Wartburg

ADMISSIONS: APPLICATION FOR ADMISSION

This application must be submitted before any individual can be considered for admission. Submitting an application does not create any entitlement to admission or mean that the applicant will be placed on a waiting list.
In compliance with New York State and Federal laws, which prohibit discrimination based on race, creed, color, national origin, blindness and handicap, sex, sexual preference, age, martial status, and source of payment, The Wartburg treats all applicants on this non-discriminatory basis.

Name:		Date:
Street Address:		
City:	State:	Zip:
Telephone #:		

Background Information

Date of Birth:	U.S. Citizenship ☐ Yes ☐ No	Place of Birth:
Length of stay in U.S.:	Clergy Name:	
Mother's Maiden Name:	Congregation:	
Father's Name:	Congregation Address:	
Your Religion:	Telephone:	

Health Insurance Information

Medicare # (Including suffix)		Medicaid #:	
Medicare Supplemental Carrier:		Policy #:	
Major Medical Carrier:		Policy #:	
Long Term Care Insurance ☐ Yes ☐ No (Please provide photocopy of contract)			
Long Term Care Insurance Carrier:			
Medicare Part D: ☐ Yes ☐ No	Plan Name:		Group #:

Life Insurance Information

Life Insurance ☐ No ☐ Yes	[Please provide photocopies of policy(ies)]
Name of Carrier (1):	Name of Carrier (2):
Policy #:	Policy #:
Face Value: Cash Value:	Face Value: Cash Value:

Medical Information

Weight: Height:
List any serious illness(es) in the past five years with attending physician's name:
List any current illness(es) or handicap(s):
List any allergies to medication or foods:
Indicate any special equipment:

Financial Information

Income Per Month $:	Per Month $
Social Security #:	SSI:
Railroad Retirement #:	Annuity:
Private Person(s):	Dividends:
Veterans Benefit(s):	Interest:

Assets

Note: All financial information must be documented. Please provide photocopies of all assets listed below with this application. Copies of bank statements and income tax returns for the past three years may be needed. Use additional pages as necessary.

Bank	Account Type (Savings, Checking, Money Market, Also Stocks, Bonds, Etc.)	Account #	Ownership	Balance

Provide a copy of deed and present value of all Real Estate Owned: ☐ Private House ☐ Co-op ☐ Condo ☐ Other

Other Assets: (describe and indicate value)

Have you disposed any assets within the last 5 years? ☐ No ☐ Yes (If yes, give amount, date and reason.)

Do you maintain assets in a safe deposit box? ☐ No ☐ Yes (If yes, please specify assets and give location and name(s) of person(s) who have access)

If you have Medicaid, please indicate county, case worker, name, address and telephone. (In addition, if Medicaid is pending, Indicate date filed)

To the best of my knowledge and belief, all of the foregoing information is accurate and true in all respects.

Signature of Applicant:	Date:
Signature of Applicant Representative:	Date:

Please complete this Psychosocial Intake Form for our Social Services Department. Thank you for providing this important information.

Background Information				
Name of Applicant			Date:	
Former Occupation		Last Employed (Date):		
Education (describe)				
☐ Married	☐ Single	☐ Widowed	☐ Separated	☐ Divorced
Name of Spouse		Occupation:		
Date of Marriage		Deceased: ☐ Yes ☐ No	Date of Death:	

List Next-of-Kin				
Relationship	**Name**	**Address**	**Tel. # Home/Bus**	**Desig. Rep. (check)**

Does the applicant have any advance directives? Please check and provide photocopy with application.									
Health Care Proxy	☐ Yes	☐ No			Do Not Resuscitate	☐ Yes	☐ No		
Medical POA	☐ Yes	☐ No			Living Will	☐ Yes	☐ No		
Previous Housing	☐ Private House	☐ Apartment	☐ Condo	☐ Co-op	☐ Other Explain:				
Were home care services provided?	☐ Yes	☐ No	If yes, explain:						
Has the applicant or their spouse ever served in the United States Military?	☐ Yes	☐ No							
Do you have a person or firm with your general Power of Attorney? If so, give name, address, and provide a copy.									

Burial Arrangements			
Responsible Party Name			
Address		Telephone:	
Deeded Cemetery Plot Location		Burial Pre-Arrangement	☐ Yes ☐ No
Name of Funeral Home			
Address:			
Telephone:			
Please provide photocopy of cemetery deed and burial pre-arrangement.			

Psychosocial Information
Please provide a complete description of the applicant's level of functioning prior to seeking admission.

Describe the applicant's daily routine prior to placement (i.e. eating, sleeping patterns, habits)
Discuss the applicant's past roles (i.e. life-long occupation, language, interests and skills)
Describe the applicant's family involvement and family relationships.
Describe the applicant's ability to communicate. Does he/she understand his/her medical condition?
Describe the cognitive status of the applicant (i.e. alert, forgetful, confused, impaired judgment, poor short-term memory, etc.)
Describe the applicant's present social and behavioral functioning (i.e. sociable, passive, anxious, sad, gregarious, agitated,
isolated, talkative, etc.) and indicate any behavioral problems (i.e. wandering, agitation, combativeness).
Is the applicant taking any psychoactive medication currently or has he/she taken this type of medication in the past?
Has the applicant ever had a psychiatric hospitalization? Is so, explain:

Signature:	Date:	Relationship: