68 Hauppauge Road
Commack, NY 11725

GURWIN
HEALTHCARE SYSTEM
Gurwin Jewish Nursing & Rehabilitation Center
Social Adult Day Program

631-715-2520
Gurwin.org

ADMISSION APPLICATION

(To be completed by Applicant/Family Member/Caseworker)

Name of Applicant:_____
(Last Name) (M.I.) (First Name)

Address:_____
(Street) (City) (State) (Zip)

Date of Birth:_____ Age:_____ Sex: M F

Phone Number:_____ Email: _____

Marital Status:_____ Place of Birth:_____

Culture:_____ Start Date:_____

Individuals to be contacted regarding this application:

(1) Name:_____ Relationship to Applicant:_____
Address:_____
(Street) (City) (State) (Zip)
Home Phone:_____ Business Phone:_____
Cell Phone:_____ E-Mail Address:_____

* *

(2) Name:_____ Relationship to Applicant:_____
Address:_____
(Street) (City) (State) (Zip)
Home Phone:_____ Business Phone:_____
Cell Phone:_____ E-Mail Address:_____

Physician Information:

Name of Physician:_____Specialty:_____
Address:_____
(Street) (City) (State) (Zip)
Phone:_____ Fax Number:_____

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Applicant Information:

Applicant currently lives: [ ] Alone [ ] With someone

Name:_____ Relationship to Applicant:_____

Major Health Concerns:_____

_____

Diet:_____

Does the applicant have a past history of psychiatric illness; approximate treatment dates as well as the facility where the treatment was rendered:_____

_____

Are you able to provide your own transportation? [ ] Yes [ ] No
If no, which transportation company will you utilize?_____

Has applicant received the full COVID-19 Vaccine? [ ] Yes [ ] No
If YES, date of last dose: _____ Brand: _____

Mental Status Information:	YES	NO
1) Is the applicant alert?	[ ]	[ ]
2) Does the applicant recognize the family?	[ ]	[ ]
3) Does the applicant speak a language other than English?	[ ]	[ ]
If yes, what language:_____		
4) Is the applicant confused?	[ ]	[ ]
If yes, do you feel the confusion is: (please circle)		
a. Mild b. Severe		
5) Does the applicant experience hallucinations?	[ ]	[ ]
If yes, has the applicant been treated for hallucinations?	[ ]	[ ]
6) Does the applicant exhibit any aggressive behavior?	[ ]	[ ]
_____		
_____		
7) Is client able to tolerate wearing a mask?	[ ]	[ ]

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Financial Information:

Financial arrangements upon admission to Gurwin SADP:

[ ] Private [ ] Medicaid [ ] Private Ins. [ ] Other

If other, please specify:_____

Social Security #:_____ Medicare #:_____

Medicaid #:_____ Medicaid County:_____

Medicaid caseworker name & telephone #:_____

Amount of Monthly Income:

Social Security: $_____ Veterans Benefits: $_____ Pension: $_____

Disability:$_____ Other Income:$_____

Do you receive food stamps/EBT? [ ] Yes [ ] No If yes, how much: $_____

Health Insurance Information:

Name of Insurance Company:_____

Address:_____
(Street) (City) (State) (Zip)

Phone #:_____ Policy/ID #:_____

Name of Policyholder:_____

I hereby declare that the information provided in this application is accurate to the best of my knowledge.

Signature:_____ _____
(Applicant) (Family Member/Caseworker)

Date:_____