ANDRUS ON HUDSON
185 Old Broadway
Hastings-on-Hudson, New York 10706

ADMISSIONS

Application for Admission

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, marital status, and source of payment, the Andrus on Hudson treats all applicants on this non-discriminatory basis.

Name		Date
Street Address		
City	State	Zip
Telephone #		

Background Information

Date of Birth	U.S. Citizenship o Yes o No	Place of Birth
Length of stay in U.S.		Clergy Name
Mother's Maiden Name		Congregation
Father's Name		Congregation Address
Your Religion	Telephone	

Health Insurance Information

Medicare # (including suffix)	Medicaid #
Medicare Supplemental Carrier	Premium Payment $
Policy #	o Monthly o Quarterly

Life Insurance Information

Life Insurance o Yes o No	(Please provide photocopies of policy(ies)
Name of Carrier (1)	Name of Carrier (2)
Policy #	Policy #
Face Value Cash Value	Face Value Cash Value

Medical Information

Weight Height
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
o Dentures o Hearing Aides o Pacemaker o Special Appliances o Other

Financial Information

Income	Per Month $		Per Month
Social Security #		SSI	
Railroad Retirement #		Annuity	
Private Pension(s)		Dividends	
Veterans Benefit(s)		Interest	

Assets

Note: All financial information must be documented. Please provide photocopies of all assets listed below with the application. Copies of bank statements and income tax returns for the past five years may be needed. Use additional pages as necessary

Bank	Account Type (Savings, Checking, Money Market, Also Stocks, Bonds, Etc.	Account #	Ownership	Balance

Provide a copy of deed and present value of all Real Estate Owned: o Private House o Co- Op
o Condo o Other

Other Assets: (describe and indicate value)

Have you disposed of any assets within the last 36 months? o No o Yes (If yes, give amount, date and reason)

Do you maintain assets in a safe deposit box? o No o Yes (If yes, please specify assets and give location and name(s) of person(s) who have access

If you have Medicaid, please indicate county, caseworker 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's Representative	Date

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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)				
o Married	o Single	o Widowed	o Separated	o Divorced
Name of Spouse		Occupation		
Date of Marriage	Deceased: o Yes o No		Date of Death	

List Next-of-Kin

Relationship	Name	Address	Tel. # Home/Bus	Design. Rep. (Check)
				o
				o
				o
				o
				o

Does the applicant have any advance directives? Please check and provide photocopy with application.

Health Care Proxy	o Yes o No	Do Not Resuscitate	o Yes o No
Medical POA	o Yes o No	Living Will	o Yes o No

Previous Housing o Private House o Apartment o Condo o Co-op o Other Explain:

Were home care services provided? o Yes o No If yes, explain:

Do you have a person or firm with your general Power of Attorney? If so, give name, address, and Provide a copy

Funeral Arrangements

Responsible Party Name:	
Address:	Telephone:
Deeded Cemetery Plot Location	Burial Pre-Arrangement: o Yes o No
Name of Funeral Home	
Address	
Telephone	

Please provide photocopy of cemetery deed and burial pre-arrangement.

Psychological Information

Please provide a complete description of the applicant's level of functioning prior to seeking Nursing Home Placement

Does the applicant smoke?

Describe the applicant's daily routine prior to placement (i.e., eating, sleeping patterns, habits)

Discuss the applicant's past roles (i.e., life-long occupation, language, interests and skills)

Describe the applicant's family involvement and family relationship.

Describe the applicant's ability to communicate. Does he/she have an understanding of his/her medical condition?

Describe the applicant's present social and behavioral functioning (i.e., sociable, passive, anxious, sad, gregarious, agitated, isolated, talkative, etc.) and indicate behavioral problems (i.e., wandering, agitation, combativeness)

Is the applicant taking any psychoactive medication currently or has he/she taken this type of medication in the past?

Has the applicant ever had a psychiatric hospitalization? If so, explain:

Signature	Relationship
Date	(7380037)

ANDRUS ON HUDSON
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(914) 478-3700
(914) 478-3541 (FAX)

MEDICAL INFORMATION

(Must be completed by physician)

RESIDENT'S NAME: ____________________ DATE OF BIRTH: ______ MARITAL STATUS ____
(Please Print)

Supplemental Insurance Carrier: ________________________ Policy No.: ______________________

Complete Medical History (Use separate sheet if necessary) ______________________________________
____
____
____
____

Current Medication (Include OTC's)

Medication	Date Prescribed	Dosage/Times Per Day	Diagnosis

Diet: ____
Allergies, Drug Sensitivities: ____
Surgical History: ____
Family History: ____
Major Injuries: ____
GYN History: ____
Psychiatric History: ____
Social History (Profession, hobbies, etc.): ____
Use of Alcohol: ____________________ Use of Tobacco: ____________________
Vaccination History:
Tetanus ____________________
Last Flu Vaccine ________________
Pneumococcal Vaccine ________________
PPD Status (Must be completed)
Date: ____________ Results: ________________
ROS (Review of System)
____
____

MEDICAL INFORMATION

(Must be completed by physician)

Please complete every item

General Appearance ________ Hgt. ____ Wt. ____ B/P ____ HR ____ RR ____
Skin: ________ Neck/Thyroid: ________
E.N.T. ________ Eyes: ________ Mouth & Teeth: ________
Chest & Lungs: ________
Heart Rate: ________ Rhythm ________
Heart Sounds: ________ Murmurs: ________
Abdomen: ________ Breasts: ________ Rectal: ________
Genito-Urinary: ________
Extremities: ________
Neurological: ________
Diagnoses: ________

FUNCTIONAL STATUS:	YES	NO	
Patient is continent	____	____	Bowel ____ Urine ____ Both (If no, describe assistance required)
Able to feed self	____	____	________
Able to dress self	____	____	________
Able to bathe self	____	____	________
Wears eye glasses	____	____	For reading ____ Full Time ____
Dentures	____	____	
Hearing Aid	____	____	
Surgical Dressing	____	____	
Orthopaedic Appliance	____	____	If yes, describe ________
Ambulation (describe distance)			

____

With appliance: Cane ____ Walker ____ Crutches ____
Stairs: Unaided: ____ Aided ____
Drives car: ________ Recommended Driver Evaluation: ________
Manages Household Affairs (finances, shopping, etc.) ________
If no, describe ________
Mental/Emotional Assessment: Good Fair Poor
Orientation (Person, Place, Time) ____
Periodic loss of orientation: Yes __ No __ Describe ________
Mini-Mental State Exam Score (Optional): ________
Has there been any change or deterioration in the patients functioning level in the last year, and if so, please specify: ________

____

Date of Exam: ____ Physician's Name (please print): ________
Street Address: ________ City & State: ________
Phone Number: ________ State and State License No.: ________
Physician's Signature: ________