Shaker Place
REHABILITATION & NURSING CENTER

Daniel P. McCoy
County Executive

Larry I. Slatky
Executive Director

Application for Admission

Date: _____

Name: _____ Maiden Name: _____

Address: _____
STREET CITY STATE ZIP CODE

Currently Located. *(ex: Hospital, Home, Assisted Living)*: _____

Date of Birth: _____ Age: _____ Place of Birth: _____

Social Security #: _____ Citizen Of: _____ County of Residence: _____

Marital Status: Widowed ____ Single ____ Married ____ Separated ____ Divorced ____

Name of Spouse: _____

If living, address: _____

Number of Children: _____ Religion: _____

Occupation: _____ Former Occupation: _____ Military: _____

Please select one. Looking for: _____ Short Term Rehab
_____ Long Term Placement
_____ Respite Care

Has the applicant established a pre-paid funeral or burial agreement? Yes ____ No ____

How did you hear about Shaker Place? _____

_____

Insurance Information

Medicare #: _____ Medicare A Effective Date: _____ Medicare B Effective Date: _____

Managed Medicare: _____ ID Number: _____

Secondary Insurance: _____ ID Number: _____

Medicaid #: _____ County Medicaid was established or approved: _____

Medicaid Application Pending: Yes _____ No _____ If yes, date submitted: _____

Managed Medicaid: _____ ID Number: _____

Does the applicant have Long Term Care Insurance? Yes _____ No _____

If yes, company: _____

Please provide documentation to verify benefits/coverage.

Primary Physician: _____

Person Representing Resident: _____

Relationship: _____

Address: _____
STREET CITY STATE ZIP CODE

Power of Attorney: Yes _____ No _____ Legal Guardian: Yes _____ No _____ Healthcare Proxy: Yes _____ No _____

Phone Numbers for Applicant Representative:

Home: _____ Work: _____ Other: _____

Please include copies front and back of insurance cards, <u>as well as</u>, a copy of long term care policy, if applicable.

Financial Disclosure *(information is considered confidential)*

Income	**Monthly Amount** *(Applicant)*	**Monthly Amount** *(Spouse if Applicable)*
Social Security		
*Retirement Pension(s)		
Veteran's Pension		
Supplemental Security Income		
Annuities		
Other Income		
Total Income		

*Pension Company: _____

_____

_____

If the applicant is married, please list spousal income and resources: _____

_____

_____

Does the applicant file income taxes? Yes ___ No___ If yes, last four years filed: _____

Does the applicant own/lease any vehicles? Yes ___ No___ If yes, please indicate: Lease ___ Own ___

If yes, what is the make/model? _____

Is the applicant currently making payments? Yes ___ No___ Current payment per month:_____

Does the applicant and/or spouse have a life insurance policy? Yes ___ No___

If yes, cash value: _____ Face value: _____

Long Term Care Pre-Admission Information

Assets:

Checking Account:

Bank: _____

Balance: $ _____ Joint Account: Yes _____ No _____

Savings Account(s):

Bank #1: _____

Balance: $ _____ Joint Account: Yes _____ No _____

Bank #2: _____

Balance: $ _____ Joint Account: Yes _____ No _____

Certificates of Deposit:

Bank Institution: _____

Does the applicant and/or spouse own a home? Yes _____ No _____ Estimated Value: _____

Is the home jointly owned with anyone? Yes _____ No _____

If yes, please list them and their relationship to the applicant: _____

Does the applicant and/or spouse own property/properties other than primary residence (Land, Vacation Home, Timeshare, Rental Property)? Yes _____ No _____

Other Assets (Please List, ie. Stocks, Bonds, IRAs): **Amount**

1 _____ $ _____

2 _____ $ _____

3 _____ $ _____

Long Term Care Pre-Admission Information – Continued

Have any assets been transferred in the last 60 months? Yes _____ No _____

If yes, please describe: _____

_____

_____

_____

Has an estate trust been established? Yes _____ No _____ Date established: _____

To the best of my knowledge, all the information provided is correct and valid. I understand that the information contained in this form will be shared with nursing homes in which I have an interest.

X _____ _____

SIGNATURE OF RESIDENT OR RESPONSIBLE PARTY DATE

THE INFORMATION PROVIDED SHALL REMAIN CONFIDENTIAL AND SHALL BE MADE AVAILABLE ONLY TO AUTHORIZED HOSPITALS AND NURSING HOME PERSONNEL INVOLVED IN THE PLACEMENT PROCESS AND TO ANY GOVERNMENTAL OFFICIALS AUTHORIZED ACCESS BY LAW TO SUCH RECORDS.

THE FACILITIES HAVING ACCESS TO THIS INFORMATION DO SO WITHOUT REGARD TO RACE, CREED, COLOR, AGE, SEX, RELIGION, NATIONAL ORIGIN, SPONSOR, SEXUAL PREFERENCE, DISABILITY, OR MARITAL STATUS. PERSON UNDER AGE 16 YEARS OF AGE ARE NOT ELIGIBLE FOR ADMISSION CONSIDERATION, UNLESS SPECIAL APPROVAL HAS BEEN RECEIVED FROM THE DEPARTMENT OF HEALTH.

PLEASE NOTE: *In addition to the Application for Admission, Shaker Place Rehabilitation & Nursing Center requires clinical documentation to screen an applicant for possible placement. Documentation will depend on the applicants' current location (i.e. home, nursing home, hospital, etc.). Please contact the Admissions Department at 518-213-8700 to verify appropriate paperwork is submitted.*

Jen Travis, Director of Admissions
Laura Rabideau, Assistant Director of Social Work
Jennifer Farnsworth, Admissions Officer