



Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\* If any changes in addresses and phone numbers after admission, please notify us as soon as possible so that the changes can be made.

### FAMILY HISTORY

Place Raised: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Marriage: \_\_\_\_\_

Children and grandchildren:

Name (If married include spouse's name in parentheses and any grandchildren from that child underneath child and spouse)	Where Live	Frequency of Contact prior to Nursing Home Admission

Siblings:

Name	Where live, if alive	Frequency of Contact prior to Nursing Home Admission

Important Family Dynamics (close family, estranged family members, primary caregivers, etc)

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Other Important People in Applicant's life:

Name	Relationship	Frequency of Contact prior to Nursing Home Admission

### MEDICAL INFORMATION

History of Mental Illness, Suicide Attempts, or Alcohol/Drug Abuse: \_\_\_\_\_

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History of Verbal, Sexual or Physical Aggression; History of Wandering: \_\_\_\_\_

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Primary Physician (include address & ph. #): \_\_\_\_\_

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## COMMUNICATION

Speech: Clear      Garbled                      Communicates Needs:    Yes    No  
Makes Choices:    Yes      No                      Establishes Own Goals:    Yes    No

## RESIDENTIAL HISTORY FOR THE PAST 5 YEARS

Home Setting:     Apartment     House     Assisted Living/Adult Home     Nursing Home

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Were any Family Members/Community Agencies Assisting Resident With Needs? Please describe (i.e.; meals on wheels, visiting nurses, housekeeper, transportation, medication, etc):

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Is the Applicant Aware/Accepting of Possible Placement in a Nursing Home? \_\_\_\_\_

How Does the Family Feel About Placement? \_\_\_\_\_

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Is Placement Expected to be Permanent or Temporary? \_\_\_\_\_

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How Often Do Family Members Expect to Visit? \_\_\_\_\_

Applicant's Former and Current Interests/Hobbies: \_\_\_\_\_

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Applicant's Life Long Personality Traits (i.e.: easy going, outgoing, shy, kept to self, stubborn, etc.)

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**ADVANCE DIRECTIVES**

Which directives have been completed by the applicant?

\_\_\_\_\_ Health Care Proxy    \_\_\_\_\_ Do Not Resuscitate    \_\_\_\_\_ Living Will

**BURIAL ARRANGEMENTS**

Funeral Home: (name) \_\_\_\_\_

(address) \_\_\_\_\_

(phone) \_\_\_\_\_

Are arrangements prepaid? YES/NO

**INSURANCE**

Applicant’s Social Security #: \_\_\_\_\_ Spouse’s Social Security #: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Does applicant have Part B? YES    NO

Does applicant have Medicare Part D (drug coverage)? YES    NO

Medicaid (CIN) # and County: \_\_\_\_\_

Community    or    Chronic Care (Please circle)

**Attach copy of Medicaid Budget Letter**

Medicaid Application Pending? YES/NO    If yes, date submitted: \_\_\_\_\_

Name of Caseworker: \_\_\_\_\_ County submitted: \_\_\_\_\_

**Attach copy of Medicaid Application**

HMO Insurance (please provide name and #): \_\_\_\_\_

Is HMO in place of Medicare? YES/NO

Other Health and/or Drug Insurance(s) (please name and #): \_\_\_\_\_

**Copies of social security card, Medicare card, and any insurance cards must be submitted with this application.**

## FINANCIAL INFORMATION

All information provided on this form is subject to verification

### Current Monthly Income:

	Applicant	Spouse
Social Security:	\$ _____	\$ _____
SSI or SSD:	\$ _____	\$ _____
Pensions (Retirement):	\$ _____	\$ _____
Name of Administrator:	_____	_____
Address of Administrator:	_____	_____
<hr/>		
Pensions (Retirement):	\$ _____	\$ _____
Name of Administrator:	_____	_____
Address of Administrator:	_____	_____
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Veteran's Pension:	\$ _____	\$ _____
Railroad Pension:	\$ _____	\$ _____
Rental Income:	\$ _____	\$ _____
Interest/Dividends:	\$ _____	\$ _____
Annuity Income/IRA:	\$ _____	\$ _____
Name of Administrator:	_____	_____
Address of Administrator:	_____	_____
<hr/>		
Annuity Income/IRA:	\$ _____	\$ _____
Name of Administrator:	_____	_____
Address of Administrator:	_____	_____

*If any additional income, please list above information on back of this page*

**\*\* Names and addresses for all pension and other income sources must be provided. Upon admission all social security and pension and annuity checks shall be immediately transferred to come directly to the facility. During the transition period, please be prepared to provide income to the facility.**

**ASSETS: Bank Accounts (Applicant or spouse)**

Please list all bank accounts (open or closed) that exist or existed in the Applicant's name (& spouse if applicable) in the last 60 months. **(Provide copy (ies) of last monthly/quarterly statement(s))**

**Type of Account:** Checking \_\_\_\_ Saving \_\_\_\_ Money Market \_\_\_\_ Certificate of Deposit (CD) \_\_\_\_  
Credit Union Account \_\_\_\_ None \_\_\_\_

Bank name: \_\_\_\_\_

**Current Balance:** \_\_\_\_\_ **Account #:** \_\_\_\_\_

Joint Account? YES/NO If yes, with whom? \_\_\_\_\_

**Type of Account:** Checking \_\_\_\_ Saving \_\_\_\_ Money Market \_\_\_\_ Certificate of Deposit (CD) \_\_\_\_  
Credit Union Account \_\_\_\_ None \_\_\_\_

Bank name: \_\_\_\_\_

**Current Balance:** \_\_\_\_\_ **Account #:** \_\_\_\_\_

Joint Account? YES/NO If yes, with whom? \_\_\_\_\_

**Type of Account:** Checking \_\_\_\_ Saving \_\_\_\_ Money Market \_\_\_\_ Certificate of Deposit (CD) \_\_\_\_  
Credit Union Account \_\_\_\_ None \_\_\_\_

Bank name: \_\_\_\_\_

**Current Balance:** \_\_\_\_\_ **Account #:** \_\_\_\_\_

Joint Account? YES/NO If yes, with whom? \_\_\_\_\_

**Type of Account:** Checking \_\_\_\_ Saving \_\_\_\_ Money Market \_\_\_\_ Certificate of Deposit (CD) \_\_\_\_  
Credit Union Account \_\_\_\_ None \_\_\_\_

Bank name: \_\_\_\_\_

**Current Balance:** \_\_\_\_\_ **Account #:** \_\_\_\_\_

Joint Account? YES/NO If yes, with whom? \_\_\_\_\_

**Type of Account:** Checking \_\_\_\_ Saving \_\_\_\_ Money Market \_\_\_\_ Certificate of Deposit (CD) \_\_\_\_  
Credit Union Account \_\_\_\_ None \_\_\_\_

Bank name: \_\_\_\_\_

**Current Balance:** \_\_\_\_\_ **Account #:** \_\_\_\_\_

Joint Account? YES/NO If yes, with whom? \_\_\_\_\_

*If any additional accounts, please list above information on back of this page*

**INVESTMENTS: (applicant or spouse)**

**(including but not limited to stocks, bonds, savings bonds, annuities, mutual funds)**

Please list all stocks, bonds, savings bonds, mutual funds and annuities the Applicant owns (& spouse if applicable) or owned in the last 60 months. **(Provide proof of ownership and value):**

Does the Applicant (& spouse if applicable) have, or did Applicant (and spouse, if applicable) have, any investments including but not limited to stocks, bonds, savings bonds, annuities, mutual funds in the last 60 months? YES/NO **(Provide copy (ies) of most recent statements)**

Stocks \_\_\_\_ Bonds \_\_\_\_ Mutual Funds \_\_\_\_ Annuities \_\_\_\_ Savings Bonds \_\_\_\_\_

If Yes –

Investment/Brokerage Company \_\_\_\_\_

Owner \_\_\_\_\_ Account Value: \$ \_\_\_\_\_

Stocks \_\_\_\_ Bonds \_\_\_\_ Mutual Funds \_\_\_\_ Annuities \_\_\_\_ Savings Bonds \_\_\_\_\_

If Yes –

Investment/Brokerage Company \_\_\_\_\_

Owner \_\_\_\_\_ Account Value: \$ \_\_\_\_\_

Stocks \_\_\_\_ Bonds \_\_\_\_ Mutual Funds \_\_\_\_ Annuities \_\_\_\_ Savings Bonds \_\_\_\_\_

If Yes –

Investment/Brokerage Company \_\_\_\_\_

Owner \_\_\_\_\_ Account Value: \$ \_\_\_\_\_

**IRA OR RETIREMENT ACCOUNTS (applicant or spouse)**

Does the Applicant (& spouse if applicable) have, or did Applicant (and spouse, if applicable) have, any IRA, Keogh, 401(k), or Deferred Compensation Accounts in the last 60 months? YES/NO **(Provide copy (ies) of most recent statements)**

Bank/Investment/Brokerage Company \_\_\_\_\_

Owner \_\_\_\_\_ Account Value: \$ \_\_\_\_\_

Type of Investment \_\_\_\_\_

Bank/Investment/Brokerage Company \_\_\_\_\_

Owner \_\_\_\_\_ Account Value: \$ \_\_\_\_\_

Type of Investment \_\_\_\_\_

**LIFE INSURANCE (applicant or spouse)**

Does Applicant (& spouse, if applicable) have any Life Insurance Policies? YES/NO

Name of Insurance Company \_\_\_\_\_

Face Value: \$ \_\_\_\_\_

Cash Value: \$ \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Face Value: \$ \_\_\_\_\_

Cash Value: \$ \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Face Value: \$ \_\_\_\_\_

Cash Value: \$ \_\_\_\_\_

**(Provide copy (ies) of all policies)**

**REAL PROPERTY (applicant or spouse)**

Does the Applicant (and/or spouse) own a home? YES/NO Estimated Value: \_\_\_\_\_

**(If yes, provide copy of last tax bill and deed)**

Is the Home Jointly Owned? YES/NO With Whom? \_\_\_\_\_

Who Lives in the Home with Applicant? \_\_\_\_\_

Outstanding mortgage or loan? \$ \_\_\_\_\_

Does the Applicant (and/or spouse) own any other real estate (vacation homes, rental property, etc.) YES/NO

If yes, address \_\_\_\_\_ Value: \$ \_\_\_\_\_

Outstanding mortgage or loan? \$ \_\_\_\_\_

Has the Applicant (and/or spouse) transferred or sold any real estate (including rentals or vacation homes) in the last 60 months? YES/NO

If Yes – Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If property was sold, was it sold for Fair Market Value? YES/NO \$ \_\_\_\_\_

Does the Applicant Have Life Use in the Home That He/She Transferred? YES/NO

**(If yes, provide copy of deed.)**

Has the Applicant (& spouse if applicable) Created a Trust in the last 60 months?

**(If yes, provide copy of trust.)**

Revocable: YES/NO

Irrevocable: YES/NO

What is the Date the Trust Was Created? \_\_\_\_\_

How Much Has Been Transferred into the Trust? \$ \_\_\_\_\_

Other Assets: \_\_\_\_\_

\_\_\_\_\_

**TRANSFERS/GIFTS (this includes but is not limited to large gifts of money for weddings, paying for college education for grandchildren, large birthday/holiday gifts, any payments made for un-receipted expenditures of \$500 or more, transferring property)**

Have any of the Applicant's (& spouse if applicable) Assets Been Transferred or Gifted to an Individual in the last 60 months? YES/NO

If Yes – Date of the Transfer(s), amount or value, reason and recipient: \_\_\_\_\_

How much was transferred 60 months or more prior to the date on this application? \_\_\_\_\_

How much was transferred within the past 60 months? \_\_\_\_\_

Are the transferred/gifted funds still available if it is determined that the transfer/gift will disqualify the Applicant for Medicaid? YES/NO

Have any of the Applicant's (& spouse if applicable) Assets Been Transferred to a Trust in the last 60 months? YES/NO

If Yes – Date of the Transfer(s), amount or value, reason and recipient: \_\_\_\_\_

How much was transferred 60 months or more prior to the date on this application? \_\_\_\_\_

How much was transferred within the past 60 months? \_\_\_\_\_

Are the transferred/gifted funds still available if it is determined that the transfer/gift will disqualify the Applicant for Medicaid? YES/NO

Has the Applicant filed a tax return in the last 5 years? YES/NO

**If yes, please provide a copy of the most recent return.**

**LIABILITIES:**

Name of Creditor: \_\_\_\_\_ Balance Due: \$ \_\_\_\_\_

Name of Creditor: \_\_\_\_\_ Balance Due: \$ \_\_\_\_\_

**Smoker? YES/NO**

*\*This nursing home is a non-smoking facility. Admission priority is given to applicants who do not smoke. Residents are not allowed to smoke in the facility or on the grounds of the facility.*

*\*This facility does not discriminate in admission, retention or care of its residents because of race, creed, color, nationality, national origin, sex, disability, age, religion, source of payment, marital status or sexual preference.*

*\*The information provided shall remain confidential and shall be made available only to authorized hospital and nursing home personnel involved in the placement process, to any governmental officials authorized access by law to such records, and to any government or individual insurance programs for purposes of reimbursement/payment for care at the facility. Any copies of financial documents provided to the facility shall only be shared with those parties involved with providing financial resources for the care of the resident.*

*\*The facilities having access to this information do so without regard to race, creed, color, age, sex, religion, national origin, sponsor, sexual preference, disability, marital status, or upon any other ground prohibited by the law of the State of New York or the United States of America; persons 16 years of age or younger are not eligible for admission consideration, unless special approval has been received from the Department of Health*

***To the best of my knowledge and belief, all the information provided herein is accurate and true and will be held confidential as per above. I further understand that withholding information requested or providing inaccurate information is grounds for legal action to be taken against me:***

Signature of Person  
Completing Application: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_ Date: \_\_\_\_\_