AMSTERDAM NURSING HOME CORP.
1060 Amsterdam Avenue
New York, NY 10025
TEL: (212) 316-7728
FAX: (212) 678-1740

ADMISSION APPLICATION

Applicant Seeking (Check all that apply)
❑ Long Term Care ❑ Sub-Acute/Rehabilitation Care
❑ Palliative Care/Hospice ❑ Dementia Special Care ❑ Unsure

Applicant's Name: ______________________________

Address: ______________________________ Telephone #______________________
Street Apt

____
City State Zip Code

❑ Male ❑ Female

Birthplace: ______________________________ Date of Birth: ______________________

Are you a US citizen? ❑ Yes ❑ No Race ______________________

If no, are you a legal alien? ❑ Yes ❑ No

Primary Language: ______________________________ Religion: ______________

Marital Status (Check One) ❑Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

If married, name of spouse: ______________________________

Were you or your spouse in the Military Service? ❑ Yes ❑ No

Applicant's admission is anticipated from:

If currently hospitalized or in another facility please indicate name of facility: ______________________

______________________________ Admission Date: ______________________

LIST OF CONTACTS IN ORDER OF RESPONSIBILITY:

1. Name: ______________________________ Relationship: ______________________

   Address: ______________________________ Apt. ____________

   City: ______________________________ State: __________ Zip Code: ________

   Telephone #: ______________
   Home Work Cell

2. Name: ______________________________ Relationship: ______________________

   Address: ______________________________ Apt. ____________

   City: ______________________________ State: __________ Zip Code: _______

   Telephone #: ______________________________
   Home Work Cell

3. Name:____ Relationship: _______________________

Address: ____Apt. _____________

City: ____ State: _____________ Zip Code: ________

Telephone #:_________________

Home Work Cell

LIST OF ALL HOSPITAL ADMISSIONS:

List all hospital admissions including dates of admission and discharge during the last 12 months:

Name of facility:_________________________________Admission Date:____________Discharge Date:_________

Name of facility:_________________________________Admission Date:___________ Discharge Date:________

Name of facility: _________________________________ Admission Date: ____________Discharge Date:_________

LIST OF ALL RESIDENTIAL AND/OR REHABILITATION OR SKILLED NURSING PLACEMENTS:

List all residential and/or rehabilitation or skilled nursing placements including dates of admission and discharge during the last 12 months:

Name of facility: _________________________________ Admission Date: ____________Discharge Date: ________

Name of facility:_________________________________Admission Date:____________Discharge Date: ________

Name of facility: _________________________________Admission Date: ____________Discharge Date: ________

FINANCIAL DATA:

Social Security #______________________________ Part A Only _____ Part B Only _______ Both

Medicare Number:_____________________________________

Medicaid Number: _____________________________________County of Residence: ____________________

Other Health Insurance: (Long term care, Secondary, etc.)

1. ____

Name Policy No. Phone #

2. ____

Name Policy No. Phone #

3. ____

Name Policy No. Phone #

INCOME INFORMATION: Amount Name of Company

Social Security _________________________________ $____________________ ____________________

Private Pension ______________________________ $__________________ __________________
Please include name and address of company

VA Benefit ______________________________ $ __________________ __________________

Please list any other assets such as Stocks, Bonds, Annuity or Real Estate, amount or approximate value:

____

Other ______________________________ Type __________________

With whom do you reside: ______________________ Do you rent or own? ❑ Rent ❑ Own

BANK ACCOUNTS

Bank Name/Address	Account Holder Name	Account Number	Amount
______________	______________	______________	$__________
______________	______________	______________	$__________
______________	______________	______________	$__________

Have you disposed of or transferred any assets within the last five years? ❑ Yes ❑ No

(If yes, please specify amount, date and reason) ______________________________________

____

Does the applicant own any real estate? If yes, type of residence and value: ______________________

Life Insurance Policy(s): Company ______________________ Beneficiary ______________

ADVANCE DIRECTIVES:

A. Have you appointed a Health Care Proxy: ❑ Yes ❑ No

Name: ____

Address: ____

Telephone # ______________________

B. Do you have a Living Will: 1:1 Yes ❑ No If yes, have you signed a DNR: ❑ Yes ❑ No

C. Do not resuscitate order (DNR): ❑ Yes ❑ No

D. Power of Attorney: ❑ Yes ❑ No

If yes: Name: ______________________________ Telephone # ______________

BURIAL ARRANGEMENTS: (Complete if applying for Long Term Care)

Name and address of Cemetery: ____

Is there a burial plot reserved: ____

Who holds the deed? ____

Funeral Home Name and Address: ____

____

Does the applicant want to be cremated?____

Who will be responsible for funeral arrangements? ____

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

____ ____________________
Signature of Applicant Date

____ ____________________
Signature of Person Completing Form Date

In compliance with New York State and Federal Laws which prohibit discrimination based on race, creed, color, national origin, sex, sexual preference, marital status, disability, blindness, sponsorship, or source of payment, the Amsterdam Nursing Home admits and treats all patients and residents on a non-discriminatory basis.