LONG TERM CARE APPLICATION

This Application consists of a **General Information** section and a **Financial Statement**. Please furnish information requested as completely and accurately as possible. Information should be current as of the date of the application. All personal information will be held in strict confidence.

ST. ANN'S
COMMUNITY

1500 Portland Avenue
Rochester, NY 14621
585.697.6311
www.stannscommunity.com

Caring for the Most Important People On Earth

EQUAL HOUSING OPPORTUNITY

ST. ANN'S COMMUNITY LONG TERM CARE APPLICATION

Name: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone #: _____ County of Residence: _____

DOB: _____ Marital Status: M W D S Sex: M F

Religion: _____ Place of Worship: _____

U. S. Citizen: Y N If naturalized citizen, date: _____

Occupation: _____ Employer: _____

Are you currently working? Y N Is your spouse currently working? Y N

Are you a veteran? Y N Is your spouse a veteran? Y N

Current location of applicant: _____

If applicant is currently hospitalized or has been hospitalized within the past 30 days, please complete the following:

Name of Hospital: _____ Dates of Stay: _____

Reason for Hospitalization: _____

Has the applicant had a previous nursing facility stay? Y N

If yes, please give the name of the facility and dates of stay: _____

Please list names of Physicians including specialists and dentist (use separate sheet, if necessary)

Name	Specialty	Telephone/Fax Numbers
_____	_____	
_____	_____	
_____	_____	

Have Advanced Directives been established (MOLST, Living Will, DNR, Health Care Proxy)?

Please list:_____

Please provide a copy of the Advanced Directives at the time of admission.

Name of Funeral Home: _____ Telephone Number:_____

Has a pre-need burial account been established? Y N

Is this account irrevocable? Y N

INSURANCE COVERAGE FOR APPLICANT: Please provide a copy of all cards (both sides)

Medicare: _____ Part A: Y N Part B: Y N

Medicaid: _____ County: _____

Do you have a Medicaid Managed Long Term Care Plan? (ie. Fidelis, I-Circle) Y N

If yes, which plan? _____ Case Manager Name and Number:_____

Health Insurance: _____

Case Worker Name: _____ Telephone Number: _____

Other Insurance: _____

Medicare D Plan (prescription plan): _____

Long Term Care Insurance: _____

SNF daily rate: _____ Lifetime Benefit: _____ NYS Partnership Plan: Y N

PRIMARY CONTACTS: Please list in order to be contacted (Use a separate sheet, if necessary)

Name: _____ Relationship: _____

Address:_____City:_____State:_____Zip:_____

Home phone: _____ Cell phone: _____ Work phone: _____

Email address: _____

Power Of Attorney: Y N Health Care Agent: Y N

Name: _____ Relationship: _____

Address:_____City:_____State:_____Zip:_____

Home phone:_____ Cell phone: _____ Work phone: _____

Email address: _____

Power Of Attorney: Y N Health Care Agent: Y N

FISCAL AGENT: (manages financial obligations for applicant)

Name of Power of Attorney/Guarantor: _____

Relationship: _____

Address:_____City:_____State:_____Zip:_____

Home phone:_____ Cell phone: _____ Work phone: _____

Email address: _____

Has a conservator/guardian been appointed? Y N (Please provide a copy)

Have you gifted or transferred anything out of your name, money or property, greater than $2,000? If yes, please explain and provide dates of transfer: _____

_____

Have you given away any cash, or sold/transferred any cash, real estate, income or personal property in the past or created a trust in the past 60 months ? Y N If yes, please explain: _____

_____

Have you consulted with an attorney or financial advisor regarding payment for nursing home care? Y N

If yes, please provide:

Name: _____ Telephone number: _____

Please list any and all trusts you have created or to which you contributed assets. Please provide a copy of all trust documents.

	Trustee	Beneficiaries	Date Created/Funded
1.)			
2.)			
3.)			

FINANCIAL INFORMATION – If married, please include financial information for spouse

Monthly	**Applicant**	**Spouse**
Salary	_____	_____
Social Security	_____	_____
Retirement Pension	_____	_____
Veteran's Benefits	_____	_____
Interest/Dividends	_____	_____
Other	_____	_____
Total Monthly Income	$_____	$_____

Assets			**Amount**
Life Insurance (cash value)	Y	N	_____
Checking Account	Y	N	_____
Name of Bank: _____			
Savings Account	Y	N	_____
Name of Bank: _____			
Certificates of Deposit			_____
In whose name is this asset held?			_____
Stocks			_____
In whose name is this asset held?			_____
Annuities			_____
In whose name is this asset held?			_____
Are you drawing income?	Y	N	
Does this have cash value?			_____
Money Market			_____
In whose name is this asset held?			_____
Bonds			_____
In whose name is this asset held?			_____
IRAs/401K/403B			_____
In whose name is this asset held?			_____
Total Assets:			$_____

REAL ESTATE

Does the Applicant own a home? Y N

Spouse, disabled adult or child in the home? Y N

Please list all Real Estate assets. Please include property and building address as well as approximate value

_____

_____

_____

LIABILITIES (example: mortgage, liens, credit cards, loans) **Amount**

_____ _____

_____ _____

_____ _____

_____ _____

Total Liabilities: $_____

Please provide additional financial information that may be pertinent to this application:

_____

_____

Additional information/comments, which may be helpful in processing this application: _____

_____

_____

I, _____, certify that this information is accurate and true to the best of my knowledge.

_____

Signature of Applicant/Responsible Party Date Relationship

St. Ann's Community respects the rights of all people and applications are considered without regard to race, creed, color, age, gender, marital status, disability, sexual orientation, national origin, or sponsor. Alliance for Senior Care Communities are also smoke-free campuses.

CONSENT FOR RELEASE OF INFORMATION TO ST ANN'S COMMUNITY

NAME: _____ DOB: _____

I hereby expressly authorize and request that each of the following persons, agencies, and organizations give full detailed, and relevant information regarding me to St. Ann's Community:

1. Social Security Administration
2. Any and all physicians, dentists, social workers, psychologists, nurses, technicians, clinics, hospitals, and psychiatric facilities, Nursing Homes, Assisted Living Facilities where I have been a patient.
3. Any and all banks and bankers which now hold or heretofore held my funds; and all persons, firms, or corporations which hold my funds or funds payable to me
4. Any and all persons, firms, or corporations which hold my funds or funds payable to me
5. Any and all insurance companies by which I am an insured or which hold my funds or funds payable to me

_____ _____

Signature of Applicant Date

(OR)

_____ _____

Signature of Responsible Party Date

_____

Relationship to Applicant

STATEMENT REGARDING MONTHLY INCOME AMOUNTS

I, as Power of Attorney or as the person responsible for _____'s Financial affairs, agree to sign all documentation required to change the address on any and all monthly social security or pension payments so that these payments will be sent directly to the SNF where I am admitted to be used for the resident's cost of care. I agree to sign the required paperwork on the resident's day of admission for the Nursing Home.

I also agree that beginning with the first month of admission and continuing until the change of address has been implemented by the payer, to submit upon receipt, all funds received on behalf of the resident to the Nursing Home to pay for the resident's care. I understand that I am not to submit payments in excess of the resident's cost of care.

If the resident is eligible for Medicaid, I understand that the $50.00 allowed for the resident's personal needs, may either be deposited into an individual fund for the resident or maintained at the Nursing Home or returned to me. If the resident is not eligible for Medicaid, the entire payment will be applied to the resident's bill unless otherwise directed.

I understand that all the above referenced payments will be applied against the resident's account and will appear on the monthly statements that I receive from the Nursing Home.

_____ _____

Responsible Party Date

FISCAL AGENT AGREEMENT

This agreement made effective the ___ day of _____ by and between the St. Ann's Home (the "Home") and _____, residing at _____(street), _____(city, state, zip), (hereinafter "Fiscal Agent"), as an individual with legal access to funds or resources of _____(hereinafter "Resident").

WHEREAS, the Home is reviewing whether to admit this Resident and to provide the services specified in the Resident Admission Agreement; and

WHEREAS, Fiscal Agent as legal access to the income, funds or other resources of the Resident; and

WHEREAS, Fiscal Agent agrees and acknowledges that the Home will rely on the Fiscal Agent's agreements contained herein.

NOW, THEREFORE, for good and valuable consideration, the parties hereby agree as follows:

1. Fiscal Agent hereby agrees to promptly and timely assist the Resident in fulfilling his/her responsibilities under the Resident Admission Agreement.

2. Fiscal Agent hereby certifies that the information set forth in the Application for Admission to the Home is true, complete and accurate to the best of Fiscal Agent's knowledge, and Fiscal Agent hereby agrees to promptly and timely cooperate with the Home in obtaining payment from the Resident's funds for all of Resident's charges, and to assist Resident to make all payments due on a timely basis in accordance with the terms of the Resident Admission Agreement. Fiscal Agent is not required, and is not being asked, to pay for the Resident's care from Fiscal Agent's assets or income.

3. Fiscal Agent agrees that Resident's assets, income, Medicare and insurance benefits and other resources will be used to timely pay all of Resident's charges incurred at the Home.

4. Fiscal Agent hereby agrees and covenants that Fiscal Agent will make payment to the Home of all charges, fees and expenses, payments for physician visits and all properly authorized additional charges and rate increases from the Resident's assets, income, Medicare and insurance benefits and other resources.

5. Fiscal Agent agrees that if the Resident becomes eligible for Medicaid benefits, Fiscal Agent shall promptly and timely initiate, complete and file an application for Medicaid benefits and all subsequent recertifications that may be required by Medicaid to ensure uninterrupted Medicaid benefits for Resident. The Home agrees to assist Fiscal Agent in completing the Medicaid application process, if specifically requested by Fiscal Agent.

6. If Fiscal Agent is the attorney-in-fact for the Resident through a power of attorney, Fiscal Agent appoints the Home as limited Power of Attorney for Resident for the purpose of obtaining bank and financial information necessary to complete Resident's Medicaid application.

7. If the Resident becomes Medicaid eligible, the Fiscal Agent agrees to assure that the Home is paid that portion of the monthly Medicaid rate (the "NAMI" amount) on a monthly basis which the Medicaid agency may direct the Resident to pay towards the cost of care.

8. Fiscal Agent personally agrees that if he/she is representative payee or otherwise receives or controls any of Resident's NAMI, and if he/she or Resident fails to pay such NAMI in a timely manner, the Home is hereby directed to apply for and become representative payee of the Resident to provide for the direct deposit of Social Security benefits upon the filing of the Resident's Medicaid application.

9. Fiscal Agent agrees, warrants and covenants that all of Resident's assets, income, insurance benefits and all other resources as disclosed to the Home prior to and/or at the time of admission shall be used to satisfy in full all future bills and invoices from the Home and shall not be otherwise used, transferred, diverted, gifted, loaned, or pledged to any other person or party.

10. Fiscal Agent represents and warrants that no transfer of Resident's assets, income, Medicare or insurance benefits or other resources, has taken place or will occur which would prevent Resident from qualifying for Medicaid benefits. If a transfer is made and if it is later determined that such a transfer results in a full or partial denial of Medicaid benefits for any period of time, Fiscal Agent shall take any and all steps necessary to immediately return such assets, income, benefits or other resources to Resident's use in order for Resident to fully qualify for Medicaid.

11. Fiscal Agent expressly understands that the Home is relying upon each and every statement, representation, covenant and warranty by Fiscal Agent in this Agreement and in the financial statements presented by Resident and Fiscal Agent prior to and/or upon admission and, in light thereof, Fiscal Agent expressly represents and warrants to the Home the truthfulness, accuracy and completeness of each of the statement made herein.

12. Fiscal Agent agrees to pay damages to the Home caused by a breach of his/her personal responsibilities under this Agreement, including but not limited to attorneys' fees and costs.

Date:_____ _____

Fiscal Agent

Date:_____ _____

St. Ann's Home Representative