



FINANCIAL DISCLOSURE

Corporate Admissions office
700 East Brighton Avenue
Syracuse, New York 13205

◆ Phone (315) 413-3400 ◆ Fax (315) 492-0765

PART OF OUR RESPONSIBILITY TO OUR RESIDENTS IS TO INSURE THEIR ABILITY TO AFFORD THEIR COST OF CARE. PLEASE ASSIST US BY PROVIDING A GENERAL OVERVIEW OF YOUR FINANCIAL STATUS TO DETERMINE IF WE MAY ASSIST YOU.

ANY SERVICES NOT COVERED BY MEDICARE AND/OR INSURANCE ARE THE RESPONSIBILITY OF THE INSURED.

IT IS THE RESIDENTS AND/OR REPRESENTATIVES RESPONSIBILITY TO PROVIDE LORETTO WITH THE PROPER INFORMATION IN A TIMELY MANNER.



Financial Disclosure Statement

PERSONAL INFORMATION:

Applicant's Name: _____
First Middle Last

Present Address: _____

Home Phone Number: _____ Date of Birth: _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed _____ Legally Separated

Social Security Number: _____

Religion: _____ Race: _____ Veteran/Spouse of Veteran: _____

Name of Spouse: _____
(even if deceased)

Address: _____

DOB: _____ Social Security Number: _____

Health Insurance Coverage:

(Please provide copies of any marked "yes")

ApplicantSpouse

Medicare: Part A Yes No

Medicare: Part A Yes No

Part B Yes No

Part B Yes No

Part D Yes No

Part D Yes No

Medicare #: _____

Medicare #: _____

Medicaid: Yes No

Medicaid: Yes No

If yes, Medicaid # _____

If yes, Medicaid # _____

Blue Cross: Yes No

Blue Cross: Yes No

Contract #: _____

Contract #: _____

Blue Shield: Yes No

Blue Shield: Yes No

Contract #: _____

Contract #: _____

Group # / Plan #: _____

Group # / Plan #: _____

Other Insurance:

Policy #: _____

Previous Nursing Home Stay: _____

(Must be completed by each individual; joint holdings must so be noted)

Sources of *current* monthly income (*record actual amount*)

Applicant	Spouse	
\$ _____	\$ _____	Social Security
\$ _____	\$ _____	SSI (ceases upon nursing home placement)
\$ _____	\$ _____	Veterans Pension
\$ _____	\$ _____	Railroad Pension Retirement # _____
\$ _____	\$ _____	Other Pension _____ # _____
\$ _____	\$ _____	Dividends
\$ _____	\$ _____	Interest
\$ _____	\$ _____	IRA / TDA / TSA
\$ _____	\$ _____	Trust
\$ _____	\$ _____	Other income (list sources) _____
\$ _____	\$ _____	Other income (list sources) _____

\$ _____

\$ _____

Total Monthly Income

Applicant: **Financial Institution:** _____

<i>Type of account</i>	<i>Account number</i>	<i>Balance or Market value</i>	<i>"As of" date</i>	<i>Applicant or Spouse</i>
Checking				
Savings				
Certificate of deposit				
Money Market				
Mutual Funds				
Stocks				
Bonds				
IRA account				
Annuities				
Other:				
Life Insurance	Policy # _____	Face value \$ _____		
		Cash value \$ _____		

Spouse: **Financial Institution:** _____

<i>Type of Account</i>	<i>Account number</i>	<i>Balance or Market value</i>	<i>"As of" date</i>	<i>Applicant or Spouse</i>
Checking				
Savings				
Certificate of deposit				
Money Market				
Mutual Funds				
Stocks				
Bonds				
IRA account				
Annuities				
Other:				
Life Insurance	Policy # _____	Face value \$ _____		
		Cash value \$ _____		

Applicant: **Financial Institution:** _____

<i>Type of account</i>	<i>Account number</i>	<i>Balance or Market value</i>	<i>"As of" date</i>	<i>Applicant or Spouse</i>
Checking				
Savings				
Certificate of deposit				
Money Market				
Mutual Funds				
Stocks				
Bonds				
IRA account				
Annuities				
Other:				
Life Insurance	Policy # _____	Face value \$ _____		
		Cash value \$ _____		

Spouse: **Financial Institution:** _____

<i>Type of Account</i>	<i>Account number</i>	<i>Balance or Market value</i>	<i>"As of" date</i>	<i>Applicant or Spouse</i>
Checking				
Savings				
Certificate of deposit				
Money Market				
Mutual Funds				
Stocks				
Bonds				
IRA account				
Annuities				
Other:				
Life Insurance	Policy # _____	Face value \$ _____		
		Cash value \$ _____		

Safe Deposit Box? ☐ Yes ☐ No If yes, Financial Institution: _____

Address of Financial Institution: _____

Real Estate Assets (Please provide addresses):

Home: _____ Market value: _____

Additional property: _____ Market value: _____

_____ Market value: _____

Rental property? ☐ Yes ☐ No If yes, Address: _____

Rental income: \$_____ per month \$_____ per year.

Please list all debts & obligations: (specify type of debt and the amount)

Description of debt/obligation	Amount
A) _____	\$ _____
B) _____	\$ _____
C) _____	\$ _____
D) _____	\$ _____

HAS THERE BEEN ANY TRANSFER OF ASSETS WITHIN THE LAST FIVE YEARS?

_____ ☐ Yes

_____ ☐ No

If yes, list what was transferred, \$ amount or value of transfer (s), as well as date of transfer, and to whom?

Asset Transferred	\$ amount or value	Date of transfer	Receiver
A) _____	\$ _____	_____	_____
B) _____	\$ _____	_____	_____
C) _____	\$ _____	_____	_____
D) _____	\$ _____	_____	_____

Is there a trust? _____ ☐ Yes

_____ ☐ No

If yes, complete the following information:

Attorney's Name: _____

Attorney's Firm: _____

Attorney's Address: _____ Phone Number: _____

Date Trust was established: _____

EMERGENCY INFORMATION:

In case of Emergency, who should be notified:

- 1) Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Work Phone: _____
- 2) Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Work Phone: _____

Physicians:

Primary Care Physician: _____ Phone #: _____
Address: _____ Emergency Phone#: _____

Other Health/Mental Health Providers:

Name: _____ Specialty: _____
Address: _____ Phone #: _____
ame: _____ Specialty: _____
Address: _____ Phone #: _____

IMPORTANT NOTICE:

Please be aware that insurance is not a guarantee of payment and that all claims submitted to an insurance carrier are subject to review by the carrier and that all services must be medically necessary as defined by the insurance company.

Any services not covered by insurance are then the responsibility of the insured.

FINANCIAL DISCLOSURE STATEMENT

PLEASE NOTE:

Both Federal and State laws impose severe penalties for obtaining Medicaid fraudulently. Therefore, you must provide an accurate and complete financial disclosure statement, which is required to decumbent the nature and use of your assets. This completed section of Loretto Financial Disclosure Statement may be used in the future, if necessary, to substantiate your request and application for Medicaid.

Please be advised that effective August 10, 1993, Federal Law prohibits the transfer of assets for 60 months (5 years) prior to applying for Medicaid.

I hearby declare that all statements made herein are true to the best of my knowledge. I authorize you to verify the financial information through credit checks and inquiry to financial institutions.

Resident's Signature: _____ Date: _____

Resident's Representative's Signature: _____ Date: _____

Admission's Finance Unit
Representative's Signature: _____ Date: _____

Admission's Signature: _____ Date: _____

Administrator's Signature: _____ Date: _____

(Where applicable)
Notes: (please sign and date each note)

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