The Alice Center

Skilled Care • Rehabilitation Services • Assisted Living

Assisted Living Program

45 6th Street - Malone NY 12953

General Information

Name_____ SS#_____-_____-_____

Address_____ City_____ Zip_____

Telephone_____ Cell Phone_____

Contact Information

Name_____ Relationship_____

Address_____ City_____ Zip_____

Telephone_____ Cell Phone_____ Alternate_____

How did you hear about The Alice Center Assisted Living Program ? _____

_____

Background Information

Birth Date____/____/____Gender at Birth_____

Gender You Identify as_____ Education_____

Occupation(s)_____

Veteran **Y** or **N** Branch_____ Spouse Veteran **Y** or **N** Branch_____

Organization(s)_____

Interests/Hobbies_____

Religion_____ Place of Worship_____

Medical History

Illness_____

_____

Surgeries_____

_____

Alergies_____

_____

Daily Living

Are there any problems or concerns that our staff should know about you or any special support that you might need? _____

_____

Do you currently need someone to assist you during the day? ☐ **Y** or **N** ☐

If yes, what type of assistance do you receive? _____

_____

_____

Task	No Assistance	Minimal Assistance	Full Assistance
Housekeeping	☐	☐	☐
Laundry	☐	☐	☐
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Grooming/Shaving	☐	☐	☐
Medication Reminder	☐	☐	☐
Walking	☐	☐	☐
Night Care	☐	☐	☐
Shopping	☐	☐	☐
Transportation	☐	☐	☐
Getting in/out Car	☐	☐	☐
Using a Telephone	☐	☐	☐

Primary Care Physician_____

Address_____ Telephone_____

Hospital that you use_____

How would you describe your current health? ☐ Excellent ☐ Good ☐ Fair

How often do you see your doctor? _____

Do you use cane, wheelchair, or walker? _____ Type? _____

Do you own a car? ☐ **Y** or **N** ☐

Are you on a special or restricted diet? ☐ **Y** or **N** ☐

Describe_____

_____

Do you have a ☐ DNR ☐ Health Care Proxy ☐ Power of Attorney

☐ MOLST ☐ Living Will

Name of Person_____

Other information that we should know about you and what we can do to help_____

_____

_____

Medical Insurance Information

Medicare A Number-	
Medicare B Number-	
Medicaid Number-	
Private Insurance-	Co-Pay Amount-
Prescription Plan-	Co-Pay Amount-
Dental Plan-	Co-Pay Amount-

Financial Information

Employment Income	$_____ Per Month
Social Security Income	$_____ Per Month
SNA Income	$_____ Per Month
Employer Pension	$_____ Per Month
Interest & Dividend Income	$_____ Per Month
Annuity Income	$_____ Per Month
Life Insurance Income	$_____ Per Month
VA Benefits	$_____ Per Month
Rental Income	$_____ Per Month
Other	$_____ Per Month
Other	$_____ Per Month
Total Monthly Income	$_____

Assets/Savings_____

Checking Account_____

Savings Account_____

Stocks/Investments_____

Real Estate (Value of your Home less any outstanding Mortgage Balances) _____

Are any of these Assets above held jointly? ☐**Y** or **N**☐

Long Term Insurance Policy ☐**Y** or **N**☐

Company Name _____

Company Address_____

I understand and agree that this application is neither a contract, nor a reservation for residency. Nothing contained in this document is legally binding on The Alice Center – Assisted Living Program or me unless and until all parties have signed an Admission Agreement.

Signature of Applicant

_____ Date_____

Signature of Advisor

_____ Date_____

Signature of Administrator or Designee

_____ Date_____