St. Camillus
SKILLED NURSING · SHORT-TERM REHAB

813 Fay Road

Syracuse, NY 13219

Phone (315) 488-2951 Fax (315) 488-2834

APPLICATION FOR ADMISSION

Please give ALL information requested on pages 1 -4

Name of Applicant_____ Date ___/___/___

Last First Middle

Is placement considered (check one): Short Term ☐ or Long Lerm ☐

Does Applicant have wandering (check one) **Yes** ☐ **No** ☐ or aggressive behaviors (check one): **Yes** ☐ **No** ☐

Please Explain:_____ _____

Home Address _____ Telephone No. _____

Street

_____

City State County Zip Code

Birth Date_____ Age_____ Sex _____ Citizenship _____

Marital Status (check one): Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Name of Spouse _____ Spouse SS #_____

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

Address_____

Street City State Zip Code

Former Residence in a Nursing Home or Adult Care Facility (check one): Yes ☐ No ☐ If so where_____

Social Security No. _____Veteran(check one): Yes ☐ No ☐ Spouse Veteran (check one): Yes ☐ No ☐

Medicare No. _____ Part A ☐ Part B ☐ Effective Date _____

Medicaid Case No. _____ CIN No. _____ County _____

Effective Date _____ Pending Application/Date Submitted _____

Medical Insurance Name and No. _____ Insurance Prescription Card No. _____

Attending Physician _____

Address _____ Telephone No:

Street City State Zip Code

please supply copies of all insurance cards

Funeral Home _____

Name Address Phone #

Responsible Party:

Name Address Home Ph. Cell Ph. Relationship

Responsible Party: E-Mail Address _____

Power of Attorney/Guardians/Conservators

(Attach copies of Power of Attorney, Guardianship and Conservator Court Orders)

Name_____ Telephone No._____

Address _____

Street City State Zip Code

Income Asset Form

Resident Name:	Date of Birth:

**Note: If there is a spouse, information is needed for both the resident AND the spouse.*

INCOME	Amount	Location & Account #	Resident	Spouse	Joint
Wages					
Social Security/SSI					
Retirement Pension #1					
Retirement Pension #2					
Veteran's Pension					
Railroad Pension					
Investment Income					
Investment Income					
Rental Income					
Mortgages Held					
Annuities Income					
Other Income (list):					

ASSETS	Amount	Location & Account #	Resident	Spouse	Joint
Savings Account #1					
Savings Account #2					
Checking Account #1					
Checking Account #2					
Credit Union					
CD #1					
CD #2					
Retirement Plans (IRA)					
Retirement Plans 401K					
Life Insurance Policy #1					
Life Insurance Policy #2					
Primary Home					
Addtitional Real Estate					
Trust Funds					
Stocks/Bonds					
Mutual Funds					
Money Market Funds					
Business Interest					
Vehicles					
Burial Funds					
Other Assets (list):					

EXPENSES (please list type & amount: e.g., Mortgage, Auto Loan, Utilities, Medical; etc.)

Income Asset Form (continued)

Please list any transfers in the past five years, by the Resident, the Resident's spouse, and/or the Resident's or Resident's spouse's agents under Power(s) of Attorney, made for less than fair market value (gifts and sales), or to a trust. An example of transfers with less or no fair market value includes gifts of cash or assets to family members.

You may be asked to provide copies of bank and/or investment account statements to verify assets, the first two pages of your most recent IRS Form 1040, the interest and dividend schedule from your most recent income tax return, or records or gifts in excess of $5,000 made within the last five years. St. Camillus Residential Health Care Facility reserves the right to conduct credit checks.

Important notice: St. Camillus Residential Health Care Facility relies on the information disclosed in this profile in making decisions regarding admission. If you are unable to pay for the cost of care because you give away (divest) income or assets (legal or otherwise), you may be discharged if you are unable to pay for services. As a prospective resident you should be aware that public funding of your stay is NOT guaranteed. That decision is made by the Department of Social Services (DSS) and not by St. Camillus.

I attest that the information reported on this form is true and accurate. I understand that the St. Camillus Residential Health Care Facility is entitled to rely on the information disclosed on this profile in making decisions regarding admission. I agree to advise the St. Camillus of any changes to the asset, liability or income information supplied on this form, prior to or after admission.

Attorney name:	Phone #:
Name of person completing this form (print):	
Relationship to Resident:	Phone #:
Are you POA (check one)? Yes ☐ No ☐ If no, who is POA on file?	**(*Provide a copy*)**
Signature	Date:

Date to reverify:

NOTES:

*** Please print this Income Asset Form and provide to the Patient Financial Services department***