

APPLICATION FOR ADMISSION

Date of Application: _____

Applicant's Name: _____

Legal Address: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Current Physician: _____ Address: _____

PERSON TO CONTACT IN REGARD TO THIS APPLICATION:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

-1-

PAYMENT INFORMATION:

Social Security Number: _____

Medicare Number: _____ Effective Date: _____

Do you currently have Medicare Part D or other Private Insurance for drug coverage:

Yes No

Current Medicare D Plan Name/Numbers: _____

Private Insurance Plan Name/Numbers: _____

Do you have Medicaid: Yes No

Medicaid Number: _____ County: _____

Other Insurance Coverage (Please specify company and policy numbers): _____

Financial Plan for Payment (Medicaid, private funds, etc.): _____

Responsible Party for Payment: _____

Address: _____

Home Phone: _____ Work Phone: _____

Power of Attorney: _____

Legal Representative: _____

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.**

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

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.

Income

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

<u>Source of Income</u>	<u>Amount \$ (resident)</u>	<u>Amount \$ (spouse)</u>	<u>Frequency (e.g. monthly)</u>
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

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: _____