



PRE-ADMISSION INFORMATION AND APPLICATION

Adirondack Medical Center ~ Uihlein and Mercy

A Skilled Nursing & Rehabilitation Center

185 Old Military Road
Lake Placid NY 12946

114 Wawbeek Ave.
Tupper Lake, NY 12986

Tel: 518-359-3355 Fax: 518-359-9044

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THANK YOU FOR INQUIRING ABOUT ADMISSION TO AMC-UIHLEIN AND AMC-MERCY.
PLEASE COMPLETE THE FOLLOWING APPLICATION AND RETURN TO THE APPROPRIATE ADDRESS OR
FAX NUMBER ABOVE, OR E-MAIL TO: tstave@amccares.org

Date: ____ / ____ / ____ Phone #: (____) ____ - ____

Applicant: _____ Maiden Name: _____

Address: _____ County: _____ State: _____

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

Citizen: Yes No Sex: M F Religion: _____ Attending Physician: _____

Where is the applicant at this time? _____ Does the applicant smoke? Yes No

MARITAL STATUS

Single Married Widowed Divorced Separated

Date of Marriage: ____ / ____ / ____ Spouse's Name: _____ Living: Yes No

If living where: _____ If deceased, date: ____ / ____ / ____

Spouse's telephone # (____) ____ - ____

RELATIVES/FRIENDS (in order of importance)

Name: _____ Name: _____ Name: _____

Address: _____ Address: _____ Address: _____

City: _____ State: ____ Zip: _____ City: _____ State: ____ Zip: _____ City: _____ State: ____ Zip: _____

Relationship: _____ Relationship: _____ Relationship: _____

Telephone: (____) ____ - ____ Telephone: (____) ____ - ____ Telephone: (____) ____ - ____

FINANCES/RESOURCES/INSURANCES

(please complete all that apply, giving amounts and identifying numbers)

Public:

Social Security: \$ _____ SS # ____ / ____ / ____ Veteran's Benefits \$ _____ VA # _____

Other: \$ _____ # _____

Private:

Pensions: \$ _____ Source: _____

Savings: \$ _____ Certificates of Deposits: \$ _____

Checking Account: \$ _____ Stocks/Bonds: \$ _____

Property: \$ _____ Location: _____

Rental Income: \$ _____ Location: _____

INSURANCES:

Primary: _____ # _____

Secondary: _____ # _____

Medicare: _____ # _____

Medicaid: _____ # _____

POWER OF ATTORNEY **GUARANTOR** **EXECUTOR:** **HEALTH CARE PROXY**

Name: _____ Name: _____

Address: _____ Address: _____

City : _____ State: _____ zip: _____ City: _____ State: _____ zip: _____

GENERAL INFORMATION

Were you or your spouse in the U.S. Armed Services: Yes resident spouse No resident spouse

Highest level of education completed: _____ Where: _____

Former Occupation: _____

Name of Funeral Home: _____

PAPER WORK NEEDED TO COMPLETE APPLICATION

Advance Directive Sheet

Medicare Card, Medicaid Card

Any other Insurance Cards (BCBS, AARP, etc.) Copy of Front and Back

Most recent Bank Statement for each Account listed

Regular Sources on Income (Social Security Check, Pension Check. etc.)

Power of Attorney form completed

Health Care Proxy, DNR, Living Will

I Authorize Release of Applicant's Medical Records to AMC-UIHLEIN OR MERCY for Admission Purposes

To the best of my knowledge, all of the information provided above is correct and valid. I understand that the information contained in this form is for the admission purposes to AMC-Uihlien or Mercy only.

_____ Date: ____/____/____

Signature of Applicant or Responsible Party

THE INFORMATION PROVIDED SHALL REMAIN CONFIDENTIAL AND SHALL BE MADE AVAILABLE ONLY TO AUTHORIZED NURSING HOME PERSONNEL INVOLVED IN THE PLACEMENT PROCESS AND TO ANY GOVERNMENTAL OFFICIALS AUTHORIZED BY LAW TO SUCH RECORDS.

BASED ON OUR PHILOSOPHY AND CONSISTENT WITH FEDERAL AND STATE LAW, AMC (Uihlein, Mercy) DOES NOT DISCRIMINATE IN ADMISSION, RETENTION AND CARE OF RESIDENTS WITH REGARDS TO RACE, COLOR, RELIGION, CREED, GENDER, NATIONAL ORIGIN, AGE, BLINDNESS, DISABILITY, MARITAL OR VETERAN STATUS, SEXUAL ORIENTATION, SPONSOR, OR PAYOR SOURCE.