PLACEMENT APPLICATION

Elcor Nursing and Rehabilitation Center | 48 Colonial Dr | Horseheads, NY 14845 | 607-739-3654 | Elcor.us

TO BE COMPLETED BY RESIDENT OR DESIGNATED REPRESENTATIVE

All questions must be answered, and all information must be provided for this application to be considered by Elcor. If you need help completing this form, call the Admissions Director at 607-739-3654 Ext 205.

General Information:

Applicant's Name:_____ Date of Birth: ___ /___ /____

Age:_____ Marital Status:_____ Religion:_____ Social Security #:_____

Sex:_____

Street Address (Do not use PO Box):_____

City:_____ State:_____ Zip:_____ County:_____

Applicant's present location:_____

Date of Admission: ___/___ /____ Email address: _____

Has the applicant had any Skilled Nursing Facility stays within the last 60 days? ☐Yes ☐ No

If yes, please include the following Facility Information:

Facility Name: _____

Street Address: _____

City:_____ State:_____ Zip:_____

Facility Phone Number:(_____)_____ Admittance Date:_____ Discharged Date:_____

Please check one. [ ] Application is for placement [ ] Application is for rehabilitation and discharge

Resident Representatives: Please list in order of emergency contact

Name:_____ Name:_____

Relationship: _____ Relationship:_____

Address:_____ Address: _____

Home #: _____ Home #:_____

Cell/work #:_____ Cell/work #:_____

Email: _____ Email: _____

Contractual Agreements:

Does applicant have any of the following? If yes, please attach a copy to this application.

POA?	☐Yes	☐ No	Living Will?	☐ Yes	☐ No
Guardian/Conservator?	☐Yes	☐ No	Health Care Proxy?	☐ Yes	☐ No
VA Status?	☐Yes	☐ No	DNR?	☐Yes	☐ No

Pre-paid Funeral Arrangements? ☐Yes ☐ No

Funeral Home Information: _____

Person responsible for handling financial transactions:

Name_____

Relationship _____

Address_____

Home _____

Work/Cell _____

Email: _____

Insurance Information:

MEDICARE

Medicare#:_____ Effective Date: ___ /___/____

Medicare coverage for Part A, Part B, or Both? ☐Part A ☐Part B ☐Both

Is this a Medicare HMO? ☐Yes ☐No

If yes, what is the name of the insurance?_____

Drug coverage plan name/ID#:_____

Supplemental Insurance Company Name/Address:_____

_____

ID#:_____ Plan#/Name:_____

Does the applicant have Long Term Care coverage? ☐Yes ☐No

If Yes, please provide the following:

Insurance Company Name and Address:_____

Policy #:_____

MEDICAID

Medicaid ID#:_____ County:_____

Has the applicant applied for Medicaid? ☐ Yes ☐No If Yes, when was the appointment?_____

Has all information requested been provided to Medicaid? ☐Yes ☐No

Case worker name/ number:_____

Are you currently working with an Attorney or Medicaid planner for Medicaid planning purposes?
☐Yes ☐No If yes: Applicant Name:_____

Please list their name, address and phone number here: _____
_____

May we contact them for information if needed? ☐Yes ☐No

Does the applicant and/or spouse have life insurance? ☐Yes ☐No

If yes, what are current cash values?_____

Financial Information: All information provided here is subject to verification.

INCOME Please list all monthly household income:

Source of Income	**Applicant**	**Spouse**
Social Security	$_____	$_____
(Type and SS# if different from your own)	_____	
SSI	$_____	$_____
Pension(s)	$_____	$_____
Source (Company name and ID#)	_____	
Veterans	$_____	$_____
Rental Income	$_____	$_____
Interest/Dividends	$_____	$_____
Annuity/IRA Income	$_____	$_____
Trust Income	$_____	$_____
Other Income	$_____	$_____

ALIMONY Applicant must provide copy of court order.

Alimony Paid Out: ☐Yes ☐No Amount $_____
Alimony Paid Type: ☐Domestic Relations Order ☐Separation Agreement / Spousal Order

Alimony Received: ☐Yes ☐No Amount $_____
Alimony Received Type: ☐Domestic Relations Order ☐Separation Agreement / Spousal Order

ASSETS

Does the applicant own a home? ☐Yes ☐No If yes, Jointly owned? ☐Yes ☐No

With whom?_____ Estimated Value: $ _____

Current Mortgage Balance: $_____ Does applicant have life estate in any property?

☐Yes ☐No If yes, date established:_____

If yes, Applicant Name:_____

Please list any other properties owned by applicant and their values:

_____

Has any home or property been sold or transferred in the last 5 years? ☐Yes ☐No

If yes: Sale Date_____ Amount of Sale: $_____

Address of Property _____

BANK ACCOUNTS – Please list all accounts here including CDs, Savings, Checking, Money Markets, etc.

Bank: _____ Bank: _____

Current Balance: $_____ Current Balance: $_____

Joint owner's name: _____ Joint owner's name: _____

Please continue on another page if more space is needed.

INVESTMENTS - Please list all stocks, bonds, savings bonds, annuities, mutual funds or other investments here. Continue on a second page if needed.

Bank/Brokerage Company:_____ Owner(s):_____ Current Value: $_____

Type of Investment:_____ Owner:_____

Bank/Brokerage Company:_____ Owner(s):_____ Current Value: $_____

Type of Investment:_____ Owner:_____

Please continue on another page if more space is needed.

GIFTING INFORMATION: (includes birthday, wedding, graduation gifts, charitable gifting, Tithing, etc.)

Has the applicant gifted or given away any funds, property ☐Yes ☐No

or assets, to anyone in the last 5 years? If yes, when? _____

How much was given? $_____

To Whom? _____

TRUST INFORMATION:

Has a Trust been established? ☐Yes ☐No If yes, When?_____

Is the Trust Revocable or Irrevocable? ☐Revocable ☐Irrevocable

How much was placed in Trust? $_____

Have any funds been transferred into the trust since its inception? ☐Yes ☐No

If yes, When?_____ How much? $_____

Please provide a copy of the trust with this application.

Are the transferred/gifted funds still available if it is determined that the transfer/gift will disqualify the resident for Medicaid? ☐Yes ☐No

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Applicant Acknowledgement:

Applicant Name: _____

You may be required to provide documentation to support the information provided on this application. The applicant and/or Responsible party hereby state that the information provided on this application is complete and accurate to the best of my knowledge. As the financially responsible party, I hereby agree not to transfer or otherwise dispose of assets which would render the resident ineligible for Medicaid coverage.

If the applicant is capable of signing, both the applicant and financially responsible party should sign here. If the applicant is not capable of signing, the financially responsible party should sign as a representative and should also sign the applicant's name as POA. This should be signed as follows: (applicant name) by (POA Name) as agent for (applicant name)

_____ ___ / ___ /_____

Signature of Applicant Date Signed

_____ ___ / ___ /_____

Signature of Representative (POA) Date Signed