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SchofieldCare.org
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Residential Health Care Facility-Application for Admission

All questions must be answered in full either by or on behalf of the Applicant desiring admission. No application for admission will be considered unless it is complete. Submission of an application does not guarantee admission, nor does it create entitlement to admission or placement on any waiting list. State and Federal laws prohibit discrimination on the basis of race, color, creed, sex, sexual preference, national origin, sponsor, blindness, handicap or method of payment on the acceptance, retention or care of residents. All information given is considered confidential.

Personal Data

1. Name _____ Phone:_____

   Street Address_____

   City, State Zip_____ County_____

   Is there a lease agreement at the applicant's current location? Yes___ No___

2. Where is applicant presently? (Facility name, if any):_____

3. Date of Birth:_____

4. Is applicant a citizen of the United States? Yes_____ No_____*

   *If not a citizen of the U.S., a copy of applicant's Green Card is required.

5. Is applicant a veteran? Yes_____ No_____

6. Name of spouse, relatives, and/or responsible party:

   Name:_____ Relationship_____

   Address_____City/State/Zip_____

   Phone Number(s): Home_____Business_____Cell_____

   E-mail Address (optional):_____

   Name:_____ Relationship_____

   Address:_____ City/State/Zip_____

   Phone Number(s): Home_____Business_____Cell_____

   E-mail Address (optional):_____

   Name:_____ Relationship_____

   Address:_____ City/State/Zip_____

   Phone Number(s): Home_____Business_____Cell_____

   E-mail Address (optional):_____

Statistical Section

7. Social Security Number:_____ *(copy of card is required)*
   Medicare Claim Number:_____ *(copy of card is required)*
   Is entitled to Hospital Insurance: Effective Date_____
   Is entitled to Medical Insurance: Effective Date_____

   Is applicant approved for nursing home care under the **New York State Medical Assistance Program**? **(Medicaid)** ____Yes ____No If yes, Medicaid No.:_____
   Access No.:_____If pending, interview date:_____

   Does applicant have health insurance? Yes_____ No_____
   If yes, give company name and policy number:_____

   Does applicant's policy have prescription coverage? Yes_____ No_____
   Medicare Part D-name of PDP (Prescription Drug Plan)_____
   If no PDP, please provide a copy of letter indicating credible coverage exists.

   Does applicant have long term care insurance? Yes_____ No_____
   If yes, give company name and policy number:_____

   Please submit a copy of all applicable insurance cards along with this application.
   ___Social Security ___Medicaid ___Medicare ___Health Insurance(s) ___Long Term Insurance

8. **New York State Law requires that a funeral home be assigned prior to admission.**
   Funeral Home:_____
   Full Address and Phone Number:_____
   Is applicant an organ donor? ____Yes ____No *If yes*, a copy of donor card is required upon admission.

9. Does applicant have a Health Care Proxy? ____Yes ____No *If yes*, please bring a copy upon admission.
   Does applicant have a Living Will? ____Yes ____No
   Does applicant have a Do Not Resuscitate Order (DNR)? ____Yes ____No
   If yes, please bring copy upon admission.

Financial Section (All Information is Considered Confidential)

No application for admission will be considered unless all requested financial information is provided.

10. **Monthly Income**

	Applicant	Spouse
Salary		
Social Security		
Retirement Pension		
Veteran's Pension		
Railroad Pension		
Supplementary Security Income		

Other Monthly Income_____Source_____
Have you transferred any assets within the past 5 years?_____If so, identify all such assets and their value amount $_____
To Whom_____

11. **Assets**

Checking Account: Bank_____ Amount_____

Savings Account: Bank_____ Amount_____

CD's, Stocks, Bonds, Mutual Funds_____ Amount_____

Real Estate_____ Jointly Owned? Yes____ No____

Insurance Policies_____ Cash Value_____

Other Assets_____

12. **Liabilities**:

Home Mortgage Amount_____

Loan/Installment Payments_____

13. **Power of Attorney**

Name_____ Telephone No._____

Address_____

Street City State Zip

14. Designated Representative or Power of Attorney who will take full responsibility in insuring that payment will be made from Applicant's income, assets and/or resources for all expenses incurred while at the facility, which are not covered by Medicare, Medicaid or other Health Insurance.

Name:_____

Full Address and Phone No.:_____

_____

15. A copy of one of the following should be returned with the application. Please check the one that applies:

___Power of Attorney ___Bank Power of Attorney ___Order Appointed Guardian, Conservator or Committee

16. To be completed by both Applicant (if able) and Designated Representative.

I, _____, do solemnly swear or affirm that the information contained on this form is true, complete and accurate to the best of my knowledge and acknowledge that the facility will rely on the above information and representations in making its decision regarding admission of the applicant.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Designated Representative Date

17. To be completed by Power of Attorney, if different from Designated Representative.

I, _____, do solemnly swear or affirm that the information contained on this form is true, complete and accurate to the best of my knowledge and acknowledge that the facility will rely on the above information and representations in making its decision regarding admission of the applicant.

_____ _____

Signature of POA, if different from Designated Representative Date