OUT OF THE STORM
SENIOR HOUSING

Phone 1-718-663-4151 / Fax 1-888-556-9797

Part 1: Application for Residency

Personal Information: **Date:**_____

Name_____
Address_____
E-mail_____ Phone ( ) _____
Date of Birth_____ Place of Birth_____
Social Security Number_____ Education Level_____
Former Occupation_____
Marital Status ☐ Married ☐ Partnered ☐ Separated ☐ Single ☐ Divorced ☐ Widowed
Name of Spouse/Partner_____
☐ Anniversary Date (Optional): _____

Person to be notified about moving to Out of the Storm Senior Residence if other than Applicant:

Name_____ Home Phone ( ) _____
Address_____ Cell Phone ( )_____
City/State/Zip_____ Work Phone ( )_____
Relationship to applicant_____

Religious Affiliation (Optional)

Name_____
Address_____
City/State/Zip_____
Contact Person _____ Phone ( ) _____

Would you like to be on?

☐ Immediate List (Will move when accommodation becomes available)
☐ Future List (Not quite ready to move yet)

Type of Housing

☐ Single Bedroom ☐ Shared Bedroom

Rent

What is the maximum rent you are willing to pay? _____

(Revised 1/9/2019)

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Application for Residency (Cont'd)

Insurance Information

Primary Insurance_____ Policy #_____

Secondary Insurance_____ Policy #_____

Medicaid Insurance ▫ Yes #_____ ☐ No

Other Health Insurance/Type of Insurance_____
Name of Insurance Company_____ Phone ( )_____
Insurance Policy Number_____
Billing Address_____

Prescription Drug Coverage/Plan
Name_____
Policy #_____ Group #_____

Long-Term Care Insurance ☐ Yes ☐ No
Name of Insurance Company_____ Phone ( )_____
Insurance Policy Number_____
Amount of Coverage_____ Length of Coverage_____
Billing Address _____
_____

Veteran Status: Applicant ☐ Yes ☐ No Spouse/Partner ☐ Yes ☐ No

Do you have any pets? ☐ Yes ☐ No What kind? _____

Why did you select *Out Of The Storm Senior Housing?*

_____

_____

Do you know someone who lives here? ☐ Yes ☐ No If Yes, who?

_____

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Application for Residency (Cont'd)

Emergency Contacts

Out Of The Storm Senior Housing recommends that residents designate a durable Power of Attorney (DPOA) and a Health Care Proxy. Please list each person, their relationship, and the level of responsibility (DPOA and/or Health Care Proxy). Please list in the order you wish them contacted in the event of an emergency. You give *Out Of The Storm Senior Housing* permission to share Personal Health Information (PHI) with these individuals.

1. Name_____
   Relationship_____
   Address_____
   City/State/Zip_____
   E-mail_____ Phone ( )_____ Cell ( )_____

2. Name_____
   Relationship_____
   Address_____
   City/State/Zip_____
   E-mail_____ Phone ( )_____ Cell ( )_____

3. Name_____
   Relationship_____
   Address_____
   City/State/Zip_____
   E-mail_____ Phone ( )_____ Cell ( )_____

Health Care Proxy

Name_____
Relationship_____
Address_____
City/State/Zip_____
E-mail_____ Phone ( )_____ Cell ( )_____

Power of Attorney

Name_____
Relationship_____
Address_____

City/State/Zip_____ Phone ( )_____ Cell ( )_____

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Application for Residency (Cont'd)

End of Life Preferences

Is a Do Not Resuscitate order in effect? ☒ Yes ☒ No

Are there Advance Directives? ☐ Yes ☐ No

Location of Advance Directives?

_____

Funeral Arrangements

Do you have a pre-paid funeral agreement for yourself? ☐ Yes ☐ No

Do you have a burial plot? ☐ Yes ☐ No

Is there a burial plot for anyone else? ☐ Yes ☐ No
Who is that? _____

Do you have money in a bank account set aside for a burial fund? ☐ Yes ☐ No

Do you have Life Insurance to be used as your burial fund? ☐ Yes ☐ No

Funeral Home Preference

Name_____

Address_____

City/State/Zip _____Phone ( )_____

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Application for Residency (Cont'd)

Individual Financial Information

Assets

(Please provide a copy of last year's Income Tax returns and the most recent Bank Statement, including Investments.)

Checking Accounts $_____ Savings Accounts $_____ Real Estate $_____
Certificates of Deposit $_____ Money Markets $_____ Mutual Funds $_____
Stocks $_____ Bonds $_____ Trust $_____
Name of Trust_____
Date of Trust_____
Primary Trustee(s) _____
Beneficiary(s) _____
Other Major Assets (Attach details) $_____
Total Assets $ _____

Liabilities: Long-Term Loans, Mortgages

Home Mortgage $_____ Reverse Mortgage $_____ Auto Loans $_____
Other (Attach details) $_____
Are you a co-signer on any loans? ☐ Yes ☐ No
If yes, name of co-signer_____
Total Liabilities $_____

Monthly Income/Expenses

Social Security Income $_____ Investment Income $_____
Annuities Income (Years remaining: ____) $_____ Pensions Income $_____
Long-Term Care Insurance Income $_____ Out-of-Pocket Med. Expenses $_____

Are these sources of income expected to continue throughout your lifetime? ☐ Yes ☐ No
If unexpected developments should reduce your future income below the level needed, would family members or others provide needed funds? ☐ Yes ☐ No

Do you have SNAP (Food Stamps)? ☐ Yes ☐ No (If yes, amount:_____)

Do you have a Safe Deposit Box? ☐ Yes ☐ No
Location of the Safe Deposit Box? _____
Whose names are on the Safe Deposit Box? _____

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Part 2: Personal Health Information

From the following list, please check off all current disabilities or conditions that might apply:

Cardiovascular/Pulmonary

Anemia . . . . . ☐ Yes ☐ No
Angina. . . . . ☐ Yes ☐ No
Arteriosclerosis/Atherosclerosis. . . . . ☐ Yes ☐ No
Asthma . . . . . ☐ Yes ☐ No
Bypass Surgery. . . . . ☐ Yes ☐ No
If Yes, Date: _____
Chronic Obstructive Pulmonary Disease. . . . . ☐ Yes ☐ No
Congestive Heart Failure . . . . . ☐ Yes ☐ No
Cystic Fibrosis . . . . . ☐ Yes ☐ No
Defibrillator . . . . . ☐ Yes ☐ No
Emphysema . . . . . ☐ Yes ☐ No
Heart Attack . . . . . ☐ Yes ☐ No
If Yes, Date: _____
HTN/Hypertension. . . . . ☐ Yes ☐ No
Peripheral Vascular Disease . . . . . ☐ Yes ☐ No
Phlebitis . . . . . ☐ Yes ☐ No
Thrombosis. . . . . ☐ Yes ☐ No
Other: _____

Neuromuscular

ALS/Lou Gehrig's Disease. . . . . ☐ Yes ☐ No
Equilibrium/Balance Problems . . . . . ☐ Yes ☐ No
Fibromyalgia . . . . . ☐ Yes ☐ No
Hemiplegia/Hemiparesis . . . . . ☐ Yes ☐ No
Multiple Sclerosis. . . . . ☐ Yes ☐ No
Muscular Dystrophy. . . . . ☐ Yes ☐ No
Neuropathy. . . . . ☐ Yes ☐ No
Paraplegia . . . . . ☐ Yes ☐ No
Parkinson's Disease . . . . . ☐ Yes ☐ No
Polio . . . . . ☐ Yes ☐ No
Quadriplegia . . . . . ☐ Yes ☐ No
Sciatica . . . . . ☐ Yes ☐ No
Spina Bifida. . . . . ☐ Yes ☐ No
Stroke/Cerebral Trauma /TBI. . . . . ☐ Yes ☐ No
If Yes, Date: _____
TIA's (Transient Ischemic Attack). . . . . ☐ Yes ☐ No
Other: _____

(Revised 1/9/2019)

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Personal Health Information (Cont'd)

From the following list, please check off all current disabilities or conditions that may apply:

General Medical:
- AIDS . . . . . ☐ Yes ☐ No
- Atrophy . . . . . ☐ Yes ☐ No
- Chemotherapy Treatment. . . . . ☐ Yes ☐ No
  - Dates: _____
- Diabetes. . . . . ☐ Yes ☐ No
- Edema. . . . . ☐ Yes ☐ No
- Hearing Aid: ☐Left ☐Right ☐ Both. . . . . ☐ Yes ☐ No
- HIV. . . . . ☐ Yes ☐ No
- Lupus. . . . . ☐ Yes ☐ No
- Rheumatoid Arthritis. . . . . ☐ Yes ☐ No
- Kidney Dialysis . . . . . ☐ Yes ☐ No
- Radiation Treatment . . . . . ☐ Yes ☐ No
  - Dates: _____

Other_____

Orthopedic:
- Amputation . . . . . ☐ Yes ☐ No
  - Specify extremity(ies)_____
- Broken/Fractured . . . . . ☐ Yes ☐ No
  - What/Where? _____Date: _____
- Degenerative Joint Disease . . . . . ☐ Yes ☐ No
- Gout . . . . . ☐ Yes ☐ No
- Hip Replacement . . . . . ☐ Yes ☐ No
- Knee Replacement . . . . . ☐ Yes ☐ No
- Osteoarthritis . . . . . ☐ Yes ☐ No
- Osteoporosis . . . . . ☐ Yes ☐ No
- Scoliosis . . . . . ☐ Yes ☐ No
- Spondylitis . . . . . ☐ Yes ☐ No

Other_____

Vision:

Cataracts.	☐ Yes ☐ No	☐ Left Eye	☐ Right Eye
Cortical Blindness . . .	☐ Yes ☐ No	☐ Left Eye	☐ Right Eye
Glaucoma (all types) . . .	☐ Yes ☐ No	☐ Left Eye	☐ Right Eye
Macular Degeneration . . .	☐ Yes ☐ No	☐ Left Eye	☐ Right Eye
Retinal Detachment. . . .	☐ Yes ☐ No	☐ Left Eye	☐ Right Eye
Legally Blind	☐ Yes ☐ No		

Other: _____

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Personal Health Information (Cont'd)

From the following list, please check off all current disabilities or conditions that may apply:

Cognitive/Psychological

Alzheimer's Disease. . . . . ☐ Yes ☐ No
ADD/Attention Deficit Disorder. . . . . ☐ Yes ☐ No
Anxiety . . . . . ☐ Yes ☐ No
Dementia. . . . . ☐ Yes ☐ No
Depression. . . . . ☐ Yes ☐ No
Head Trauma . . . . . ☐ Yes ☐ No
History of Wandering . . . . . ☐ Yes ☐ No
Panic Disorder . . . . . ☐ Yes ☐ No
Schizophrenia. . . . . ☐ Yes ☐ No
Psychiatric Hospitalizations . . . . . ☐ Yes ☐ No
Dates: _____
History of Substance Abuse. . . . . ☐ Yes ☐ No
Reoccurring ☐ Yes ☐ No Current ☐ Yes ☐ No

Other: _____

Surgeries

Please list any surgeries or procedures you have had, including the date/year:

_____

_____

Diet

Do you have a special diet? (If Yes, please list) ☐ Yes ☐ No

_____

Allergies

Please list any known food and/or medication allergies you may have.

_____

Other Problems

Have you ever experienced any bed bug problems? ☐ Yes ☐ No When? _____

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Personal Health Information (Cont'd)

Medications

Please list all current medications (use additional pages as necessary):

Medication_____ Dose_____ Frequency_____
Medication_____ Dose_____ Frequency_____
Medication_____ Dose_____ Frequency_____
Medication_____ Dose_____ Frequency_____
Medication_____ Dose_____ Frequency_____
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Medication_____ Dose_____ Frequency_____
Medication_____ Dose_____ Frequency_____
Medication_____ Dose_____ Frequency_____
Medication_____ Dose_____ Frequency_____

Doctors

Please list the Physicians involved in your health care (use additional pages as necessary):

Primary Physician_____Phone ( )_____
Address_____
City/State/Zip_____

Specialist_____ Specialty_____ Phone ( )_____
Address_____
City/State/Zip_____

Specialist_____ Specialty_____Phone ( )_____
Address_____
City/State/Zip_____

Specialist _____ Specialty_____Phone ( )_____
Address_____
City/State/Zip_____

Pharmacy
Name_____
Address_____Phone ( )_____

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Personal Health Information (Cont'd)

Activities of Daily Living

Please select the level of assistance needed, if any, in the following areas:

Task	Independent	Some Assistance	Full Assistance
Eating	☐	☐	☐
Bathing/Personal Care	☐	☐	☐
Finances	☐	☐	☐
Transportation	☐	☐	☐
Dressing	☐	☐	☐
Stairs/Walking	☐	☐	☐

What other assistance do you feel you need? _____

What special equipment or devices do you require? _____

Do you use:

A wheelchair ☐ Yes ☐ No A Walker? ☐ Yes ☐ No A Cane ☐ Yes ☐ No

Hobbies and Activities of Interest (Check all that apply)

Art ☐	Cards/Board Games ☐	Cooking ☐	Physical Activity ☐
Music ☐	Intellectual Pursuits ☐	Reading ☐	Theatre ☐
Writing ☐	Religious Activities ☐	Computers ☐	Volunteering ☐

Other_____

Referred By: _____ **Agency:** _____ **Contact Number:** _____

Signature of Applicant/Representative: _____ **Date**_____

(By signing, you agree that all of the information given above is complete, true, and up to date.)

Please add the name/contact of anyone who may have assisted with this Application:

_____

Please mail this application to: **Out Of The Storm Senior Housing**
1110 South Avenue, Suite 404
Staten Island, NY 10314

OUT OF THE STORM SENIOR HOUSING

Client Name: _____

Date: _____

Insurance ID#: _____

SUBSTANCE ABUSE ASSESSMENT

Patterns of Use

Types of Substance Abuse	Never Used	Age Of First Use	Past History (prior to 12 Months) Past Pattern Dose & Frequency	Present History (past 12 months) Current Patterns Dose & Frequency	Usual Route of Administration (oral, IV, smoke, snort)	Date Of Last Use
Tobacco	☐					
Alcohol	☐					
Cocaine, Crack	☐					
Uppers (amphetamine, speed, crack)	☐					
Narcotics	☐					
Heroin	☐					
Other Opiates	☐					
Hallucinogens LSD	☐					
Downers	☐					
Inhalants (glue, paint)	☐					
Other	☐					

Physical Signs and Symptoms

Is the recipient experiencing the following at present? ☐ None

☐ Staggering gait ☐ Nervousness ☐ Nausea ☐ Tremors to Extremities ☐ Agitation ☐ Cramping

☐ Tongue Tremors ☐ Sweating ☐ Vomiting ☐ Slurred Speech ☐ Headache ☐ Diarrhea

☐ Other: _____

Has the recipient experienced the following in the past? (in regard to substance use or withdrawal)

☐ Delirium Tremens ☐ Profuse Sweating ☐ Night Sweats ☐ Chest Pain ☐ Smothering Sensation ☐ Chills

☐ Shortness of breath ☐ Faintness ☐ Palpitations ☐ Seizures ☐ Fainting ☐ Sleeplessness ☐ Blackouts

☐ Panic ☐ Double Vision ☐ Hallucinations ☐ Dizziness ☐ Other: _____

Disease Associated with chronic use:

☐ Cirrhosis ☐ Pancreatitis ☐ Gastritis ☐ Korsakoff's Syndrome

OUT OF THE STORM
SENIOR HOUSING

Client Name: _____

Date: _____

Insurance ID#: _____

Recipient's Perception

Are you an alcoholic? ◯ Yes ◯ No ◯ Not Sure

Are you a drug addict? ◯ Yes ◯ No ◯ Not Sure

Do you drink alone? ◯ Yes ◯ No

Have you ever made attempts to cut back on drinking/drug abuse? ◯ Yes ◯ No

Have you ever felt guilty about your drinking/ drug abuse? ◯ Yes ◯ No

Are you interested in stopping or cutting down on your drinking/drug use? ◯ Yes ◯ No

Describe:

What is your history of abstinence?

Prioritize your drinking/ drug(s) of choice?

What problems have you had because of drinking/ using drugs?

If interested in stopping or cutting down on drinking/drug use, why?

Describe patterns of use and abuse in family members and significant others:

Substance Abuse / Dependency Indicators

Current / Recent Abuse Indicators (last 12 months):

- ☐ Recurrent use resulting in major role failure
- ☐ Recurrent use in situation in which it is physically hazardous
- ☐ Recent substance-related legal problems
- ☐ Continued use despite causing persistent or recurrent social or interpersonal problems

Current / Recent Dependence Indicators (last 12 months):

- ☐ Tolerance
- ☐ Withdrawal
- ☐ Substances taken in larger amounts or over longer time than intended
- ☐ Persistence desire or unsuccessful efforts to cut down or control substance use
- ☐ Great deal of time spent in activities necessary to obtain substance
- ☐ Important social, occupation, or recreational activities given up or reduced because of substance use
- ☐ Use continued despite knowledge of having persistence/recurrent physical psychological problem

OUT OF THE STORM
SENIOR HOUSING

Client Name: _____

Date: _____

Insurance ID#: _____

Legal Problems

☐ Denies legal problems

☐ Automobile accidents: specify number and nature: #: Nature:

☐ DUI charges/convictions: specify number and nature: #: Nature:

☐ Possession w/ intent to sell: specify number and nature: #: Nature:

☐ Misdemeanor charges/convictions: specify number and nature: #: Nature:

☐ Felony charges/convictions: specify number and nature: #: Nature:

Are charges pending? ◯ Yes ◯ No What charges?

Are you on probation? ◯ Yes ◯ No Comments:

Are you on parole? ◯ Yes ◯ No Comments:

Have you ever inflicted self-injury while under the influence? ◯ Yes ◯ No

Have you ever harmed anyone else (intentionally or unintentionally) while under the influence? ◯ Yes ◯ No

If yes to either self-injury or harmed others above, explain:

Previous Treatment

Date	Type of program reason for admission	Completed program Y/N	Length of Sobriety	Follow-Up / Outcome