



1001 Lincoln Avenue Lockport, NY 14094 716.433.1513

# Briarwood Manor Assisted Living Program

*It is the policy of Briarwood Manor to admit and treat all persons without regards to race, creed, color, religion, sponsor, national origin, sex, sexual preference, blindness, other handicaps or source of payment.*

Please Answer All Questions As Completely As Possible.

## Personal Data

1. Name \_\_\_\_\_ Phone \_\_\_\_\_  
*Last First M.I.*

2. Home Address \_\_\_\_\_  
*Street City State Zip Country*

Own  Rent  Other  \_\_\_\_\_

How long have you lived at the above address? \_\_\_\_\_

3. Where is the person currently? \_\_\_\_\_ Admision Date \_\_\_\_\_

4. Date of Birth \_\_\_\_\_ Sex M  F  Birthplace \_\_\_\_\_

5. American citizen? Yes  No

6. Marital Status Single  Married  Widowed  Separated  Divorced

Name of spouse (even if deceased) \_\_\_\_\_ Maiden Name \_\_\_\_\_

Date of spouse's birth \_\_\_\_\_ death \_\_\_\_\_ marriage \_\_\_\_\_ divorce \_\_\_\_\_

7. List nearest relatives/Significant others:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Business Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Business Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Business Phone \_\_\_\_\_

8. What has been your occupation? \_\_\_\_\_

Date of Retirement \_\_\_\_\_

9. Are you a US Veteran Yes  No  Date of Service \_\_\_\_\_

Are you a spouse of a Veteran Yes  No

10. Attending Physician Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

## Financial Section

(Do not leave spaces blank - enter 0 where appropriate)

11. Please state monthly income

Amount of Total Income \_\_\_\_\_

Social Security \_\_\_\_\_ Interest \_\_\_\_\_

Pensions \_\_\_\_\_ Other \_\_\_\_\_

SSI \_\_\_\_\_ VA \_\_\_\_\_

12. Please list cash value of all resources with the Names of Financial Institution

Savings account \_\_\_\_\_ Checking account \_\_\_\_\_

Securities \_\_\_\_\_ Real Estate \_\_\_\_\_

Burial Fund \_\_\_\_\_  
*Type* *Amount* *Where*

Other \_\_\_\_\_

Remarks \_\_\_\_\_

\_\_\_\_\_

## Statistical Section

13. Medicaid Yes  No  Effective date \_\_\_\_\_

14. If 'yes' Medicaid number \_\_\_\_\_ Type of coverage \_\_\_\_\_

County of Origin \_\_\_\_\_ Case Worker \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

15. Please list Social Security number \_\_\_\_\_

Medicare number \_\_\_\_\_ Medicare A effective date \_\_\_\_\_

Medicare B effective date \_\_\_\_\_

16. Do you have prescription coverage?

Name of Policy \_\_\_\_\_ ID# \_\_\_\_\_ Effective date \_\_\_\_\_

17. Do you have hospital insurance? Yes  No

If 'yes' give Company and policy number \_\_\_\_\_ Group \_\_\_\_\_

18. Preferred Hospital \_\_\_\_\_

19. Who shall be notified in case of serious illness or death? (include business phone if appropriate)

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

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

20. Funeral home Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

21 Do you have a burial lot? Yes  No

Cemetery \_\_\_\_\_ Lot No. \_\_\_\_\_

22. Do you have: Health Care Proxy  Living Will  Donor Card  Do Not Resuscitate Order

\* Please submit copies of all pertinent identification cards.

**Social Data**

23. What are your present living arrangements? (do you live alone, with spouse, or with others?) \_\_\_\_\_

24. Do you need assistance with meal preparation or personal care? Please explain \_\_\_\_\_

25. Are you on a special diet? \_\_\_\_\_ Specify \_\_\_\_\_

26. Do you need assistance of any device for ambulation? Yes  No  Explain \_\_\_\_\_

27. Do you have a visual impairment? Yes  No  Describe \_\_\_\_\_

Glass Yes  No

Hearing Aid Yes  Right  Left  No

Dentures Yes  Upper  Lower  No

28. Briawood Manor desires to provide and promote a smoke free environment for its residents and staff. All perspective residents must sign an agreement not to smoke in the building or on the grounds.

Do you presently smoke? Yes  No

Did you smoke in the past? Yes  No

How long ago did you quit? \_\_\_\_\_

29. Why do you desire residence? \_\_\_\_\_

30. Education - circle highest year completed

Grade School - 1 2 3 4 5 6 7 8

High School 1 2 3 4

Further training - specify \_\_\_\_\_

31. Mental health care in the past 5 years? Yes  No

Provider \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

32. Person filing this application (other than self)

Name \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

33. Power of Attorney/Responsible Party Yes  No

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

34. How did you hear about us? \_\_\_\_\_

**Pre-Admission Record**

- Official Use Only -

Date completed application was received \_\_\_\_\_

Rating by social Work representative \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Placed on waiting list Date \_\_\_\_\_ Private  Semi  First Floor  Second Floor