HILTON EAST
Assisted Living Community

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 application 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: _____ Sex: Male☐ Female☐

Current address: _____ Social Security ____/____/_____

Date of Birth: ____/____/_____ Place of Birth: _____

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: _____

Have you ever been convicted of a crime? Yes☐ No☐ If Yes, when?_____

What were the charge(s)_____

_____

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 pricing)

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

Private Rooms (Single and Shared) with en-suite bathroom (setup fee may be 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: $_____	SSDI:	$_____
	Child Support: $_____	Veteran Benefits:	$_____
	SSI: $_____	Employment:	$_____
	Family: $_____	Life Ins. (Cash Value):	$_____
Current assests	Checking: $_____	Real Property (Value):	$_____
	Trust Fund: $_____	Certificate of Deposit:	$_____
	Savings: $_____	Pension Plan	$_____
	401k, 403b, IRA, Roth $_____	Other (Annuity, ect.):	$_____

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

1._____ $_____
2._____ $_____
3._____ $_____
4._____ $_____

Which benefits did 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 ☐

How do you handle your finances: On my own ☐ Someone helps me ☐ Someone handles them for me ☐

Financial Representative Payee: _____ Relationship: _____

Financial Payee Phone (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: _____

Email: _____

Legal Power of Attorney: _____

Address: _____

Home/Cell Phone: _____ Work Phone: _____

Email: _____

Please list any other pertinent information 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? Yes ☐ No ☐ Do you have a HCP? Yes ☐ No ☐

Do you need Oxygen? Yes ☐ No ☐ If yes, who supplies your tanks? _____

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 ☐ If yes, please list_____

We can provide for NCS and NAS.

Are you a smoker? Yes ☐ No ☐ If yes, What & how often_____

If former smoker, when did you quit?_____

Do you drink alcohol? Yes ☐ No ☐ If yes, What & how often_____

If former drinker, when did you quit?_____

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: _____

Physical Limitations? Ambulation ☐ Sight ☐ Hearing ☐ Other _____

Please describe any limitations that you checked: _____

_____

Other physical limitations: _____

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

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

What Pharmacy do you currently use? (Name & Address)_____

Do you plan to continue using your current pharmacy or switch to our house pharmacy? Keep ☐ Switch ☐

Do you plan to keep your current primary care physician? Keep ☐ Switch ☐

Do you want to see our in-house podiatrist? Yes ☐ No ☐

Do you plan to have Hilton East to set up your medical appointments and transportation or will your family?

Hilton East ☐ Family ☐

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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: _____

Opthalmologist:_____ 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: _____

Please provide list of any additional doctors or specialists that you use

Do you have a prepaid Burial Account? Yes ☐ No ☐ **Do you have a prepaid Burial space?** Yes ☐ No ☐

Do you have a preferred Cemetery? Yes ☐ No ☐ If yes, name: _____

Do you have a preferred funeral home? Yes ☐ No ☐

Undertaker: _____ Date of last visit: _____/_____/_____

Phone: _____ Address: _____

Burial Instructions:_____

_____

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Additional Contacts

Name:_____ Relationship: _____

Address: _____

Home : _____ Phone: _____ Email: _____

Name:_____ Relationship: _____

Address: _____

Home : _____ Phone: _____ Email: _____

Name:_____ Relationship: _____

Address: _____

Home : _____ Phone: _____ Email: _____

Name:_____ Relationship: _____

Address: _____

Home : _____ Phone: _____ Email: _____

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

Resident Name: _____

Signed: _____ Date: ____/_____/_____

Resident Representaive Name: _____

Resident Representative Signed: _____ Date: ____/_____/_____