The Commons on St. Anthony A Loretto Community

Skilled Nursing & Short-Term Rehabilitation

RESIDENCY APPLICATION AND FINANCIAL DISCLOSURE

If you have any Admissions questions, please contact Beth Rabuano, RN Director of Admissions at:

- **P: (315) 282-6849**
- **F: (315) 255-0472**
- brabuano@lorettosystem.org

3 St. Anthony Street • Auburn, NY 13021
(315) 253-0351 • Fax: (315) 253-7445 • lorettocny.org/comoms

The Commons on St. Anthony A Loretto Community

Personal Information:
Applicant's Full Name: _____ Date of Birth: ____/____/_____
Social Security Number:_____Religion:_____

Current Address:_____
County: _____ Number of Years: _____
Home Phone Number: _____

Previous Address:_____
County: _____ Number of Years: _____

Marital Status: ___ Single ___ Married __ Divorced __ Widowed __Legally Separated
Name of Spouse (even if deceased):_____Date of Marriage: _____
Social Security Number: _____Date of Birth: _____
Date of Death: _____ Address (if applicable):_____

Health Insurance Coverage: (Provide copies of cards for all that apply)

	Applicant	**Spouse**
Medicare	**Part A** Yes No **Part B** Yes No Medicare #:	**Part A** Yes No **Part B** Yes No Medicare #:
Medicaid Yes No Applying	Medicaid #: _____ Effective Date: ____/____/____	Medicaid #: _____ Effective Date: ____/____/____
Managed Medicaid, VNA, Fidelis, UHC or Total Care (circle one)	Medicaid #: _____ Effective Date: ____/____/____	Medicaid #: _____ Effective Date: ____/____/____
Medicare Supplemental Insurance	Name: Address: Policy #:	Name: Address: Policy #:
Medicare D Prescription Plan	Name: Address: Policy #:	Name: Address: Policy #:

Health Insurance Premium Amount: _____

The Commons on St. Anthony A Loretto Community

Emergency Contacts:

	Primary	Secondary
Name		
Relationship		
Address		
Home Phone		
Work Phone		
Cell Phone		
Email address		

Physicians:

	Primary	Other
Name		
Phone		
Address		
Emergency		
Specialty		

Hospital Preference: _____

Monthly Income Amount:

Source	Applicant	Spouse
Social Security		
SSI (ceases upon NH placement)		
Veterans Pension		
Railroad Retirement Pension		
Other Pension _____		
IRA/TDA/TSA		
Trust Income		
Other _____		
Total Monthly Income		

The Commons on St. Anthony A Loretto Community

ASSETS: (Provide copies of current statements for all that apply)

Type of Account	**Institution Name**	**Balance/Mkt Value**	**"As of" Date**	**Applicant or Spouse**
Checking Acct (1)				
Checking Acct (2)				
Savings Acct (1)				
Savings Acct (2)				
Direct Express Card				
CD (1)				
CD (2)				
Investment Funds				
Stocks/Bonds				
Annuity/IRA				
Other				

Life Insurance:	**Ins Co. Name**	**Face Value**	**Cash Value**	
Life Ins. Policy (1)				
Life Ins. Policy (2)				

Property Owned:

Home Address: _____ Market Value:_____

Rental/Other Property Address: Market Value: _____

Life Use Estate Address: Market Value: _____

Funeral Information:

Pre-paid burial? Yes_____ No_____Funeral Home Name: _____

Cemetery Name: _____

Has either the applicant or spouse ever been in the Military? Yes____ No____

If yes, who _____

3 St. Anthony Street • Auburn, NY 13021
(315) 253-0351 • Fax: (315) 253-7445 • lorettocny.org/commons

The Commons on St. Anthony A Loretto Community

Medical Debts Outstanding: **Amount Owed:**

1._____

2._____

3._____

4._____

5._____

6._____

Has the applicant and/or spouse created a Trust? Yes____ No_____
Date established:_____ Attorney Name:_____

Is the applicant or spouse currently working with an attorney? Yes_____ No____
If yes, Attorney Name: _____ Phone:
_____

Transfer of Assets within the last five years:

Asset Transferred	$ Amount or Value	Date of Transfer	Receiver Name

Applications expire after 30 days.

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

The Commons on St. Anthony A Loretto Community

assets. This completed section of The Commons on St. Anthony Residency Application and Financial Disclosure Statement may be used in the future, if necessary, to substantiate your request and application for Medicaid.

Please be advised that effective 2006 Federal Law prohibits the transfer of assets for 60 months (5 years) prior to applying for Medicaid.

I hereby 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.

_____ _____

Applicant or Representative Signature **Date**

_____ _____

Administrator Signature **Date**