San Simeon by the Sound
Center for Nursing & Rehabilitation
61700 Route 48
Greenport, NY 11944

Fax: 631-477-0793

Application for Admission

Personal Information:

Name________________________________ Phone________________

Address______________________________ E-Mail _______________

____

Years at this Address __________________ Marital Status ________

Social Security #______________________ U.S. Citizen ___________

Place of Birth_________________________ Date of Birth__________

Language Spoken_____________________ Race_________________

Religion_____________________________ Sex__________________

Military Service____

San Simeon by the Sound Center for Nursing and Rehabilitation will abide by New York State and Federal Laws Prohibiting discrimination in the admission, retention and care of its residents because of race, creed, color, national origin, sex, sponsorship, disability, blindness, age, marital status, sexual preference or military status.

Medical Information:

Referred by____

Reason for applying____

Community Physician_______________________________________

Address ____________________________ Phone_____________

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Hospitalizations within the last year:

Hospital________________ Reason_________________ Date_____

Hospital________________ Reason_________________ Date_____

Nursing Home and/or Rehabilitation stays in the past 5 years:

Facility ________________ Reason_________________ Date_____

Facility ________________ Reason_________________ Date_____

Facility ________________ Reason_________________ Date_____

Insurance Information:

Medicare # ____

Medicare Part D Coverage_____________________________________

Health Insurance Company____________________________________

Policy # ____

Medicaid # ____________ Medicaid HMO _______________________

Medicaid Case Worker _____________________________________

Contact Information:

Names with Power of Attorney ______________________________________

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Names of Health Care Proxy ______________________________________

____

Check if you have a Living Will for Health Care ______

Lead Contact:

Name ____________________________________ Home Phone__________

Address__________________________________ Cell Phone___________

__________________________________ Work Phone__________

Relationship______________________________ E-Mail ______________

People who may call for information:

Name ___________________________________ Home Phone__________

Address__________________________________ Cell Phone___________

__________________________________ Work Phone__________

Relationship______________________________ E-Mail ______________

Name ____________________________________ Home Phone__________

Address__________________________________ Cell Phone___________

__________________________________ Work Phone__________

Relationship______________________________ E-Mail ______________

Financial Information:

Bank Accounts

Checking
Name of Bank(s) ____
Name(s) on Account _____________________________________
Balance (circle)
$100 to $3,000 $3,001 to $25,000 $25,001 or more

Savings
Name of Bank(s) ____
Name(s) on Account _____________________________________
Balance (circle)
$100 to $3,000 $3,001 to $25,000 $25,001 or more

Income
Sources ____
Total Monthly Income (circle)
$500 to $1,000 $1,001 to $3,000 $3,001 or more

Stocks, Annuities and Trusts
Describe portfolio _______________________________________
Worth (circle)
$1,000 to $35,000 $35,001 to $100,000 $100,001 or more

Do you own your home? __________________________________
Worth (circle)
$20,000 to $300,000 $300,001 to $800,000 $800,001 or more
Names on Deed ____

Other property
Description other properties ______________________________
Total Worth (circle)
$20,000 to $200,000 $200,001 to $800,000 $800,001 or more
Names on Deeds, Accounts or Partnerships___________________
____

Burial Fund____

List all transfers of assets or substantial gifts made in the last 7 years:

____

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By signing this form I agree to furnish on request certification as to my assets, income and sources of income. My spouse and/or designated representative also agree to provide financial information as may be required for application for medical benefits. To the best of my knowledge and belief the foregoing is complete, accurate and true in all respects.

I acknowledge understanding that Medicare and other insurances do not guarantee coverage for short-term placement in a skilled nursing facility. I also understand that I may be billed privately for any expenses not covered by Medicare or other insurances I may have in place. If paying privately, I understand that the minimum billable rate will be the current room and board rate plus the New York State Assessment Tax and any additional services not covered by that rate.

I agree, if admitted, to abide by the regulations of San Simeon by the Sound Center for Nursing and Rehabilitation, Inc.

I understand that San Simeon by the Sound is a smoke free facility.

Date___________________

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Signature of Applicant or
Designated Representative