Daughters of Sarah
Nursing & Rehabilitation Center

180 Washington Avenue Extension
Albany, New York 12203

APPLICATION FOR ADMISSION

State and Federal laws prohibit discrimination based on Sex, Race, Creed, Color, National Origin, Sexual Preference, Marital Status, Blindness, Disability, Age, Source of Payment, or Sponsorship in admission, retention and care of residents.

I. PERSONAL INFORMATION

Full Name _____ Date _____
Current Address _____ City _____ State _____
County _____Zip _____ Tel. No _____ SS# _____
I have been residing at this address since: _____ DOB: _____ Place of birth: _____
If foreign born, please provide documentation of proof of citizenship.
Medicare ID # _____ Part A: Yes ☐ No ☐ Part B: Yes ☐ No ☐
Medicaid ID# _____ Effective Date: _____ Medicaid County: _____
Other Insurance: _____ ID # _____
Maiden Name _____ Wife's maiden name _____
Name of Father _____ Maiden name of Mother _____
Have you or your spouse ever served in the United States Military: Yes ☐ No ☐
Occupation or Trade _____ Religious Preference _____
Marital status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐
Name of spouse _____Marriage Date_____ Spouse's deceased date _____

Personal Contacts

1. Name _____ Relationship _____
   Home Address _____ Zip _____
   Home Tel.# _____ Business Tel. #_____
2. Name _____ Relationship _____
   Home Address _____ Zip _____
   Home Tel. #_____ Business Tel. #_____

II. ADVANCE PLANNING

1.) I have a Power of Attorney: Yes ☐ No ☐ *(If yes, please attach a copy of the document.)*
Name of Attorney-in-Fact: _____
Address and Phone Number: _____

2.) I have a Health Care Proxy: Yes ☐ No ☐ *(If yes, please attach a copy of the document.)*
Name of Health Care Agent: _____
Address and Phone Number: _____

3.) I have a Living Will: Yes ☐ No ☐ *(If yes, please attach a copy of the document.)*

4.) I am working with an Elder Law or similar Attorney? Yes ☐ No ☐
(*If yes, please provide name, address, and phone number*)
_____

5.) Who is the Executor of your estate?
Name _____ Relationship _____ Tel.# _____
Address _____

6.) **Membership in Benevolent society:**
Name of Organization / Undertaker _____ Tel. _____
Address _____
I have a paid ☐ unpaid ☐ burial plot
Cemetery _____ Location _____

7.) Arrangements for organ donation/anatomical gift: Yes ☐ No ☐ *(If yes, please attach a copy of documents).*

8.) In the event of accident or death, I direct you to notify _____
Address and Tel. #, _____

III. APPLICANT'S FINANCIAL ASSETS AND INCOME

ASSETS: Attach photocopies of the current statements, reflecting all assets listed below. Be sure copies include bank branch, account number, and name (s) of account holders. (We may request additional financial information depending on each applicant's financial status). *If needed, attach an additional page(s).*

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). Please note, Medicaid considers joint accounts as belonging to the applicant at 100%.
   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 valued at $250.00 or more?
   Yes ☐ No ☐ If yes, provide dollar amount or value and dates for each transfer.
   Amount/Value: _____ Date: _____ Amount/Value: _____ Date: _____
   Amount/Value: _____ Date: _____ Amount/Value: _____ Date: _____

3. Within the past 60 months, have you entered into any "**TRUST**" arrangements?
   Yes ☐ No ☐ If yes, list value of assets involved and date of transfer. Also, provide a copy of the Trust.
   Value: _____ Date: _____ Value: _____ Date: _____
   Value: _____ Date: _____ Value: _____ Date: _____

4. I own the following real property: Yes ☐ No ☐
   Location: _____ Property Value: $_____
   Type of property: Primary Residence ☐ Rental ☐ Vacation ☐ Commercial ☐
   Location: _____ Property Value: $_____
   Type of property: Primary Residence ☐ Rental ☐ Vacation ☐ Commercial ☐
   If real estate is "Primary Residence," please answer the following.
   a. Is property currently listed for sale? Yes ☐ No ☐
   b. Is applicant's intention to return to this property within six (6) months? Yes ☐ No ☐
   c. Is property currently occupied? Yes ☐ No ☐
      1. If yes, by whom? _____ Relationship to Applicant _____
   d. Is there any mortgage on any of this property? Yes ☐ No ☐ If yes, amount remaining on mortgage: _____

5. I own life insurance and/or annuity contracts: Yes ☐ No ☐
   a. Name of Insurance Company _____ Policy _____

Present cash surrender value $ _____

6. I own Stocks and/or Bonds: Yes ☐ No ☐
   Name of Investment: _____ Market Value: _____
   Name of Investment: _____ Market Value: _____

7. Do you have Long Term Care Insurance? Yes ☐ No ☐
   If yes, provide the name and address of the insurance carrier and the daily benefit amount.
   Name of Carrier: _____ Daily Benefit: $_____

8. 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: (Please attach documents to show proof of income)

1. Social Security $ _____
2. Pensions
   a. Government $ _____ ID _____
   b. VA $ _____ ID _____
   c. Company $ _____ Name of Company _____
   d. Other $ _____ Describe _____
3. Interest Income $ _____ Describe _____
4. Trust Income $ _____ Describe _____
5. Other Income $ _____ Describe _____

Please provide a copy of your Social Security card, Medicare card, Medicaid card (if applicable), and any other health insurance card (s).

EXPENSES: **Cost of any medical insurance premiums $_____**

IV. PLAN OF PAYMENT FOR COST OF CARE AT DAUGHTERS OF SARAH

1. ☐ Own assets and/or income ☐ Medicaid

2. Designated Representative Responsible for Payments on your behalf.
Name _____ Relationship _____Phone _____
Address _____

Our Nursing Center makes important decisions based on the information contained herein, therefore, do you have future plans to amend what funds are available toward the cost of care? ☐ Yes ☐ No

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.

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