

# Application for Admission To Long Term Care Facilities in St. Lawrence County

## **General Information**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Legal Address \_\_\_\_\_  
 Present Location \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Married  Single  Widowed  Separated  Divorced  
 Spouse or Significant Other's Name \_\_\_\_\_  
 Sex  Male  Female Place of Birth \_\_\_\_\_ U.S. Citizen  Yes  No  
 Father and Mother's Names \_\_\_\_\_  
 Religion (optional) \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Personal Physician \_\_\_\_\_

## **Relatives/Friends To Be Notified In Emergency**

Name _____	Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Relationship _____	Relationship _____
Home # _____ Work # _____	Home # _____ Work # _____
Cell # _____	Cell # _____

## **Advance Directives**

Health Care Proxy <input type="checkbox"/> Yes <input type="checkbox"/> No	Body Donor <input type="checkbox"/> Yes <input type="checkbox"/> No
Living Will <input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Tissue Donor <input type="checkbox"/> Yes <input type="checkbox"/> No
DNR Order <input type="checkbox"/> Yes <input type="checkbox"/> No	

## **Personal Preferences**

- |  |   |
|--|---|
| <input type="checkbox"/> United Helpers Canton Nursing Home<br>Canton, New York 13617<br><br><input type="checkbox"/> United Helpers Nursing Home<br>Ogdensburg, New York 13669<br><br><input type="checkbox"/> St. Joseph's Home<br>Ogdensburg, New York 13669<br><br><input type="checkbox"/> Claxton Hepburn Medical Center<br>Residential Health Care Facility<br>Ogdensburg, New York 13669 | <input type="checkbox"/> Highland Nursing Home<br>Massena, New York 13662<br><br><input type="checkbox"/> St. Regis Nursing Home<br>Massena, New York 13662<br><br><input type="checkbox"/> Kinney Nursing Home<br>Gouverneur, New York 13642 |
|--|---|

**Funeral Arrangements**

**Funeral Home or Person Responsible for Funeral**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**Insurance Coverage**

Medicare # \_\_\_\_\_ PDP (Prescription Drug Plan) \_\_\_\_\_

Medicaid # \_\_\_\_\_ County \_\_\_\_\_ Medicaid Applying  Yes  No

Blue Cross/Blue Shield ID # \_\_\_\_\_ Policy # \_\_\_\_\_ Plan # \_\_\_\_\_

Veteran  Yes  No Spouse of a Veteran  Yes  No VA# \_\_\_\_\_

Other Medical Coverage (Include Long Term Care Coverage or Hospice)

**Insurance Company**

**Address**

**Policy/Group Numbers**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Financial Resources (amount per month)**

Social Security \$ \_\_\_\_\_ Railroad Retirement \$ \_\_\_\_\_

Retirement Pension \$ \_\_\_\_\_ Dividends \$ \_\_\_\_\_

SSI \$ \_\_\_\_\_ Interest \$ \_\_\_\_\_

Veterans Pension \$ \_\_\_\_\_ Other Income \$ \_\_\_\_\_

**Bank Accounts**

Name and Address of Bank Type of Account (Checking, Savings, CD's, etc.) Balance

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a Representative Payee for your Social Security checks?  Yes  No If yes, Name \_\_\_\_\_

Do you have your "Letter of Creditable Prescriptions Drug Coverage Notice?"  Yes  No

Do you have a Power of Attorney?  Yes  No If yes, Name \_\_\_\_\_

Person responsible for payment of care \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant or Representative

\_\_\_\_\_  
Date

FEDERAL AND STATE LAWS PROHIBIT RESIDENTIAL HEALTH CARE FACILITIES FROM DENYING ADMISSION TO ANYONE BECAUSE OF RACE, CREED, COLOR, PLACE OF BIRTH, SEX, DISABLIITY, BLINDNESS, SOURCE OF SPONSORSHIP, SOURCE OF PAYMENT, MARITAL STATUS.

Applicants Name: \_\_\_\_\_

**Due to Medicaid's Deficit Reductions Act of 2005, there have been changes evaluating Long Term Care Medicaid Eligibility. Please respond to the following:**

Has the Applicant had a transfer of any resources or real estate on/after February 8, 2006?  Yes  No

Has the Applicant/Spouse purchased any Life Estates in another individual's home on/after February 8, 2006?  Yes  No

Has the Applicant/Spouse purchased a Note, Loan, Mortgage or Annuity on/after February 8, 2006?  Yes  No

Does the Applicant/Spouse own real property other than their homestead?  Yes  No

Has the Applicant had a transfer of any resources or real estate in the last three years?  Yes  No

Does the Applicant have a Trust Fund?  Yes  No If yes, was it established within the last 60 months?  Yes  No

Does the Applicant own their own home?  Yes  No

If the Applicant is the sole owner of their home, is the equity of the said home valued at \$750,000 or above?  Yes  No

\_\_\_\_\_  
Signature of Applicant or Representative

\_\_\_\_\_  
Date