

Residency Application and Financial Disclosure

How to complete this form

1. Type into the shaded boxes on your computer, or print this form and fill it in by hand.
2. Print it, sign on the last page, and include copies of insurance cards and current financial statements.
3. Return it in person, by mail to the address above, or by fax to 315-571-0800.

Your privacy: this form is not sent anywhere as you type. Your information stays on your own device. If you save a filled-in copy, keep it somewhere secure. Please do not email it. Questions? Call 315-459-7402.

1. Personal Information

APPLICANT

Applicant's full name

Date of birth (MM/DD/YYYY)

Social Security number

Religion

Current address

County

Number of years

Home phone number

PREVIOUS ADDRESS

Previous address

County

Number of years

MARITAL STATUS AND SPOUSE

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated

Name of spouse (even if deceased)

Date of marriage

Spouse's Social Security number

Spouse's date of birth

Spouse's date of death

Spouse's address (if applicable)

2. Health Insurance Coverage

(provide copies of cards for all that apply)

	Applicant	Spouse
Medicare Part A	☐ Yes ☐ No	☐ Yes ☐ No
Medicare Part B	☐ Yes ☐ No	☐ Yes ☐ No
Medicare number		
Medicaid	☐ Yes ☐ No ☐ Applying	☐ Yes ☐ No ☐ Applying
Medicaid number		
Medicaid effective date		
Medicare supplemental: name		
Medicare supplemental: address		
Medicare supplemental: policy #		
Medicare Part D plan: name		
Medicare Part D plan: address		
Medicare Part D plan: policy #		

Health insurance premium amount

3. Emergency Contacts

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

4. Physicians and Hospital

	Primary	Other
Name		
Phone		
Address		
Emergency phone		
Specialty		

HOSPITAL PREFERENCE

Preferred hospital

5. Monthly Income

	Applicant	Spouse
Social Security		
SSI (ceases upon nursing home placement)		
Veterans pension		
Railroad retirement pension		
Other pension:		
IRA / TDA / TSA		
Trust income		
Other:		
Total monthly income		

6. Assets

(provide copies of current statements for all that apply)

	Institution name	Balance / market value	"As of" date	Applicant or spouse
Checking account (1)				
Checking account (2)				
Savings account (1)				
Savings account (2)				
CD (1)				
CD (2)				
Investment funds				
Stocks / bonds				
Annuity / IRA				
Other:				
Other:				

LIFE INSURANCE

	Insurance company	Face value	Cash value
Life insurance policy (1)			
Life insurance policy (2)			

7. Property Owned

Home address	Market value
Rental / other property address	Market value
Life use estate address	Market value

8. Funeral Information

Pre-paid burial? ☐ Yes ☐ No

Funeral home name	Cemetery name

9. Military Service

Has either the applicant or spouse ever been in the military? ☐ Yes ☐ No

If yes, who?

10. Medical Debts Outstanding

	Owed to / description	Amount owed
1		
2		
3		
4		
5		
6		

11. Trusts and Legal

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

12. Transfer of Assets Within the Last Five Years

	Asset transferred	\$ Amount or value	Date of transfer	Receiver name
1				
2				
3				
4				
5				

13. Declaration and Signature

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

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 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 2006 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.

SIGNATURE _____

Applicant or Representative Signature

Date

Printed name of person signing

Relationship to applicant

For office use only

Administrator Signature

Date