SHORT TERM REHABILITATION 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: _____

Financial Information:

Has applicant applied for Medicaid? ☐Yes ☐No *If yes*, when? _____

INCOME - Self and Spouse (List all monthly household income.
Continue on a second page if needed)

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

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.

Life insurance policies? ☐Yes ☐No
If yes, list cash values: _____

Pre-Paid burial? ☐Yes ☐No

_____

Do you own a home? ☐Yes ☐No
If yes, property address: _____

Is home jointly owned? ☐Yes ☐No

Life estate on any property? ☐Yes ☐No
If yes, date Life Estate established : _____

Transferred or sold any property/assets in the last 5 years? ☐Yes ☐No
If yes, list property/asset information:

_____

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: *(This includes birthday, wedding, graduation gifts, charitable gifting, Tithing, etc.)*

Has the applicant gifted or given away any funds, property or assets, totaling $1,000 or more to anyone in the last 5 years? ☐Yes ☐No

If yes, when? _____
How much was given? $_____
To Whom? _____

Has a Trust been established? ☐Yes ☐No

If yes, when? _____ Is it revocable or irrevocable? _____

Do you have Long term Care insurance? _____

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