



Daniel P. McCoy
County Executive

Mark S. Olsen
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 _____ Medicare B _____
Effective Date: _____ 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 _____ Legal Guardian: Yes _____ Healthcare Proxy: Yes _____
No _____ No _____ 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 <i>(Applicant)</i>	Monthly Amount <i>(Spouse if Applicable)</i>
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 _____ DATE

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



