY ADVANCE DIRECTIVES)

NAME AND ADDRESS OF FUNERAL HOME DESIRED__________________________

PHONE NUMBER____

IS THERE A BURIAL FUND_________ WHERE________________________________

HAS ANYONE BEEN APPOINTED POWER OF ATTORNEY OR GUARDIAN_______

IF YES, WHO AND WHAT TYPE____

(PLEASE ATTACH COPY OF POWER OF ATTORNEY)

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HEALTH HISTORY:

PLEASE GIVE YEAR IF APPROPIATE

ACCIDENTS: FALLS_______ CONCUSSION, FRATCTURE, LACERATION, BURNS,

NO INJURY____________ SUTURES____

ARTHRITIS_____________________ HEART DISEASE____________________________

ASTHMA_______________________ HYPERTENSION____________________________

ALLERGIES: FOOD_______________________ DRUGS____________________________

KIDNEY DISEASE_______________________ CANCER (TYPE) ___________________

PNEUMONIA____________________________ CATARACTS______________________

DIABETES_________________________________ SEIZURE DISORDER______________

EMPHYSEMA____________________________ THYROID DISEASE_______________

GOITER___________________________________TUBERCULOSIS__________________

GLAUCOMA_______________________________ULCER__________________________

VENERAL DISEASE_______________________________

OPERATIONS (TYPE) ____

HAS APPLICANT RECEIVED PNEUMONVAX VACCINE WITHIN THE PAST FIVE

YEARS_____________YES___________NO IF YES, YEAR___________________

FLU VACCINE DATE_______________________

WHAT HAS BEEN APPLICANTS ADJUSTMENT TOWARD PRESENT OR PAST

ILLNESS, HANDICAPPING CONDITION OR HOSPITALIZATION

____

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CASH ASSETS IN BANKS, CREDIT UNIONS, SAVINGS, OR OTHER:

INSTITUTION NAME_____________________________ LOCATION________________

BALANCE IN ACCOUNT $___________ NAME ON ACCOUNT___________________

INSTITUTION NAME_____________________________ LOCATION________________

BALANCE IN ACCOUNT $___________ NAME ON ACCOUNT___________________

DOES APPLICANT HAVE LIFE INSURANCE WITH CASH VALUE ____YES____NO

APPROXIMATE CASH VALUE $______________________

COMPANY NAME____

OTHER ASSESTS/INVESTMENTS (STOCKS, BONDS, IRA'S) ____________________

____

HAS THE APPLICANT APPLIED, OR WILL THE APPLICANT SHORTLY BE

APPLYING FOR MEDICAL ASSISTANCE? _____________ YES___________NO

DATE OF APPLICATION____________________ COUNTY____________________

SOCIAL HISTORY:

ADDRESS PRIOR TO ADMISSION____

DID THE APPLICANT LIVE ALONE? ______________YES___________________NO

IF NO, THEN WHOM___________________________________

RELATION TO APPLICANT_________________________________

LEISURE ACTIVITIES____

____

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FINANCIAL INFORMATION:

SOCIAL SECURITY NUMBER_______________ MEDICARE NUMBER_____________

MEDICAID NUMBER_____________________________ COUNTY__________________

COUNTY CASE WORKER____

PRIVATE INSURANCE NAME AND ADDRESS__________________________________

INSURANCE NUMBER____________________________PHONE NUMBER___________

PHARMACY INSURANCE NAME AND ADDRESS_______________________________

INSURANCE NUMBER__________________________ PHONE NUMBER___________

(PLEASE BRING INSURANCE CARDS WITH YOU FOR FACILITY TO PHOTOCOPY)

MONTHLY INCOME:

SOCIAL SECURITY $___________________________

SSI $___________________________

PRIVATE PENSION $___________________________

VETERAN'S PENSION $___________________________

RAILROAD RETIREMENT $___________________________

ANNUITY $___________________________

OTHER (SPECIFY) $___________________________

DOES THE APPLICANT OWN REAL ESTATE ______ YES _______ NO

APPROXIMATE VALUE $___________________________

IS PROPERTY OWNED JOINTLY OR INDIVIDUALLY? (CIRCLE ONE)

NAME OF CO-OWNER (IF APPLICABLE) ______________________________________

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INDIVIDUUAL RESPONSIBLE FOR PAYING BILLS:

NAME_______________________________________ RELATIONSHIP_________________

HOME ADDRESS____

CITY_________________________ STATE_______________ ZIP CODE_________________

HOME TELEPHONE NUMBER__________________________WORK__________________

CELL PHONE__________________________

NEXT OF KIN TO BE LISTED FOR EMERGENCY CONTACT:

NAME_______________________________________ RELATIONSHIP_________________

HOME ADDRESS____

CITY_________________________ STATE_______________ ZIP CODE_________________

HOME TELEPHONE NUMBER__________________________WORK__________________

CELL PHONE__________________________

LIST NAME AND ADDRESS OF OTHER NEAR RELATIVE OR FRIEND:

NAME_______________________________________ RELATIONSHIP_________________

HOME ADDRESS____

CITY_________________________ STATE_______________ ZIP CODE_________________

HOME TELEPHONE NUMBER__________________________WORK__________________

CELL PHONE__________________________

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HAS APPLICANT HAD PSYCHIATRIC TREATMENT OR HOSPITALIZATION?

DETAILS____

____

DOES THE APPLICANT HAVE ANY SIGNIFICANT EATING OR SLEEPING PATTERNS?____

____

SMOKING HABITS__________________________ USE OF ALCOHOL_______________

DESCRIBE ANY SPEECH, HEARING OR VISION HANDICAPS: (USE OF GLASSES AND/OR HEARING AIDES)

____

____

____

SIGNATURE OF APPLICANT___________________________________ DATE________

SIGNATURE OF SPONSER_____________________________________ DATE________

(RETURN COMPLETED APPLICATION TO HOME SWEET HOME OF ATHENS TO COMPLETE ADMISSION PROCESS.)