8 Bushey Boulevard
Plattsburgh, New York 12901
Tel.(518)563-3261
Fax.(518)563-3294

Hassett Adult Day Services
Restorative Care
Skilled Nursing Care

APPLICATION FOR ADMISSION

STATE AND FEDERAL LAW PROHIBIT DISCRIMINATION BASED ON RACE, CREED, COLOR, AGE, SEX, RELIGION, NATIONAL ORIGIN, SPONSOR, SEXUAL PREFERENCE, DISABILITY, OR MARITAL STATUS, BLINDNESS, SOURCE OF PAYMENT IN ADMISSION, RETENTION AND CARE OF RESIDENTS. PERSONS UNDER 16 YEARS OF AGE ARE NOT ELIGIBLE FOR ADMISSION CONSIDERATION, UNLESS SPECIAL APPROVAL HAS BEEN RECEIVED FROM THE DEPARTMENT OF HEALTH.

THE INFORMATION PROVIDED SHALL REMAIN CONFIDENTIAL AND SHALL BE MADE AVAILABLE ONLY TO AUTHORIZED HOSPITAL AND NURSING HOME PERSONNEL INVOLVED IN THE PLACEMENT PROCESS AND TO ANY GOVERNMENTAL OFFICIALS AUTHORIZED ACCESS BY LAW TO SUCH RECORDS.

Full Name____
Current Address____________________City__________________State_____
County__________Zip__________Telephone No.______________________
I have been residing at this address since________________________________
Date of Birth________________Place of Birth_________________________
If foreign born, please provide documentation of proof of citizenship.
Name of Father________________Maiden name of Mother________________
U.S. Military Service: Yes_____ No_____ Branch ______________________
Occupation or Trade____
Marital Status: Single________ Married_______ Widowed______
Separated _______ Divorced _______
Name of spouse____
U.S. Military Service of spouse: Yes__________ No___________
Date of marriage_______________If spouse is deceased, date_______________
Does anyone have Power of Attorney or control to manage your funds of property?
__________**If yes, please attach a copy of the document.**

Who is the Executor of your estate?
Name____________________________________Relationship____________
Address____
Telephone No. _____________________

Personal Contacts:
1. Name__________________________________Relationship____________
Home Address___________________________________Zip____________
Home Telephone_______________________Business Telephone____________
2. Name__________________________________Relationship____________
Home Address___________________________________Zip____________
Home Telephone_______________________Business Telephone_____________

Name of Primary Physician:____
Have Funeral Arrangements been completed: Yes_________ No________
Name of Funeral Home:____
Telephone No.____
I have a paid________ unpaid________ burial plot
Cemetery___________________________Location__________________

Do you have a Health Care Proxy / Advance Directives: Yes___ No___
If yes, please attach a copy of documents.

FINANCIAL DISCLOSURE:

INCOME	MONTHLY AMOUNT
SOCIAL SECURITY	$______________________
RETIREMENT PENSION	$______________________
VETERAN'S PENSION	$______________________
RAILROAD PENSION	$______________________
SSI	$______________________
OTHER INCOME	$______________________

Please provide a copy of your Social Security card, Medicare card, Medicaid card (if applicable), and any other health insurance card(s).

ASSETS:

1. Bank accounts (* Indicate savings, checking, money markets, IRA's etc.)
   A. Name of Bank____________Current Balance_____Type of account*______
   B. Name of Bank____________Current Balance_____Type of account*______
   C. Name of Bank____________Current Balance_____Type of account*______
   D. Name of Investment_________________________Market value_________
   E. Name of Investment_________________________Market value_________

(If needed, attach an additional page to list all accounts)

2. Within the past 60 months, have you entered into any "TRUST" arrangements?
   _________no ________yes **If yes, provide a copy of the Trust.**

3. I own the following real and/or personal property:
   A. Location________________________Type of property_________________
   Mortgage against property__________Taxes on property________________

To the best of my knowledge all the information provided herein is correct and valid. I hereby apply for admission to the Evergreen Valley Nursing Home.

____ ____________
SIGNATURE OF APPLICANT OR RESPONSIBLE PARTY DATE

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, hereby authorize Evergreen Valley Nursing Home to request and

Name: ____

Address: ____

____

Date of Birth: ____

Social Security Number: _________________________________

This information is required for the purpose of:

- Evaluation for admission into the Evergreen Valley Nursing Home
- Continuation of services and care following admission into the Evergreen Valley Nursing Home

Signed: _____________________________________

Relationship to patient: _________________________

Witness: _____________________________________

Date: ____