



Beechtree

CARE CENTER

Rehabilitation & Skilled Nursing

318 South Albany Street, Ithaca, NY 14850

(607) 273-4166

ADMISSION APPLICATION

**To be completed by the applicant or designated representative.
All information will be kept confidential by Beechtree Care Center**

This application is for (please check one): Residential Care _____ Rehabilitation _____

Applicant name: _____

First Middle Last (Maiden)

Home Address: _____

Street/Number City State Zip Code County

Telephone () _____ Gender _____ Date of birth _____ Place of birth _____

Applicants Social Security Number _____

Married/partner **Y or N?** _____ If Yes, spouse/partner name _____

Spouse/partner resides at: _____

Street/Number City State Zip Code County

Applicant's primary diagnosis: _____

Applicant's most recent occupation: _____ Veteran **Y or N?** _____

Physician's name: _____ Telephone () _____

Do you have an advanced healthcare directive **Y or N?** Do you have: a Do Not Resuscitate order signed by a Physician **Y or N**

Healthcare proxy **Y or N** Living Will **Y or N?** Most recent date of: **Pneumovac** _____ **PPD** _____ **Flu Vaccine** _____

Please list Funeral Home preference _____ City _____ State _____ Phone () _____

Please list your designated representative or contact person, and an alternate contact person.

First contact _____ Relationship to you _____

Their address _____

Street/Number City State Zip code

Telephone: Home () _____ Work () _____ Cell () _____

Second contact _____ Relationship to you _____

Their address _____

Street/Number City State Zip code County

Telephone: Home () _____ Work () _____ Cell () _____

Please list your financial resources

Medicare # _____ Medicare Part B (Yes or No) _____ Medicare HMO (Yes or No) _____

Medicaid (Yes or No) _____ Medicaid # _____ County _____

Private insurance: Name _____ Policy number _____

Prescription drug coverage **Y or N** If yes, company and Policy number? _____

Financial Resources:

Checking/savings (circle one) account number _____ bank _____ Balance _____

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Please list assets (money or real estate) that you have transferred to family or friends within the last 3 years:

Do you have life insurance **Y or N**, if yes, Company _____ Policy number _____

Please list your monthly income from:

Social Security _____ Stocks _____ Trust funds _____ Veterans' Benefits _____ Pension(s) _____

Pension(s) Address: _____

Please list amount of outstanding debt _____ How much health care expense can you afford each month? _____

Person managing applicant's finances

Name _____ Relationship to applicant _____

Their address _____
Street/Number City State Zip code

Telephone: Home () _____ Work () _____ Cell () _____

Does the applicant have a power of attorney (POA)? **Y or N**

If yes, Name _____ Relationship to applicant _____

Their address _____
Street/Number City State Zip code

Telephone: Home () _____ Work () _____ Cell () _____

In compliance with New York State and Federal laws, which prohibit discrimination based on race, creed, color, national origin, sex, age, sexual orientation, disability, blindness, marital status, sponsorship, employment or source of payment; this facility admits and treats patients on a non-discriminatory basis.

According to the best of my knowledge, the above information is accurate and true.

Signature of applicant: _____ Date: _____

Signature of designated representative: _____ Date: _____