Finger Lakes Health
Long Term Care
SM

Living Center at Geneva — North
Living Center at Geneva — South
The Homestead
Huntington Living Center

APPLICATION FOR ADMISSION

DEMOGRAPHIC INFORMATION

Name_____Phone_____

Address_____City_____State_____Zip_____County_____

Date of Birth_____ Place of Birth_____ Sex **M F** Veteran **Y N**

Social Security # _____ Marital Status **S M W D** U.S. Citizen **Y N**

Spouse _____Veteran **Y N** Primary Language_____ Religion (optional) _____

Primary Care Physician _____ Physician Phone_____

INSURANCE INFORMATION

Medicare #_____

Medicaid #_____ State _____ County _____

Other Insurance _____ Policy ID # _____

Long Term Care Insurance_____ Policy ID#_____Daily Benefit _____

Prescription Drug Plan _____ Medicare D _____

CONTACT INFORMATION

Primary Contact _____ Relationship _____ Power of Attorney? **Y N**

Address _____

Home Phone (___)_____ Work Phone (___)_____ Other _____

Alternate Representative _____ Relationship _____ Power of Attorney? **Y N**

Address _____

Home Phone (___)_____ Work Phone (___)_____ Other _____

Email Address _____

DNR **Y N** MOLST **Y N** Health Care Proxy **Y N** HCP Name _____ Living Will **Y N**

Funeral Home Selected _____

Please list all inpatient hospital/nursing home stays in the last 60 days.

Date	Hospital/Nursing Home	Date	Hospital/Nursing Home
_____	_____	_____	_____
_____	_____	_____	_____

NEW YORK STATE AND FEDERAL LAWS PROHIBIT DISCRIMINATION IN ADMISSION, RETENTION, AND CARE OF RESIDENTS ON THE BASIS OF RACE, CREED, COLOR, AGE, NATIONAL ORIGIN, BLINDNESS, MARITAL STATUS, PHYSICAL HANDICAP, SEX, SEXUAL ORIENTATION.

INCOME

Monthly	**Applicant**	**Spouse**	
Social Security	$_____	$_____	
Pension	$_____	$_____	Where is pension(s) received from?_____
	$_____	$_____	_____
VA Benefits	$_____	$_____	
Annuities	$_____	$_____	Where is annuity(s) received from?_____
Others	$_____	$_____	
Trust	$_____	$_____	

ASSETS

Bank Accounts

Bank Name	Account #	Balance	Checking or Savings?	Joint* Y N (Name)

CD's _____

Stocks/Bonds _____

Life Insurance (Cash Value) _____

Real Estate Address_____ Joint* **Y N** Assessed Value_____

EXPENSES

Outstanding Debts _____

Has there been any transfer of assets (including money, stock, real estate) within the last 60 months: **Yes** or **No**

If Yes: Date, Amount & To Whom:_____

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF THE INFORMATION PROVIDED IS ACCURATE AND TRUE. (VERIFICATION OF ABOVE INCOME AND EXPENSE WILL BE PROVIDED UPON REQUEST.)

DATE: _____ SIGNATURE OF APPLICANT: _____
(or person acting for applicant)

Please Fax this completed form to: (315)787-4691
or mail to: Long Term Care Administration
LTC Director of Admissions
196 North Street
Geneva, NY 14456

Rev. 10-06,11/07, 7/09

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FINANCIAL AGREEMENT

This Agreement made effective on (date)_____ by and between (name of facility)_____ ("Nursing Home") and (name of the responsible party) _____ residing at _____ _____ (hereinafter "Signator") as the individual with legal access to the assets, property, funds, income and resources of (name of resident) _____ ("Resident").

Whereas, (name of facility)_____ has agreed to admit the Resident and to provide the services specified in the Admission Agreement dated and executed on _____; and

Whereas, Signator has legal access to the funds or other resources of the Resident;

Now, therefore, for good value and consideration, the parties hereby agree as follows

1. Signator hereby agrees to assist the Resident in fulfilling his/her responsibilities under the Admission Agreement.

2. Signator agrees to cooperate with the Nursing Home in obtaining payment from the Resident's funds for all of the Resident's charges.

3. Signator agrees that the Resident's income, Medicare and insurance benefits, and other resources will be used to timely pay all of the Resident's charges at the Nursing Home.

4. Signator agrees, represents, and warrants to make payment to the Nursing Home for all charges, fees and expenses, payments for physician visits and all properly authorized additional charges and rate increases from the Resident's assets, income, Medicare and insurance benefits, and other resources.

5. Signator agrees that if the Resident becomes eligible in the future for Medicaid benefits, Signator will promptly and timely initiate and accurately complete the application for Medicaid benefits and all re-certifications. Nursing Home agrees to assist the Signator in completing the Medicaid application process and all re-certifications, as specifically requested by the Signator.

6. Signator agrees that if the Resident is eligible for Medicaid, most of the Resident's monthly income must be paid to the Nursing Home as directed by the Medicaid Agency. Signator agrees to pay the Nursing Home such monthly income on or before the 20th of each month in which the income was received. The Nursing Home will assist in effecting Direct Deposit into the Resident's trust account such monthly income if the account is 60 days in arrears.

7. Signator agrees, represents, and warrants that the Resident's assets, property, income, Medicare and insurance benefits, and other resources, shall not be used, transferred or in any way misused so as to prevent the Resident from qualifying for or maintaining Medicaid benefits.

8. Signator warrants that no transfer of the Resident's assets, property, income, Medicare or insurance benefits, or other resources, has taken place or will occur which would prevent the Resident from qualifying for Medicaid benefits; and Signator agrees that should it be later determined that a transfer of the Resident's assets, income, property, Medicare or insurance benefits, or other resources has occurred (including the creation and placement of the Resident's assets in a trust fund) which prevents the Resident's full qualification for Medicaid, Signator shall take any and all steps necessary to return such assets, property, income, benefits or other resources to the Resident's use for payment of charges incurred at the Nursing Home.

Date: _____ Signator: _____

Finger Lakes Health
Date: _____ Representative: _____