Aaron Manor
Rehabilitation and Nursing Center

100 Saint Camillus Way Fairport, NY 14450 l **P** 585.377.4000 l **F** 585.377.0013 l www.AaronManor.com

LEGAL NAME OF APPLICANT, AS APPEARS ON MEDICARE CARD

Last_____ First_____ *MI_____

Home Address_____City_____County_____

State _____Zip Code _____Telephone _____Email_____

APPLICANT HISTORY

Has the Applicant previously been in a Nursing Facility? **No/Yes.** If yes, please list facility name and dates of stay_____

Social Security Number _____ Birth Date _____Sex_____

Primary Language_____ Secondary Language_____

Marital Status_____ Citizenship _____ Birthplace_____

Education_____ Lifetime Occupation_____

Spouse_____ Maiden_____ Father_____ Mother_____

Religion _____Funeral Home_____

RESPONSIBLE PERSON(S)

Financial Representative (manages financial obligations for applicant)

Name_____ Relationship_____

Home Address_____ City_____ County_____

State_____ Zip Code_____ Home Phone_____ Work Phone_____

Other Phone Numbers_____ Email_____

☐ Health Care Proxy ☐ Power Of Attorney ☐ Designated Representative
(Oversees needs of applicant)

Emergency Contacts:

Name____ Relationship_________________________________
Home Address______________________________ City_____________________ County_________________
State_______ Zip Code____________ Home Phone____________________ Work Phone________________
Other Phone Numbers_____________________________________ Email______________________________
◻ Health Care Proxy ◻ Power Of Attorney ◻ Designated Representative

Name____ Relationship_________________________________
Home Address______________________________ City_____________________ County_________________
State_______ Zip Code____________ Home Phone____________________ Work Phone________________
Other Phone Numbers_____________________________________ Email______________________________
◻ Health Care Proxy ◻ Power Of Attorney ◻ Designated Representative

Name____ Relationship_________________________________
Home Address______________________________ City_____________________ County_________________
State_______ Zip Code____________ Home Phone____________________ Work Phone________________
Other Phone Numbers_____________________________________ Email______________________________
◻ Health Care Proxy ◻ Power Of Attorney ◻ Designated Representative

Insurance Coverage

Veteran______ Yes/No or Spouse a Veteran? _______ Yes/No
Medicare Number_____________________________________
Medicaid Number____________________________ Effective Date_____________ County______________
◻Pending Case Worker ________________________________ * Date Applied_________________________
Other Medical Insurance ____________________________ Policy Number____________________________
Presceiption coverage ___________________________ Policy Number_________________________________
Medicare Part D Plan ID ____________________________ Group Number____________________________
Long Term Care Insurance____

Financial Information

Monthly Income	Applicant	Spouse	
Salary	$_______________	$_______________	
Social Security	$_______________	$_______________	
Retirement Pension	$_______________	$_______________	
Veteran pension	$_______________	$_______________	
IRA	$_______________	$_______________	
Trust	$_______________	$_______________	Date Established__________
401K	$_______________	$_______________	
Other (Specify)	$_______________	$_______________	
Total Monthly Income	$_______________	$_______________	

Assets	(Check if applicable)	**Approximate Value**	**Name (s) Owner**
Owns Real Estate	_____	$_____	_____
Life Insurance (cash Value)	_____	$_____	_____
Trust Account/TYPE	_____	$_____	_____
Stocks/Bonds	_____	$_____	_____
Annuities	_____	$_____	_____
Pre-Paid Funeral Home	_____	$_____	_____

Please list bank accounts (Checking, Savings, Other)

Name(s) on Account	Type	Approximate Value
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____
	Total Assets	$ _____

Have any assets been transferred from the resident to others in the last 60 months ? ◘ Yes ◘ No

If yes, please describe in detail _____

_____

Are you currently working with an attorney? ◘ Yes ◘ No If yes, name of firm _____

How long have you been working with this Atty/Firm_____

Reason for retaining: ◘ Nursing Home Placement ◘ Real Estate ◘Trust Fund/Accounts ◘Personal

◘Other

TRUTHFULNESS OF INFORMATION PROVIDED:

The resident and the undersigned each separately warrant that the financial information they have submitted to the facility concerning the residents finances is true, correct, complete and accurate in all material respects and that there are no material omissions. By signing this application the resident and the undersigned acknowledge that the facility relies on such information.

I hereby give permission to all medical providers and insurers to release information regarding the above named applicant for purposes of placement in a skilled nursing facility.

In conformity with requirements of the Civil Rights Compliance Unit of the New York State Department of Health, we hereby affirm that it is the policy of Aaron Manor to admit and treat all residents without regard to race, color, creed, national origin, age, sex, religion, handicap, ancestry, marital or veteran status, sexual preference, and/or payment source (EOE).

RESIDENT SIGNATURE: _____

POA/RESPONSIBLE PARTY SIGNATURE: _____

DATE: _____