Application for Admission
M.M. Ewing Continuing Care Center

350 Parrish St., Canandaigua, NY 14414
Phone: (585) 396-6021 | Fax: (585) 396-6026
Email: ccc.admissions@thompsonhealth.com

UR MEDICINE | THOMPSON HEALTH

Date _____

APPLICANT INFORMATION

Name _____ Social Security # _____
LAST FIRST MIDDLE INITIAL

Address _____ City _____ State ____ ZIP _____

Email Address _____ Phone _____

Date of Birth _____ Age _____ ☐ Male ☐ Female Religious Preference _____

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Spouse: _____ If deceased,spouse's date of death _____
LAST FIRST MIDDLE INITIAL

PRIMARY CARE PHYSICIAN _____

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

HOSPITAL _____ ADMISSION DATE _____ DISCHARGE DATE _____

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

FACILITY _____ ADMISSION DATE _____ DISCHARGE DATE _____

HEALTH INSURANCE

Please provide copies of all insurance cards with the application.

MEDICARE INFORMATION Medicare number _____ ☐ Part A ☐ Part B

OTHER INSURANCE (e.g. Blue Choice, MVP, United Health) Plan name and number _____

MEDICAID Medicaid number _____ County _____

Caseworker's name_____ Caseworker phone _____

PRESCRIPTION COVERAGE Plan name and number _____

LONG TERM CARE INSURANCE Plan name and number_____

Contact name_____ Phone _____

CONTACT INFORMATION

Primary Contact Is contact Power of Attorney? ☐ Yes ☐ No Copy attached? ☐ Yes ☐ No

Name _____ Relationship _____
LAST FIRST MIDDLE INITIAL

Address _____ City _____ State _____ ZIP _____

Home Phone (_____) _____ Work (_____) _____ Cell (_____) _____

Secondary Contact Is contact Power of Attorney? ☐ Yes ☐ No Copy attached? ☐ Yes ☐ No

Name _____ Relationship _____
LAST FIRST MIDDLE INITIAL

Address _____ City _____ State _____ ZIP _____

Home Phone (_____) _____ Work (_____) _____ Cell (_____) _____

Person Responsible for Applicant's Financial Matters

Is contact Power of Attorney? ☐ Yes ☐ No Copy attached? ☐ Yes ☐ No

Name _____ Relationship _____
LAST FIRST MIDDLE INITIAL

Address _____ City _____ State _____ ZIP _____

Home Phone (_____) _____ Work (_____) _____ Cell (_____) _____

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 INCOME
Health Insurance Premiums			
Mortgage			
Other			
Total Monthly Expense			

Has the applicant or spouse established and funded a trust? ☐ Yes ☐ No

Date trust was established _____ Value of trust _____ Date of last transaction _____

Has applicant transferred any assets in past 60 months (i.e., money, stock, real estate)? ☐ Yes ☐ No

Describe transfer _____ Date of transfer _____ Value of transfer _____

Liquid Assets owned by applicant and/or spouse

ASSETS	DESCRIPTION	NAME(S) ON ASSETS	CURRENT VALUE
Savings Account			
Checking Account			
Retirement Account			
Stocks and Bonds			
Other Assets			
Life Insurance ☐ Term ☐ Whole Life			

TOTAL ASSETS _____

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

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)

NAME OF LIABILITY	OUTSTANDING BALANCE

I declare (pursuant to 28 U.S.C. Section 1746) under penalty of perjury that the foregoing is true and correct, and I certify that all information on this application is accurate, true and complete.

Applicant's Signature _____ *Date* _____

Designated Representative _____ *Date* _____