SCHOELLKOPF HEALTH CENTER

APPLICATION FOR ADMISSION

Please complete and return to Admissions Department at Schoellkopf Health Center.

APPLICANT DEMOGRAPHICS:

Name of Applicant_____
last first middle

Home Address_____

Telephone No _____ Social Security Number_____

Birthdate _____Age _____Sex _____Citizenship _____ Birthplace _____

Marital Status_____ Name of Spouse_____ No. of Living Children_____

Present Location of Applicant (if other than home address):

Name of Location_____

Address_____

Date of beginning residence at above_____Reason for residence at above_____

Primary Care Physician_____

INSURANCE COVERAGE:

Medicare No._____ Part A _____ Part B _____ Effective Date_____

Medicaid No._____Effective Date_____Pending Application/Date Submitted_____

Medical Insurance_____

Long Term Care Insurance _____

RESPONSIBLE PARTIES:

Name_____Relationship_____

Address_____ Telephone #_____

_____Alternate Telephone #_____

Name_____Relationship_____

Address_____ Telephone #_____

_____Alternate Telephone #_____

POWER OF ATTORNEY:

Name_____Telephone No._____

Address_____

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FINANCIAL INFORMATION ABOUT APPLICANT
(All information is considered confidential)

INCOME:

	Monthly Income of Applicant	Monthly Income of Spouse
Salary	_____	_____
Social Security	_____	_____
Retirement Pension	_____	_____
Veteran's Pension	_____	_____
Railroad Pension	_____	_____
SSI	_____	_____

Other Monthly Income_____Source_____

ASSESSTS/RESOURCES:

Checking Account Bank_____Amount_____

Bank_____Amount_____

Savings Account Bank_____Amount_____

Bank_____Amount_____

Real Estate ☐ Yes ☐ No Type of ownership ☐ Sole ☐ Joint with _____

Life Estate ☐ Yes ☐ No Year Established _____

Location of Real Estate_____ Value _____

Life Insurance ☐ Yes ☐ No If yes, Face Value _____ Cash Value _____

Face Value _____ Cash Value _____

Pre-Paid Funeral ☐ Yes ☐ No Location _____

Other Assets_____

Annuity, Stocks, Bonds, CD's _____

Have you transferred or gifted any money within the past 5 years?_____ If so, amount $_____

To Whom_____ Date _____

Have you transferred or gifted any property within the past 5 years?_____ If so, what _____

To Whom_____ Date _____

LIABILITIES:

Home Mortgage ☐ Yes ☐ No If yes, amount owed _____

Loans ☐ Yes ☐ No If yes, amount owed _____

Credit Cards ☐ Yes ☐ No If yes, amount owed _____

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COUNSEL:

Are you currently working with an attorney or other firm for estate planning or medical planning? ☐ Yes ☐ No
If yes, please list the name of the firm: _____

I, _____ the resident and/or the designated representative, each separately and individually, warrant that the financial information submitted to the facility concerning the resident's finances is true, accurate and complete in all material respects, and there are no material omissions.

I/we acknowledge that the facility has relied and will continue to rely upon my/our truthful representation of all the resident's known income, assets, resources and liabilities, as well as my/our full disclosure of any transfers of income, and that my/our misrepresentation or failure to provide full disclosure may result in an interruption in payment or qualification for benefits for payment of expenses incurred by the resident.

Bank statements or other similar documentation may be requested to verify that the above assets are available.

The resident and/or designated representative assure payment of all expenses incurred to the extent of the applicant's resources.

REPRESENTATIONS AND INDEMNIFICATION AGREEMENT:

1. The resident and/or representative attest that all the resident's assets are fully and accurately disclosed on the application. The resident and/or representative attest that there have been no transfers of the resident's ownership in any assets or resources within the past 60 months for which fair payment has not been received, other than those disclosed in the nursing home application.

2. The resident and/or representative agree that neither of them have previously done anything, nor will do anything at any time hereafter that would cause the resident to become ineligible or disqualified for Medicaid for any period of time. This would include, transferring the resident's present or further acquired assets without receiving fair payment or value for such a transfer.

3. If the resident is the owner of a residence, the resident and/or the representative accept that if or when the resident is no longer able to return to their residence, the home will promptly be sold for fair market value. The proceeds of the sale will then be used toward the resident's financial obligation to the facility if and when the other resources are exhausted. Prior to exhausting the resident's other assets they will list the residence for sale for its then fair market value and diligently pursue the closing of the sale. The proceeds of the sale will be held and used solely toward the resident's legal obligations, including to the facility.

4. The resident and/or representative agree that prior to exhausting the resident's assets and resources, they will complete the application for Medicaid timely. The application shall be made in such a manner and time, that the resident will be able to pay his/her obligations to the facility by means of the resident's assets and resources and/or medical assistance provided by their health insurance. If the resident is discharged from the facility prior to Medicaid approval, the resident/and or representative agree to fully comply with the Medicaid process to ensure timely enrollment.

5. If the resident is denied timely Medicaid coverage as a result of the resident and/or representative's failure or neglect to comply with the Medicaid requirements they each agree to pay and reimburse the facility unconditionally all amounts that the facility would have received had a timely Medicaid enrollment date occurred.

I have reviewed the information contained herein and represent that it is factually true, accurate, and complete. I understand that the facility uses this information in the admission decision process. The above terms and conditions will become effective and be binding upon and enforceable against the resident and the representative upon the facility's admission of the resident pursuant to the application, the terms and provisions of which are hereby agreed to this.

Upon review of the application, the facility will accept and consider all individuals without regard to race, creed, color, national origin, sex, handicaps, blindness, sponsor, or sexual preference.

Date_____

_____
Signature of Applicant or Responsible Party (Required)