Dear Friend:

Enclosed please find our application for admission to the New York Armenian Home. We trust you will find some pertinent information that may be helpful to you.

Please return both sections completed, also make sure the potential resident signs the application and that the physician signs both Medical Forms.

Once we receive the application and it is reviewed, the Home will contact you of their decision and instruct you as to the next step of the admission process.

Please feel free to call or write if you have any further questions.

Thank you for your interest in our Home.

Sincerely,

Aghavni "Aggie" Ellian
Executive Director

DOCUMENTS NEEDED FOR ADMISSION (where applicable)

1. Social Security Number and Card.
2. Naturalization papers or Green Card.
3. Medicare Card.
4. Medicaid Card.
5. Name and address of bank where Social Security check is deposited (if directly deposited).
6. Amounts of the following:

- Social Security Check
- Life insurance

7. Copies of papers and bank books pertaining to assets
8. Supplemental insurance card or number, if any.

FINANCIAL INFORMATION

“Room rates are for basic services only by State regulations.

“Enhanced Living and Supportive Living Categories”

Will be an assessed case by our Administrator and Doctors for additional charges.

Converted – private with semi private bath-$3,500.00

Converted – private with private bath - $4,000.00

Single room private bath-$2,800.00

Single room semi-private bath - $2,500.00

Semi private (two persons) share bath with other semi-private-$2,000.00

Semi private first floor residents are $2,500.00 (includes extra care charges)

Additional charge of $500.000 monthly applies to residents in need of extra care

Temporary residency: $700.00 per week

A security deposit of one (1) month is required for all new private and semi-private residents upon admission. Personal and/or Social Security checks may make both payments.

Administrator and Doctors will evaluate all residents as necessary.

ITEMS THAT HAVE TO BE BROUGHT IN BY RESIDENT

Medication, clothing, bathrobe; washcloth, towels, toiletries (as hair brush, comb, tooth paste, toothbrush, shaving articles, cologne, any and all personal items to be approved by the Administrator.)

THE NEW YORK ARMENIAN HOME

QUESTIONS AND ANSWERS

- **WHAT TO DO TO ENTER THE HOME?**

Prospective resident shall meet the health requirements for the Home. A physical examination at the applicant's expense, by the applicant's physician is required. The Home's physician will then review the application and reserves the right to make the appropriate admission decision.

- **WHAT ARE THE ADMISSION REQUIREMENTS FOR AN ADULT RESIDENCE?**

New residents must be ambulatory, continent and capable of caring for themselves, such as dressing and feeding.

- **IS THERE A DOCTOR AT THE HOME?**

The Home has two Armenian physicians on call, as well as a psychiatrist, a psychologist and a podiatrist. Residents will be examined by doctors as needed and will have the routine tests as required by the Department of Social Services. When ophthalmologic and dental works are needed appointments are made by the Home's Case Manager.

- **HOW ARE MEDICAL BILLS PAID?**

The resident is responsible for all medical charges. MEDICARE is a health insurance program that helps pay certain hospital costs and medical care after deductibles, coinsurance and / or premiums. The resident is responsible for payment of prescriptions not covered by MEDICARE. This procedure is the same as before moving into the New York Armenian Home.

MEDICARE accepted charges for medical services such us: doctor's fees, X- ray and Laboratory bills which are covered under Part B are paid by Medicare after the annual deductible has been met. The remaining 20% of the charges are the resident's responsibility.

NEW YORK ARMENIAN HOME
137-31 45TH 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
( ) Naturalized
( ) Alien
( ) No data
( ) Other (specify) ____________________
____

Occupation: ________________________

Religion
( ) Protestant
( ) Roman Catholic
( ) Apostolic
( ) No data
( ) Other (specify) ____________________

Name and Address of Pastor or Priest: ____

____

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

____

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

Maiden Name of Wife ____

Name of Last Known Spouse ____

Husband's Occupation: ____

(Wife's) ( ) Inappropriate Birthplace ______________________
( ) No Data Death Date ______________________
( ) Never Married

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

The Home is only interested to receive the contracted amount for Room/Board by the 1st of each month. We need not know your financial status – just your ability to pay. These items will be thoroughly investigated by Social Security when the resident applies for Supplemental Security Income (SSI). Social Security will investigate three years of financial spend down prior to granting Supplemental Security Income (SSI).

FINANCIAL CIRCUMSTANCES

Type of Income:

	Yes	No	
Private			
Social security			
Pension			
SSI			
Other			

Health Care Proxy

1) I, ____

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 deeding 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 come 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 deeding 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 you 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 signed copy. You 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 hers. 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 you 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.

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

PRIMARY DIAGNOSIS:	**SECONDARY DIAGNOSIS:**
RECENT SURGERY: (Type of procedure) ___ **None Known.**	**RECENT ACUTE ILLNESS: (Type and Date)**
DIET: **REGULAR**.. _____ **LOW SALT**.. _____ **LOW SUGAR/NCS**....................................... _____ WE SERVE 1-2% FAT MILK AND SPECIAL DESERTS FOR DIABETIC DIET	**ALLERGIES TO : (List any known)** ___ **None Known** **MEDICATIONS:** ___ **NONE** **FOOD:** ___ **NONE** **OTHER:** ___ **NONE** **ACTIVITY RESTRICTIONS:** ___ **NONE**
WEIGHT BEARING: **FULL:** **PARTIAL:** **NONE:**	**CHRONIC ILLNESS, PHYSICAL OR MENTAL LIMITATIONS** **PPD (mantoux) test date** _______________ **Results** ___________ **BLOOD PRESSURE:** **WEIGHT:**

REQUIRED MEDICAL EXAMINATIONS AND/OR COMMUNITY BASED MEDICAL SERVICES:

REQUIRED NEED	PROVIDED BY	FREQUENCY

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:
______________________________	_________/ _________/ _________	_________/ _________/ ________