



180 Washington Avenue Extension  
Albany, New York 12203

**APPLICATION FOR ADMISSION**

State and Federal laws prohibit discrimination based on Sex, Race, Creed, Color, National Origin, Sexual Preference, Marital Status, Blindness, Disability, Age, Source of Payment, or Sponsorship in admission, retention and care of residents.

**I. PERSONAL INFORMATION**

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Current Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

County \_\_\_\_\_ Zip \_\_\_\_\_ Tel. No \_\_\_\_\_ SS# \_\_\_\_\_

I have been residing at this address since: \_\_\_\_\_ DOB: \_\_\_\_\_ Place of birth: \_\_\_\_\_

*If foreign born, please provide documentation of proof of citizenship.*

Medicare ID # \_\_\_\_\_ Part A :Yes  No  Part B: Yes  No

Medicaid ID# \_\_\_\_\_ Effective Date: \_\_\_\_\_ Medicaid County: \_\_\_\_\_

Other Insurance: \_\_\_\_\_ ID # \_\_\_\_\_

Maiden Name \_\_\_\_\_ Wife's maiden name \_\_\_\_\_

Name of Father \_\_\_\_\_ Maiden name of Mother \_\_\_\_\_

US Military Service: Yes  No  Branch \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

Occupation or Trade \_\_\_\_\_ Religious Preference \_\_\_\_\_

Marital status: Single  Married  Widowed  Separated  Divorced

Name of spouse \_\_\_\_\_ Marriage Date \_\_\_\_\_ Spouse's deceased date \_\_\_\_\_

**Personal Contacts**

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Address \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel.# \_\_\_\_\_ Business Tel. # \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Address \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel. # \_\_\_\_\_ Business Tel. # \_\_\_\_\_

**II. ADVANCE PLANNING**

1.) I have a Power of Attorney: Yes  No  (If yes, please attach a copy of the document.)

Name of Attorney-in-Fact: \_\_\_\_\_

Address and Phone Number: \_\_\_\_\_

2.) I have a Health Care Proxy: Yes  No  (If yes, please attach a copy of the document.)

Name of Health Care Agent: \_\_\_\_\_

Address and Phone Number: \_\_\_\_\_

3.) I have a Living Will: Yes  No  (If yes, please attach a copy of the document.)

4.) I am working with an Elder Law or similar Attorney? Yes  No

(If yes, please provide name, address, and phone number)

5.) Who is the Executor of your estate?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Tel.# \_\_\_\_\_  
Address \_\_\_\_\_

6.) **Membership in Benevolent society:**

Name of Organization / Undertaker \_\_\_\_\_ Tel. \_\_\_\_\_

Address \_\_\_\_\_

I have a paid  unpaid  burial plot

Cemetery \_\_\_\_\_ Location \_\_\_\_\_

7.) Arrangements for organ donation/anatomical gift: Yes  No  (If yes, please attach a copy of documents).

8.) In the event of accident or death, I direct you to notify \_\_\_\_\_

Address and Tel. #, \_\_\_\_\_

**III. APPLICANT'S FINANCIAL ASSETS AND INCOME**

**ASSETS:** Attach photocopies of the current statements, reflecting all assets listed below. Be sure copies include bank branch, account number, and name (s) of account holders. (We may request additional financial information depending on each applicant's financial status). *If needed, attach an additional page(s).*

1. Bank accounts **NOT** contained in a Trust and are therefore available for care(\*Indicate: savings, checking, money markets, IRA's CD's, Mutual Funds, etc). Please note, Medicaid considers joint accounts as belonging to the applicant at 100%.

A. Bank \_\_\_\_\_ Balance \$ \_\_\_\_\_ Type of account\* \_\_\_\_\_ Names on Acct \_\_\_\_\_

B. Bank \_\_\_\_\_ Balance \$ \_\_\_\_\_ Type of account\* \_\_\_\_\_ Names on Acct \_\_\_\_\_

C. Bank \_\_\_\_\_ Balance \$ \_\_\_\_\_ Type of account\* \_\_\_\_\_ Names on Acct \_\_\_\_\_

D. Investment \_\_\_\_\_ Market Value \$ \_\_\_\_\_ Names on Acct \_\_\_\_\_

E. Investment \_\_\_\_\_ Market Value \$ \_\_\_\_\_ Names on Acct \_\_\_\_\_

2. Within the past 60 months, have you **gifted/transferred** any assets or property to family or friends valued at \$250.00 or more?

Yes  No  If yes, provide dollar amount or value and dates for each transfer.

Amount/Value: \_\_\_\_\_ Date: \_\_\_\_\_ Amount/Value: \_\_\_\_\_ Date: \_\_\_\_\_

Amount/Value: \_\_\_\_\_ Date: \_\_\_\_\_ Amount/Value: \_\_\_\_\_ Date: \_\_\_\_\_

3. Within the past 60 months, have you entered into any **"TRUST"** arrangements?

Yes  No  If yes, list value of assets involved and date of transfer. Also, provide a copy of the Trust.

Value: \_\_\_\_\_ Date: \_\_\_\_\_ Value: \_\_\_\_\_ Date: \_\_\_\_\_

Value: \_\_\_\_\_ Date: \_\_\_\_\_ Value: \_\_\_\_\_ Date: \_\_\_\_\_

4. I own the following real property: Yes  No

Location: \_\_\_\_\_ Property Value: \$ \_\_\_\_\_

Type of property: Primary Residence  Rental  Vacation  Commercial

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Type of property: Primary Residence  Rental  Vacation  Commercial

If real estate is "Primary Residence," please answer the following.

a. Is property currently listed for sale? Yes  No

b. Is applicant's intention to return to this property within six (6) months? Yes  No

c. Is property currently occupied? Yes  No

1. If yes, by whom? \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_

d. Is there any mortgage on any of this property? Yes  No  If yes, amount remaining on mortgage: \_\_\_\_\_

5. I own life insurance and/or annuity contracts: Yes  No

a. Name of Insurance Company \_\_\_\_\_ Policy \_\_\_\_\_  
Present cash surrender value \$ \_\_\_\_\_

6. I own Stocks and/or Bonds: Yes  No

Name of Investment: \_\_\_\_\_ Market Value: \_\_\_\_\_  
Name of Investment: \_\_\_\_\_ Market Value: \_\_\_\_\_

7. Do you have Long Term Care Insurance? Yes  No

If yes, provide the name and address of the insurance carrier and the daily benefit amount.

Name of Carrier: \_\_\_\_\_ Daily Benefit: \$ \_\_\_\_\_

8. Does anyone owe you money under any loan, note or mortgage? Yes  No

If yes: Date of loan: \_\_\_\_\_ Total amount owed: \$ \_\_\_\_\_ Monthly Payment: \$ \_\_\_\_\_

**INCOME PER MONTH:** (Please attach documents to show proof of income)

1. Social Security \$ \_\_\_\_\_
2. Pensions
  - a. Government \$ \_\_\_\_\_ ID \_\_\_\_\_
  - b. VA \$ \_\_\_\_\_ ID \_\_\_\_\_
  - c. Company \$ \_\_\_\_\_ Name of Company \_\_\_\_\_
  - d. Other \$ \_\_\_\_\_ Describe \_\_\_\_\_
3. Interest Income \$ \_\_\_\_\_ Describe \_\_\_\_\_
4. Trust Income \$ \_\_\_\_\_ Describe \_\_\_\_\_
5. Other Income \$ \_\_\_\_\_ Describe \_\_\_\_\_

Please provide a copy of your Social Security card, Medicare card, Medicaid card (if applicable), and any other health insurance card (s).

**EXPENSES:** Cost of any medical insurance premiums \$ \_\_\_\_\_

**IV. PLAN OF PAYMENT FOR COST OF CARE AT DAUGHTERS OF SARAH**

1.  Own assets and/or income  Medicaid

2. Designated Representative Responsible for Payments on your behalf.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Our Nursing Center makes important decisions based on the information contained herein, therefore, do you have future plans to amend what funds are available toward the cost of care?  Yes  No

To the best of my knowledge, all the information provided herein is complete, accurate and valid. The finances described above are available and will be used to pay for the cost of care. I hereby apply for admission to the Daughters of Sarah Nursing Center.

Date: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_

If you cannot sign your name, please mark an X and have it witnessed.

Witnessed by \_\_\_\_\_ Date: \_\_\_\_\_