# ADMISSIONS: APPLICATION FOR RESIDENCY

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: |

**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 #: |

**Medical Information**

| | | |
|---|---|---|
| Weight: | Height: | Does the applicant smoke? |
| 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: | | |
| ❑ Dentures ❑ Hearing Aids ❑ Pacemaker ❑ Special Appliances ❑ Other | | |

**Financial Information**

| | |
|---|---|
| Income Per Month $: | Per Month $ |
| Social Security #: | SSI: |
| Railroad Retirement #: | Annuity: |
| Private Person(s): | Dividends: |

**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 |
|---|---|---|---|---|
| | | | | |
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|---|
| 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 36 months? ❑ No ❑ Yes (If yes, give amount, date and reason.) |
| |
| 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: |

## PSYCHOSOCIAL

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)** |
|---|---|---|---|---|
| | | | | |
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|---|
| 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 |
| Do you have a person or firm with your general Power of Attorney? If so, give name, address, and provide a copy. | | | |