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:_____

Social Security # _ _ _ - _ _ - _ _ _ _ Age:____ Date of Birth: _ _ / _ _ / _ _ _ _ Gender:_____

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

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III. Patients Marital Status: □Single □Married □Widowed □Separated □Divorced

U.S. Citizen □Yes □No

Primary Physician:

Name:_____Phone:_____

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._____	$_____

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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 a 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.