61700 Route 48 ~ Greenport, NY 11944 Phone 631-477-2110

APPLICATION FOR PLACEMENT FOR SKILLED NURSING AND REHABILIATION CARE

PLEASE RETURN WITHIN 3 DAYS TO Pdean@sansimeonbythesound.org or fax to (631) 477-0793 ATTN. Pamela Dean

Date of Application:_____

APPLICANT INFORMATION

APPLICANT: _____

ADDRESS: _____

_____

Applicant's Birthdate: _____ Age: _____ Sex: _____

Religion: _____

MARRIED: YES NO NAME OF SPOUSE: _____PHONE: _____

WIDOW: YES NO Date Widowed _____
DIVORCED: YES NO Date Divorced _____
SEPERATED: YES NO Date Separated _____

PRESENT PHYSICIAN

Current Physician: _____

Physician's Address: _____

Physician's Phone: _____

PRIOR NURSING HOME STAYS THIS YEAR:

Name of Facility _____ Date of admission: _____ Date of Discharge: _____

Name of Facility _____ Date of admission: _____ Date of Discharge: _____

Name of Facility _____ Date of admission: _____ Date of Discharge: _____

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MEDICARE INSURANCE INFO

Social Security (Copy of front and back of card needed)

Medicare: Part A Effective Date: _____ (Copy of front and back of card needed)
Part B Effective Date: _____ (Copy of front and back of card needed)

Medicare: Part D drug plan YES NO If yes name of plan _____
(Copy of front back of card needed)

INSURANCE INFORMATION (Co-insurance and HMO)

HMO Insurance Plan Name: _____

Plan# _____ Address: _____

Phone: # _____ Contact: _____

Is this a Medicare replacement plan: Yes No Is this working age policy plan? Yes No

Is this a Long Term Care Private insurance Policy? Yes No

Primary Plan holders Name _____ Social Security # _____

Premium Amount Paid Monthly/ Quarterly _____

MEDICAID INFORMATION

Medicaid "all covered service" or "Chronic Care level is needed to pay for Skilled Nursing Services

Community Medicaid Number: _____

Pending Case # _____ County: _____

Has the applicant applied for Medicaid in the past and been denied? _____

Did the applicant give 5 years of information on the original application for Medicaid assistance?
(Please circle one) YES NO

Does the applicant currently pay an overage for Community Medicaid? (Please Circle One)
YES NO Amount $_____

Attorney or Agency if applicable who is assisting or will be assisting with Chronic Care Application
Name _____ Phone: _____

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DESIGNATED REPRESENTATIVE

Name: _____ Address: _____

Phone: _____ Cell: _____

Email: _____

Will the above named be assisting with Medicaid application process? (Please circle one)

YES NO

DOES APPLICANT HAVE A POWER OF ATTORNEY YES NO

IF YES, NAME_____ PHONE NUMBER_____
If NO, CAN RESIDENT SIGN FOR HIS/HER SELF? YES NO

RESIDENCY

Where has the applicant lived in the past five years? _____

_____

_____

Is this address an apartment or a home? (Please circle) Apartment Home

Is this address an adult home or assisted Living? (Please circle) YES NO

If yes where did the applicant live prior to assisted living or adult home?

_____

Were any residences owned by the applicant over the past 5 years starting from year 2012?
(Please Circle one) YES NO

If yes, can you provide closing papers, copy of checks cut, and were the funds from proceeds were sent from home sale? (Please circle one) YES NO

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LIFE ESTATE

Does applicant have a life estate in any property: YES NO

If Yes, who is on the deed of the property? _____

Has resident transferred or gifted funds or property within the past 5 years? YES NO (please circle one)

If yes, please list here:

_____

_____

_____

RESOURCE INFORMATION

CURRENT BANKING INFORMATION 2012- Current year

Checking & Savings Accounts

Account Title Name: _____ Account # _____
Bank name & Branch _____
Current Balance: _____ Closing Balance: _____
Year Closed: _____

Account Title Name: _____ Account # _____
Bank name & Branch _____
Current Balance: _____ Closing Balance: _____
Year Closed: _____

Account Title Name: _____ Account # _____
Bank name & Branch _____
Current Balance: _____ Closing Balance: _____
Year Closed: _____

Account Title Name: _____ Account # _____
Bank name & Branch _____
Current Balance: _____ Closing Balance: _____
Year Closed: _____

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INVESTMENT ACCOUNTS

Kindly list the bank or investment group for each stock, IRA, CD or Annuity Account you have held in the past five years, including accounts that are currently closed.

Does the applicant currently hold Stocks, bonds, IRA, CD or annuity at this time? (Please circle one)
YES NO

Has the applicant surrendered or transferred an Annuity or IRA or CD in the past 5 years, starting year 2012? (Please circle one) YES NO

Account Title Name: _____ Account # _____

Current Balance: _____ Closing Balance: _____

Year Closed: _____

Account Title Name: _____ Account # _____

Current Balance: _____ Closing Balance: _____

Year Closed: _____

Account Title Name: _____ Account # _____

Current Balance: _____ Closing Balance: _____

Year Closed: _____

Account Title Name: _____ Account # _____

Current Balance: _____ Closing Balance: _____

Year Closed: _____

Does the applicant own a motor Vehicle? (Please circle one) YES NO

Has the applicant filed a tax return in the past five years? YES NO

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BURIAL INFORMATION

Funeral Home _____ Revocable burial Amount _____
Irrevocable burial Amount _____

Burial Plot _____

Does the applicant hold a life insurance policy? (Please circle one) YES NO

Is the policy TERM LIFE or WHOLE LIFE (please circle one)

If Yes,

Name of Policy _____ Number _____

Current Cash Value of Policy: _____ Current Face Value of Policy: _____

Name of Policy _____ Number _____

Current Cash Value of Policy: _____ Current Face Value of Policy: _____

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INCOME INFORMATION

Income contributions while Pending Medicaid determination and decision are required to be made upon entry to our facility. Income contributions are determined by adding all income received within a month less any insurance premiums, and $50 for personal needs. Income contributions are due to the facility by the 10th of each month.

	APPLICANT	SPOUSE
Social Security	_____	_____
Pension	_____	_____
Pension	_____	_____
VA Pension	_____	_____
Annuity	_____	_____
IRA	_____	_____
Stock Dividend	_____	_____
Life Insurance	_____	_____
Rental Property	_____	_____

FACILITY INFORMATION

The current facility room and board rate is $491.28 for a semi private room and $507.30 per day for a private room. This rate does not include pharmacy and other provider charges that may be incurred and billed separately to you.

Medicare guidelines in a Skilled Nursing Home can be found in your "Medicare and You 2017" handbook or online at Medicare.gov. ***Medicare does not guarantee 100 days of covered Skilled Nursing Care, nor do most HMO primary plans***. Co-Insurance begins after 20 days in the facility and it is the patient's responsibility to provide evidence of insurance coverage. If insurance does not cover the co-insurance, patient will be billed at the current rate of **$164.50** per day.

All needs are based on ***"skilled level of care"*** under specific guidelines such as receiving restorative therapy and extensive need care. Any care that is deemed "basic daily needs care"

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within a 24 hour time period is not covered under Medicare or HMO Policies in a Skilled Nursing Home.

It is understood the care you will receive at San Simeon by the Sound Center for Nursing and Rehabilitation, is at a ***skilled nursing level***, and will be stated as such to your insurance company. Policy holders of Long Term Care Insurance plans are subject to pay the difference of the daily room and board rate vs. what the Long Term Care plan pays.

Medicaid Applicants:

**San Simeon by the Sound Center for Nursing and Rehabilitation offers assistance and review of your application. There is no guarantee you will qualify for benefits with this assistance. Each application is reviewed by the facility's Medicaid Coordinator and sent out in proper format to your respective county Medicaid office. Applications noted to have potential issues, that may affect the success rate for benefit approval, will prompt a referral for the applicant to seek outside assistance. The facility staff cannot assist in transfers, promissory notes, home sales, or NYSARC trust.*

It is the applicant's responsibility or the designated authorized representative of the applicant to:

1. *Inform the staff at San Simeon by the Sound truthful information that may be crucial to the success rate of your application.*
2. *Supply all general documentation to support your application as noted on the facility's check-list.*
3. *Sign all applications and documents that are needed to support your application*
4. *Support the process of your application by meeting county deadlines for further information requested after discharge or expiration of the applicant.*
5. *Agree to follow Medicaid guidelines regarding income contribution toward your cost of care.(All income is due the first day you would like the facility to bill Medicaid for services)*

Please refer to the admission agreement you have signed upon entering regarding "Pending Medicaid" patient's responsibility and policy of San Simeon by the Sound Center for Nursing and Rehabilitation.

For questions about the financial portion of this application, please contact Pamela Dean at (631)-477-2110 x 402.

Signature_____

Date _____