Hilton East Assisted Living Community
231 East Avenue, Hilton, NY 14468
Phone: 585-392-7171 ● Fax: 585-392-3631
www.HiltonEast.com

Please complete the entire reservation form with the most up-to-date information as possible in order to expedite the admission process. (Please note, information requested is required by New York State for admission to a state-licensed care facility.)

Full Name: ____

Current Address: ____

Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Place of Birth:_____________________________________

Social Security Number: _______-______-_______ Religious Preference _____________________________________

Are you or your spouse a veteran? ☐ Yes ☐ No If yes, did you serve during war time? ☐ Yes ☐No

Current Living Situation:

☐ Own Home ☐ With Family ☐ Nursing Home ☐ Apartment ☐ Hospital ☐ Other ______________________________

Family Information

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____________________________________

Spouse's Name (if applicable):____

Mother's Name (including maiden name): ____

Father's Name:____

Children's Names: ____

Other Important Relatives to Note:____

Health Insurance

Primary Health Insurance: ________________________________ Insurance #: _________________________________

Secondary Health Insurance: _______________________________ Insurance #: ________________________________

Medicaid #: ______________________

Room Request

(Call for current pricing)

When are you planning to move in? _____/_____/_____

Private Rooms (Single and Shared) with en-suite bathroom (setup fee required):

☐ Cozy Private ☐ Large Private ☐ Semi-Private ☐ Two-Room Suite (with shower)

Medicaid Rooms:

☐ Please place me on a waiting list if not currently available ☐ I can privately pay until a room is available

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Financial Information

Income (Please supply your total **annual** income amount including employment plus benefits for each.)

Social Security: $ ________
Child Support: $ ________
SSI: $ ________
Family: $ ________
SSDI: $ ________
Veteran's Benefits: $ ________
Employment: $ ________
Other: $ ________

Current Assets

Checking: $ ________
Trust Fund: $ ________
Savings: $ ________
Real Property (Value): $ ________
Certificate of Deposit: $ ________
Other (Annuity, etc.): $ ________

Liabilities (notes, taxes, loans, credit cards, and other debts)

1. ______________________________ $ ______________________________
2. ______________________________ $ ______________________________
3. ______________________________ $ ______________________________
4. ______________________________ $ ______________________________

Which benefits have you **already** applied for? ☐ VA Benefits ☐ SS Supplemental Income ☐ Disability ☐ Medicaid

Which benefits will you **need to** apply for: ☐ VA Benefits ☐ SS Supplemental Income ☐ Disability ☐ Medicaid

Financial Representative Payee: ______________________________ Relationship: ______________________________

Financial Representative Telephone (Work): __________________________ (Home): ______________________________

Are you your own guardian? ☐ Yes ☐ No

If no, were you adjudicated incompetent by a court hearing? ☐ Yes ☐ No (Effective Date: _____/_____/_____)

Name of Legal Guardian: ______________________________ Relationship: ______________________________

Type of Guardianship: ____

Address: ____

Home/Cell Phone: ______________________________ Work Phone: ______________________________

Legal Power of Attorney: ____

Address: ____

Home/Cell Phone: ______________________________ Work Phone: ______________________________

Please list any other pertinent information relative to resident representation and/or guardianship:

____

____

Please note: All room and board payments are now required to be made via direct deposit EFT.

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Medical Information

Do you have a DNR order? ☐ Yes ☐ No Do you need oxygen? ☐ Yes ☐ No

Do you have any food allergies? ☐ Yes ☐ No If yes, please list: ____

Do you have any medication allergies? ☐ Yes ☐ No If yes, please list: ____

Do you have any other allergies? ☐ Yes ☐ No If yes, please list:____

Do you use a device? (I.e. a walker) ☐ Yes ☐ No If yes, please list:____

Do you require a special diet? ☐ Yes ☐ No (Please note, Hilton East only provides the following diets: Regular, No Concentrated Sweets, No Added Salt)

Are you a smoker? ☐ Yes ☐ No

Mental Health Information

Have you ever been diagnosed with a mental illness? ☐ Yes ☐ No

If yes, what is your primary diagnosis? ____

What is your secondary diagnosis? ____

Do you take medication for your mental illness? ☐ Yes ☐ No

If yes, please list by name: ____

Do you take medications by yourself? ☐ Yes ☐ No

Medical/Physical Information

Primary Diagnosis: ____

Secondary Diagnosis: ____

Other Physical Limitations:____

Do you take medications? ☐ Yes ☐ No Do you take medications independently? ☐ Yes ☐ No

Physical limitations? ☐ Ambulation ☐ Sight ☐ Hearing ☐ Other____

Please describe any limitations you checked: ____

____

Do you need assistance with medication administration? ☐ Yes ☐ No

What pharmacy do you currently use? ____

Do you plan to keep your current primary care physician or switch to our house physician? ☐ Keep ☐ Switch

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Current Provider Contact Information

Primary Care Physician:____ Date of last visit: _________________________

Phone: ________________________ Address: ____

Preferred Hospital: ____ Date of last visit: __________________________

Phone: ________________________ Address: ____

Psychiatrist: ____ Date of last visit: _________________________

Phone: ________________________ Address: ____

Dentist: ____ Date of last visit: __________________________

Phone: ________________________ Address: ____

Ophthalmologist: ____ Date of last visit: __________________________

Phone: ________________________ Address: ____

Podiatrist: ____ Date of last visit: __________________________

Phone: ________________________ Address: ____

Other Physician: ____ Date of last visit: __________________________

Phone: ________________________ Address: ____

Mental Health Provider: ____ Date of last visit: _________________________

Phone: ________________________ Address: ____

Undertaker: ____ Date of last visit: ___________________________________

Phone: ________________________ Address: ____

Burial Instructions: ____

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Additional Contacts

Name: ____ Relationship: _______________________________

Address: ____

Home Phone: ___________________ Work Phone: ___________________ Email: _____________________________

Name: ____ Relationship: _______________________________

Address: ____

Home Phone: ___________________ Work Phone: ___________________ Email: _____________________________

Name: ____ Relationship: _______________________________

Address: ____

Home Phone: ___________________ Work Phone: ___________________ Email: _____________________________

All of the information provided in this reservation form is accurate and truthful to the best of my knowledge.

Resident Name: ____

Signed: ____ Date: ________________________