TOLSTOY FOUNDATION REHABILITATION & NURSING CENTER

100 Lake Road, Valley Cottage, N.Y. 10989
845.268.6813, Ext. 114 • FAX 845.268.7673

APPLICATION FOR ADMISSION

Please complete all questions. If information is not available, please indicate so.

Applicant will be required to sign a Financial Guarantee Statement.
This Financial Guarantee Statement may be waived in some already approved Medicaid applications.

Name: Mr./ Mrs./ Ms. ____
First Middle Last

Date of Birth: ____________________ Place of Birth: ______________________________________

Legal Address / Present Address:
____
____

Check One: ❐ Own Home ❐ Apartment ❐ w/ Family-Friends ❐ Adult Home ❐ Nursing Home ❐ Other

Status: ❐ Never Married ❐ Married ❐ Widowed ❐ Separated ❐ Divorced

Name of Spouse: ____

Is Applicant a Citizen of the U.S.? ❐ Yes ❐ No______

If Yes: ❐ Natural Born Naturalized Citizen Date: ______________________________

If **not** U.S. Born: Please provide **copy** of Alien Registration or Naturalization Papers

Date of Arrival: ____________________ Country Entered From: __________

Port of Entry: ____________________ Date moved to N.Y. State: __________

Social Security #: ________________________________

Medicare #: ____________________ Medicaid #: ______________________ County: _________

Private Health Insurance Co.: ______________ Policy #_______________ (Attach copy of card/policy)

Nursing Home Coverage ❐ Yes ❐ No Medical Coverage ❐ Yes ❐ No

Should applicant no longer meet the requirements for skilled nursing care and discharge become necessary, what alternatives would be available:

____

Power of
Attorney:____
Name Address Telephone

Responsible Parties in decision-making:

Name | Address | Tel.# (Home/Business/Cell) | Relationship

____

____

Person to be notified in the event of illness:

____

❐ **ANY TIME** day or night ❐ between 8AM & 10PM ❐ At time of death **ONLY**

Do all children know about this application? ❐ Yes ❐ No

Physician's Name: ______________ Address: ____________________ Phone #: __________________

Dentist's Name: _______________ Address: ____________________ Phone #: ___________________

Will Physician Care for Patient in Nursing Home: ❐ Yes ❐ No

Existing Health Care Advance Directives (Check all that apply and attach copies)

❐ Health Care Proxy ❐ Living Will ❐ Do Not Resuscitate

❐ Feeding Restrictions ❐ Other

Will you be in need of financial assistance? ❐ Yes ❐ No

Social Security Pension Amount: $__________________ Receives at: ________________________

Name & Address
Other Income Source and Amount: ____

If there is no Medicaid Number for Chronic Care - copies of 60 months of financial information is requested with application.

Bank Accounts & Names of Signors: ____

Bank: ___________________________ Account#: __________________ Amount: ______________

Property Owned: _____________________________ Value $: _______________________________

Name of Life Insurance Policy and Number, Including Cash Value: $ _____________________________

Do you have a will? ❐ Yes ❐ No

Are you a veteran? ❐ Yes ❐ No Is your spouse a veteran? ❐ Yes ❐ No

Present or Past Union Member? ❐ Yes ❐ No Benefits: $_________________________________

Burial Pre-Arrangements:

Person responsible for burial arrangements: ____

Funeral Home Preference: _______________ Plot Location: ______________________________

Burial Fund: ❒ Yes ❒ No With: ______________________________________

NOTE: ***If you do not indicate a preference above, the Tolstoy Foundation Rehabilitation & Nursing Center will call upon a local funeral home for holding in the event of death.***

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1. I understand admission is based on medical need and therefore authorize Tolstoy Foundation Rehabilitation & Nursing Center to request any and all medical information necessary.
2. I understand the Bed Retention Policy which was attached to the admission application.
3. I understand that the attending physician may be calling in medical consultants when he deems it necessary, and that I will be informed in advance if any invasive procedures are advised.

Signature: ____

Relationship (if other than Applicant): ______________________________

Date: ______________________

Federal and state laws prohibit discrimination based on race, sex, handicap, disability; color, creed, blindness; religion, national origin; source of payment; marital status; age; sexual preference and retention and care of Residents.