BROADLAWN MANOR ADULT DAY HEALTH CENTER
399 COUNTY LINE ROAD
AMITYVILLE, NY 11701

APPLICATION FOR ADMISSION
(To be completed by applicant/family member/caseworker)

Name of Applicant:_____
(Last Name) (First Name)
Address:_____
(Street) (City) (State) (Zip Code)
Telephone No.:_____ Date of Birth:_____Age_____Sex:_____
Marital Status:_____ Place of Birth:_____ Religion: (Optional)_____

Individuals to be contacted regarding this application:

CONTACT #1:
Name: _____ Relationship to Applicant:_____
Address:_____
(Street) (City) (State) (Zip Code)
Home Phone:_____Business Phone:_____ Cell Phone: _____
E-MAIL ADDRESS: _____

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CONTACT #2:
Name: _____ Relationship to Applicant:_____
Address:_____
(Street) (City) (State) (Zip Code)
Home Phone:_____Business Phone:_____ Cell Phone: _____

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Physician Information:
Name of Applicant's physician:_____
Address:_____
Telephone No._____

Applicant Information:
Applicant currently lives o alone o with someone
Name: _____ Relationship: _____
Major Health Concerns:_____
_____
_____
Does the applicant have a past history of psychiatric illness? o Yes o No
If yes, please specify the nature of the illness, approximate treatment dates as well as the facility where treatment was rendered_____
_____
_____

Are you able to provide your own Transportation: o Yes o No

Mental Status Information:

		Yes	No
1.	Is the applicant alert?	o	o
2.	Does the applicant recognize the family?	o	o
3.	Does the applicant speak a language other than English?	o _____	o
4.	Is the applicant confused?	o	o
	If yes, do you feel the confusion is: (please circle)		
	a. Mild		
	b. Severe		
5.	Does the applicant experience hallucinations?	o	o
	If yes, has the applicant been treated for hallucinations?	o	o
6.	Does the applicant exhibit any aggressive behavior?	o	o

If yes, please provide additional information _____

_____

_____

Financial Information:

Financial arrangements upon admission to Broadlawn:

o Private Funds o Medicaid o Private Insurance o Other

If other, please specify_____

Social Security Number:_____ Medicare Number:_____

If applying for ***Adult Day Health Services***, please indicate amount of Medicaid Coverage, _____

Medicaid Number:_____ Medicaid County:_____

Medicaid Caseworker name and telephone number:_____

Amount of monthly income:

Social Security:_____ Veterans Benefits:_____ Pension:_____

Disability:_____ Other Income (annuities, dividends, etc):_____

Do you receive food stamps? o Yes o No

If yes, how much?_____

Health Insurance Information:

Name of Insurance Company:_____

Address:_____

Telephone No._____ Policy/Identification No.:_____

Name of policy holder:_____

7. Do you have homecare (Personal Care Aide)? o Yes o No

If yes, Specify the time each day:

Days:

Mon.	o	_____
Tues.	o	_____
Wed.	o	_____
Thurs.	o	_____
Fri.	o	_____
Sat.	o	_____
Sun.	o	_____

Department of Social Services, Registered Nurse:

Name:_____Phone #:_____

Home Care Agency:

Name: _____

Contact Person:_____ Phone #: _____

8. Are you a participant of an MLTC?
(Medicaid long-term program)? o Yes o No

If Yes, Name: _____

Contact Person: _____

Are you receiving any assistance from any Social or Health Agencies at this time?

o Yes o No

Name of Agency: _____

Contact Person: _____

I have been referred to Broadlawn Manor Day Care Program by: _____

BROADLAWN MANOR DOES NOT DISCRIMINATE IN THE ADMISSION OR RETENTION OR CARE OF ITS RESIDENTS BECAUSE OF RACE, CREED, COLOR, NATIONAL ORIGIN, SEX, DISABILITY, AGE, SOURCE OF PAYMENT, MARITAL STATUS OR SEXUAL PREFERENCE.

I hereby declare that the information provided in this application is accurate to the best of my knowledge.

Signature:_____ _____

Applicant Family Member/Caseworker

Date: _____ Date Received:_____By:_____