Daughters of Sarah
Nursing & Rehabilitation Center

180 Washington Avenue Extension
Albany, New York 12203

FINANCIAL INFORMATION

(All information is kept confidential)

Patient Name _____ Date _____
Legal Address _____ City _____ State___ County_____ Zip_____
Marital status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Person Completing Form _____Relationship to Patient_____
Phone #:_____Status: HCP ☐ POA ☐ Legal Guardian ☐ Responsible for Financial Transactions ☐

ASSETS:

1. Bank accounts **NOT** contained in a Trust and are therefore available for care(*Indicate: savings, checking, money markets, IRA's CD's, Mutual Funds, etc).
   A. Bank _____ Balance $_____ Type of account* _____ Names on Acct _____
   B. Bank _____ Balance $_____ Type of account*_____ Names on Acct _____
   C. Bank _____ Balance $_____ Type of account* _____ Names on Acct _____
   D. Investment _____ Market Value $_____ Names on Acct _____
   E. Investment _____ Market Value $ _____ Names on Acct _____
2. Within the past 60 months, have you **gifted/transferred** any assets or property to family or friends?
   Yes ☐ No ☐ If yes, provide dollar amount or value and dates for each transfer.
   Amount/Value: _____ Date: _____ Amount/Value: _____ Date: _____
3. Within the past 60 months, have you entered into any "**TRUST**" arrangements? Yes ☐ No ☐
   Value(s): _____ Date(s) of Transfer: _____
4. Does the patient own a home: Yes ☐ No ☐ Property Value: $_____
   Type of property: Primary Residence ☐ Rental ☐ Vacation ☐ Commercial ☐
5. Does the patient or spouse own life insurance: Yes ☐ No ☐
   Patient- Company _____Face Value_____ Cash Value_____
   Spouse-Company _____Face Value_____ Cash Value_____
6. Do you have Long Term Care Insurance? Yes ☐ No ☐
   Name of Carrier: _____ Daily Benefit: $_____
7. Does anyone owe you money under any loan, note or mortgage? Yes ☐ No ☐
   If yes: Date of loan: _____Total amount owed: $_____ Monthly Payment: $_____

INCOME PER MONTH:

	Patient	Patient's Spouse
1. Social Security	$ _____	$ _____
2. Pensions		
a. Government	$ _____	$ _____
b. Other_____	$ _____	$ _____
3. Interest Income	$ _____	$ _____
4. Trust Income	$ _____	$ _____
5. Other Income	$ _____	$ _____

To the best of my knowledge, all the information provided herein is complete, accurate and valid. The finances described above are available and will be used to pay for the cost of care. I hereby apply for admission to the Daughters of Sarah Nursing Center, Inc., d/b/a Daughters of Sarah Nursing & Rehabilitation Center.

Date:_____ Applicant's Signature: _____
If you cannot sign your name, please mark an X and have it witnessed.
Witnessed by _____Date: _____