

APPLICATION FOR ADMISSION

SECTION 1: GENERAL INFORMATION

Date: _____

Applicant's Name: Last: _____ First: _____ Initial: _____

Home Address _____

City _____ State _____ Zip _____

Telephone (_____) _____ Date of Birth _____

Applicant's Current Location (if different from home address) _____

Applicant's Marital Status: () Single () Married () Widowed () Separated () Divorced

Person Completing the Application _____

Relationship to Applicant _____

Home Telephone(_____) _____ Work Telephone(_____) _____

Status: () Power of Attorney () Guardian () Person Responsible for Handling Financial Transactions
*Provide proof of Power of Attorney or Guardian

Significant Contacts:

Emergency Contacts: _____ Relationship: _____

Address: _____

Telephone #: _____ Work Telephone #: _____

Other Contact:

Emergency Contacts: _____ Relationship: _____

Address: _____

Telephone #: _____ Work Telephone #: _____

Burial Account:

Responsible Party for Planning: _____

Address: _____ Telephone #: _____

Funeral Home: _____

Address: _____ Telephone #: _____

Please complete and return this application to the Director of Social Services.

SECTION 2: HEALTH INSURANCE INFORMATION

Social Security #: _____ - _____ - _____ Medicare #: _____
Medicare Part () A () B C () D ()

Medicaid #: _____ Application pending? () Yes () No

Date submitted: _____ County: _____

Medical: Insurance: _____

Long Term Care Insurance: _____

Primary Care Physician _____

SECTION 3: PROOF OF CITIZENSHIP: Any of the following documents are acceptable as proof of citizenship:

United States Passport, Certificate of Naturalization, Certificate of Citizenship, United States Public Birth Record, Certification of Report of Birth, Consular Report of Birth Abroad of a Citizen of the United States, Certification of Birth Abroad, United States Identification Card, American Indian Card, Northern Mariana Card, Final Adoption Decree, Evidence of Civil Service Employment by the U.S. Government and Official Military Record of Service.

SECTION 4: FINANCIAL DISCLOSURE (information is considered confidential)

<u>INCOME</u>	<u>MONTHLY AMOUNT</u>
SOCIAL SECURITY	\$ _____
RETIREMENT PENSION	\$ _____
VETERAN'S PENSION	\$ _____
SUPPLEMENTARY SECURITY INCOME	\$ _____
ANNUITIES	\$ _____
OTHER INCOME (please specify)	\$ _____

TOTAL MONTHLY INCOME \$ _____

Bank Accounts: Savings / Checking / Certificates of Deposit

<u>Name of bank</u>	<u>Account #</u>	<u>Balance</u>	<u>Joint Account</u>
_____	_____	\$ _____	_____ yes _____ no
_____	_____	\$ _____	_____ yes _____ no

Please complete and return this application to the Director of Social Services.

Stocks / Bonds / Other Securities

<u>Name of Security</u>	<u># of Shares</u>	<u>Total Current Market Value</u>	<u>Joint Account</u>
_____	_____	\$ _____	____ yes ____ no
_____	_____	\$ _____	____ yes ____ no
_____	_____	\$ _____	____ yes ____ no

Joint Accounts Held with Whom _____

Name of Broker _____

Assets:

Does the Applicant Own a Home? () Yes () No Estimated value \$ _____

Is the Home Owned with Anyone? () Yes () No If yes, Name: _____

Outstanding Mortgage \$ _____

Other Assets (please list):

	<u>Amount</u>
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____

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

If yes, describe: _____

Has an estate trust been established? () Yes () No If yes, please provide a copy.

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

Signature of Applicant or Responsible Party

Date

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

"ADMISSION AND ACCESS TO NATHAN LITTAUER HOSPITAL AND NURSING HOME WILL BE AVAILABLE WITHOUT DISCRIMINATION TO ALL APPLICANTS REGARDLESS OF RACE, CREED, COLOR, NATIONAL ORIGIN, HANDICAP, SEX, AGE, PAYOR SOURCE, MARITAL STATUS, SEXUAL PREFERENCE, BLINDNESS, VETERAN STATUS OR RELIGION. PERSONS UNDER 16 YEARS OF AGE ARE NOT ELIGIBLE FOR ADMISSION CONSIDERATION UNLESS SPECIAL APPROVAL HAS BEEN RECEIVED FROM THE DEPARTMENT OF HEALTH."

Please complete and return this application to the Director of Social Services.

RELEASE OF FINANCIAL INFORMATION

I HEREBY AUTHORIZE **Nathan Littauer Hospital and Nursing Home**

To request and receive financial information necessary to evaluate my current financial status including a copy of my credit history to be used in the determination of my financial status and to verify the information disclosed in this application.

To the best of my knowledge and belief, all of the foregoing information is accurate and true.

Applicants Name (please print): _____

Applicant's or Designated Representative's Signature:

Date: _____



99 East State Street
Gloversville, New York 12078
(518) 773-5617 Fax (518) 775-4225

RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE **Nathan Littauer Hospital and Nursing Home**

To request and receive medical information necessary to evaluate my current medical status.

Applicants Name (please print): _____

Applicant's or Designated Representative's Signature:

Date: _____

Please complete and return this application to the Director of Social Services.