



# PLEASANT VALLEY

## Admission Application



### General Information Regarding Prospective Resident

Prospective Resident's Name:					Last:		First:		Initial:	Nickname:	
DOB:		Age:	Sex:	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> S <input type="checkbox"/> D							
Home Address:											
City, State & Zip:											
Primary Physician:											
Present location (if different from home address):		Address: City, State, Zip:									
Advanced Directives:		<input type="checkbox"/> POA <input type="checkbox"/> DNR <input type="checkbox"/> LIVING WILL <input type="checkbox"/> HCP									
Social Security #:		Are you a US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Were you born in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No					Religion:				
Significant Others:											
Name:											
Relationship:											
Check if applicable:		<input type="checkbox"/> POA <input type="checkbox"/> HCP <input type="checkbox"/> Guardian <input type="checkbox"/> Bank Trustee <input type="checkbox"/> Other, specify:									
Address:											
Telephone Number(in order of contact preference)		#1: <input type="checkbox"/> Home <input type="checkbox"/> cell <input type="checkbox"/> work		#2: <input type="checkbox"/> Home <input type="checkbox"/> cell <input type="checkbox"/> work		#3: <input type="checkbox"/> Home <input type="checkbox"/> cell <input type="checkbox"/> work					
Email address:											
Name:											
Relationship:											
Check if applicable:		<input type="checkbox"/> POA <input type="checkbox"/> HCP <input type="checkbox"/> Guardian <input type="checkbox"/> Bank Trustee <input type="checkbox"/> Other, specify:									
Address:											
Telephone Number(in order of contact preference)		#1: <input type="checkbox"/> Home <input type="checkbox"/> cell <input type="checkbox"/> work		#2: <input type="checkbox"/> Home <input type="checkbox"/> cell <input type="checkbox"/> work		#3: <input type="checkbox"/> Home <input type="checkbox"/> cell <input type="checkbox"/> work					
Email address:											
Patient Information:											
Mental Status: <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person								Read: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Ability to Communicate: <input type="checkbox"/> Verbal <input type="checkbox"/> Non-Verbal Primary Language:								Write: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Patient's Attitude toward placement:											
Family's Attitude toward placement:											
Insurance Information:		Yes	No	Identification# and/or Plan/Group Name				Effective Date:			
Medicaid: County:											
Medicaid Pending:				Application Date:				County:			
Traditional Medicare# Part A											
Traditional Medicare# Part B											
Medicare Supplemental Plan/Plan C											
Medicare Managed by Other											
Medicare D:											
Other Supplemental Ins.											
VA Services eligible:				Name of Veteran: Type: <input type="checkbox"/> Lifetime <input type="checkbox"/> Short Term				Branch:			

MONTHLY INCOME:					
Type	Amount	Type	Amount	Type	Amount
Social Security		Private Pension		Annuity	
Veteran's Pension		Rental Property		Trusts	
Railroad Pension		Supplemental SI		Other Income	
ASSETS					
Bank Accounts	Bank	Balance	Balance as of date:	Joint Account?	
				Yes	No
Checking		\$			
Savings		\$			
Savings		\$			
CD's- Bank or Financial Institution:			Balance:		
Stocks – Name of Stock			#Shares:	Market Value:	
Does Applicant own a home? <input type="checkbox"/> Yes <input type="checkbox"/> No		Jointly owned? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Who?		Estimated Value: \$	
Any lien, mortgage or home equity loan on property? <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>Please contact your local Department of Social Services to discuss the impact of property ownership on Medicaid eligibility.</i>			
Has Applicant ever owned a home? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when was ownership transferred?			
Other Real Estate <input type="checkbox"/> Yes <input type="checkbox"/> No Estimated Value		If so, in what amount:			
Other Assets- (Please list)				Amount	
				\$	
				\$	
Have any assets (i.e. cash, property, real estate)- been transferred in the last 60 months?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please describe:					
Funeral Arrangements:					
Funeral Home Name:					
Address:					
Phone Number:			Prepaid <input type="checkbox"/> Yes <input type="checkbox"/> No Amount:		
Has an estate trust been established? (If yes, please provide a copy)				<input type="checkbox"/> Yes <input type="checkbox"/> No	
To the best of my knowledge, all of the information provided herein is correct and valid. I understand that the information contained in this form will be shared with nursing homes in which I have an interest.					
X _____					
Signature of Applicant or Responsible Party					Date
The information provided shall remain confidential and shall be made available only to authorized hospital and nursing home personnel involved in the placement process and to any governmental officials authorized access by law to such records. The facilities having access to this information do so without regard to race, creed, color, age, sex, religion, national origin, sponsor, sexual preference, disability, or marital status: Persons under 16 years of age are not eligible for admission consideration, unless special approval has been received from the Department of Health.					