RESIDENTIAL HEALTH CARE FACILITY APPLICATION

Applicant Name: ______________________________________ Phone: ______________

Address____ Birth Date: ___________

Selected Facilities Preferences of Nursing Homes are noted as below: (Identify 5 preferences)

James Square		Other Facilities:	
Jewish Home		Birchwood Health Care	
Loretto		Hallmark Nursing Center	
Rosewood Heights		Iroquois Nursing Home, Inc.	
St. Camillus		Stonehedge NH (Chittenango)	
Syracuse Home Association		Sunnyside NH	
Vivian Teal Howard		Van Duyn Nursing Home	

*James Square, Rosewood & St. Camillus do not require an application form.
** Iroquois does not generally accept patients from University Hospital

The above residential health care facilities make every effort to honor your preferences, but please understand that this may not always be possible due to bed availability. DISCHARGE WILL BE ARRANGED WHEN THE FIRST BED IF OFFERED BY ANY OF YOUR SELECTIONS.

Federal & State law prohibits facilities from denying admission to anyone because of race, color, creed, age, sex, religion, national origin, sexual preferences, handicap or sponsor.

Where is applicant at present: ____

Why is Nursing Home Care being sought now? ______________________________________

Please explain goals for applicant: ____

Does the applicant have any of the following: ___Living Will ___Health Care Proxy
___Organ Donor Card ___Do Not Resuscitate Order ___Power of Attorney

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Power of Attorney:
Name:____Relationship:_______________
Address____Phone:____________________

If no Power of Attorney, person who whom the bill should be sent:

Name:____Relationship:_______________
Address____Phone:____________________

Designated Representative:
(The person to be contacted regarding changes in condition or concerns involving the applicant)

Name:____Relationship:_______________
Address____Phone:____________________

If above person is unavailable, person to be contacted:

Name:____Relationship:_______________
Address____Phone:____________________

Social Security #______________________________________ Medicare #_________________
Part A Effective Date:________
Part B Effective Date:________

Does the applicant currently have Medicaid ____Yes ____No
If yes: Medicaid #:__________________________________ County Received from:_______

Has a Medicaid application been filed? ____Yes ____No _____ Unsure
If Yes, Date filed _________________________________County Filed in ___________

Does a Medicaid application need to be completed prior to Nursing Home Admission:
___Yes ___ No ___ Unsure (Who have you talked to about this?______________

Medical Insurance Information: (E.g.: AARP, BC/BS, Union, Government, Long Term Care Ins., etc) Please list:

Company Name	Policy ID#	Group#	Other Information

Financial Information: Please list amount applicant receives each month

Salary: ____________________________________ Social Security ____________________

Veteran's Benefits___________________________ Pension & Source _________________

Other & Source______________________________ Own:___Home ___Homes __Properties

Received Supplemental Security Income (SSI): ____Yes $______________ ___ No ___Unsure

Approximate financial assets (not including home or vehicle

____$0-$5,999 ___ $6,000-$9,999 ___$10,000-$14,999

____$15,000-19,000 ___ $20,000-$49,999 ___$50,000-$84,999

____$85,000-99,999 ___ $100,000-$199,999 ___$200,000

Marital Status: ___Single ___Married ___Widowed ____Divorced ____ Separated

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Have funeral arrangements been made? ___ Yes ____ No ___Unsure
What Funeral Home will be used? ____

Within 24 hours: Please return this application, to ___________________________, as it will be forwarded to the residential facilities you have chosen to apply to. It is recommended that you call your preferred facilities for a follow-up on the status of your application.

***We strongly suggest you call ahead for a tour to insure someone will be available to meet with you.**

According to my knowledge and belief, the foregoing information is complete, accurate, and true in all respects.

____ ___________________________
Signature of applicant/representative (REQUIRED) Date

Diagnosis: ___________________________________ ALC Date:_________________
Long Term Placement ________ Short Term Placement____________