**Please save this PDF file to your computer before completing it.

Email completed application to Admissions@waveny.org

Waveny LifeCare Network

Leading Fuller Lives

Application to be completed by applicant or authorized representative

Please print, Thank you

RESIDENCE, SERVICE, PROGRAM OR FACILITY REQUESTED *(please select)*

☐ **Short-Term Rehabilitation**
Waveny Care Center

_____
Surgery Date Hospital

☐ **Assisted Living***
The Village

☐ **Long-Term Care**

☐ **Short-Term Respite Care**

☐ **Adult Day Program**

☐ **Long-Term Skilled Nursing Care**
Waveny Care Center

☐ **Independent Living***
The Inn

☐ **Long-Term Special Care Unit**
for cognitive impairment
Waveny Care Center

* All applicants to The Village and The Inn are automatically placed on Waveny's long-term care wait list should the need arise at a later date.

APPLICANT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Occupation (Current or Former): _____

Religious Affiliation (optional): _____

Social Security #: _____

Medicare #: _____

Medicaid #: _____

Other Insurance #: _____ Type: _____

* Copies of all cards (Social Security, Medicare/Medicaid, Insurance) must be provided before or upon admission.

NEXT OF KIN/EMERGENCY CONTACT

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Business Phone: _____

ADDITIONAL INFORMATION

Does the applicant have Advanced Directives? ☐ Yes* ☐ No

*If yes, check all that apply: ☐ Power of Attorney ☐ Living Will ☐ Health Care Agent ☐ Conservator

*Please provide documentation before or upon admission.

Is the applicant a veteran: ☐ Yes ☐ No Serial Number: _____

Has the applicant ever been treated or cared for at Waveny LifeCare Network or an affiliate? ☐ Yes ☐ No

If yes, in what capacity: _____

PRIMARY CARE PHYSICIAN

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

SECONDARY PHYSICIAN/SPECIALIST

Name: _____

Address: _____

Specialty: _____

City: _____ State: _____ Zip: _____

Phone: _____

ATTORNEY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

_____ _____

Signature of applicant or authorized person **Date**

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FOR INTERNAL OFFICE USE ONLY

Dx: _____

Dx: _____

Med. Record #: _____ Room #: _____

Date of Application: _____

FINANCIAL APPROVAL:

CFO Signature: _____ Date: _____