Steven M. Neuhaus
County Executive

Laurence LaDue
Administrator

2 Glenmere Cove Road
Goshen, New York 10924
Tel: (845) 291-4740 FAX: (845) 291-4715

Application for Admission

NAME_____ **MAIDEN NAME**_____

Permanent Legal Address_____ County _____

Present Location: _____ Email address_____

Date of Birth_____ Place of Birth_____

Is there a Alzheimer's/Dementia Diagnosis? **YES** or **NO** Is there wandering or risk for elopement? **YES** or **NO**
Religion:_____

MARITAL STATUS: Single ____ Married ____ Widowed ____ Separated ____ Divorced ____
Spouse's Name (if applicable) _____
Citizen: **YES** or **NO** Veteran: **YES** or **NO**

RESPONSIBLE PERSON(S) / FAMILY CONTACTS:
(Please Name Power or Attorney or Health Care Proxy first, if applicable)

Name_____Relationship_____

Address_____City/Zip_____Email Address:_____

Home # _____Work _____Other_____

Health Care Proxy: **YES or NO** Power of Attorney: **YES or NO**

Name_____Relationship_____

Address_____City/Zip_____Email Address:_____

Home # _____Work _____Other_____

Health Care Proxy: **YES or NO** Power of Attorney: **YES or NO**

DOES APPLICANT HAVE ANY OF THE FOLLOWING: (If so, please provide copies)

Health Care Proxy _____ DNR _____ Living Will _____ Power Of Attorney _____ Guardian _____

Name of Primary Care Doctor_____Telephone_____

INSURANCE INFORMATION: (Please provide a copy of insurance cards)

Social Security Number:_____

Medicare # _____Part A ____ Part B ____ Part D ____

RX Plan Name:_____ ID#_____

Other Insurance Plan Name:_____ ID#:_____

Medicaid # _____ Case No._____ If pending, date applied_____

LONG TERM CARE POLICY: (Please provide a copy of policy)

Name of Member: _____ Social Security #: _____

Group Number: _____ Policy Number: _____

Phone Number: _____

FINANCIAL INFORMATION:

INCOME:	**MONTHLY AMOUNT**
Social Security	$_____/month
Retirement Pension	$_____/month
Name of Pension Company_____(please provide statement/stub if available)	
Veteran's Pension	$_____/month
Supplementary Security Income	$_____/month
Annuities	$_____/month
Name of Company Holding Annuity_____	
Other Income	$_____/month
Total Monthly Income	$_____/month

Bank Accounts:	Account Number	Name(s) on Account	Type of Account	Balance

Have any assets been transferred in the last 60 months? **YES** or **NO** Amt $_____

Do you own any real estate**? YES** or **NO** **Value** $_____

Do you own Stocks? **YES** or **NO** If yes, specify type, approximate value, and where located:_____

_____

I CERTIFY THAT THE FOREGOING INCLUDES A TRUE, FULL AND COMPLETE STATEMENT OF MY ASSETS AND LIABILITIES, AND UNDERSTAND THAT THE VALLEY VIEW CENTER FOR NURSING CARE & REHABILITATION WILL ACT IN RELIANCE UPON IT. I AUTHORIZE THE VALLEY VIEW CENTER FOR NURSING CARE & REHABILITATION TO SEEK OR FOLLOW-UP MEDICAL INFORMATION NECESSARY FOR THE PROCESSING OF MY APPLICATION FOR ADMISSION.

THIS AUTHORIZATION APPLIES TO APPLICANT ONLY, NOT DESIGNATED REPRESENTATIVE OR SPONSOR.

Signature of Applicant _____ Date of Application _____

Signature of Designated Representative or Sponsor _____ Date Signed _____

NO APPLICANT SHALL BE DENIED ADMISSION, RETENTION OR CARE ON THE BASIS OF RACE, RELIGION, CREED, COLOR, NATIONAL ORIGIN, HANDICAP, SEX, SEXUAL PREFERENCE, BLINDNESS, MARITAL STATUS, AGE SPONSOR OR SOURCE OF PAYMENT.

You must provide copies of the following:

Medicare Card
Medicaid Card
Secondary Insurance Card
Prescription Card
Pension statement/stub (if applicable)
Health Care Proxy forms (if applicable)
Power of Attorney forms (if applicable)
DNR (if applicable)