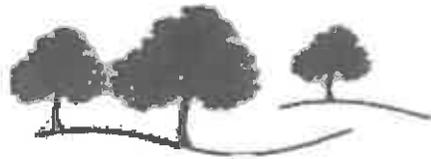


The Cottages
at Garden Grove



A Skilled Nursing Community

RESIDENCY APPLICATION AND FINANCIAL DISCLOSURE

Phone: 315-459-7402

Fax: 315-571-0800

The Cottages
at Garden Grove



A Skilled Nursing Community

Personal Information:

Applicant's Full Name: _____ Date of Birth: ____/____/____
 Social Security Number: _____ Religion: _____
 Current Address: _____
 County: _____ Number of Years: _____
 Home Phone Number: _____

Previous Address: _____
 County: _____ Number of Years: _____

Marital Status: Single Married Divorced Widowed Legally Separated
 Name of Spouse (even if deceased): _____ Date of Marriage: _____
 Social Security Number: _____ Date of Birth: _____ Date of Death: _____
 Address (if applicable): _____

Health Insurance Coverage: (Provide copies of cards for all that apply)

	Applicant			Spouse		
	Part A	Yes	No	Part A	Yes	No
Medicare	Part B	Yes	No	Part B	Yes	No
	Medicare #:			Medicare #:		
Medicaid	Yes	No		Medicaid #:		
	Applying			Effective Date: ____/____/____		
Medicare Supplemental Insurance	Name:			Name:		
	Address:			Address:		
	Policy #:			Policy #:		
Medicare D Prescription Plan	Name:			Name:		
	Address:			Address:		
	Policy #:			Policy #:		

Health Insurance Premium Amount: _____

Emergency Contacts:

	Primary	Secondary
Name		
Relationship		
Address		
Home Phone		
Work Phone		
Cell Phone		
Email address		

Physicians:

	Primary	Other
Name		
Phone		
Address		
Emergency		
Specialty		

Hospital Preference: _____

Monthly Income Amount:

Source	Applicant	Spouse
Social Security		
SSI (ceases upon NH placement)		
Veterans Pension		
Railroad Retirement Pension		
Other Pension _____		
IRA/TDA/TSA		
Trust Income		
Other _____		
Total Monthly Income		

ASSETS: (Provide copies of current statements for all that apply)

Type of Account	Institution Name	Balance/Mkt Value	"As of" Date	Applicant or Spouse
Checking Acct (1)				
Checking Acct (2)				
Savings Acct (1)				
Savings Acct (2)				
CD (1)				
CD (2)				
Investment Funds				
Stocks/Bonds				
Annuity/IRA				
Other				
Life Insurance:	Ins Co. Name	Face Value	Cash Value	
Life Ins. Policy (1)				
Life Ins. Policy (2)				

Property Owned:

Home Address: _____ Market Value: _____
 Rental/Other Property Address: _____ Market Value: _____
 Life Use Estate Address: _____ Market Value: _____

Funeral Information:

Pre-paid burial? Yes _____ No _____ Funeral Home Name: _____
 Cemetery Name: _____

Has either the applicant or spouse ever been in the military? Yes _____ No _____
 If yes, who _____

Medical Debts Outstanding:

Amount Owed:

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Has the applicant and/or spouse created a Trust? Yes ___ No ___

Date Established: _____ Attorney Name: _____

Is the applicant or spouse currently working with an attorney? Yes ___ No ___

If yes, Attorney Name: _____ Phone: _____

Transfer of Assets within the last five years:

Asset Transferred	\$ Amount or Value	Date of Transfer	Receiver Name

Applications will need to be reviewed and updated after 30 days.

PLEASE NOTE:

Both Federal and State laws impose severe penalties for obtaining Medicaid fraudulently. Therefore, you must provide an accurate and complete financial disclosure statement, which is required to document the nature and use of your assets. This completed section of the The Cottages at Garden Grove Residency Application and Financial Disclosure Statement may be used in the future, if necessary, to substantiate your request and application for Medicaid.

Please be advised that effective 2008 Federal Law prohibits the transfer of assets for 60 months (5 years) prior to applying for Medicaid.

I hereby declare that all statements made herein are true to the best of my knowledge; I authorize you to verify the financial information through credit checks and inquiry to financial institutions.

Applicant or Representative Signature

Date

Administrator Signature

Date