

Application for Admission



M.M. Ewing Continuing Care Center

350 Parrish Street
 Canandaigua, NY 14424
 (585) 396-6045 or 396-6021
 Fax: (585) 396-6026
 ccc.admissions@thompsonhealth.com

The Brighter Day

30 Fort Hill Avenue
 Canandaigua, NY 14424
 (585) 396-6644
 Fax: (585) 396-0454
 brighter.day@thompsonhealth.com

Date of Application _____ How did you hear about us? _____

Reason for Admission Request _____

Please **return completed and signed** application. The **financial section** is required for **all** applications. *Please do not leave any blanks if a section does not apply, enter a NA in that section.* Please return application by next business day. The information on the application is held in the strictest confidence.

Applicant Information

Name (Last, First, Middle)		Social Security #	
Date of Birth	<input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Age	<input type="checkbox"/> Female	Name of Spouse	
Religious Preference	Military Service	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	Naturalized Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Birthplace	Date of Naturalization
Address		Email	
City	State	Zip	
Home Phone ()	Work ()	Cell ()	

Primary Care Physician

Name	Address	Phone
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If applicant is currently hospitalized or has been hospitalized within the last 30 days, list below:

Name of hospital	Admission Date	Discharge Date

If applicant has had previous skilled nursing facility stay, list below:

Name of skilled nursing facility	Admission Date	Discharge Date

Contact Information

Please list the names and addresses of family members and friends who should be contacted with information and/or in case of emergency. We will be using this information both pre-admission and once the applicant has been admitted.

Advanced Directives

Please provide with the application copies of all applicable documents

Does applicant have:	Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No	Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No	Health Care Proxy <input type="checkbox"/> Yes <input type="checkbox"/> No
Have advanced directives been established?	Living Will <input type="checkbox"/> Yes <input type="checkbox"/> No	DNR/DNI <input type="checkbox"/> Yes <input type="checkbox"/> No	MOLST form <input type="checkbox"/> Yes <input type="checkbox"/> No

Primary Contact

Is Contact: | Power of Attorney Yes No | Health Care Proxy Yes No | Guardian Yes No

Please provide copies of all applicable documents

Name (Last, First, Middle)		Relationship	
Address		Email	
City		State	Zip
Home Phone ()	Work ()	Cell ()	

Secondary Contact

Is Contact: | Power of Attorney Yes No | Health Care Proxy Yes No | Guardian Yes No

Please provide copies of all applicable documents

Name (Last, First, Middle)		Relationship	
Address		Email	
City		State	Zip
Home Phone ()	Work ()	Cell ()	

Person Responsible for Applicant's Financial Matters

Is Contact: | Power of Attorney Yes No | Health Care Proxy Yes No | Guardian Yes No

Please provide copies of all applicable documents

Name (Last, First, Middle)		Relationship	
Address		Email	
City		State	Zip
Home Phone ()	Work ()	Cell ()	

Is this admission a result of:

A *motor vehicle* accident? Yes No | A *work-related* accident? Yes No

Or *any other* accident? Yes No **If yes, please explain:**

APPLICANT NAME _____

Health Insurance Information

Medicare Information *Please provide copies of cards*

Medicare No.	Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date	Part B <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date
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Supplemental Insurance *Please provide copies of cards*

(e.g. Blue Cross, AARP)

Plan Name	Policy #
Plan Name	Policy #

Medicare Advantage *Please provide copies of cards*

(e.g. Preferred Care, Blue Choice)

Plan Name	Policy #
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Medicaid *Please provide copies of cards*

Medicaid Number	Active <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Pending <input type="checkbox"/> Yes <input type="checkbox"/> No If pending, appointment date:	
County	Caseworker	Caseworker's Ph #

Prescription Coverage *Please provide copies of cards*

Plan Name	Policy #
EPIC	Policy #

Long Term Care Insurance *Please provide proof of insurance*

Plan Name	Policy #
Contact Name	Phone#

Personal Financial Statement

Monthly Income Source	Applicant	Spouse	Total Income
Social Security			
SSI (Social Security Supplemental Income)			
Pension/Retirement			
Veterans Benefits			
Interest/Dividends/Annuity Income			
Other			
Total Monthly Income			

Monthly Expense	Applicant	Spouse	Total Expenses
Health Insurance Premiums			
Mortgage			
Other			
Total Monthly Expense			

(Personal Financial Statement, continued)

Does the Applicant Have a **Trust Fund**? Yes No

Date trust was established	Type of trust	Value of trust
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Has the applicant **transferred** any of their assets in the past 60 months (i.e., money, stock, real estate)? Yes No

Describe Transfer

Date of Transfer	Amount of transfer
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Please estimate applicant's net worth Greater than \$90,000 Less than \$90,000

Liquid Assets (include all checking, or savings accounts, as well as CD's, IRA's, Annuities, Mutual Funds, Stocks/Bonds, Life Insurance that can be converted to cash, or any other investments that can be turned into cash)

Assets	Description	Name(s) on Assets	Current Value
Savings Account			
Checking Account			
Retirement Account			
Stocks and Bonds			
Other Assets			
Life Insurance	<input type="checkbox"/> Term <input type="checkbox"/> Whole Life <input type="checkbox"/> None		
	Cash Value \$		
	Death Benefit \$		
TOTAL ASSETS			

Funeral Arrangements Does the applicant have prepaid funeral arrangements? Yes No

Name of funeral home _____ Phone _____

Real Estate Property Address	Name(s) on Property	Current Value

Is there a spouse, disabled adult or child living in the home? Yes No

Current Liabilities (mortgages, taxes, loans and other debts)	Outstanding Balance

THE RESIDENT AND/OR THE RESIDENT'S FINANCIAL GUARANTOR IS RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MEDICARE OR OTHER INSURANCE CARRIERS.

State and federal laws prohibit discrimination in admission, retention and care of residents on the basis of race, creed, color, blindness, marital status, disability, national origin, sex, sexual preference, source of payment, sponsorship, or age. The undersigned certifies that all information on this application and personal financial statement is accurate, true and complete. The undersigned represents and warrants that he/she has the authority to authorize the associated financial institutions to provide verification of assets to M.M. Ewing Continuing Care Center. The undersigned understands that it is his/her responsibility to apply for financial aid on the resident's behalf on a timely basis and to cooperate completely in obtaining such aid to avoid any lapse in coverage for services rendered. The undersigned agrees to complete and submit an updated financial statement concerning the resident as requested. The undersigned understands that by not fully disclosing all assets to this application, and/or the disposition of all such assets, possible legal action may result.

Applicant's Signature _____ Date _____

Designated Representative for Applicant _____ Date _____