

MEADOWBROOK HEALTHCARE
ADMISSION FINANCIAL DISCLOSURE
154 Prospect Avenue, Plattsburgh, NY 12901
Telephone (518) 563-5440, Fax (518) 563-1206

I. GENERAL INFORMATION

Date: _____

PATIENT INFORMATION:

Last: _____ First: _____ Initial: _____

Address: _____

City: _____ State / Zip: _____

Age: _____ Date of Birth: _____ Sex: _____

Where is the applicant at this time? _____

II. INSURANCE INFORMATION

Medicare: _____

Other Insurance: _____

Medicaid Application Pending: YES NO If yes, date submitted: _____ County: _____

First Contact: _____ Second Contact: _____

Address: _____ Address: _____

City: _____ City: _____

State / Zip: _____ State / Zip: _____

Home Phone: _____ Home Phone: _____

Work / Cell Phone: _____ Work / Cell Phone: _____

Status: (Please Check) Power of attorney
 Legal Guardian Health care proxy
 Person Responsible for handling Financial Transactions

Status: (Please Check) Power of attorney
 Legal Guardian Health care proxy
 Person Responsible for handling Financial Transactions

III. Patients Marital Status: Single Married Widowed Separated Divorced

U.S. Citizen Yes No

Primary Physician:

Name: _____ Phone: _____

MEADOWBROOK HEALTHCARE
ADMISSION FINANCIAL DISCLOSURE
PAGE 2

IV. FINANCIAL DISCLOSURE (All information is kept confidential)

INCOME	MONTHLY AMOUNT (For Applicant)	MONTHLY AMOUNT (For Spouse if applicable)
Social Security	\$ _____	\$ _____
Retirement Pension	\$ _____	\$ _____
Veteran's Pension	\$ _____	\$ _____
Railroad Pension	\$ _____	\$ _____
Supplementary Security Income	\$ _____	\$ _____
Annuities	\$ _____	\$ _____
Other Income	\$ _____	\$ _____
Total Combined Monthly Income	\$ _____	

ASSETS: INCLUDE ASSETS FOR BOTH PATIENT AND SPOUSE

(Please attach additional information if needed)

CHECKING ACCOUNTS:

Bank Name: _____
Account Balance \$ _____ Joint Account: Yes No

SAVINGS ACCOUNTS:

Bank Name: _____
Account Balance \$ _____ Joint Account: Yes No

OTHER ACCOUNTS:

Bank Name: _____
Account Balance \$ _____ Joint Account: Yes No

CERTIFICATES OF DEPOSIT:

Bank Institution: _____ Balance: \$ _____

INVESTMENTS (e.g. stocks, bonds, 401K, etc.) and OTHER ASSETS

Amount

- | | |
|----------|----------|
| 1. _____ | \$ _____ |
| 2. _____ | \$ _____ |
| 3. _____ | \$ _____ |

MEADOWBROOK HEALTHCARE
ADMISSION FINANCIAL DISCLOSURE
PAGE 3

Does the patient own a HOME: Yes No Estimated Value\$ _____

If yes, is the home jointly owned with anyone? _____

Does the patient have LONG TERM CARE INSURANCE: Yes No Company _____

Does patient or spouse have LIFE INSURANCE?

Patient Yes No Company _____ Face Value _____ Cash Value _____

Spouse Yes No Company _____ Face Value _____ Cash Value _____

Has an ESTATE or FAMILY TRUST been established: Yes No

If yes, date established _____ Please provide copy

Do you have Legal Representation for financial affairs at current time? Yes No

Have any assets been transferred in the last 60 months that may disqualify you from Medicaid eligibility? Yes No

If yes, please describe: _____

I, the undersigned, personally agree to use my access to the Resident's funds to ensure continuity of payment and agree not to use the Resident's funds in a manner that places the Facility in a position where it cannot receive payment from either the Resident's funds or Medicaid. If I receive a transfer of assets from the Resident that causes such non-payment, I agree to use such assets or an amount equal to such assets to assume continuity of payment until Medicaid covers such costs.

To the best of my knowledge, all the information provided is correct and valid. I understand that the Information contained in this form will be shared with local department of Social Services for the purpose of determining Medicaid eligibility.

X _____
Signature of Patient or Responsible party

Date

The information provided shall remain confidential and shall be made available only to authorized hospital and nursing home personnel involved in the placement process and to any governmental officials authorized access by law to such records.