❑ Doris L. Patrick Campus
❑ Elizabeth Church Campus
❑ Hilltop Campus

APPLICATION FOR RESIDENCY

Applicant's Name ______________________________

Residence: No. and Street ______________________________

P.O. Box No.__________ City______________________ State__________ Zip Code__________

Telephone No.______________________ Social Security No.______________________

Birth Date______________________ Sex______________ Marital Status______________

Are you a United States Citizen? ❑ Yes ❑ No

Are you a Veteran? ❑ Yes ❑ No

Physician's Name______________________________ Phone#______________________

Address ______________________________

Please identify any physical or mental limitations or impairments of the Applicant(s):

____

Please check level of care/type of accommodation

_______ Independent Living _______ Residential Living _______ Adult Care _______ Assisted Living

_______ Skilled Nursing _______ Short Stay Rehabilitative Services

Has the Applicant ever been a resident in another senior housing or nursing facility? ❑ Yes ❑ No

How did you hear about us? ______________________________

Responsible Party______________________________ Phone#______________________

Address ______________________________

Has any person been appointed as Power of Attorney or appointed as Guardian by a court? ❑ Yes ❑ No

Name of person holding Power of Attorney______________________ Guardian______________________

Relationship______________________________ Phone#______________________

Address ______________________________

(Please provide a copy of Power of Attorney or Order of Guardianship.)

Person to notify in an emergency______________________ Phone #______________________

Address ______________________________

Person to notify to set up an interview______________________ Phone#______________________

Address ______________________________

Is there a Health Care Proxy? ❑ Yes ❑ No **If yes, please provide a copy.**

Name of Agent____Phone #______________________________

Address ____

Insurance

Medicare #_______________________________ ______ Part A ______ Part B ______ Part D

Medicare Supplemental Insurance ____________________________ Plan ______________________________________

Long-Term Care Insurance __________________________________ Policy # ___________________________________

Other Insurance____ Policy # ___________________________________

Prescription Care____ Policy # ___________________________________

Have you executed a trust? ❑ **Yes** ❑ **No**

If you have executed a trust, please attach a copy to this application. This application will not be considered complete until a copy of any and all trust agreements executed by the applicant have been provided.

On admission, you will be asked to provide copies of all your insurance cards including: Medicare, Medicaid, SSI, Blue Cross, Blue Shield, Prescription Plan and/or other health insurance cards where applicable.

DECLARATION OF APPLICANT

In completing this application for admission I affirm that, to the best of my knowledge, the answers to the above questions are complete and accurate. I understand that the filing of this application does not obligate me to enter, nor does it guarantee admission to the applicable retirement community. It merely places my name on the waiting list.

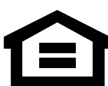
Applicant's Signature____**Date**______________________

State and Federal laws prohibit discrimination based on race, color, creed, sex, age, national origin, sponsor, handicap or source of payment.

For additional information regarding the Hilltop Campus and Elizabeth Church Campus, please contact **Residential Services Center, located at 286 Deyo Hill Rd., Johnson City, NY 13790, (607) 729-2305.**

For additional information regarding the Doris L. Patrick Campus, 88 Calvary Drive, Norwich, NY 13815,

Please contact (607) 336-3915.



Equal Housing Opportunity

NY Application, Revised 09/06

FOR OFFICE USE ONLY
Facility ______________________
Applicant ______________________

The Methodist Homes for the Aging
Of the Wyoming Conference, its Affiliates and Managed Facilities

Applicant's Financial Information Form

The following information is required by The Methodist Homes for the Aging of the Wyoming Conference, its Affiliates and Managed Facilities (the "Homes"). This information is used to determine whether the Homes is likely to be asked to contribute toward the future support of a resident and to determine whether the applicant has a source of payment. It will be held in confidence and not released to any persons, agency or party other than the Homes and the Homes' advisors unless so directed by the applicant or unless the resident defaults on any obligation to the Homes or release of such information is required or permitted by law.

Please complete the information requested below.

ASSETS

CASH ASSETS	Name and Address of Bank or Financial Institution	Account Number(s)	How Titled/Names	Balance
Checking Account(s)				
Saving Account(s)				
Certificates of Deposit				
Other				

If more, please attach on a separate sheet.

MARKETABLE SECURITIES	Name and Address of Financial Institution	How Titled/Names	Market Value
Stocks			
Bonds			
Mutual Funds			
Other			

ANNUITIES	Name of Company	Owner	Beneficiary	Approximate Value

REAL ESTATE ASSETS	Location	How Titles/Names	Approximate Value
Residential Home			
Other Real Property (e.g., summer home, commercial property, vacant land)			

IRA's/Retirement Accounts	Name of Company	Titled	Beneficiary	Approximate Value

LIFE INSURANCE	Company	Owner	Named Beneficiary	Cash Surrender Value
Paid Up Policies				
Life Policies Requiring Payment of Premiums				

LIABILITIES

Name and Address Of Creditor	Property Securing Debt	Monthly Payment	Amount of Debt/Amount of Mortgage

INCOME

Please indicate below the amount of income you receive from each of the following sources and whether this income is received monthly, quarterly, semi-annually or annually or on a periodic basis.

Source of Income	How Often Received i.e. monthly/annually	Amount
Social Security		
Supplemental Security		
Interest Income		
Dividend Income		
Pension		
Rental Income		
Annuity		
Disability Income		
Support from Relatives		
Public Assistance		
Veterans Benefits		
Trust Income		
Other		

The undersigned acknowledge(s) that the Homes is relying on their representations and promises set forth herein in considering the applicant for admission. We understand that if any information has been falsely represented, then that is sufficient cause for the Homes' denial of this Application for Admission.

The financial information set forth herein is a true and correct statement of the applicant's current financial position. The undersigned acknowledge(s) that the Homes considers this application as a continuing statement of the applicant's financial condition and the undersigned agree(s) to furnish the Homes with an updated financial statement as follows:

a) At any time there is a change in the applicant's financial condition; or
b) Once annually when requested by the Homes ; and
c) At any time the applicant is in need of a different level of care and/or desires to transfer to another facility owned or operated by the Homes or an affiliate of the Homes and the applicant is applying to such different level of care or facility; and
d) At any time requested by the Homes in writing.

If you have transferred or donated assets to other persons or entities, including trusts, in the past 60 months, please indicate exact dates and amounts below so we may review, in accordance with the SSI or Medicaid eligibility requirements. **Have you executed a Trust? Yes_____ No_____**

If you have executed a trust, please attach a copy to this application. This application will not be considered complete until copies of any and all trust agreements executed by the applicant have been provided.

Explanation regarding transfer or donation of assets. Please state the exact dates, the amounts, and the names of the persons receiving the gift or transfer

The undersigned further understand(s) that a gift by the applicant which disqualifies the applicant for Medicaid status for any period of time may constitute a "fraudulent conveyance" under the New York State Debtor and Creditor Law and that the Homes intends to pursue its legal rights against the applicant and any person to whom the applicant makes a gift which constitutes a fraudulent transfer.

The undersigned acknowledge(s) that the Homes may request additional information and/or disclosures prior to accepting the applicant for admission to any of its facilities, and the applicant's application for residency and this financial information form are not considered complete until all of such additional financial information and/or disclosures have been provided to the Homes and verified by the Homes. The undersigned hereby gives the Homes permission to verify all such additional financial information and/or disclosures with appropriate third parties.

The undersigned also acknowledge(s) that if the undersigned request(s) that the Homes provide financial assistance to the undersigned, the Homes may require the undersigned to provide additional financial information and/or disclosures. Such additional information and disclosures will need to be verified by the Homes with appropriate third parties prior to the grant of any such financial assistance. In such event, the undersigned hereby gives the Homes permission to verify all such additional financial information and disclosures with appropriate third parties.

The above information is affirmed under penalty of perjury this _____ day of _________________, 200____.

____

Applicant

____

Applicant

____

Financially Responsible Party for Applicant

A photocopy of this Application shall have the same effect as an original.

Equal Housing Opportunity