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, as well as, 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