

Somers Manor Nursing Home

Admission Application & Financial Information

(Please Print)

Date ___/___/___

Resident's Name _____ Age _____ Sex _____

Resident's Address _____ Telephone # _____

Race _____

Date of Birth _____ Place of Birth _____ Citizen YES NO

Marital Status (Circle One) Single Married Widowed Divorced

Maiden Name _____ Date of Marriage ___/___/___ Name of Spouse _____

Religion _____ Former Occupation _____ Retired/Date ___/___/___

Community Physician _____ Hospital Preference _____

The following physicians have admitting privileges to SMNH. (Please **circle** Geriatric Services or one of the following as primary physician.)

Geriatric Services: Dr. Surbhi Agarwal & Dr. Kyongmi Kim

Dr. Ernest Terranova

Dr. Michael Healy

Primary Contact (Please print)

Name _____

Address _____

Telephone # _____

Cell Phone # _____

Work # _____

Fax # _____

E-Mail Address _____

Relationship to Resident _____

Discuss Financial Matters with YES NO

Alternate Contact

Name _____

Address _____

Telephone # _____

Cell Phone # _____

Work # _____

Fax # _____

E-Mail Address _____

Relationship to Resident _____

Discuss Financial Matters with YES NO

Residential History (5 years prior to entry)

Prior stay at Somers Manor YES NO

Stay in other Nursing Home YES NO

Other Residential Facility YES NO

Adult Home YES NO

Assisted Living YES NO

Group Home YES NO

MH/Psychiatric Setting YES NO

MR/DD Setting YES NO

None of the above _____

If any residential history is YES, please provide:

Name, Address, Telephone # and dates of stay.

Name _____

Address _____

Telephone # _____

Dates of Stay _____

Does the resident have any Advance Directives?

Health Care Proxy YES NO

Living Will YES NO

Do Not Resuscitate (DNR) YES NO

Power of Attorney YES NO

over

Financial Disclosure
(Confidential)

| Income | Monthly Amount | | Monthly Amount |
|--------------------|----------------|-----------------------|----------------|
| Social Security | \$ _____ | Supplemental Security | \$ _____ |
| Retirement Pension | \$ _____ | Annuities | \$ _____ |
| Veteran's Pension | \$ _____ | Other Income | \$ _____ |
| Railroad Pension | \$ _____ | TOTAL INCOME | \$ _____ |

Assets

| | |
|----------------------------------|--|
| Savings Account - Joint? YES NO | Savings Account - Joint? YES NO |
| Bank Name _____ | Bank Name _____ |
| Balance _____ | Balance _____ |
| Checking Account - Joint? YES NO | Certificate of Deposit - Joint? YES NO |
| Bank Name _____ | Bank/Financial Institution _____ |
| Balance _____ | Amount _____ |

Does the resident own a home? YES NO Is the home jointly owned? YES NO
If yes, estimated value? _____

| Other Assets | Amount | Other Assets | Amount |
|---------------------|---------------|---------------------|---------------|
| _____ | \$ _____ | _____ | \$ _____ |
| _____ | \$ _____ | _____ | \$ _____ |

Have any assets been transferred from the applicant to others in the last 60 months? YES NO
If Yes, describe _____

Medicare # _____ Medical Insurance # _____
Medicare Part D YES NO Carrier # _____
Other Pharmacy Insurance _____

Medicaid Status

County _____
Pending YES NO If pending, date submitted ___/___/___
Approved YES NO If approved, Medicaid # _____
Application Denied YES NO If YES, reason _____

Department of Social Service Case Worker's Name _____
Department of Social Service Case Worker's Telephone # _____

To the best of my knowledge all of the information provided herein is correct and valid. I have been informed that the resident's name will be included in the facility directory.

Signature Relationship to Resident Date

Print Name

The information provided shall remain confidential and shall be made available only to authorized hospital and nursing home personnel involved in the admission process. Somers Manor Nursing Home, Inc. abides by the HIPAA Privacy Act. State and Federal Laws prohibit discrimination based on sex, national origin, disability, marital status, sexual preference, blindness, source of payment or sponsor.