Application for Admission

M.M. Ewing Continuing Care Center

APPLICANT INFORMATION

Name _____ _____ _____
LAST FIRST MIDDLE INITIAL

Social Security # _____

Address _____

City _____ State ____ ZIP _____

Phone _____

Date of Birth _____ Age _____ ☐ Male ☐ Female Religious Preference _____

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Spouse: _____ _____ _____
LAST FIRST MIDDLE INITIAL

If deceased,spouse's date of death _____

PRIMARY CARE PHYSICIAN

_____

If applicant is currently hospitalized or has been hospitalized within the last 30 days, list below:

HOSPITAL _____ ADMISSION DATE _____ DISCHARGE DATE _____

If applicant has had a previous skilled-nursing facility stay within the past year, please list the loction and time frame below:

FACILITY _____ ADMISSION DATE _____ DISCHARGE DATE _____

350 Parrish St., Canandaigua, NY 14414
Phone: (585) 396-6021 | Fax: (585) 396-6026
Email: ccc.admissions@thompsonhealth.com

FINANCIAL INFORMATION

PERSONAL FINANCIAL STATEMENT

MONTHLY INCOME SOURCE	APPLICANT	SPOUSE	TOTAL
Social Security			
SSI (Social Security Supplemental Income)			
Pension/Retirement			
Veterans Benefits			
Interest/Dividends/Annuity Income			
Other			
Total Monthly Income			

MONTHLY EXPENSE	APPLICANT	SPOUSE	TOTAL
Health Insurance Premiums			
Mortgage			
Other			
Total Monthly Expense			

Has the applicant or spouse established and funded a trust? ☐ Yes ☐ No

Date trust was established _____ Value of trust _____ Date of last transaction _____

Has applicant transferred any assets in past 60 months (i.e., money, stock, real estate)? ☐ Yes ☐ No

Describe transfer _____ Date of transfer _____ Value of transfer _____

Liquid Assets owned by applicant and/or spouse

ASSETS	DESCRIPTION	NAME(S) ON ASSETS	CURRENT VALUE
Savings Account			
Checking Account			
Retirement Account			
Stocks and Bonds			
Other Assets			
Life Insurance ☐ Term ☐ Whole Life			

TOTAL ASSETS _____

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Funeral Arrangements Does the applicant have prepaid funeral arrangements ☐ Yes ☐ No

Name and location of funeral home: _____

Phone: _____

Real Estate Property

ADDRESS	NAME(S) ON PROPERTY	CURRENT VALUE
_____	_____	_____
_____	_____	_____

Is there a spouse, disabled adult or child living in the home? ☐ Yes ☐ No

Current Liabilities (mortgages, taxes, loans and other debts)

NAME OF LIABILITY	OUTSTANDING BALANCE
_____	_____
_____	_____

THE RESIDENT AND/OR THE RESIDENT'S FINANCIAL GUARANTOR IS RESPONIBLE FOR ALL CHARGES NOT COVERED BY MEDICARE OR OTHER INSURANCE CARRIERS

State and federal laws prohibit discrimination in admission, retention and care of residents on the basis of race, creed, color blindness, marital staus, disability, national origin, sex, sexual preference, source of payment, sponsorship, or age.

I declare (pursuant to 28 U.S.C. Section 1746) under penalty of perjury that the foregoing is true and correct, and I certify that all information on this application is accurate, true and complete.

Applicant's Signature _____ *Date* _____

Designated Representative _____ *Date* _____