

NEW YORK ARMENIAN HOME  
137-31 45<sup>TH</sup> Avenue, Flushing, NY 11355  
Tel: #718-461-1504 Fax #718-461-3079

APPLICATION FOR RESIDENCE

APPLICANT \_\_\_\_\_  
Surname First Name Middle Name

ADDRESS: \_\_\_\_\_

\_\_\_\_\_ COUNTY \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

Place of Birth: \_\_\_\_\_  
City State or Country

Father's Full Name \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_

Mother's Occupation \_\_\_\_\_ Birthplace \_\_\_\_\_ Death Date \_\_\_\_\_

Father's Occupation \_\_\_\_\_ Birthplace \_\_\_\_\_ Death Date \_\_\_\_\_

Year of Entry into U.S. \_\_\_\_\_

Sex: ( ) Female ( ) Male Race: \_\_\_\_\_

Age: ( at last birthday ) \_\_\_\_\_

Citizenship Status: ( ) Native ( ) No data  
( ) Naturalized ( ) Other (specify) \_\_\_\_\_  
( ) Alien \_\_\_\_\_

Occupation: \_\_\_\_\_

Religion ( ) Protestant ( ) No data  
( ) Roman Catholic ( ) Other (specify) \_\_\_\_\_  
( ) Apostolic

Name and Address of Pastor or Priest: \_\_\_\_\_

If Apostolic, show which Parish Known best by the Priest: \_\_\_\_\_

Marital Status: ( ) Single ( ) Divorced ( ) Separated  
( ) Married ( ) Widowed ( ) No data  
( ) Other \_\_\_\_\_

Maiden Name of Wife \_\_\_\_\_

Name of Last Known Spouse \_\_\_\_\_

Husband's Occupation: \_\_\_\_\_

- (Wife's)      ( ) Inappropriate  
 ( ) No Data  
 ( ) Never Married

Birthplace \_\_\_\_\_  
 Death Date \_\_\_\_\_

RELATIVES NOW LIVING: (children, brothers, sisters, nieces and nephews; if there are none or few, list cousins)

NAME \_\_\_\_\_  
 RELATIONSHIP \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME \_\_\_\_\_  
 RELATIONSHIP \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME \_\_\_\_\_  
 RELATIONSHIP \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME \_\_\_\_\_  
 RELATIONSHIP \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME \_\_\_\_\_  
 RELATIONSHIP \_\_\_\_\_ TELEPHONE \_\_\_\_\_

Person to be notified in case of illness, emergency:
Name _____
Phone No. _____
Address : _____
_____

Physician responsible for Ongoing medical care:
Name _____
Phone No. _____
Address: _____
_____

Education: (U.S.) Highest Grade Completed:

- ( ) Grade-school                      ( ) College  
 ( ) High -school                      ( ) Other (specify) \_\_\_\_\_

Readiness of Applicant to enter the Home:

- ( ) Is ready to enter now at time of application.  
 ( ) Is applying in advance of expected readiness in the future.

Languages: Reads \_\_\_\_\_  
 Writes \_\_\_\_\_  
 Speaks \_\_\_\_\_

Burial Plans: Name & Address of Funeral Director (if chosen) \_\_\_\_\_  
 Cemetery Plot Location & No. \_\_\_\_\_  
 Who holds deed \_\_\_\_\_  
 Any Special Arrangement: \_\_\_\_\_

Date \_\_\_\_\_

Signed \_\_\_\_\_



**SUBSTITUTE FOR DSS-3122**

**MEDICAL EVALUATION (6/96)**

(ALL SPACES MUST BE COMPLETED)

STATEMENT OF PURPOSE

Adult Residential Care Program provide 24 hour residential care settings for dependent adults. They are not medical facilities. Persons in need of constant medical care and supervision should not be admitted or retained in an adult residential care facility because such a facility lacks the staff and expertise to provide needed services. Persons who, by reason of age and/or physical and/or mental limitations, are in need of assistance with the basic activities of daily living can be cared for in adult residential care settings.

The information solicited in this medical evaluation will assist you, the individual, and the operator of an adult residential care facility in determining level of care needed to assure the health, safety and well being of the individual. It will become part of the resident's record and subject to review by the Department of Social Services, which is responsible for supervision of the Adult Residential Care Programs.

**SECTION I: PERSONAL**

**NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**ADDRESS:** \_\_\_\_\_

\_\_\_\_\_

**SEX:**    M    F

**SECTION II: MEDICAL HISTORY**

<b>PRIMARY DIAGNOSIS:</b>	<b>SECONDARY DIAGNOSIS:</b>
<b>RECENT SURGERY: (Type of procedure)</b> ___ None Known.	<b>RECENT ACUTE ILLNESS: (Type and Date)</b>
<b>DIET:</b>	<b>ALLERGIES TO : (List any known)</b> ___ None Known <b>MEDICATIONS:</b> ___ NONE <b>FOOD:</b> ___ NONE <b>OTHER:</b> ___ NONE <b>ACTIVITY RESTRICTIONS:</b> ___ NONE
<b>WEIGHT BEARING:</b> <b>FULL:</b> <b>PARTIAL:</b> <b>NONE:</b>	<b>CHRONIC ILLNESS, PHYSICAL OR MENTAL LIMITATIONS</b>  <b>BLOOD PRESSURE:</b>  <b>WEIGHT:</b>

**REQUIRED MEDICAL EXAMINATIONS AND/OR COMMUNITY BASED MEDICAL SERVICES:**

<u>REQUIRED NEED</u>	<u>PROVIDED BY</u>	<u>FREQUENCY</u>
_____	_____	_____
_____	_____	_____

OVER

**LIST ALL CURRENT MEDICATIONS (PRESCRIPTION AND OTC) AND NOTE SPECIAL INSTRUCTION**

MEDICATION (Type, Frequency and Dosage)

**SECTION IV: OBSERVATION OF INDIVIDUAL**

IS INDIVIDUAL: (PLEASE CHECK EITHER YES OR NO)	YES	NO	DESCRIBE AS NEEDED
AMBULATORY?			
CAPABLE OF SELF-ADMINISTRATION OF MEDICATIONS?			
HABITUATED TO DRUGS?			
HABITUATED TO ALCOHOL?			
DANGER TO SELF OR OTHERS?			
FREE OF COMMUNICABLE DISEASE?			
INCONTINENT?			

**SECTION V: EVALUATION**

IN YOUR OPINION CAN THE INDIVIDUAL'S NEED BE MET BY THE SUPPORT SERVICES AVAILABLE IN AN ADULT CARE FACILITY?  
 YES     NO (PLEASE DESCRIBE OPTIONAL)

  

DOES THE INDIVIDUAL REQUIRE PLACEMENT IN A NURSING FACILITY?  
 YES     NO (IF YES, PLEASE GIVE REASONS)

  

DOES THE INDIVIDUAL HAVE A RELEVANT HISTORY, CURRENT CONDITION OR RECENT HOSPITALIZATION FOR MENTAL ILLNESS?  
 YES     NO (IF YES, EXPLAIN)

  

IF YES TO THE ABOVE QUESTION, DOES THE INDIVIDUAL REQUIRE A MENTAL HEALTH EVALUATION?       YES     NO

PHYSICIANS SIGNATURE:	DATE OF EXAMINATION:	FORM COMPLETED:
	_____ / _____ / _____	_____ / _____ / _____

# Health Care Proxy

- 1) 1. \_\_\_\_\_  
Hereby appoint \_\_\_\_\_  
\_\_\_\_\_  
(Name, home address and telephone number)

As my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

- 2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Unless your agent knows your wishes about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions on reverse for samples of language you could use.)

- 3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.  
\_\_\_\_\_  
(Name, home address and telephone number)

- 4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific date or conditions, if desired):  
\_\_\_\_\_

- 5) Signature \_\_\_\_\_  
Address \_\_\_\_\_  
Date \_\_\_\_\_

## Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1. \_\_\_\_\_  
Address \_\_\_\_\_  
Witness 2. \_\_\_\_\_  
Address \_\_\_\_\_

# About the Health Care Proxy

This is an important legal form. Before signing this form, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or withhold life-sustaining treatment.
3. Unless your agent knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse those measures for you.
4. Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and /or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

*If I become terminally ill, I do/don't want to receive the following treatments...*

*If I am in a coma or unconscious, with no hope or recovery, then I do/don't want....*

*If I have brain damage or brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve. I do/don't want....*

*I have discussed with my agent my wishes*

*About-----and I want my agent to make all decisions about these measures.*

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list for the treatments about which you may leave instructions.

- Artificial respiration
- Artificial nutrition and hydration (nourishment and water provided by feeding tube)
- Cardiopulmonary resuscitation (CPR)
- Antipsychotic medication
- Electric shock therapy
- Dialysis
- Transplantation
- Blood transfusions
- Abortion
- Sterilization

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker, before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. You do not need a lawyer to fill out this form.

You can choose any adult (over 18), including a family member, or close friend, to be your agent. If you select a doctor as your agent, he or she may have to choose between acting as your agent or as your attending doctor. A physician cannot do both at the home or mental hygienic facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask staff at the facility to explain those restrictions.

You should tell the person you choose that he or she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be sued for health care decisions made in good faith.

## Filling out the Proxy Form

Item (1) Write your name and the name, home address and telephone number of the person you are selecting as your agent.

Item (2) If you have special instruction for your agent, you should write them here. Also, if you wish to limit your agent's authority in any way, you should say so here. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

Item (3) You may write the name, home address and telephone number of an alternate agent.

Item (4) This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire.

Item (5) You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Two witnesses at least 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.