



SHORT TERM REHABILITATION APPLICATION

Cayuga Nursing & Rehabilitation Center | 1229 Trumansburg Rd | Ithaca, NY 14850 | 607-273-8072 | Cayuganursingandrehab.org

TO BE COMPLETED BY RESIDENT OR DESIGNATED REPRESENTATIVE

All questions must be answered, and all information must be provided for this application to be considered by Cayuga. If you need help completing this form, call the Admissions Director at 607-273-8072 Ext 103.

General Information:

Applicant's Name: _____ Date of Birth: ___/___/___
Age: _____ Marital Status: _____ Religion: _____ Social Security #: _____
Sex: _____
Street Address (Do not use PO Box): _____
City: _____ State: _____ Zip: _____ County: _____

Applicant's present location: _____
Date of Admission: ___/___/___ Email address: _____
Has the applicant had any Skilled Nursing Facility stays within the last 60 days? Yes No

If yes, please include the following Facility Information:

Facility Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____

Facility Phone Number: (____) _____ Admittance Date: _____ Discharged Date: _____
Please check one. [] Application is for placement [] Application is for rehabilitation and discharge

Resident Representatives: Please list in order of emergency contact

| | |
|---------------------|---------------------|
| Name: _____ | Name: _____ |
| Relationship: _____ | Relationship: _____ |
| Address: _____ | Address: _____ |
| Home #: _____ | Home #: _____ |
| Cell/work #: _____ | Cell/work #: _____ |
| Email: _____ | Email: _____ |

Financial Information:

Has applicant applied for Medicaid? Yes No *If yes, when?* _____

INCOME - Self and Spouse (List all monthly household income.

Continue on a second page if needed)

| Source of Income | Applicant | Spouse |
|---|------------------|---------------|
| Social Security | \$ _____ | \$ _____ |
| (Type and SS# if different from your own) | _____ | |
| SSI | \$ _____ | \$ _____ |
| Pension(s) | \$ _____ | \$ _____ |
| Source (Company name and ID#) | _____ | |
| Veterans | \$ _____ | \$ _____ |
| Rental Income | \$ _____ | \$ _____ |
| Interest/Dividends | \$ _____ | \$ _____ |
| Annuity/IRA Income | \$ _____ | \$ _____ |
| Trust Income | \$ _____ | \$ _____ |
| Other Income | \$ _____ | \$ _____ |

ALIMONY - Applicant must provide copy of court order.

Alimony Paid Out: Yes No Amount \$ _____

Alimony Paid Type: Domestic Relations Order Separation Agreement / Spousal Order

Alimony Received: Yes No Amount \$ _____

Alimony Received Type: Domestic Relations Order Separation Agreement / Spousal Order

BANK ACCOUNTS – Please list all accounts here including CDs, Savings, Checking, Money Markets, etc.

Bank: _____ Bank: _____

Current Balance: \$ _____ Current Balance: \$ _____

Joint owner's name: _____ Joint owner's name: _____

Please continue on another page if more space is needed.

Life insurance policies? Yes No
If yes, list cash values: _____

Pre-Paid burial? Yes No

Do you own a home? Yes No
If yes, property address: _____

Is home jointly owned? Yes No

Life estate on any property? Yes No
If yes, date Life Estate established : _____

Transferred or sold any property/assets in the last 5 years? Yes No
If yes, list property/asset information:

INVESTMENTS - Please list all stocks, bonds, savings bonds, annuities, mutual funds or other investments here. Continue on a second page if needed.

Bank/Brokerage Company: _____ Owner(s): _____ Current Value: \$ _____

Type of Investment: _____ Owner: _____

Bank/Brokerage Company: _____ Owner(s): _____ Current Value: \$ _____

Type of Investment: _____ Owner: _____

Please continue on another page if more space is needed.

GIFTING INFORMATION: *(This includes birthday, wedding, graduation gifts, charitable gifting, Tithing, etc.)*

Has the applicant gifted or given away any funds, property or assets, totaling \$1,000 or more to anyone in the last 5 years? Yes No

If yes, when? _____

How much was given? \$ _____

To Whom? _____

Has a Trust been established? Yes No
If yes, when? _____ *Is it revocable or irrevocable?* _____

Do you have Long term Care insurance? _____

Applicant Acknowledgement:

Applicant Name: _____

You may be required to provide documentation to support the information provided on this application. The applicant and/or Responsible party hereby state that the information provided on this application is complete and accurate to the best of my knowledge. As the financially responsible party, I hereby agree not to transfer or otherwise dispose of assets which would render the resident ineligible for Medicaid coverage.

If the applicant is capable of signing, both the applicant and financially responsible party should sign here. If the applicant is not capable of signing, the financially responsible party should sign as a representative and should also sign the applicant's name as POA. This should be signed as follows: (applicant name) by (POA Name) as agent for (applicant name)

Signature of Applicant

___ / ___ / ___

Date Signed

Signature of Representative (POA)

___ / ___ / ___

Date Signed