LONG TERM CARE
ADMISSION APPLICATION

Application Date _____

Contact Person of available opening _____ Relationship _____

Name of Applicant _____ Telephone # _____

Address _____ City _____ State _____ Zip _____

Social Security #: _____ Medicare #:_____

Medicaid #: _____ Supplemental Security Income: Yes No

Medical (Supplemental) Insurance: _____
Address: _____
Policy #: _____

Nursing Home Insurance Company: _____
Address: _____
Policy #: _____

Self Pay _____ Other _____

Date of Birth: _____ Birthplace: _____

Marital Status: Single Married Widowed Divorced

Father's name: _____ Birthplace: _____

Mother's maiden name: _____ Birthplace: _____

Spouse's name: _____

Living: Yes No Date of death: _____

Spouse's Birthdate: _____ Birthplace: _____

Date & Place of Marriage: _____

Applicant's Last Regular Occupation: _____

Hobbies & Past Interests: _____

Name & Address of Applicant's Church: _____

Name of Applicant's Doctor: _____
Address: _____

Where has applicant lived the past 5 years: _____

Education: _____ Military Service: _____

CHILDREN:

Name & Address	Age	Marital Status	Occupation	Telephone #
Name & Address	Age	Marital Status	Occupation	Telephone #
Name & Address	Age	Marital Status	Occupation	Telephone #
Name & Address	Age	Marital Status	Occupation	Telephone #
Name & Address	Age	Marital Status	Occupation	Telephone #

SIBLINGS: Brothers & Sisters

Name & Address	Age	Marital Status	Occupation	Telephone #
Name & Address	Age	Marital Status	Occupation	Telephone #
Name & Address	Age	Marital Status	Occupation	Telephone #
Name & Address	Age	Marital Status	Occupation	Telephone #
Name & Address	Age	Marital Status	Occupation	Telephone #

OTHER RELATIVES:

Name & Address	Age	Marital Status	Occupation	Telephone #
Name & Address	Age	Marital Status	Occupation	Telephone #
Name & Address	Age	Marital Status	Occupation	Telephone #

PLEASE LIST EMERGENCY CONTACT PERSON:

_____

Name Relationship Address Telephone #

Have you and/or your spouse transferred and/or gifted any assets to anyone (family, friends, etc.) during the past 5 years. Yes No

If yes, explain:

_____

_____

Do you and/or your spouse have a trust? Yes No

If yes: Type of trust: _____ Date established: _____

What is in it? _____ What is not? _____

Trustee: _____ Address: _____

Have you previously applied for Medicaid: Yes No

If yes: Date: _____ County: _____

Approved: Yes No

Do you have a:

Financial POA: Yes No Name: _____ Relationship: _____

Address: _____ Telephone #: _____

Durable POA for Healthcare: Yes No Name: _____

Address: _____ Telephone #: _____

Guardian: Yes No Name: _____

Address: _____ Telephone #: _____

Conservator: Yes No Name: _____

Address: _____ Telephone #: _____

Life Estate: Yes No Name: _____

Address: _____ Telephone #: _____

Health Care Directive: Yes No

Agent, if one appointed: _____ **Organ Donor:** Yes No

If you have transferred or gifted assets, have a Trust, Life Estate, or have granted someone financial POA; will you apply for Medicaid assistance and/or asset assessment through the County Social Services and will you authorize the County Social Services to release information to Tioga Medical Center regarding your application, eligibility, and/or reasons for denial, etc. Yes No

_____ _____

Signature of Applicant Date

_____ _____

Signature of Legal Representative/Responsible Party Date

NOTE: Please provide copies of the following:

1. Social Security Card
2. Medicare Card
3. Medicaid Notification
4. Insurance Card
5. Authorization papers for Power of Attorney (Financial&/or Healthcare), Guardianship, Conservatorship, Life Estate, etc.
6. Medicare Prescription Drug Plan Card
7. Healthcare Directive