SAMARITAN LONG TERM CARE APPLICATION FOR ADMISSION

Please Circle one: Assisted Living or Skilled Nursing

Applicant Name: _____ Telephone Number: _____

Address: _____

Present Location: _____

Primary Care Physician: _____ Phone#: _____

Religion: _____ Church: _____

Have you been hospitalized in the past 90 days: ___ Yes ___ No

If yes, where: _____

Sex: __M __F Date of Birth: _____ Place of Birth: _____

Marital Status: _____ Name of Spouse: _____

Placement discussed with resident on: (date) _____ by _____.

Reaction to discussion of placement: _____

Persons To Be Notified:

1. Name: _____ Relationship: _____ HCP: __No __Yes
Address: _____

Telephone Number: Day: _____ Evening: _____

2. Name: _____ Relationship: _____ POA: __No __Yes

Address: _____

Telephone Number: Day: _____ Evening: _____

Person/Agency Responsible for Payment: _____

Address: _____ Telephone Number: _____

Do you have a Health Care Proxy: ___ Yes ___ No * please note: HCP must be 1st contact.

If yes, name: _____ Telephone Number: _____

Do you have a Guardian appointed by Court? _____Yes _____No. If yes, please provide name, address and telephone number: _____

_____

Financial Information:

Presently receiving SSI: ___ No ___ Yes Social Security #: _____

Medicare #: _____ Medicaid #: _____ Medicaid Worker _____

County (or Counties of Residence): _____

Do you have a Medicaid appointment: ___ Yes ___ No If yes, date: _____

Long Term Care Insurance & Policy#: _____ Telephone Number: _____

Other Health Insurance & Policy#: _____ Telephone Number: _____

Prescription Insurance/Medicare D Plan: _____

Do you need prior approval: ___ Yes ___ No

Veteran Status: ___ Non-veteran ___ Veteran ___ Veteran Related

United States Citizen: ___ Yes ___ No, if No, Previous

Occupation: _____

Previous Employer(s): _____

Does the Applicant have a prepaid funeral arrangement? ☐ Yes ☐ No If yes, state the name and phone number of Funeral Home and the amount already remitted to the Funeral Home:

Cemetery Plot? ____ Yes or ____ No

Name of Cemetery: _____

Monthly Income Source	Applicant	Spouse	Total Income
Social Security			
SSI/SSDI			
Pension/Retirement			
Veterans Benefits			
Interest/Dividends/Annuity Income			
Other (i.e. rental income)			
Total Monthly Income			

Monthly Expense	Applicant	Spouse	Total Expenses
Health Insurance Premiums			
Mortgage			
Other (taxes, utilities, cable, phone, etc.)			
Total Monthly Expense			

Does the Applicant have a Trust which he/she created or is the beneficiary of? ☐ Yes ☐ No

Date trust was established	Type of trust	Value of trust

*****A copy of the trust must be provided prior to admission.*****

Has the Applicant transferred any of his/her assets in the past 60 months (i.e. money, stock, real estate)? ☐ Yes ☐ No

Describe Transfer(s) (including gifts):

Date of Transfer(s) and Recipient of Transfer(s)	Asset(s) Transferred and Value(s)

*****If any of the Transfers has been made within the past 60 months, Applicant must provide copies of cancelled check(s), deed(s), or other evidence documenting the Transfer(s) prior to admission.*****

Applicant's Liquid Assets (include all checking, savings, CD's, IRA's, Annuities, Mutual Funds, Stocks/Bonds, Life Insurance, or any other investments) Please attach current copies of all.

Assets	**Financial Institution & Account Number**	**Name(s) on Assets**	**Current Value**
Savings			
Checking			
Retirement			
Stocks and Bonds			
Other Assets			
Life Insurance	Term Whole Life		
TOTAL			$

Real Property (Must explain Applicant's and Spouse's Ownership Interest) _____

Real Property Address	Owner (s) of Property	Current Value

Please be sure all questions have been answered.

Important Notice:

Please provide copies of bank and/or investment account statements to verify assets; the first two pages of most recent IRS Form 1040; the interest and dividend schedule from your most recent income tax return; and records or gifts in excess of $2,000 made by Applicant and Spouse within the last five years.

Copies of all Advance directives (HCP, POA, MOLST, Living Will, DNR), and All insurance cards, Social Security Card, LTC Policy, and Guardianship Papers, must be submitted with the Application.

Samaritan Inc. relies on the information disclosed in this application in making decisions regarding admission. Unless otherwise stated, this application may be shared with any of Samaritan Inc.'s affiliates.

Submission of an application does not guarantee admission or a spot on a wait list. Placement is offered only after an application is reviewed and approved by Samaritan Inc.

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I, _____, attest that the information reported in this application is true and accurate. I understand that Samaritan Inc. is relying on the information disclosed in this application in making decisions regarding admission of the Applicant herein. I agree to supplement this application if there are any changes to the asset, liability or income information disclosed in this application.

*Effective November 15, 2007, All Samaritan Health Facilities are now Tobacco free. Individuals are not permitted to smoke on grounds. All tobacco, including electronic cigarettes are prohibited on facility grounds.

Signature of Person Completing Form: _____ Date: _____

Federal and State law prohibit the SNF from denying admission to anyone because of race, creed, color, national origin, sex, handicap, marital status, source of payment, sexual preference, or presence or absence.

Samaritan Health
Watertown, New York

Place patient identification sticker here

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:	Date of Birth:	MR #:
Address:		Phone:

I hereby authorize:

TO:

- ☐ Samaritan Medical Center, 830 Washington Street, Watertown, NY 13601
- ☐ Samaritan Keep Nursing Home, 133 Pratt Street, Watertown, NY 13601
- ☒ Samaritan Summit Village, 22691 Campus Drive, Watertown, NY 13601
- ☐ Samaritan Family Health Center, Location: _____
- ☐ Other: _____

to release personal health information from the medical records of the above named patient:

From: _____

Name & Address of Person/Organization to which disclosure is to be made

For the following purpose: _____

For the following dates of service (must be completed): _____

Type of Access Requested		Select Portions Requested	
☒ Copies of record	☐ Entire Record	☒ Labs	☒ MD Progress Notes
☐ View Record Only	☐ Emergency Room Visit	☒ Imaging/Radiology (most recent)	☐ MD Orders
☒ Face Sheet	☒ History & Physical	☐ Cardiac/EKG	☒ Other: Last Two Office Visit Notes and Shot Record.
	☒ Consultations (if any)	☒ Discharge Summary	
	☐ Operative/Procedure	☐ Pathology Report Only	

This authorization expires on _____ unless otherwise revoked or 90 days from the date signed below.

I, the undersigned, request that the health information regarding my care and treatment be released as indicated on this form.

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996, I understand that:

1. *I have the right to revoke this authorization at any time (except to the extent that information has already been released based on this authorization) by notifying Samaritan's Health Information Management Department in writing. My written request to revoke this authorization must be signed, dated and sent to: Samaritan Medical Center, Medical Records, 830 Washington Street, Watertown, New York 13601.*
2. *Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.*
3. *Information disclosed by this authorization might be re-disclosed by the recipient and may no longer be protected by federal or state law. I release and discharge this facility of any liability and hold this facility harmless for complying with this "Authorization for Release of Medical Information".*

_____ Print Name

_____ Date

_____ Signature of Patient/Legal Representative

_____ Relationship/Authority

We may impose a reasonable, cost-based fee, in compliance with all laws and regulations applicable to release of information.

Federal Register, Department of Health & Human Services, 45 CFR, Standards for Privacy of Individually Identifiable Health Information, Section 164.524

Please list method used to verify identity if records are to be hand delivered.