

FOLTSBROOK CENTER FOR SENIOR LIVING
104 NORTH WASHINGTON STREET – HERKIMER – NY – 13350

Phone #: 315-866-6964 Ext: 252

Application for Residency



Who besides yourself will take care of your affairs while at FoltsBrook Senior Living?

Name: _____ Relationship: _____

Address: _____

Phone#: _____ Email: _____

Applicant's Legal Representative(s): (please attach a copy of the Power of Attorney and Health Care Proxy)

Power of Attorney: Name: _____

Address: _____ Phone#: _____

Applicant's Attorney: Name: _____

Address: _____ Phone#: _____

Health Care Proxy: Name: _____

Address: _____ Phone#: _____

Guardian: Name: _____

Address: _____ Phone#: _____

Living Will: Yes No DNR: Yes No

INSURANCE INFORMATION

Please provide copies of applicant's insurance(s) with application

Medicare #: _____

Medicaid/SSI Recipient: Yes No If yes, Medicaid #: _____

If no, have you recently applied for Medicaid benefits? Yes No

What county? _____ Name of case worker: _____

Primary Insurance: _____ Group #: _____

Secondary Medical/Health Insurance Company: _____ Policy#: _____

Life Insurance Company: _____ Policy#: _____

Are you enrolled in Medicare Part D? Yes No

If yes, indicate Insurance Company: _____

Medicare Part D Policy #: _____

Other Prescription plan: _____ Policy#: _____

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Do you have private long term care insurance? Yes No

If yes, please provide a copy of the insurance policy or insurance binder

MEDICAL INFORMATION AND HISTORY

Physician: _____

Address: _____

Phone #: _____ Fax#: _____

Dentist: _____

Address: _____

Phone #: _____ Fax#: _____

Podiatrist: _____

Address: _____

Phone #: _____ Fax#: _____

List any other physicians you are currently seeing and for what condition:

Specialist: _____ Phone: _____

Address: _____

Fax: _____ Condition: _____

Specialist: _____ Phone: _____

Address: _____

Fax: _____ Condition: _____

Do you currently attend Physical, Occupational, or Speech Therapy? Yes No

If yes, please provide type, time frame, frequency and name the ordering physician:

List any treatments you are undergoing:

Treatment: _____ Frequency: _____

Treatment: _____ Frequency: _____

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Are you a diabetic? Yes No

If yes: How often do you test your blood sugar? _____

Are you able to self-test your blood sugar? Yes No

Can you self-administer insulin? Yes No

Do you have any dietary restrictions? _____

Do you suffer from any digestive disease or disorder? _____

Have you ever been treated or hospitalized for a psychiatric condition? Yes No

If yes, please explain:

Are you currently being treated for a psychiatric condition? Yes No

Physician: _____ Phone: _____

Address: _____

Fax: _____ Diagnosis: _____

Do you have any problems taking medications? Yes No

Please explain: _____

Has a swallow evaluation been ordered or completed? Yes No

Have you experienced a significant change in medical condition, if so what is your understanding of the present handicapping condition or illness? Yes No

Please explain: _____

Have you refused any treatments suggested by your physician? Yes No

Please explain: _____

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Previous Nursing Home/Rehab Admissions:

Has applicant had a prior nursing home/rehab stay in the past six months? Yes No

If yes, please provide - Admission date: _____ Discharge date: _____

Most recent Hospitalization Dates: _____

Name of Hospital: _____

Reason for Admission: _____

MEDICATIONS

Medication	Dose	Frequency

Do you take any vitamins or supplements?

Vitamin or Supplement	Dose	Frequency

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Place a (X) self (M) Mother (F) Father (B) Brother (S) Sister if applicable.

Dermatitis		Frequent Urinary Tract Infections	
Congestive Heart Failure		Frequent Constipation	
Pulmonary Artery Disease		Venereal Disease	
Kidney Failure		Anxiety	
Diabetes		Agitation	
Tuberculosis		Depression	
**Colostomy (See Below)		Arthritis	
Hypertension		Dementia	
Emphysema		Alzheimer's	
Cancer: Type		Measles	
Shingles		Mumps	
Sores or open wounds		Smallpox	

** How often do you change your colostomy bag? _____

**Where do you get your ostomy supplies from? _____

ALLERGIES:

Food Allergies: _____ Reaction: _____

Food Allergies: _____ Reaction: _____

Food Allergies: _____ Reaction: _____

DRUG Allergies: _____ Reaction: _____

DRUG Allergies: _____ Reaction: _____

DRUG Allergies: _____ Reaction: _____

IMMUNIZATIONS: Please indicate the date you received each of the following:

Pnuemovax Vaccine: _____ Administered by: _____

Flu Vaccine: _____ Administered by: _____

Tetnus Toxoid Vaccine: _____ Administered by: _____

Shingles Vaccine: _____ Administered by: _____

Pertussis Vaccine: _____ Administered by: _____

COVID 19 Vaccine: _____ Administered by: _____

Have you had a TB test within the last year? Yes No

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FINANCIAL RESOURCES

Social Security Benefits \$ _____/month Direct Deposit? Yes No

Are you a Veteran? Yes No If yes, years served _____

Veteran's Benefits \$ _____/month Direct Deposit? Yes No

Pension \$ _____/month From: _____

Other Income \$ _____/month From: _____

Retirement \$ _____/month

Annuities \$ _____

Do you own bonds? Yes No Value \$ _____ Owned by: _____

Do you own stocks? Yes No Value \$ _____ Owned by: _____

Do you own real-estate? Yes No Value \$ _____

Location of property(s): _____

Mortgage (including reverse mortgage and/or home equity loan(s) ? Yes No

If you own a home, please list the current outstanding balance – and monthly payment of each mortgage/home equity loan:

Mortgage/Home Equity Loan	Outstanding Principal Balance	Monthly Payment

If you own a home – what is your home's current fair market value? \$ _____

"LIFE USE" of home? Yes No

Identify other assets below: (i.e., investments, land contracts, vehicles, interest from savings accounts, stock dividends, interest from land contracts, rent paid to you) **attach additional sheet if necessary**

Asset: _____ Value \$ _____

Asset: _____ Value \$ _____

Asset: _____ Value \$ _____

Asset: _____ Value \$ _____

Asset: _____ Value \$ _____

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Bank/Credit Union Accounts: Include Joint Accounts Held (attach additional sheet if necessary)

Name of Bank/Credit Union: _____ Type of Account: _____

Name(s) on account: _____

Account #: _____ Present Balance: _____

Name of Bank/Credit Union: _____ Type of Account: _____

Name(s) on account: _____

Account #: _____ Present Balance: _____

Name of Bank/Credit Union: _____ Type of Account: _____

Name(s) on account: _____

Account #: _____ Present Balance: _____

Have you or your spouse purchased an annuity? Yes No

If yes, was the annuity purchased more than 60 months ago? Yes No

If no, and the annuity was purchased less than 60 months ago, is the State of New York named a remainder beneficiary in either the first or second position? Yes No

Is the annuity irrevocable and non-assignable? Yes No

Is the annuity actuarially sound? Yes No

Does the annuity provide for equal payments for the term of the annuity? Yes No

Does the annuity provide for deferred payments or balloon payments? Yes No

In the past 60 months, have you purchased a promissory note, loan or mortgage? Yes No

If yes, please provide a copy of the note, loan, or mortgage purchases, is the repayment term actuarially sound? Yes No

Does the note, loan or mortgage provide for payments to be made in equal amounts? Yes No

During the term of the loan, note or mortgage? Yes No

Does the loan, note or mortgage provide for deferred payments or balloon payments? Yes No

Does the note, loan or mortgage provide for cancellation of the balance upon your death? Yes No

Have you purchased a life estate interest in another individual's home in the past 60 months? Yes No

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Have you established a trust? Yes No

Date Established: _____ Trust Administrator: _____

Address: _____ Phone #: _____

Have you transferred any bank/credit union accounts, resources, real estate, or other assets in the past 60 months? Yes No

If yes, please indicate the date of each transfer, the type of asset transferred (cash, real property/other) and the value of the asset transferred.

Date	Type	Value

Assets transferred in the past 60 months to the following person(s):

Name	Address	Phone#

BURIAL INFORMATION

Does the applicant have a burial account? Yes No If yes, is it irrevocable? Yes No

Held by: _____ Value: _____

Funeral Home to be contacted in the event of death:

Name _____ Phone _____

Address _____

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SOCIAL HISTORY AND PREFERENCES

What is your religion? _____

What role does religion play in your life?

Education	Completed (Y/N)
Elementary	
High School	
College-University	
Trade-Specialty	

Do you smoke? Yes No

Please be advised that FoltsBrook Senior Living is a non-smoking facility. Smoking in any area of the facility is prohibited.

What are your favorite foods? _____

What foods do you dislike? _____

What hobbies do you enjoy? _____

Do you know of anyone who presently resides at FoltsBrook Senior Living? _____

List any questions or concerns you have regarding application to FoltsBrook Senior Living

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APPLICATION FOR ADMISSION

I, _____ do hereby make application for admission to FoltsBrook Senior Living, located at 104 NORTH WASHINGTON STREET – HERKIMER – NY – 13350I understand that admissions are granted according to bed availability in the appropriate program for which the applicant is approved. Approval is arrived through a personal interview, a completed Medical Evaluation by the applicants physician and/ when needed a PRI and Nursing Social Assessment. The FoltsBrook Senior Living Admission Coordinator will be contacting me with further instruction.

The undersigned applicant has read the application and knows the contents thereof; that, under penalties of perjury, applicant swears that the information contained in the application is true, correct and complete; and further, the applicant hereby authorizes FoltsBrook Senior Living and its affiliates to verify any of the information in this application as may be necessary.

Signature of Applicant: _____ Date: _____

Note: This application will be reviewed in accordance with the policies and procedures of the affiliates of FoltsBrook Senior Living . The act of filing an application does not guarantee placement. Misrepresentation or falsification of any information provided in this application may result in the automatic denial of this application or may necessitate the subsequent discharge of the applicant from FoltsBrook Senior Living in which they are residing.

FoltsBrook Senior Living *will not engage in discrimination against any person because of race, color, religion, national origin, ancestry, age, marital status, disability, sexual orientation including gender identity, unfavorable discharge from the military or status as a protected veteran and will comply with all federal and state nondiscrimination, equal opportunity and affirmative action laws, orders and regulations.*

Office Use Only: ALP _____ AH _____ Application Received: _____

Contact Log:

Date	Contact	Discussion	FoltsBrook Senior Living Rep

Interview: _____ Date: _____ Time: _____

Applicant Accepted: _____ Refused: _____ Bed: _____ Denied: _____

Mental Health: Evaluation completed: Y _____ N _____ Date Completed: _____

Evaluation obtained for Resident record: Y _____ N _____

Physician Signature: _____

Reviewed By: _____ Date Reviewed: _____