Lewis County Health System
Your Health Partner

7785 N. State Street, Lowville, NY 13367
315-376-5200

APPLICATION FOR LONG-TERM ADMISSION

Patient Identifiers (2)

DATE: _____

NAME: _____
(Last) (First) (Middle) (Maiden)

PREFERRED NAME: _____

PERMANENT ADDRESS: _____
(Route or Street) (City) (County) (State) (Zip)

PHONE: _____ E-MAIL: _____

CURRENT LOCATION: _____
(Route or Street) (City) (County) (State) (Zip)

CONTACT PERSON(S)

CONTACT PERSON #1

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

(Home) _____ (Work)PHONE: _____ (Cell) _____

(E-mail) _____

CONTACT PERSON #2

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

PHONE: (Home) _____ (Work) _____ (Cell) _____

(E-mail) _____

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APPLICANT INFORMATION

DATE OF BIRTH: _____ AGE: _____ SEX: ☐ MALE ☐ FEMALE

PLACE OF BIRTH: _____ Race / Ethnicity: _____

OCCUPATION (CURRENT or PAST: _____ ☐ CURRENTLY EMPLOYED ☐ RETIRED

MARITAL STATUS: (Circle One) M W D S SPOUSE NAME: _____

RELIGION: _____ CHURCH: _____

PRIMARY LANGUAGE: _____ INTERPRETER REQUIRED: ☐ YES ☐ NO

Mother's First Name: _____ Mother's Maiden Name: _____

INSURANCE INFORMATION

MEDICARE #: _____

MEDICAID #: _____ COUNTY _____

OTHER HEALTH INSURANCE (include name of insurance, address, telephone #, applicant's ID #, and group #.)

_____

_____

_____

INSURANCE COVERAGE FOR MEDICATIONS: Effective Date for Medicare A: _____

MEDICARE PART D PLAN: _____ ID# _____ Effective Date for Medicare B: _____

OTHER HEALTH INSURANCE THAT PAYS FOR MEDICATIONS: _____ ID# _____

LIFE INSURANCE: _____

VETERAN / SPOUSE OF VETERAN: ☐ YES ☐ NO

DATES AND BRANCH OF SERVICE: _____

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MEDICAL INFORMATION

CURRENT PHYSICIAN: _____

DATES & LOCATION OF LAST HOSPITALIZATION: _____

ALLERGIES (Food, Medication, Environmental): _____

_____

DOES THE APPLICANT HAVE:

_____ Power of Attorney _____
Name & Phone #

_____ Health Care Proxy _____
Name & Phone #

_____ Living Will

_____ Do Not Resuscitate Order

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR MAKING PAYMENT: _____

Relationship: _____

Address: _____

Phone #: _____

I declare that all information is true and complete according to my best knowledge. If the assets change prior to admission, the applicant or designated representative is responsible to advise the facility.

_____ _____
Date **Applicant / Designated Representative Signature**

POLICY STATEMENT

It is the policy of LCRHCF to admit and treat all residents and to provide service and make available all facilities of Lewis County Residential Healthcare Facility without regard to age, race, creed, color, handicap, blindness, religion, national origin, sex, marital status, sexual orientation, payer source, sponsor or veteran status.

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INCOME (Please specify amount per month)

	APPLICANT	SPOUSEAPPLICANT
SOCIAL SECURITY:		
PENSION SOURCE:		
AMOUNT:		
INTEREST / DIVIDENDS:		
OTHER:		
TOTAL:		

ASSETS

(Please list all assets for **applicant and spouse**.)

PLEASE PROVIDE THE NAME OF THE INSTITUTION AND AMOUNT FOR THE FOLLOWING:

CHECKING ACCOUNTS

SAVINGS ACCOUNTS

STOCKS / MUTUAL FUNDS

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BONDS

CERTIFICATES OF DEPOSIT

TRUST

PROPERTY ADDRESS

Market Value: _____

ASSETS DISPOSED OF IN THE LAST 5 YEARS

TYPE	VALUE	DATE

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LIABILITIES

(Mortgages, Loans, Insurance Payments, Medical Bills, Etc.)

TYPE	NAME OF INSTITUTION	AMOUNT

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Date: _____

Dear: _____

Thank you for you inquiry regarding admission to Lewis County Residential Healthcare Facility. Enclosed is an application form for you to complete. If the applicant is currently residing in the community, you will need to contact Home Health to complete a Patient Revew Assessment (PRI) and screen. Once this is done, please forward it to the Case Management Department along with the application.

We also require copies of the following documentation that pertains to the applicant:

- Date of Birth Verification
- Social Security Card
- Medicare Card
- Medicaid Card
- Prescription Drug Card
- Any other Medical Insurance Cards
- Power of Attorney
- Health Care Proxy
- Living Will
- Guardian
- Non Hospital Do Not Resuscitate Order

Please send copies of the above information via **one of these** methods*:

Drop off at the Switchboard at Lewis County Health System.

VIA MAIL: Attention - Danielle Beckingham RN, Lewis County Health System, 7785 N. State Street, Lowville, New York 13367

VIA EMAIL: danielle.beckingham@lcgh.net and ur@lcgh.net (pls sent to both addresses)

If you do not have access to a photocopier, you may bring in the required documents and we will make copies for you.

If you have any further questions, please do not hesitate to contact me at (315) 376-5205.

Sincerely,

Danielle Beckingham, RN
Case Manager

Enc.

Lewis County General Hospital and Residential Health Care Facility is a tobacco-free campus.