APPLICATION FOR ADMISSION

Date of Application: _______________ Applicants Name: ____

Social Security # :_______________________ Date of Birth: ____________Sex: __________________________

Legal Address:____

Marital Status: __________________County: ____

Current Primary Care Physician:______________________ Phone: ____________________________________

Financial Representative/ Power of Attorney: (please attach copy)- this is the person who will receive the monthly bill on behalf of the resident and be able pay this for them:

Name:_____________________________ Relationship to resident: _______________________________ _____

Address: ____ _____

Home Phone:___________________ Work Phone: ______________________Cell:_______________________

Health Care Proxy/Designated Representative: (Please attach copy of HCP) – Health care agent noted on Proxy would be the designated representative for the resident in regards to health care decisions. If there is not a HCP in place indicate no HCP in place and note who the designated representative is we contact for health care decision

Health Care Proxy Name: ____ _____

Designated representative Name if no Health Care Proxy in Place: _____________________________________

Address: ____ ____

Home Phone:___________________ Work Phone: ______________________Cell:______________________

Insurance Information:
Medicare Number: ______________________________ Effective Date: ________________________

Do you have **Medicaid:** Yes / No Is this a Managed Medicaid (ie. Fidelis): Yes / No

Medicaid Number: _________________ County: _______________________

Supplemental Medical Insurance: (please provide copy of front and back of card(s):

Name of Insurance: _________________________Member ID: _______________Policy#:________________

Name of Insurance: _________________________Member ID: _______________Policy#:_________________

Payment Information: What is plan for payment for services? (. I.E. Chronic Medicaid/Private funds/etc.):

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Prescription Medication Insurance Information (please provide copies of front and back of cards)

Do you have currently have Medicare Part D or other Private Insurance for drug coverage: **Yes** ☐ **No** ☐

Current Medicare D Plan Name_______________________________ Member ID________________________
Rx BIN #________________ Rx PCN # ____________________ Rx Group # ___________________________
Person Code (if you are not the cardholder)________

Private Insurance Plan Name________________________________ Member ID_________________________
Rx BIN #_________________Rx PCN #_____________________Rx Group #___________________________
Person Code (if you are not the cardholder)________

Other Prescription Insurance Coverage (Please specify company, and if more space is needed, please add to back of form)__ ____
Member ID______________________________Rx BIN #_______________Rx PCN #___________________
Rx Group #_______________Person Code (if you are not the cardholder)__________

APPLICANT'S PERSONAL FINANCIAL STATEMENT

The following personal financial information is required as part of the application process to be considered for Schuyler Hospital's Seneca View Skilled Nursing Facility. This information is used to verify the method of payment for placement. It will be held in confidence and not released to any person, agency, or party unless so directed by the resident or Schuyler Hospital requires its disclosure in order to collect a past due balance.

Uncompensated Transfers and Gifts

Has the Resident, Spouse, Power of Attorney, or any other person transferred, gifted or sold any assets of the Resident, including but not limited to cash and real property, **during the last five (5) years**?

Yes ___ **No** ___

If yes, specify each asset, its value, to whom each asset was transferred, and the value, if any, received for the asset. For example, if the Resident (or someone else on the Resident's behalf) has gifted anything of value (including money, real and/or personal property) to someone else within the past five years, those gifts must be disclosed. Similarly, any transfers of the Resident's assets, including real and/or personal property, even if something was received in exchange for the transfer, **must be reported here.**

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Real Estate Assets

Please indicate below the approximate market value or actual value of each of the following Assets you own. **List each parcel separately.**

	PROPERTY A	PROPERTY B	PROPERTY C
Type of Property (*e.g. residential, land*)			
Address Line 1			
Address Line 2			
Present Market Value			
Name of Mortgage Holder			
Mortgage Balance			
Amount of Payment per Month/Year			
Amount of any Liens/Reverse Mortgages			

Banking Assets/Investments | **Approximate Value**

Banking Assets/Investments	Approximate Value
Savings Accounts (bank): ______________________________	____________________
Checking Accounts (bank): ____________________________	____________________
Savings Certificates: __________________________________	____________________
Life Insurance (cash surrender value): ___________________	____________________
Stocks / Bonds: _______________________________________	____________________
IRA or other Retirement Accounts: _____________________	____________________
Mutual Funds: _______________________________________	____________________
Other: ____	____________________

Other Personal Property & Assets (*e.g. automobiles, boats, valuable belongings, amounts owed to resident/spouse*)

Describe. If any is pledged as security, state name and address of lien holder, amount of lien, terms of payment and, if delinquency, describe delinquency.

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Income

Please indicate below the amount of income you receive from each of the following sources and approximate frequency/interval received**:**

Source of Income	Amount $ (*resident*)	Amount $ (*spouse*)	Frequency (*e.g. monthly*)
Social Security	____________	____________	____________
Pension	____________	____________	____________
Supplemental Security	____________	____________	____________
Investment/Real Estate Income	____________	____________	____________
Interest Income	____________	____________	____________
Dividend Income	____________	____________	____________
Annuity	____________	____________	____________
Support from Relatives	____________	____________	____________
Other (*e.g. salary)*	__________	____________	____________

Debts

Please indicate below the amount of debt that you owe for any of the following items – provide details where appropriate – include any debts for which resident is co-maker, co-signer, or endorser:

Approximate Amount Owed

Item	Approximate Amount Owed
Auto Loans	____________________
Other Loans (*e.g. education, credit cards*)	____________________
Loans on Life Insurance	____________________
Unpaid Taxes	____________________
Non-Bank Loans (non-mortgage)	____________________
Legal Claims / Judgments	____________________

I authorize Schuyler Hospital, Inc. d/b/a Seneca View Skilled Nursing Facility to make inquiries as necessary to verify the accuracy of the statements made and to determine my creditworthiness. I certify the above and the statements contained in the attachments are true and accurate as of the stated date(s). These statements are made for the purpose of either obtaining nursing home services or guarantying payment of nursing home services.

Applicant's Name:___________________ Financial Rep Name: _________________________

Applicant's Signature: ________________ Financial Rep's Signature: _____________________

Date:_______________________________ Date:____

FEDERAL AND STATE LAW PROHIBIT THIS FACILITY FROM DENYING ADMISSION TO ANYONE BECAUSE OF RACE, COLOR, RELIGION, SEX,NATIONAL ORIGIN, HANDICAP, AGE, DISABILITY, MARITAL STATUS, SOURCE OF PAYMENT, OR SEXUAL PREFERENCE.