CAYUGA NURSING & REHABILITATION CENTER

PART TWO FINANCIAL APPLICATION (LONG TERM CARE PLACEMENT)

Elcor Nursing & Rehabilitation Center | 48 Colonial Dr. | Horseheads, NY | (607)739-3654 |www.elcor.us

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 607-739-3654.

General Information:

Applicant's Name:_____

Contractual Agreements:

Does applicant have any of the following? If yes, please attach a copy to this application.

POA?	☐Yes	☐ No	Living Will?	☐ Yes	☐ No
Guardian/Conservator?	☐Yes	☐ No	Health Care Proxy?	☐ Yes	☐ No
VA Status?	☐Yes	☐ No	DNR?	☐Yes	☐ No
Rep Payee?	☐Yes	☐ No			

Person responsible for handling financial transactions:

Name_____ POA: Yes or No
If yes (you are POA): Are you willing and able to act as the POA for applicant? Yes or No
Relationship _____
Address_____
Home _____
Work/Cell _____
Email: _____

Insurance Information:

Medicare #: _____ Effective Date: ___ /___ /____

Medicare coverage for Part A, Part B, or Both? ☐Part A ☐Part B ☐Both

Is this a Medicare HMO? ☐Yes ☐No

If yes, what is the name of the insurance? _____

Drug coverage plan name/ID#:_____

Supplemental Insurance Company:_____

Supplemental Insurance address:_____

ID#:_____Plan#/Name:_____

Medicaid ID#:_____ County:_____
Has the applicant applied for Medicaid? ☐Yes ☐ No If Yes, when? _____

Has all information requested been provided to Medicaid? ☐ Yes ☐No

County/Case worker number:_____

Are you currently working with an Attorney or Medicaid planner for Medicaid planning purposes?
☐Yes ☐No If yes: Name of Attorney:_____

May we contact them for information if needed? ☐Yes ☐No

Additional Asset Information:

If you have indicated you own a home on Part 1 of the application, please answer the following:

Estimated Value: $ _____ Current Mortgage Balance: $_____

Please list any other properties owned by applicant and their values:

_____

Has any home or property been sold or transferred in the last 5 years? ☐Yes ☐No

If yes: Sale Date_____ Amount of Sale: $_____

Address of Property: _____

Updated BANK ACCOUNTS (If resident is transitioning from Rehab to Long Term Care, meaning you completed Part 1 of this application upon admission to rehab.)

BANK ACCOUNTS:

Checking/Savings $_____Bank: _____Joint Owners Name: _____
Checking/Savings $_____Bank: _____Joint Owners Name:__ _____
Checking/Savings $_____Bank: _____Joint Owners Name:_____

TRUST INFORMATION:

Has a Trust been established? ☐ Yes ☐No If yes, When?_____

Is the Trust Revocable or Irrevocable? ☐Revocable ☐Irrevocable

How much was placed in Trust? $_____

Have any funds been transferred into the trust since its inception? ☐Yes ☐No

If yes, When?_____ How much? $_____

Please provide a copy of the trust with this application.

Are the transferred/gifted funds still available if it is determined that the transfer/gift will disqualify the resident for Medicaid? ☐Yes ☐No

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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