New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE
RESIDENT PERSONAL DATA FORM

Resident's Name: _____ Facility Name: GrandeVille Senior Living Community

ADMISSION / DISCHARGE INFORMATION

Date of Admission: _____ **County:** _____

Admitted from: ☐ **Own Home** ☐ **Hospital** ☐ **NH** ☐ **OMH** ☐ **Other (specify):** _____

Address Admitted from (Street, City, State, Zip): _____

Discharge Date: _____ **Discharge to:** ☐ **Own Home** ☐ **Hospital** ☐ **NH** ☐ **OMH**

☐ **Other (Specify):** _____

Address Discharged to (Street, City, State, Zip Code): _____

Reason for Discharge: _____

SECTION 1: PERSONAL DATA

Date of Birth: ____/____/____ (Month / Day / Year) Gender: ☐ M ☐ F Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Partner

NOTIFY IN CASE OF EMERGENCY

Name _____

Relationship _____

Home: _____ Work: _____

Cell Phone: _____ Other: _____

Address _____

City _____ State _____ Zip _____

ATTENDING PHYSICIAN

Name _____

Address _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____

OTHER HEALTH CARE PROVIDERS

Name _____

Specialty _____

Phone: _____ Fax: _____

Address _____

City _____ State _____ Zip _____

Name _____

Specialty _____

Phone: _____ Fax: _____

Address _____

City _____ State _____ Zip _____

OTHER HEALTH CARE PROVIDERS

Name _____

Specialty _____

Phone: _____ Fax: _____

Address _____

City _____ State _____ Zip _____

Name _____

Specialty _____

Phone: _____ Fax: _____

Address _____

City _____ State _____ Zip _____

AREA HOSPITAL / CLINIC OF CHOICE

Name _____

Address _____

Additional Information: _____

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Resident's Name: _____ Facility Name: GrandeVille Senior Living Community

SECTION 1: PERSONAL DATA Cont.: HEALTH INSURANCE

Insurer _____ ID # _____

Medicaid No. _____

Medicare No. _____

Prescription Drug Plan (if any) _____

Plan ID # _____

Other Health Care Coverage _____

_____

PHARMACY

Pharmacy(ies) _____

_____

Phone _____ Phone _____

Address(es) _____

_____

City _____ State _____ Zip _____

SECTION 2: PERSONAL BACKGROUND

Wishes to be addressed as: _____

Address (if different from ALR): _____

Resident's Representative: _____

Relationship: _____

Address: _____

_____

Phone: Home _____

Work _____

Cell _____

Significant Other: _____

Relationship: _____

Address: _____

_____

Phone: Home _____

Work _____

Cell _____

Resident's Representative: _____

Relationship: _____

Address: _____

_____

Phone: Home _____

Work _____

Cell _____

Significant Other: _____

Relationship: _____

Address: _____

_____

Phone: Home _____

Work _____

Cell _____

Residential Background (born/raised, lived most of life): _____

_____

Occupational/Educational Background: _____

_____

Religious Affiliation (if any): _____ **Place of Worship:** _____ **Phone:** _____

Health Care Proxy: ☐ Yes ☐ No _____ (Name) **DNR:** ☐ Yes ☐ No

Power of Attorney: ☐ Yes ☐ No _____ (Name) **Living Will:** Yes ☐ No ☐

Burial Instructions: _____

_____

GrandeVille Assisted Living

Personal Worth Statement and Veterans Aid and Attendance Notice

Name:_____
Address:_____
Social Security Number:_____

Veterans Aid and Attendance is "enhanced pension" for wartime veterans (or their survivor spouses), which provides cash assistance to help in covering the cost of long-term care. For additional information and assistance in applying for this benefit, contact Fong Mattice, Pension Benefits, Veterans Service Agency located at: 125 Westfall Road, Rochester, NY 14620. Phone: (585) 753-6644 Email: FMATTICE@MONROECOUNTY.GOV

I believe I may qualify for this benefit, and I would like GrandeVille to assist with the Veterans Aid and Attendance. YES / NO (circle one)

I. INCOME (Please write YES or NO in every space provided below. Fill in monthly amounts as applicable)

Do You Receive? YES or NO	**Income Source**	**Amount per month**
_____	Social Security	$_____
_____	VA Pension	$_____
_____	Retirement/Pension	$_____
_____	Alimony	$_____
_____	SSI	$_____
_____	Rental Property	$_____
_____	Other _____	$_____

Please list any other sources of income: _____

TOTAL MONTHLY INCOME: $_____

II. ASSETS (Please write YES or NO in every space provided below. List amount of asset where applicable)

YES or NO	**Asset**	**Asset Value**	**Account #**
_____	Checking Account(s)	$_____	_____
_____	Savings Account (s)	$_____	_____
_____	CDs	$_____	_____
_____	Stocks	$_____	_____
_____	Bonds	$_____	_____
_____	IRAs	$_____	_____
_____	Notes	$_____	_____
_____	Property	$_____	_____
_____	Money Market	$_____	_____
_____	Other _____	$_____	_____

Please list any other assets: _____

Life Insurance Cash Value $ _____ or _____ N/A

TOTAL CURRENT ASSETS: $ _____
Do you have Long Term Care Insurance? _____ yes _____ no

III. LIABILITIES:

YES or NO	Liability	Monthly Payment	Total Owed
_____	Bank Loans	$_____	$_____
_____	Taxes Due	$_____	$_____
_____	Mortgage	$_____	_____/Value_____
_____	Health Insurance	$_____	N/A
_____	Prescriptions	$_____	N/A
_____	Phone	$_____	N/A
_____	Cable	$_____	N/A
_____	Auto Loan	$_____	_____/Value _____
_____	Auto Insurance	$_____	$_____
_____	Other: _____	$_____	$_____

TOTAL LIABILITIES: Monthly: $ _____ **TOTAL $** _____

IV. PERSONAL NET WORTH (Total Assets **minus** Total Liabilities): $_____

Please submit proof of income source and assets with this application.

_____
Resident Name (Please Print)

_____
Resident Signature

_____
Resident Representative Name (Please Print)

_____
Resident Representative Signature

_____
GrandeVille Representative (Please Print)

_____
GrandeVille Representative

Dated this _____day of _____, 2 _____.