**2a *ELCOR NURING AND REHABILITATION CENTER***

***48 COLONIAL DRIVE***

***HORSEHEADS, NY 14845***

***(607) 739-0304***

**ADMISSION APPLICATION**

Date: Name: Maiden Name:

Current Location: Marital Status:

Usual Address: Telephone #:

Sex: Date Of Birth: Present Age: U.S. Citizen:

Place Of Birth: Current County Of Residence:

NAMES OF CLOSE LIVING RELATIVES OR CLOSE FRIENDS/SPONSORS: ***(star or circle two to be notified in case of emergency):***

A) Name: B) Name:

Relationship: Relationship:

Address: Address:

Phone No. Home: Phone No. Home: Work: Work: E-Mail Address: E-Mail Address:

C) Name: D) Name:

Relationship: Relationship:

Address: Address:

Phone No. Home: Phone No. Home:

Work: Work:

E-Mail Address: E-Mail Address:

Previous Occupation Or Profession:

Kind Of Business: Name & Location:

Current Hobbies, Interests, And Activities:

Are You A Veteran? Yes No Is Your Spouse A Veteran? Yes No

Father's Name: Mother's Maiden Name:

**CLINICAL INFORMATION**

Current Physician: Hospital Preference:

Diagnosis, If Known:

Reason For Application: Rehab LTC

Has An Assessment Been Done By A PRI Nurse/Screener: Yes No If Yes, Who:

PRI Score, If Known: ***(Please Attach A Copy Of This PRI/Screen).***

2b

**GENERAL INFORMATION**

Social Security No.: Medicare No.:

Medicaid No.: Medicare Part A & B Dates:

Blue Cross/Blue Shield No.: Group Nos.:

Address Of BC/BS:

Other Insurance Name & No.:

Address Of Other Insurance:

Prescription Card # (If Any):

Religion: Church If Any.

Do You Have Burial Arrangements Made: Yes: No:

Funeral Home: Address:

Person Responsible For Funeral Arrangements:

Name: Relationship:

Address:

Home Phone: Work Phone:

## FINANCIAL INFORMATION

Do You Have A Power Of Attorney: Yes: No:

If Yes, Name Of P.O.A.:

Address: Phone No.:

***(NOTE: A COPY OF THIS POWER OF ATTORNEY MUST BE PRESENTED AT TIME OF ADMISSION)***

# If No Power Of Attorney, Does Anyone Other Than Yourself Handle Your Affairs?

If Yes, Who: Name: Phone No.

Address: Relationship:

Do You Have A Conservator? Yes No

If Yes, Who: Name: Phone No.

Address: Relationship:

***(NOTE: A COPY OF THIS CONSERVATOR MUST BE PRESENTED AT TIME OF ADMISSION)***

**Has There Been A Transfer Of Funds/Assets, Including But Not Limited To Real Estate, In The Past 60 Months? € Yes € No** If Yes, Please Explain:

*It is the requirement of Elcor Nursing & Rehabilitation Center that the attached financial disclosure report be completed when making application to Elcor Nursing & Rehabilitation Center. This report must be completed and attached in order to actively be placed on our admission waiting list.*

*In compliance with New York state and federal laws which prohibit discrimination based on race, creed, color, national origin, age, sex, sexual preference, handicap, marital status, sponsorship, this facility admits and treats all residents on a non-discriminatory basis.*

According to my best knowledge and belief, the foregoing information is accurate and true in all respects. I agree, if admitted, to abide by the regulations of the facility.

Date Signature of Applicant

or

Date Signature of Person Applying for Applicant

### 2c ELCOR NURSING & REHABILITATION CENTER

**APPLICANT FINANCIAL REPORT**

**(ALL INFORMATION IS CONSIDERED CONFIDENTIAL)**

#### Monthly income of Applicant

Salary . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Social Security . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Retirement Pension . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $ *(company* )

Veteran's Pension . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Railroad Pension . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Supplementary Security Income . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Other Monthly Income . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Please explain

#### Assets

Bank Accounts:

# Name & Address Bank Account No. Type of Account Amount

$

$

$

$

Other . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Market Securities

Stocks, Current Value . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Bonds, Current Value . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Funds in Trust . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Real Estate (Current Market Value). . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Life Insurance (cash value) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Life Insurance (face value) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Other Assets . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

LIABILITIES

Home Mortgage . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Loans & Installment Payments . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

Other . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

***TOTAL LIABILITIES*** . . . . . . . . . . .. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

***NET BALANCE*** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $

To the best of my knowledge all of the above information is correct and valid and is a complete accurate accounting of all assets and liabilities. I acknowledge that Elcor Nursing & Rehabilitation Center reserves the right to ask for confirmation of my source of income and assets.

Applicant's and/or Responsible Party's Signature Date