



THE WESLEY COMMUNITY
WESLEY HEALTH CARE CENTER

PLACEMENT APPLICATION

The Wesley Community | 131 Lawrence Street | Saratoga Springs, NY 12866 | 518.691.1426 | www.TheWesleyCommunity.org

TO BE COMPLETED BY RESIDENT OR DESIGNATED REPRESENTATIVE

All questions must be answered and all information must be provided for this application to be considered by Wesley. If you need help completing this form, call Admissions Financial Coordinator at (518) 691-1409.

General Information:

Applicant's Name: _____ Date of Birth: ___ / ___ / ___

Age: _____ Marital Status: _____ Religion: _____

Social Security #: _____ Sex: _____

Street Address (Do not use PO Box): _____

City: _____ State: _____ Zip: _____ County: _____

Applicant's present location: _____

Date of Admission: ___ / ___ / ___ Email address: _____

Has the applicant had any Skilled Nursing Facility stays within the last 60 days? Yes No

If yes, please include the following Facility Information:

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Facility Phone Number:(_____) _____ Admittance Date: _____ Discharged Date: _____

Please check one. [] Application is for placement [] Application is for rehabilitation and discharge

Resident Representatives: Please list in order of emergency contact

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Home #: _____ Home #: _____

Cell/work #: _____ Cell/work #: _____

Email: _____ Email: _____

Contractual Agreements: Does applicant have any of the following? If yes, please attach a copy to this application.

POA? Yes No Living Will? Yes No
Guardian/Conservator? Yes No Health Care Proxy? Yes No
VA Status? Yes No DNR? Yes No

Applicant Name: _____

Funeral Home Information: _____

Person responsible for handling financial transactions:

Name: _____ Relationship: _____

Address _____

Home #: _____ Work/Cell #: _____

Email: _____

Insurance Information:

MEDICARE

Medicare#: _____ Effective Date: ___ / ___ / ___

Medicare coverage for Part A, Part B, or Both? Part A Part B Both

Is this a Medicare HMO? Yes No

If yes, what is the name of the insurance? _____

Drug coverage plan name/ID#: _____

Supplemental Insurance Company Name/Address: _____

ID#: _____ Plan#/Name: _____

Insurance Company Phone Number: _____

Does the applicant have Long Term Care coverage? Yes No *If Yes, please provide the following:*

Insurance Company Name and Address: _____

Insurance Company Phone Number: _____ Policy #: _____

MEDICAID

Medicaid ID#: _____ County: _____

Has the applicant applied for Medicaid? Yes No

If Yes, when was the appointment? _____

Has all information requested been provided to Medicaid? Yes No

Case worker name/ number: _____

Are you currently working with an Attorney or Medicaid planner for Yes No

Medicaid planning purposes?

If yes: Applicant Name: _____

Please list their name, address and phone number here: _____

May we contact them for information if needed? Yes No

Does the applicant and/or spouse have life insurance? Yes No

If yes, what are current cash values? _____

Financial Information: *All information provided here is subject to verification.*

INCOME *Please list all monthly household income:*

Source of Income	Applicant	Spouse
Social Security	\$ _____	\$ _____
SSI	\$ _____	\$ _____
Pension(s)	\$ _____	\$ _____
Source	\$ _____	\$ _____
Veterans	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Interest/Dividends	\$ _____	\$ _____
Annuity/IRA Income	\$ _____	\$ _____
Trust Income	\$ _____	\$ _____
Other Income	\$ _____	\$ _____
Alimony	\$ _____	\$ _____

ASSETS

Does the applicant own a home? Yes No

If yes, Jointly owned? Yes No With whom? _____

Estimated Value: \$ _____ Current Mortgage Balance: \$ _____

Does applicant have life estate in any property? Yes No If yes, date established: _____

If yes, Applicant Name: _____

Please list any other properties owned by applicant and their values: _____

Has any home or property been sold or transferred in the last 5 years? Yes No

If yes: Sale Date _____ Amount of Sale: \$ _____

Address of Property _____

BANK ACCOUNTS – Please list all accounts here including CDs, Savings, Checking, Money Markets, etc.

Bank: _____ Bank: _____

Current Balance: \$ _____ Current Balance: \$ _____

Joint owner's name: _____ Joint owner's name: _____

Please continue on another page if more space is needed.

INVESTMENTS - Please list all stocks, bonds, savings bonds, annuities, mutual funds or other investments here. Continue on a second page if needed.

Bank/Brokerage Company: _____ Owner(s): _____ Current Value: \$ _____

Type of Investment: _____ Owner: _____

Bank/Brokerage Company: _____ Owner(s): _____ Current Value: \$ _____

Type of Investment: _____ Owner: _____

Please continue on another page if more space is needed.

GIFTING INFORMATION: (This includes birthday, wedding, graduation gifts, charitable gifting, Tithing, etc.)

Has the applicant gifted or given away any funds, property or assets, to anyone in the last 5 years? Yes No

If yes, When? _____

How much was given? \$ _____

To Whom? _____

TRUST INFORMATION:

Has a Trust been established? Yes No
If yes, When? _____

Is the Trust Revocable or Irrevocable? Revocable Irrevocable
How much was placed in Trust? \$ _____

Have any funds been transferred into the trust since its inception? Yes No
If yes, When? _____
How much? \$ _____

Please provide a copy of the trust with this application.

Are the transferred/gifted funds still available if it is determined that the transfer/gift will disqualify the resident for Medicaid? Yes No

ANNUITY INFORMATION:

On or before February 8, 2006, have you purchased an annuity? Yes No
If yes, date of annuity purchase: ___ / ___ / _____

Is the State of New York named a remainder beneficiary in either the first or second position? Yes No

Is the annuity irrevocable and non-assignable? Irrevocable Non-assignable

Is the annuity actuarially sound? Yes No

Does the annuity provide for equal payments for the term of the annuity? Yes No

Does the annuity provide for deferred payments or balloon payments? Deferred Balloon

NOTE/LOAN/MORTGAGE INFORMATION:

On or after February 8, 2006, have you purchased a promissory note, Yes No
loan or mortgage?

If you answered yes provide:

Applicant Name: _____

Date purchased: ___ / ___ / ___

Please provide a copy of the note, loan or mortgage purchased, Yes No
and is the repayment term actuarially sound?

Does the note, loan or mortgage provide for payments to be made Yes No
in equal amounts during the term of the loan, note or mortgage?

Does the loan, note or mortgage provide for deferred payments or Deferred Balloon
balloon payments?

Does the note, loan or mortgage provide for cancellation of the Yes No
balance upon your death?

Have you purchased a life estate interest in another Yes No
individual's home on or after February 8, 2006?

If you answered yes:

Date purchased: ___ / ___ / ___

Have you resided in that individual's home for a period of at Yes No
least one year after the date of purchase of the life estate interest?

Applicant Acknowledgement:

Applicant Name: _____

You may be required to provide documentation to support the information provided on this application.

The applicant and/or Responsible party hereby state that the information provided on this application is complete and accurate to the best of my knowledge. As the financially responsible party, I hereby agree not to transfer or otherwise dispose of assets which would render the resident ineligible for Medicaid coverage.

If the applicant is capable of signing, both the applicant and financially responsible party should sign here. If the applicant is not capable of signing, the financially responsible party should sign as a representative and should also sign the applicant's name as POA. This should be signed as follows: (applicant name) by (POA Name) as agent for (applicant name)

Signature of Representative (POA)

___/___/___
Date Signed

Signature of Representative (POA)

___/___/___
Date Signed