



PART ONE APPLICATION (& REHABILITATION)

If applying for long term care placement, this application must accompany the Part 2 Financial Supplement

Waterville Residential Care Center | 220 Tower Street | Waterville, NY | 315-841-4156 | Watervillecares.com

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 Director at 315-841-4156.

General Information:

Applicant's Name: _____ Date of Birth: ____ / ____ / ____ Age: _____
Marital Status: _____ Religion: _____ Social Security #: _____ Sex: _____
Street Address (Do not use PO Box): _____
City: _____ State: _____ Zip: _____ County: _____

Applicant's **present** location: _____ Date of Admission: ____ / ____ / ____

Has the applicant had any Skilled Nursing Facility stays within the last 60 days? ☐ Yes ☐ No

If yes, please include the following Facility Information:

Facility Name: _____ Street Address: _____
City: _____ State: _____ Zip: _____ Facility Phone Number: (____) _____

Admittance Date: _____ Discharged Date: _____

Resident Representatives: Please list in order of emergency contact

#1 Name: _____	#2 Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
Home #: _____	Home #: _____
Cell/work #: _____	Cell/work #: _____
Email: _____	Email: _____

Financial Information: INCOME - Self and Spouse (List all monthly household income. Continue a second page if needed)

Source of Income (list separately)

Applicant

Spouse

Social Security	\$ _____	\$ _____
(Type and SS# if different from your own)		
SSI	\$ _____	\$ _____
Pension(s)	\$ _____	\$ _____
(Source/Company name and ID#)		
Veteran Income Benefit	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Interest/Dividends	\$ _____	\$ _____
Annuity/IRA Income	\$ _____	\$ _____
Trust Income	\$ _____	\$ _____
Other Income	\$ _____	\$ _____

BANK ACCOUNTS – Please include all accounts balances including CDs, Savings, Checking, Bonds, 401K, Money Markets, etc.

Checking/Savings \$ _____	Bank: _____	Joint Owners Name: _____
Checking/Savings \$ _____	Bank: _____	Joint Owners Name: _____
Checking/Savings \$ _____	Bank: _____	Joint Owners Name: _____

Life insurance policies? ☐Yes ☐No **If yes,** Cash values \$ _____ Policy Name: _____

Pre-Paid burial? ☐Yes ☐No **If yes, (funeral home):** _____

Do you own a home? ☐Yes ☐No **If yes, property address:** _____

Is home jointly owned? ☐Yes ☐No

Life estate on any property? ☐Yes ☐No **If yes, date Life Estate established :** _____

Transferred or sold any property/assets in the last 5 years? ☐Yes ☐No **If yes, list property/asset information:**

INVESTMENTS - List all IRAs, 401ks, stocks, bonds, savings bonds, annuities, mutual funds or other investments here.

Bank/Brokerage Company	Owner(s)	Type of Investment (stocks/CD/bonds etc..)	Current Value

ALIMONY - Applicant must provide copy of court order.

Alimony Paid Out: ☐Yes ☐No Amount \$ _____
Alimony Paid Type: ☐Domestic Relations Order ☐Separation Agreement / Spousal Order
Alimony Received: ☐Yes ☐No Amount \$ _____
Alimony Received Type: ☐Domestic Relations Order ☐Separation Agreement / Spousal Order

GIFTING INFORMATION: *(This includes birthday, wedding, graduation gifts, charitable gifting, Tithing, etc.)*

Has the applicant gifted/given away any funds, property or assets, over \$1,000 or more in the last 5 years? If yes, indicate below:

Amount Given	Date Given (month/year)	Recipient of Gift

Has a Trust been established? ☐Yes ☐No *If yes, when?* _____ **Revocable or irrevocable?** (circle one)

Do you have Long term Care insurance? ☐Yes ☐No *If yes, what company?* _____

Has applicant applied for Medicaid? ☐Yes ☐No *If yes, when:* _____ **County:** _____

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