Aaron Manor
Rehabilitation and Nursing Center

PART ONE APPLICATION (& REHABILITATION)

If applying for long term care placement, this application must accompany the Part 2 Financial Supplement

Aaron Manor Rehabilitation and Nursing Center | 100 St. Camillus Way | Fairport, NY | (585) 377-4000 | aaronmanor.com

TO BE COMPLETED BY RESIDENT OR DESIGNATED REPRESENTATIVE

All questions must be answered, and all information must be provided for this application to be considered by facility. If you need help completing this form, call the Admissions Department at (585)377-4000.

General Information:

Applicant's Name:_____ Date of Birth: ___ /___ /____ Age:_____
Marital Status:_____ Religion:_____ Social Security #:_____Sex:_____
Street Address (Do not use PO Box):_____
City:_____ State:_____ Zip:_____ County:_____

Applicant's **present** location: _____Date of Admission: __ /___ /____
Has the applicant had any Skilled Nursing Facility stays within the last 60 days? ☐Yes ☐ No

If yes, please include the following Facility Information:
Facility Name: _____Street Address: _____
City:_____State:_____ Zip:_____Facility Phone Number:(_____)_____

Admittance Date: _____ Discharged Date:_____

Resident Representatives: Please list in order of emergency contact

#1 Name:_____ #2 Name:_____
Relationship: _____ Relationship:_____
Address:_____ Address: _____
Home #: _____ Home #:_____
Cell/work #:_____ Cell/work #:_____
Email: _____ Email: _____

Financial Information: **INCOME** - Self and Spouse (List all monthly household income. Continue a second page if needed)

Source of Income *(list separately)*	**Applicant**	**Spouse**
Social Security	$_____	$_____
(*Type and SS# if different from your own)*	_____	
SSI	$_____	$_____
Pension(s)	$_____	$_____
(Source/Company name and ID#)	_____	
Veteran Income Benefit	$_____	$_____
Rental Income	$_____	$_____
Interest/Dividends	$_____	$_____
Annuity/IRA Income	$_____	$_____
Trust Income	$_____	$_____
Other Income	$_____	$_____

BANK ACCOUNTS – Please include all accounts balances including CDs, Savings, Checking, Bonds, 401K, Money Markets, etc.

Checking/Savings $_____ _Bank: _____Joint Owners Name: _____
Checking/Savings $_____Bank: _____Joint Owners Name:_____
Checking/Savings $_____Bank: _____Joint Owners Name:_____

Life insurance policies? ☐Yes ☐No ***If yes,*** Cash values $_____Policy Name: _____
Pre-Paid burial? ☐Yes ☐No ***If yes****, (funeral home):*_____
Do you own a home? ☐Yes ☐No ***If yes****, property address:* _____
Is home jointly owned? ☐Yes ☐No
Life estate on any property? ☐Yes ☐No ***If yes***, date Life Estate established : _____

Transferred or sold any property/assets in the last 5 years? ☐Yes ☐No *If yes*, list property/asset information:

_____

INVESTMENTS - List all IRAs, 401ks, stocks, bonds, savings bonds, annuities, mutual funds or other investments here.

Bank/Brokerage Company	**Owner(s)**	**Type of Investment** *(stocks/CD/bonds etc..)*	**Current Value**

ALIMONY - ***Applicant must provide copy of court order.***

Alimony Paid Out: ☐Yes ☐No Amount $_____

Alimony Paid Type: ☐Domestic Relations Order ☐Separation Agreement / Spousal Order

Alimony Received: ☐Yes ☐No Amount $_____

Alimony Received Type: ☐Domestic Relations Order ☐Separation Agreement / Spousal Order

GIFTING INFORMATION:

(This includes birthday, wedding, graduation gifts, charitable gifting, Tithing, etc.)

Has the applicant gifted/given away any funds, property or assets, over $1,000 or more in the last 5 years? If yes, indicate below:

Amount Given	Date Given (month/year)	Recipient of Gift

Has a Trust been established? ☐Yes ☐No *If yes*, when? _____ Revocable or irrevocable? (circle one)

Do you have long term Care insurance? ☐Yes ☐No If yes, what company?_____

Has applicant applied for Medicaid? ☐Yes ☐No *If yes*, when:_____ County: _____

Applicant Acknowledgement:

Applicant Name: _____

You may be required to provide documentation to support the information provided on this application. The applicant and/or Responsible party hereby state that the information provided on this application is complete and accurate to the best of my knowledge. As the financially responsible party, I hereby agree not to transfer or otherwise dispose of assets which would render the resident ineligible for Medicaid coverage.

If the applicant is capable of signing, both the applicant and financially responsible party should sign here. If the applicant is not capable of signing, the financially responsible party should sign as a representative and should also sign the applicant's name as POA. This should be signed as follows: (applicant name) by (POA Name) as agent for (applicant name)

_____ ____ / ____ /____

Signature of Applicant Date Signed

_____ ____ / ____ /____

Signature of Representative (POA) Date Signed