



NURSING & REHABILITATION CENTER
282 Riverside Drive, Johnson City, NY 13790

Phone: (607) 729-9206
FAX: (607) 797-3229

ADMISSION APPLICATION

Applicant Name: _____ (_____
_____)
First Middle Last Maiden

Where is the applicant presently? _____

Home Address: _____

Birth date: ___/___/___ Place of Birth: _____

Age: _____ Sex: _____ Marital Status: _____

Spouse's Name: _____

Social Security No.: _____ Physician: _____

U.S. Citizen: _____ Language: _____

Religion: _____ Church: _____

Veteran: _____ Yes _____ No Veteran's Spouse? _____ Yes _____

No

Temporary or Permanent Placement? _____

Funeral Home: _____

Family Members/Significant Others:

1. _____
Name Relationship

_____ Address

_____ Home Phone Work Phone

2. _____
Name Relationship

_____ Address

_____ Home Phone Work Phone

FINANCIAL INFORMATION CONCERNING APPLICANT:

Medicare Part B Coverage: Yes _____ No _____

Medicare #: _____ Medicaid #: _____

Will the applicant be paying for the care here out of their own funds? Yes _____ No _____

If the resident will be paying out of their own funds, then they must qualify financially.

Person responsible for individual's funds: _____

Do they have Power of Attorney? Yes _____ No _____

Has the applicant had any previous nursing home admissions? If so, when and where? _____

Has Medicaid application been made? Yes _____ No _____ If so, when? _____

Other Insurance Coverage:

Blue Cross # _____ Blue Shield # _____

Other Insurance: _____

A. Cash Assets:

Bank: _____ Bank: _____

Location: _____ Location: _____

Checking Account #: _____ Checking Account #: _____

Balance in Account: _____ Balance in Account: _____

Savings Account #: _____ Savings Account #: _____

Balance in Account: _____ Balance in Account: _____

Certificates of Deposit? Yes _____ No _____

If yes, identify the bank or institution where held and the amount:

(Institution) (Amount)

(Institution) (Amount)

(Institution) (Amount)

(Institution) (Amount)

Safe Deposit Box? Yes _____ No _____

If yes, please indicate the location. Bank Name: _____

B. Real Estate Assets

Does the applicant own their home? Yes _____ No _____ Approximate value? _____

Does the applicant own any other property? Yes _____ No _____

If yes, where is the property located? _____

Does the applicant receive any "rental" income? Yes _____ No _____

How much? Per Month: _____ Per Year: _____

C. Life Insurance Cash Value

Does the applicant have life insurance policies with cash value? Yes _____ No _____

Approximate amount of cash value? \$ _____

Annuities: \$ _____

Company Name: _____

Agent's Name: _____

Agent's Telephone Number: _____

D. Securities

Does the applicant have stocks, bonds, or mutual funds? Yes _____ No _____

Approximate value of all securities: \$ _____

Agent handling securities: Name: _____

Address: _____

Telephone Number: _____

E. Prepaid Burial

Does the applicant have a prepaid burial account? Yes _____ No _____

If yes, is the account irrevocable? Yes _____ No _____

F. Other Income

Social Security Check: \$ _____

Veteran's Pension: \$ _____

Other Pensions: \$ _____

Annuity: \$ _____

Disability Check: \$ _____

Public Assistance: \$ _____

Supplemental Security (SSI): \$ _____

Dividends: \$ _____

Trust Income: \$ _____

Other: \$ _____

G. Transfer of Assets

List any funds, securities, personal or real property transferred within the last 60 months. Provide dates and approximate value.

List any trusts established with your funds or any other assets.

AUTHORIZATION

The undersigned acknowledges that Susquehanna Nursing & Rehabilitation Center is relying on their representations and promises set forth herein in considering the applicant for admission.

The financial information set forth herein is a true and correct statement of the applicant's current financial position. The undersigned acknowledges that Susquehanna Nursing & Rehabilitation Center considers this application as a continuing statement of financial condition and the undersigned agrees to notify Susquehanna Nursing & Rehabilitation Center in writing of any change in the applicant's financial condition.

The undersigned further understands that a gift by the applicant, which disqualifies the applicant for Medicaid status for any period of time, may constitute a "fraudulent conveyance" under the New York State Debtor and Creditor Law and that Susquehanna Nursing & Rehabilitation Center intends to pursue its legal rights against the applicant and any person to whom the applicant makes a gift which constitutes a fraudulent conveyance.

In addition, the undersigned authorizes Susquehanna Nursing & Rehabilitation Center to verify all accounts and information contained on this financial information sheet. I agree that a photocopy shall have the full force and effect as the original of this application.

The above information is affirmed under penalty of perjury this _____ day of _____, 20 __

Applicant – Name

Applicant – Signature

Responsible Party for Applicant

Responsible Party - Signature

In compliance with New York State and Federal Laws, which prohibit discrimination based on race, color, sexual preference, blindness, or sponsorship in admission, this facility admits and treats all patients and residents on a non-discriminatory basis.