St John's HOME



ADMISSIONS APPLICATION

☐ St. John's Home ☐ Penfield Green House Homes

APPLICANT

Last Name:_____ First Name:_____ Middle Initial:_____

Street:_____ City:_____ State:_____ ZIP: _____

Phone: (__ __ __) __ __ __ - __ __ __ __ Gender: ☐ Male ☐ Female

Is the applicant a U.S. Citizen? ☐ Yes ☐ No If not, what is the country of citizenship? _____

Social Security Number: __ __ __ - __ __ - __ __ __ __ Date of Birth (mm/dd/year): __ __ / __ __ / __ __ __ __

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other:_____

Race:_____ Religion:_____

Where is the applicant currently? ☐ Home ☐ Hospital ☐ Skilled Nursing Facility ☐ Assisted Living Facility

If applicable, what is the name of the facility? _____

Has the applicant had a previous nursing home stay in the past year? ☐ Yes ☐ No

If yes, dates of stay and where: _____

Has the applicant been hospitalized in the past 30 days? ☐ Yes ☐ No Dates of Stay: _____

Name of Hospital:_____ Reason for Hospitalization: _____

EMERGENCY CONTACTS

FIRST CONTACT

☐ Financial Representative
☐ Power of Attorney
☐ Health Care Proxy

Name: _____

Relationship: _____

Street Address:_____

City:_____ State:_____ ZIP: _____

Home Phone: (__ __ __) __ __ __ - __ __ __ __

Work Phone: (__ __ __) __ __ __ - __ __ __ __

Cell Phone: (__ __ __) __ __ __ - __ __ __ __

Email:_____

SECOND CONTACT

☐ Financial Representative
☐ Power of Attorney
☐ Health Care Proxy

Name: _____

Relationship: _____

Street Address:_____

City:_____ State:_____ ZIP: _____

Home Phone: (__ __ __) __ __ __ - __ __ __ __

Work Phone: (__ __ __) __ __ __ - __ __ __ __

Cell Phone: (__ __ __) __ __ __ - __ __ __ __

Email:_____

PRIMARY CARE PHYSICIAN

Name: _____ Phone Number: (__ __ __) __ __ __ - __ __ __ __

Address: _____

City: _____ State: _____ ZIP: _____

MEDICAL INSURANCE

Medicare Number: _____

☐ Part A ☐ Part B ☐ Part D

Insurance Name: _____

Policy Number: _____

Insurance Name: _____

Policy Number: _____

Medicaid Number: _____

Have you applied for Medicaid? ☐ Yes ☐ No

Case Worker Name: _____

Phone Number: _____

County: _____

LONG-TERM CARE INSURANCE

Company Name: _____

Policy Number: _____

Elimination Period: _____

Is your long-term care insurance partnered with New York State? ☐ Yes ☐ No

Maximum Remaining Benefit (Number of Days or Dollar Amount): _____

Remaining Benefit: _____

Skilled Nursing/Nursing Home Rate Per Day: $ _____

FINANCIALS

INCOME	APPLICANT	SPOUSE
Social Security	$ _____	$ _____
Pension	$ _____	$ _____
Wages/Salary	$ _____	$ _____
IRA	$ _____	$ _____
Annuities	$ _____	$ _____
Interest Dividends	$ _____	$ _____
Other	$ _____	$ _____
Total	**$** _____	**$** _____

FINANCIALS CONTINUED

ASSETS	APPLICANT	SPOUSE
Checking	$ _____	$ _____
Savings	$ _____	$ _____
CDs/Money Markets	$ _____	$ _____
Stocks/Bonds	$ _____	$ _____
Annuities	$ _____	$ _____
IRAs/401Ks/403Bs	$ _____	$ _____
Other	$ _____	$ _____
Trusts	$ _____	$ _____
Type of Trusts:	☐ REVOCABLE OR ☐ IRREVOCABLE	☐ REVOCABLE OR ☐ IRREVOCABLE
Date Created:	_____	_____
Total	**$** _____	**$** _____

REAL ESTATE

Does the Applicant own a home? ☐ Yes ☐ No If yes, what is the value of the home? $ _____

Address: _____

Is there a spouse or disabled child residing in the home? ☐ Yes ☐ No

Does the Applicant own any other property? ☐ Yes ☐ No

Address: _____

Liquid assets available to pay for applicant's care:

$ _____ Initials: _____ Date: __ __ / __ __ / __ __ __ __

Has the applicant given away, gifted, or transferred any assets within the past 60 months of the date of this application?

☐ Yes ☐ No If yes, how much? $_____ Date of transfer: __ __ / __ __ / __ __ __ __

Have you or a family member consulted with an attorney or financial advisor regarding payment for nursing home care?

☐ Yes ☐ No If yes, please provide the person's name and phone number.

Name:_____ Phone: (__ __ __) __ __ __ - __ __ __ __

Have you or a family member consulted with a community case manager regarding long-term care placement?

☐ Yes ☐ No If yes, please provide the person's name and phone number.

Name:_____ Phone: (__ __ __) __ __ __ - __ __ __ __

HOW DID YOU HEAR ABOUT ST. JOHN'S?

☐ Television ☐ Newspaper ☐ Radio ☐ Internet ☐ Event ☐ Friend ☐ Family Member

☐ Other: _____

Please share why you chose St. John's:_____

_____

_____

APPLICATION COMPLETED BY:

Printed Name: _____

Relationship to Applicant: _____

Signature: _____ Date: __ __ / __ __ / __ __ __ __

Please include any Health Care Proxy, Power of Attorney, or Guardianship Documentation with the completed application at the time of submission.

St John's
Embrace Living

stjohnsliving.org

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