KEENE VALLEY NEIGHBORHOOD HOUSE
RESIDENT APPLICATION

Name of person completing application:____

Relationship to applicant:____

Primary Phone #________________________ Email:__________________________________

APPLICANT

Name:____ Date of Birth______________

Social Security #___________________________________ Gender_________________

Currently living in (town, state)____

Marital Status: MARRIED SINGLE DIVORCED WIDOWED PARTNER

US Veteran? NO YES - Years Served______________ Branch:________________

Spouse of a Veteran? NO YES - Years Served______________ Branch:________________

Name of Legal Representative____

Relation to Resident____

Current Address of Legal Representative______________________________________

____

Home Phone__________________________ Work Phone___________________________

Cell Phone___________________________ Email________________________________

PRIMARY EMERGENCY CONTACT

Name____

Relation to Applicant____

Address____

Home Phone:____________________________ Work Phone:__________________________

Cell Phone:_____________________________ Email:_______________________________

Note: The primary contact will be notified in case of emergency. A secondary contact, if provided, will be contacted only if the primary contact cannot be reached. The person contacted is responsible for notifying all family members and friends of any information relayed to them.

 Applicant Name______________________________

SECONDARY EMERGENCY CONTACT

Name____

Relation to Applicant____

Address____

Home Phone:____________________________ Work Phone:___________________________

Cell Phone:_____________________________ Email:________________________________

PRIMARY CARE PHYSICIAN

Name____

Street Address____

City_______________________________________ State_____________ Zip Code___________

Phone______________________________________ Fax____________________________________

OTHER HEALTHCARE PROVIDERS

Name______________________________________ Specialty______________________________

Street Address____

City_______________________________________ State_____________ Zip Code___________

Phone______________________________________ Fax____________________________________

Name______________________________________ Specialty______________________________

Street Address____

City_______________________________________ State_____________ Zip Code___________

Phone______________________________________ Fax____________________________________

Name______________________________________ Specialty______________________________

Street Address____

City_______________________________________ State_____________ Zip Code___________

Phone______________________________________ Fax____________________________________

AREA HOSPITAL / CLINIC OF CHOICE

Hospital/Clinic Name____

Street Address____

City_______________________________________ State_____________ Zip Code___________

Phone______________________________________ Fax____________________________________

 Applicant Name________________________________

Note: In the event of an emergency that requires ambulance transport, emergency medical personnel will decide which hospital to take the resident. In most cases, the resident will be taken to the nearest Emergency Room, which is located in Elizabethtown, NY.

HEALTH INSURANCE

Primary Health Insurance: Medicare Medicaid Other None

Secondary Health Insurance: Medicare Medicaid Other None

Medicare #_________________________________ Medicaid #______________________________

Other insurance:

ID #____

Additional Insurance:____

ID #____

Prescription Drug Plan____

Plan ID #____

CURRENT PHARMACY

Pharmacy Name____

Street Address____

City____ State_____________ Zip Code____________

Phone____ Fax______________________________________

PERSONAL BACKGROUND

Wishes to be addressed as ____

Address (if different from ALR)____

Name of spouse or partner, if applicable (living or deceased)___________________________________

OTHER FAMILY MEMBERS/FRIENDS WHO WISH TO BE ON THE KVNH CONTACT LIST

Name____

Relation to Applicant____

Address____

Home Phone:_______________________________ Work Phone:_____________________________

Cell Phone:_________________________________ Email:__________________________________

 Applicant Name______________________________

Other family members/friends who wish to be on the KVNH contact list (continued):

Name____

Relation to Applicant____

Address____

Home Phone:_____________________________ Work Phone:___________________________

Cell Phone:_______________________________ Email:_______________________________

(USE OTHER SIDE OF PAPER FOR ADDITIONAL NAMES)

RESIDENTIAL BACKGROUND OF APPLICANT

Born in:_____________________________________ Raised in:___________________________

Has currently has been living in:____

Education (highest level)____

Previous occupation(s)____

Religious Affiliation (if any)____________________ Place of Worship_____________________

DNR?	NO	YES
Health Care Proxy?	NO	YES (name)_______________________________
Power of Attorney?	NO	YES (name)_______________________________
Living Will?	NO	YES (location of will)_________________________

Burial Instructions____

HEALTH INFORMATION

Health Status: Excellent Very Good Good Fair Poor

Chronic Diseases:____

Diet:____

Allergies:____

Vision:	Good	Poor	**Glasses:**	Yes	No
Glaucoma:	Yes	No	**Contacts:**	Yes	No
Hearing:	Good	Poor	**Hearing Aids:**	Yes (L / R / Both)	No

 Applicant Name________________________________

DENTAL HEALTH

Dentist:____________________________________ Phone:___________________________________

Address:____

Date of Last Visit:______________________ **Dentures:** Yes (Upper / Lower / Both) No

PHYSICAL HEALTH

Mobility – can applicant walk without assistance? ____ Yes ____ No

Uses a cane? ____ Yes ____ No

Uses a walker? ____ Yes ____ No

Uses a wheelchair? ____ Sometimes ____ Most of the time ____ No

COGNITIVE ISSUES? If Yes, please describe:____

____

IMMUNIZATIONS

Flu vaccine ____ Yes (Date:______________) ____ No ___Refused

Pneumonia vaccine ____ Yes (Date:______________) ____ No ___Refused

Tetanus Shot ____ Yes (Date:______________) ____ No ___Refused

Covid Vaccine ____ Yes (Date:______________) ____ No ___Refused

Additional information or comments about the applicant that might be helpful:

____

____

Where did you hear about Keene Valley Neighborhood House?

____

 Applicant Name________________________________

FINANCIAL INFORMATION

Monthly Income

Social Security	$________________
Pension	$________________
Veteran's Pension	$________________
Disability	$________________
Dividends	$________________
Total Monthly Income	**$**________________

Savings & Assets

Total Savings $__________________

Property Value $__________________

Long-Term Care Insurance Policy

$____________________ (value)

Is the family willing or able to contribute to help with the cost of care? NO YES

The Keene Valley Neighborhood House is a not-for-profit corporation run by a community board of directors. We secure our operating budget by collecting room and board fees as well as by conducting an annual fund drive. It is important that our posted room and board fees be paid in a timely manner at the beginning of each month.

Families and/or Residents are encouraged to plan financially for a long-term stay. In some cases, a resident may become eligible for Social Security Supplemental Income while living at the Neighborhood House. If this happens, a new room rate must be negotiated, and a change of room may be necessary. It is important for the Family/Resident to recognize that we deplete our operating funds every time we agree to a rate for room and board which is below our standard posted rate. In consideration of this, we strongly encourage families to plan to contribute financially to the KVNH through direct donations, life insurance policies, or a will. This will ensure that we will be able to maintain our long tradition of service to this community.

A one-time admission fee of $3,900 will be charged and is expected at the time of admission. The Neighborhood House uses this fee primarily for refurbishing our resident rooms. The actual admission fee may vary and is at the discretion of the CEO/Administrator. Please refer to your Negotiated Rate Letter for the actual fee being charged.

____ Date____________________

Signature of person completing application