

**TEN BROECK**  
•A NYMED Health Care Facility•  
**COMMONS**

**TEN BROECK COMMONS**  
**One Commons Drive**  
**Lake Katrine, NY 12449**  
**(845) 336-6666**  
**FAX (845) 336-5531**

**APPLICATION FOR ADMISSION**

Thank you for your interest in Ten Broeck Commons. In order to process an individual's request for application, we must have the information below. Please answer all questions carefully. The information contained herein is confidential and constitutes the basis for potential resident admission.

**PERSONAL INFORMATION**

Name of Applicant \_\_\_\_\_

Home Address \_\_\_\_\_  
Last First Middle Phone

Present Location \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ U.S. Citizen Yes No

Place of Birth \_\_\_\_\_ Religion (optional) \_\_\_\_\_

Former Occupation \_\_\_\_\_

Name of Attending Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Date and Place of Last Hospital Stay \_\_\_\_\_

Hospital Preference \_\_\_\_\_

Single Married Divorced Separated Widowed

Spouse's Name \_\_\_\_\_

Address, if living \_\_\_\_\_

**DESIGNATED REPRESENTATIVE**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number (Business) \_\_\_\_\_ (Home) \_\_\_\_\_

Power of Attorney Yes \_\_\_\_\_ No \_\_\_\_\_

Guardian Yes \_\_\_\_\_ No \_\_\_\_\_

Health proxy Yes \_\_\_\_\_ No \_\_\_\_\_

**ADDITIONAL CONTACTS**

**FIRST CONTACT**

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Relationship \_\_\_\_\_

Telephone Number (business) \_\_\_\_\_ (home) \_\_\_\_\_

**SECOND CONTACT**

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Relationship \_\_\_\_\_

Telephone Number (business) \_\_\_\_\_ (home) \_\_\_\_\_

**INSURANCE INFORMATION**

Social Security Number \_\_\_\_\_

Medicare Number \_\_\_\_\_ Part A \_\_\_\_\_ Part B \_\_\_\_\_

Medicaid Number \_\_\_\_\_ County \_\_\_\_\_ Caseworker \_\_\_\_\_

HMO \_\_\_\_\_ Policy \_\_\_\_\_

Other insurance \_\_\_\_\_ Policy \_\_\_\_\_ Phone \_\_\_\_\_

Is Resident or Spouse a Veteran? Yes \_\_\_\_\_ No \_\_\_\_\_ VA# \_\_\_\_\_

**\*\*PLEASE ENCLOSE COPIES OF ALL CARDS\*\***

**MONTHLY INCOME**

**Social Security Benefits** \$ \_\_\_\_\_

**Veterans Benefits** \$ \_\_\_\_\_

**Pensions (specify)** \$ \_\_\_\_\_

**Railroad Retirement** \$ \_\_\_\_\_

**Annuity** \$ \_\_\_\_\_

**Other (specify)** \$ \_\_\_\_\_

**BANK ACCOUNTS**

**\*\*PLEASE INDICATE IF THESE ACCOUNTS ARE JOINT\*\***

<b>Bank</b>	<b>Address</b>	<b>Account #</b>	<b>Type</b>	<b>Balance</b>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**REAL ESTATE/ASSETS**

**Do you Own Real Estate?** \_\_\_\_\_ **Value \$** \_\_\_\_\_

**Do You Own Stocks/Bonds/CD's** Yes \_\_\_\_\_ No \_\_\_\_\_

**\*\*Stocks, CD's and Bonds Must Be Identified\*\***

<b>NAME</b>	<b>VALUE</b>	<b>WHERE LOCATED</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**TRANSFER OF ASSETS**

Has there been a transfer of assets in the past 3-5 years? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, date/description \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FUNERAL ARRANGEMENTS**

Person Responsible For Funeral Arrangements \_\_\_\_\_

Name of Funeral Home \_\_\_\_\_

Address/Telephone Number \_\_\_\_\_

Prepaid Burial Yes \_\_\_ No \_\_\_ If yes, Amount \$ \_\_\_\_\_

**ACKNOWLEDGEMENT**

**I understand that Ten Boeck Commons will rely upon the accuracy of the information contained on this application form for the purpose of determining when the resident may need financial assistance.**

**I hereby give Ten Boeck Commons permission to verify the financial information supplied on the application for admission and further agree that the funds listed will be for the care of the applicant during his/her stay at Ten Boeck Commons.**

\_\_\_\_\_  
Applicant's Signature/Designated  
Representative

\_\_\_\_\_  
Date

**\*THIS FACILITY DOES NOT DISCRIMINATE IN ADMISSION OR RETENTION AND CARE OF ITS RESIDENTS BECAUSE OF RACE, COLOR, CREED, SEX, AGE, NATIONAL ORIGIN, SPONSOR, SOURCE OF PAYMENT, DISABILITY, BLINDNESS, HANDICAP, SEXUAL PREFERENCE, OR MARITAL STATUS.**

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## MEDICAL HISTORY AND EXAMINATION

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**History (Hospitalizations, Illnesses, Operations):**

	YES	NO	DATE	REVIEW OF SYSTEMS	NEG.	ABNORMAL FINDINGS
Diabetes	_____	_____	_____	Skin	_____	_____
Seizure Disorder	_____	_____	_____	Head	_____	_____
Heart Trouble	_____	_____	_____	Ears	_____	_____
Tuberculosis	_____	_____	_____	Nose	_____	_____
PVD	_____	_____	_____	Throat	_____	_____
Blood Transfusion	_____	_____	_____	Neck	_____	_____
Flu Vaccine	_____	_____	_____	Chest, Lungs	_____	_____
Pneumovax	_____	_____	_____	Heart	_____	_____
Tetanus	_____	_____	_____	Abdomen	_____	_____
PPD (Tuberculin)	_____	_____	_____	Genitalia	_____	_____
Pacemaker	_____	_____	_____	Lymphatic	_____	_____
Rash	_____	_____	_____	Blood Vessels	_____	_____
Contagious Dis.	_____	_____	_____	Musculoskeletal	_____	_____
Communicable Stage	_____	_____	_____	Extremities	_____	_____
Mental Illness	_____	_____	_____	Nuerological	_____	_____
Dementia DX	_____	_____	_____	Gastrointestinal	_____	_____

**NOTE: All applicants must document a P.P.D. (Tuberculin) test done within the last six months, Date: \_\_\_\_\_ Results: \_\_\_\_\_ if positive, results of chest x-ray within last six months: \_\_\_\_\_**

**Orientation**

**Time:** \_\_\_\_\_ **Place:** \_\_\_\_\_ **Person:** \_\_\_\_\_

**Behavior Problems (Specify):** \_\_\_\_\_

**Allergies/Drug Sensitivities:** \_\_\_\_\_

**Vital Signs: Temp:** \_\_\_\_\_ **Pulse:** \_\_\_\_\_ **Resp.:** \_\_\_\_\_

**B/P:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_

**Other Pertinent Information:** \_\_\_\_\_

**Physician's Signature:**