Morgan Estates Assisted Living Community
Geneseo, New York

APPLICATION FOR ADMISSION

We appreciate your interest in Morgan Estates and ask that you complete this application for admission. The information gathered here, as well as during the admissions process, will be used to determine whether we can meet your needs. (If you are completing the application for someone else, please obtain the most accurate information from the applicant.) All portions of this application will remain confidential.

All items must be completed. Please mark "not applicable" (N/A) to those that do not apply.

PERSONAL INFORMATION

Resident Name _____ DOB _____ SS# _____

Home Address _____ E-mail _____

City _____ State _____ Zip _____ County _____

Phone _____ Cell phone _____

Years at residence _____ Spouse's Name _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Address being admitted from _____

City _____ State _____ Zip _____ County _____

MEDICAL INFORMATION

Primary Care Physician _____ Phone _____

Office Address _____ Fax _____

City _____ State _____ Zip _____ County _____

***Will this physician be responsible for your care while you are in our facility?** ☐ Yes ☐ No

SPECIALISTS

(Please list any specialists below. Example: Cardiologist, Audiologist, Dermatologist etc.)

Specialist (1) _____ Phone _____

Office Address _____ Fax _____

City _____ State _____ Zip _____ County _____

Specialist (2) _____ Phone _____

Office Address _____ Fax _____

City _____ State _____ Zip _____ County _____

CONTACT INFORMATION

Designated Representative (Primary Contact Person) _____

Phone (H) _____ Phone (W) _____ Cell _____

Relationship _____ E-Mail address _____

Address _____

City _____ State _____ Zip _____

Alternative Contact _____

Phone (H) _____ Phone (W) _____ Cell _____

Relationship _____ E-Mail address _____

Address _____

City _____ State _____ Zip _____

Alternative Contact _____

Phone (H) _____ Phone (W) _____ Cell _____

Relationship _____ E-Mail address _____

Address _____

City _____ State _____ Zip _____

To whom should we send the monthly billing statements (Financial Representative)

Name _____

Phone (H) _____ Phone (W) _____ Cell _____

Relationship _____ E-Mail address _____

Address _____

City _____ State _____ Zip _____

Are you a U.S. citizen? ☐ Yes ☐ No Primary language _____

If not a citizen, do you have a permanent visa? ☐ Yes ☐ No (If yes, please attach a copy)

MILITARY INFORMATION

Are you a veteran? ☐ Yes ☐ No Is or was your spouse? ☐ Yes ☐ No

If yes, what branch did you serve? ☐ Army ☐ Navy ☐ Air Force ☐ Marine ☐ National Guard

Have you applied for aid and attendance? ☐ Yes ☐ No

*If you need information on this program, please ask our case manager and/or our administrator

ADVANCED DIRECTIVES

Please identify how your Representatives will assist you.
Check all that applies and give us the first and last name of the Representative.

☐ Power of Attorney
Name _____
Relationship _____

☐ Health Care Proxy Agent
Name _____
Relationship _____

☐ Financial Representative
Name _____
Relationship _____

***To process this application, we will need confirmation of your representatives. Please attach appropriate documentation.**

Do you have a Living Will? ☐ Yes ☐ No Do you have a Health Care Proxy? ☐ Yes ☐ No

Do you have a DNR order? ☐ Yes ☐ No Do you have a MOLST form? ☐ Yes ☐ No

State regulations require us to collect the following information. We know this is a delicate matter and ask your cooperation. You may change this information at any time.

Funeral Home _____ Phone _____

Address _____

City _____ State _____ Zip _____

PHARMACY INFORMATION

Our pharmacy service provider is OMNICARE. Our preference is that our Residents use this service. **However, if you choose to use an alternative pharmacy, the responsibility of providing medications will then fall onto the Residents representative.** Will you be using OMNICARE? ☐ Yes ☐ No

If you do not wish to use our pharmacy, which pharmacy will you be using? _____

IN HOUSE INFORMATION

Will you be receiving "**official**" mail? (Billings of any sort, solicitations, fundraising) ☐ Yes ☐ No
All other mail will be delivered to your loved one. This mail would consist of cards, magazines, catalogs, newsletters etc. If no, please include the name and address of who will receive the "official" mail.

Name _____

Address _____

City _____ State _____ Zip _____

Will you be using our cable service? ($40.00 per month)
☐ Yes ☐ No

Phone service? ($15.00 per month)
☐ Yes ☐ No

Will you be using our internet/Wi-Fi? (No charge)
☐ Yes ☐ No

INCOME AND EXPENSES

Again, for clarification, we would appreciate your completing each item below and indication "N/A" where no amount is to be entered.

INCOME

Monthly Income	Per Month
Social Security	$ _____
Private Pension	$ _____
Veteran's Pension	$ _____
Annuities	$ _____
Mortgages/Notes	$ _____

DEBTS

Outstanding Debts/Credit Card Balances/Loans	Per Month
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

ASSETS

Bank Name	Type of Account	Account Number	Balance	Co-Owner
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____

STOCKS and BONDS

Stocks and Bonds	Number of Shares	Balance	Co-Owner
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____

HEALTH INSURANCE

Please check all that apply and attach copies of your cards

☐ Medicare Health Insurance # _____

☐ Supplemental Health Insurance # _____

Do any of your contracts provide a prescription drug rider? ☐ Yes ☐ No

If so, which one(s)? (1) _____ (2) _____

Are there any other health benefits available to you through you or your spouse's current or previous employer? (i.e. Veteran's Benefits) ☐ Yes ☐ No

If yes, please explain benefit _____

In an emergency, what would be your hospital of choice?

Name of hospital _____

Address _____

City _____ State _____ Zip _____

HEALTH CONDITION

Please share any major changes in your general health in the past year and/or any chronic illness or disability:

_____

_____

_____

_____

RESIDENT SOCIAL HISTORY

Previous or current occupation _____ Number of years _____

Birthplace _____ Hometown _____ _____
(City) (State)

Number of children _____ Grandchildren _____ Great Grandchildren _____

Wedding Anniversary _____ Spouse name _____
(Month) (Day) (Year)

What was/is your hobbies or interests? _____ _____

_____ _____ _____

Are you licensed to drive a car? ☐ Yes ☐ No If yes, driver license number _____

Will you be bringing your car? ☐ Yes ☐ No If yes, please fill in the following information:

Make _____ Model _____ Color _____ License number _____

Do you have a pet? ☐ Yes ☐ No Name _____ Type _____

Favorite food _____ Favorite meal _____

High School ☐ Yes ☐ No Graduated ☐ Yes ☐ No Where attended _____

College ☐ Yes ☐ No Where attended _____ Major _____

Religion _____ Church _____ Location _____

Clergy _____ Phone _____

***Please give us a brief synopsis of our perspective Resident's life that will help us get to know them better.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Application submitted by

_____ _____ _____

Signature Relationship Date