Application for Admission

UR MEDICINE | THOMPSON HEALTH

☐ 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	☐ Male	Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated	
Age	☐ Female	Name of Spouse	
Religious Preference	Military Service ☐ Yes ☐ No	U.S. Citizen ☐ Yes ☐ No Birthplace	Naturalized Citizen ☐ Yes ☐ No Date of Naturalization
Address			Email
City		State	Zip
Home Phone ( )	Work ( )		Cell ( )

Primary Care Physician

Name	Address	Phone

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 nuring facilitiy 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 copies of all applicable documents with the application

Does applicant have:	Power of Attorney ☐ Yes ☐ No	Guardian ☐ Yes ☐ No	Health Care Proxy ☐ Yes ☐ No
Have advanced directives been established?	Living Will ☐ Yes ☐ No	DNR/DNI ☐ Yes ☐ No	MOLST form ☐ Yes ☐ 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

Please provide copies of all insurance cards with the application

Medicare Information

Medicare No.	Part A ☐ Yes ☐ No Effective Date	Part B ☐ Yes ☐ No Effective Date

Other Insurance

(e.g. Blue Cross, AARP)

Plan Name	Policy #
☐ **Blue Choice** ☐ **MVP Health Care**	Policy #

Medicaid

Medicaid Number	☐ Active	☐ Pending	Appt. Date:
County	Caseworker	Caseworker's Ph #	

Prescription Coverage

Plan Name	Policy #
EPIC	Policy #

Long Term Care 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**

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**

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	☐ Term ☐ Whole Life ☐ 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 _____