PART ONE APPLICATION (& REHABILITATION)

If applying for long term care placement, this application must accompany the Part 2 Financial Supplement

Elcor Nursing & Rehabilitation Center | 48 Colonial Dr. | Horseheads, NY | (607) 739-3654 | www.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 facility. If you need help completing this form, call the Admissions Department at 607-739-3654.

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: __ /___ /____
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:_____

Resident Representatives: Please list in order of emergency contact

#1 Name:_____ #2 Name:_____
Relationship: _____ Relationship:_____
Address:_____ Address: _____
Home #: _____ Home #:_____
Cell/work #:_____ Cell/work #:_____
Email: _____ Email: _____

Financial Information: **INCOME** - Self and Spouse (List all monthly household income. Continue a second page if needed)

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

BANK ACCOUNTS – Please include all accounts balances including CDs, Savings, Checking, Bonds, 401K, Money Markets, etc.

Checking/Savings $_____ _Bank: _____Joint Owners Name: _____
Checking/Savings $_____Bank: _____Joint Owners Name:_____
Checking/Savings $_____Bank: _____Joint Owners Name:_____

Life insurance policies? ☐Yes ☐No ***If yes,*** Cash values $_____Policy Name: _____
Pre-Paid burial? ☐Yes ☐No ***If yes****, (funeral home):*_____
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 - List all IRAs, 401ks, stocks, bonds, savings bonds, annuities, mutual funds or other investments here.

Bank/Brokerage Company	**Owner(s)**	**Type of Investment** *(stocks/CD/bonds etc..)*	**Current Value**

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

GIFTING INFORMATION:

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

Has the applicant gifted/given away any funds, property or assets, over $1,000 or more in the last 5 years? If yes, indicate below:

Amount Given	Date Given (month/year)	Recipient of Gift

Has a Trust been established? ☐Yes ☐No *If yes*, when? _____ Revocable or irrevocable? (circle one)

Do you have long term Care insurance? ☐Yes ☐No If yes, what company?_____

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

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

PART TWO FINANCIAL APPLICATION (LONG TERM CARE PLACEMENT)

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General Information:

Applicant's Name:_____

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
Rep Payee?	☐Yes	☐ No			

Person responsible for handling financial transactions:

Name_____ POA: Yes or No
If yes (you are POA): Are you willing and able to act as the POA for applicant? Yes or No
Relationship _____
Address_____
Home _____
Work/Cell _____
Email: _____

Insurance Information:

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:_____

Supplemental Insurance address:_____

ID#:_____Plan#/Name:_____

Medicaid ID#:_____ County:_____
Has the applicant applied for Medicaid? ☐ Yes ☐ No If Yes, when? _____

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

County/Case worker number:_____

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

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

Additional Asset Information:

If you have indicated you own a home on Part 1 of the application, please answer the following:

Estimated Value: $ _____ Current Mortgage Balance: $_____

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: _____

Updated BANK ACCOUNTS (If resident is transitioning from Rehab to Long Term Care, meaning you completed Part 1 of this application upon admission to rehab.)

BANK ACCOUNTS:

Checking/Savings $_____Bank: _____Joint Owners Name: _____
Checking/Savings $_____Bank: _____Joint Owners Name:__ _____
Checking/Savings $_____Bank: _____Joint Owners Name:_____

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:

_____

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_____ ____ / ____ /____

Signature of Applicant Date Signed

_____ ____ / ____ /_____

Signature of Representative (POA) Date Signed