



PART ONE APPLICATION (& REHABILITATION)

If applying for long term care placement, this application must accompany the Part 2 Financial Supplement

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 facility. If you need help completing this form, call the Admissions Department at 607-273-8072.

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: ____ / ____ / ____

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: _____

Resident Representatives: Please list in order of emergency contact

#1 Name: _____

#2 Name: _____

Relationship: _____

Relationship: _____

Address: _____

Address: _____

Home #: _____

Home #: _____

Cell/work #: _____

Cell/work #: _____

Email: _____

Financial Information: INCOME - Self and Spouse (List all monthly household income. Continue a second page if needed)Source of Income (list separately)ApplicantSpouse

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

BANK ACCOUNTS – Please include all accounts balances including CDs, Savings, Checking, Bonds, 401K, Money Markets, etc.

Checking/Savings \$ _____	Bank: _____	Joint Owners Name: _____
Checking/Savings \$ _____	Bank: _____	Joint Owners Name: _____
Checking/Savings \$ _____	Bank: _____	Joint Owners Name: _____

Life insurance policies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, Cash values \$ _____	Policy Name: _____
Pre-Paid burial?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, (funeral home): _____	
Do you own a home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, property address: _____	
Is home jointly owned?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Life estate on any property?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 - List all IRAs, 401ks, stocks, bonds, savings bonds, annuities, mutual funds or other investments here.

Bank/Brokerage Company	Owner(s)	Type of Investment (stocks/CD/bonds etc..)	Current Value

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

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

Has the applicant gifted/given away any funds, property or assets, over \$1,000 or more in the last 5 years? If yes, indicate below:

Amount Given	Date Given (month/year)	Recipient of Gift

Has a Trust been established? Yes No *If yes, when?* **Revocable or irrevocable? (circle one)**

Do you have long term Care insurance? Yes No If yes, what company? _____

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

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