

LUTHERAN HOME AND REHABILITATION CENTER  
715 Falconer Street, Jamestown, NY 14701-1935

FINANCIAL STATEMENT

Name of Applicant: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Number Street City State Zip Code

Who do you live with? \_\_\_\_\_ Relationship: \_\_\_\_\_

Recent Hospitalizations: Hospital \_\_\_\_\_ Dates: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Is this insurance an HMO? \_\_\_\_\_ yes \_\_\_\_\_ no Does this insurance cover prescriptions? \_\_\_\_\_

Does this policy cover long-term care in concurrence with Medicare? \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Do you have Medicare Part D? \_\_\_\_\_ yes \_\_\_\_\_ no Policy Name and Number \_\_\_\_\_

Other Health Insurance: \_\_\_\_\_ Policy Number \_\_\_\_\_

Veteran? \_\_\_\_\_ yes \_\_\_\_\_ no Branch of Service: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Church Affiliation: \_\_\_\_\_ Pastor: \_\_\_\_\_

U.S. Citizen? \_\_\_\_\_ yes \_\_\_\_\_ no If not, give Alien Registration No. \_\_\_\_\_

Name of Personal Physician: \_\_\_\_\_

Have you given anyone Power of Attorney?

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Do Not Resuscitate Order? \_\_\_\_\_ yes \_\_\_\_\_ no Living Will? \_\_\_\_\_ yes \_\_\_\_\_ no

Health Care Proxy? \_\_\_\_\_ yes \_\_\_\_\_ no Other? \_\_\_\_\_

If yes, please provide Agent's name, address and phone: \_\_\_\_\_

**In the event of an emergency, notify:**

NAME/RELATION ADDRESS/EMAIL PHONE/CELL

Other Relatives:

NAME/RELATION ADDRESS/EMAIL PHONE/CELL

Funeral Home: \_\_\_\_\_  
(Name of Funeral Director) (Address) (Phone)

Date: \_\_\_\_\_ Signature of applicant, if able: \_\_\_\_\_

**PLEASE PRINT CLEARLY**

HAVE YOU TRANSFERRED REAL ESTATE/STOCKS/MONEY TO ANOTHER PARTY WITHIN THE LAST 60 MONTHS (5 years)? \_\_\_\_\_ yes \_\_\_\_\_ no. If yes, please provide a brief summary on the back of this sheet.

LIABILITIES: Major Outstanding Debts (Mortgages, Loans, etc.)

REAL ESTATE: \_\_\_\_\_ VALUE \$ \_\_\_\_\_

MONTHLY INCOME: (Please provide details) \_\_\_\_\_

The approximate monthly cost of skilled nursing care is \$8000. Based upon this figure, would the applicant have resources to cover: (Please check appropriate length of time)

\_\_\_\_\_ 1 – 3 months \_\_\_\_\_ 4 – 6 months \_\_\_\_\_ 7 – 12 months \_\_\_\_\_ over 1 year \_\_\_\_\_ unable to pay privately

**RESPONSIBLE PARTY FOR PAYMENTS:**

I/We will see that payment is made of all expenses incurred by the applicant while in placement not paid by Medicare, Medicaid, or other Health Insurance *from applicant's resources* responsibly under my/our control.

I/We understand that misuse of applicant's resources by me/us will make me/us liable for any unpaid charges incurred that would otherwise have been paid from applicant's resources.

Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

To the best of my knowledge, all of the information is correct and valid.

\_\_\_\_\_  
Applicant and/or Responsible Party Signature (required)

Date \_\_\_\_\_

Lutheran Home and Rehabilitation Center does not discriminate based on race, creed, color, national origin, sex, sexual orientation, sponsor, blindness or handicap.

