Robinson Terrace
Stamford, New York

Application for Admission

Date: _____

Patient's Name:
_____

Address:
_____
_____

Present location (if other than home):
_____
Contact person at present location:
_____

Person representing patient:
_____

Address/ phone number:
_____
_____

(Circle any that apply) Power of Attorney Conservator Health Care Proxy
Person responsible for handling financial transactions

Relationship to patient: _____

Marital Status (circle appropriate response)
Single Married Widowed Separated Divorced

Advanced Directives (circle any that apply)
Health Care Proxy Do Not Resuscitate Order Living Will Hospice

Place of Birth: _____

If not born in the United States, please provide citizenship date and location:
_____

Financial Disclosure

Medicaid Application Status

_____ Approved Medicaid number: _____
_____ Pending County: _____
Date submitted: _____
Caseworker name: _____

Has an application ever been denied?)_____

Recipients of Medicaid are required to pay their "Net Available Monthly Income" or "NAMI" to Robinson Terrace as part of their Medicaid rate. To facilitate collections I hereby agree to have the Social Security portion of my "NAMI" forwarded to and payable to "Robinson Terrace". Any surplus over and above the "NAMI" shall be deposited into the Resident's personal account. Initials: _____

Insurance company (circle all that apply)

Medicare A Medicare B

Other insurance company:
Name and address/ phone number:
_____
_____
_____

Policy #: _____

Income

Social Security	$_____/ month
Retirement Pension	$_____/ month
Veteran's Pension	$_____/ month
Railroad Pension	$_____/ month
Supplemental Security Income	$_____/ month
Annuities	$_____/ month
Other income	$_____/ month
TOTAL INCOME	$_____/ MONTH

Checking Account:
Bank: _____

Balance: $_____ Joint Account? _____

Savings Account:
Bank: _____
Balance: $_____ Joint Account? _____

(List any additional accounts on a separate page)

CDs/Stocks/ Mutual funds/ life insurance/other holdings:
Bank/ Institution: _____
List Amounts below:
_____
_____

Own a home?_____ Value: _____
Is the home owned jointly? _____

Section 366.5 of the New York State Social Service Law, enacted in 1982, states that any transfer of assets or resources within a 60 month period prior to applying for Medicaid will be presumed to have been done for the purpose of qualifying for Medicaid, resulting in being ineligible for Medicaid assistance. Initials: _____

Have any assets been transferred in the last 60 months? _____
If yes, please describe:
_____
_____
_____

Has a trust been established? _____ Date of trust?_____
If yes, please provide a copy.

To the best of my knowledge, all of the information provided herein is correct and valid. I understand that the information contained in this form will be shared with nursing homes in which I have an interest.

X_____ _____
Signature of patient or representative date

The information provided shall remain confidential and shall be made available only to authorized hospital and nursing home personnel involved in the placement process and to any governmental officials authorized access by law to such records.

The facilities having access to this information do so without regard to race, creed, color, age, sex, religion, national origin, sponsor, sexual preference, disability, or marital status; persons under 16 years of age are not eligible for admission consideration unless special approval has been received from the New York State Department of Health.

4/9/09