Universal application and financial form for all nursing homes in Wayne County

Please circle any/all homes you are interested in:

Blossom View	**DeMay**	**Newark Manor**	**Wayne County**
Sodus	**Newark**	**Newark**	**Lyons**

I. IDENTIFYING INFORMATION

Last Name	Race
First Name	U. S. Citizen (circle one) Yes No
Middle Initial	Marital Status (circle one)
Street	Single Married Divorced
City	Widowed Separated Unknown
County	
State Zip	Social Security #
Phone	**FOR FACILITY USE ONLY**
Date of Birth Age:	**Medical Record #**
Birthplace	**Admitted from (circle one)**
Sex (circle one) Male Female	**Hospital (name & date of admission)**
Veteran (circle one) Yes No	
Maiden Name	**Home**
Name of Spouse	**Other**
Name of Father	**Date of Admission Here**
Name of Mother	**Floor**
Lifetime Occupation	**Room #**
Education	
Primary Physician	**Attending Physician**
Phone #	**Phone #**
Address	**Address**
Alternate Attending Physician	**PA or Nurse Clinician**
Phone #	**Phone #**
Address	**Address**
	Social Worker

II. RESPONSIBLE PARTY/ CONTACT

Designated Representative-Responsible for Payments	**# 1 Contact**
Name	Name
Address	Address
Phone # (H) (W)	Phone # (H) (W)
Cell Phone	Cell Phone
E-mail address	E-mail address
Relationship	Relationship
Please check if appropriate: POA HCP DNR	Please check if appropriate: POA HCP DNR

#2 **Contact**	**#3 Contact**
Name	Name
Address	Address
Phone # (H) (W)	Phone # (H) (W)
Cell Phone	Cell Phone
E-mail address	E-mail address
Relationship	Relationship
Please check if appropriate: POA HCP DNR	Please check if appropriate: POA HCP DNR

III. INSURANCE INFORMATION

Medicare Claim #	**Medicaid #** County
Part A Y N Effective Date:	Effective Date Pending:
Part B Y N Effective Date:	Medicaid Worker:
Other Medical Insurance(s)	**Prescription Coverage**
Name	Name
Address	Address
Policy # Eff. Date:	Policy # Eff. Date:
Medical Insurance Self Pay (circle one) Yes No	**Long Term Care Insurance** Y N
Paid by Previous Employer (circle one) Yes No	Company Name:
Name of Employer	Address:
Address	
	Phone #:
	Daily Benefit Allowance of policy $
Copies of all insurance cards will need to be provided at time of admission	

IV. BURIAL/CLERGY INFORMATION

Religion	Funeral Home
Church Name	Address
Address	
	Phone #
Phone #	
Clergy Name	Cemetery Space

Are you enrolled in an Anatomical Gift Program?

_____ yes _____ no

If yes, please explain:

_____

V. STATEMENT OF APPLICANT' S FINANCES:

A. MONTHLY INCOME:

SOURCE	APPLICANT	SPOUSE
Salary	$	$
Social Security	$	$
Retirement/Pension	$	$
Veteran's Pension	$	$
Railroad Pension	$	$
Annuities	$	$
Mortgages/Notes	$	$
Interest/Dividends	$	$
Supplementary Security Income	$	$
Other income: (Explain)	$	$
	$	$
TOTAL MONTHLY INCOME:	$	$

B. LIABILITIES/DEBTS: BALANCE

Mortgage	$
Auto Loans	$
Credit Cards	$
Outstanding Loans	$
Other	$

C. ASSETS:

SOURCE	OWNED BY	BANK	AMOUNT
Savings Account			**$**
Checking Account			**$**
Credit Union			**$**
Cert. of Deposit			**$**

STOCKS/BONDS: _____ **AMOUNT:** _____

Annuities: _____ **AMOUNT:** _____

IRAS: _____ **AMOUNT:** _____

D. LIFE INSURANCE POLICIES:

COMPANY	FACE VALUE	CASH VALUE	Owner of Policy

E. REAL ESTATE:

1. **LOCATION: _____**

TYPE: Primary Residence Rental Property Vacation Home Other (Please circle)

Other, please specify: _____

Names(s) on Deed: _____

Estimated Value: _____

2. **LOCATION: _____**

TYPE: Primary Residence Rental Property Vacation Home Other (Please circle)

Other, please specify: _____

Names(s) on Deed: _____

Estimated Value: _____

If real estate is "Primary Residence", answer the following questions:	**YES**	**NO**
1. Is property currently listed for sale? (If yes, provide copy of listing or sale contract)		
2. Is it applicant's intention to return to Primary Residence within the next (6) months?		
3. Will the applicant's health status or mental health status prevent a return home?		
4. Does the applicant's physician agree that the applicant may be able to return home safely?		

5. Is primary residence currently occupied by one of the following? Please circle all that apply.
   a. Applicant's Spouse
   b. Applicant's child who is:
      1) under 21 years of age
      2) Certified blind
      3) disabled
   c. Other dependent relative of applicant:

6. Who is paying the taxes, insurance and the cost of upkeep of the property?
_____

VI. APPLICANT'S INTEREST IN A BUSINESS:

Name of Business: _____

Address: _____

_____

Type of Business: _____

Ownership Interest:**_____**

Are any of the above assets listed held in a Trust:

_____ yes _____ no

If yes, name of Trustee: _____

Date Trust established: _____

Has there been a transfer of real property, money, stock, or other property by gift or for any other reason from applicant on or after February 8, 2006? Sixty (60) months with a Trust?

_____No _____Yes: (Please Specify) _____

INFORMATION FURNISHED BY: _____

Applicant:

DATE: _____

Applicant's Signature _____

Responsible Party:

DATE: _____

Responsible Party's Signature _____

Relationship to Applicant _____

The Nursing Homes of Wayne County do not discriminate in admission or care of its residents because of race, creed, color, national origin, age, sex, marital status, sexual preference, blindness, disability, handicap, sponsor or source of payment.

Blossom View
6884 Maple Ave.
Sodus, NY 14551
Telephone: 315-483-9118
Fax: 315-483-9432
e-mail: blossomview.com
website: www.blossomview.com

Newark Manor
222 W. Pearl Street
Newark, NY 14513
Telephone: 315-331-4690
Fax: 315-331-8947
e-mail: abaran@newarkmanornursinghome.com
website: www.newarkmanornursinghome.com

Rochester General Health System
DeMay Living Center
100 Sunset Dr.
Newark, NY 14513
Telephone: 315-332-2700
Fax: 315-359-2146
e-mail:kathy.vanacker@rochestergeneral.org
website: www.rochestergeneral.org

Wayne County Nursing Home
1529 Nye Rd.
Lyons, NY 14489
Telephone: 315-946-5673
Fax: 315-946-5671
e-mail: wcnh@co.wayne.ny.us
website: www.waynecountynursinghome.org

Referral Information

To better assist the Nursing Homes in Wayne County please take a minute to answer the following questions.

1. Were you aware of **all** the Nursing Homes in Wayne County? Yes _____ No_____
2. If not, which nursing homes were you aware of? _____
3. Of the nursing homes you were aware of how did you hear about them: check all that apply

_____newspaper: which one? _____ _____billboards

_____movie theater ____friend/relative _____phonebook _____Internet

_____medical person: who? Doctor/hospital exit planner/etc.? _____

_____ community contacts _____other human service agency

20.2.1 - Admission Questions to Ask Medicare Beneficiaries

(Rev.)

The following *questionnaire contains* questions *that can be used* to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers *may use this* as a guide to help identify other payers that may be primary to Medicare. *This questionnaire is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations. If you choose to use this questionnaire, please note that it was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct the patient to the next appropriate question to determine MSP situations.*

Part I

1. Are you receiving Black Lung (BL) Benefits?

___ Yes; Date benefits began: *MM/DD/CCYY*

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.

___ No.

2. Are the services to be paid by a government program such as a research grant?

___ Yes; Government Program will pay primary benefits for these services

___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

___ Yes.

DVA IS PRIMARY FOR THESE SERVICES.

___ No.

4. Was the illness/injury due to a work related accident/condition?

___ Yes; Date of injury/illness: *MM/DD/CCYY*

Name and address of WC plan:

_____

Policy or identification number: _____

Name and address of your employer:

_____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, GO TO PART III.

___ No. **GO TO PART II.**

Part II

1. Was illness/injury due to a non-work related accident?

___ Yes; Date of accident: *MM/DD/CCYY*

___ No. **GO TO PART III**

2. What type of accident caused the illness/injury?

___ Automobile.

___ Non-automobile.

Name and address of no-fault or liability insurer:

_____

_____

_____

Insurance claim number: _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

___ Other

3. Was another party responsible for this accident?

___ Yes;

Name and address of any liability insurer:

_____

_____

_____

Insurance claim number: _____

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

___ No. **GO TO PART III**

Part III

1. Are you entitled to Medicare based on:

___ Age. **Go to Part IV.**

___ Disability. **Go to Part V.**

___ ESRD. **Go to Part VI.**

Part IV - Age

1. Are you currently employed?

___ Yes.

Name and address of your employer:

_____

_____

_____

___ No. Date of retirement: *MM/DD/CCYY*

___*No. Never Employed.*

2. Is your spouse currently employed?

___ Yes.

Name and address of spouse's employer:

_____

_____

_____

___ No. Date of retirement: *MM/DD/CCYY*

___*No. Never Employed.*

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?

___ Yes.

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. Does the employer that sponsors your GHP employ 20 or more employees?

___ Yes. **STOP. *GHP* IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

_____

_____

_____

Policy identification number *(this number is sometimes referred to as the health insurance benefit package number)*: _____

Group identification number: _____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient):

_____

Name of policyholder*/named insured*: _____

Relationship to patient: _____

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

Part V - Disability

1. Are you currently employed?

___ Yes.

Name and address of your employer:

_____

_____

_____

___ No. Date of retirement: *MM/DD/CCYY*

___No. Never Employed.

2. *If married, is your spouse* currently employed?

___ Yes.

Name and address of your *spouse's* employer:

_____

_____

_____

___ No. Date of retirement: MM/DD/CCYY

___No. Never Employed.

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?

___ Yes.

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO THE QUESTIONS IN PART I OR II.**

4. Are you covered under the group health plan of a family member other than your spouse?

_____*Yes.*

Name and address of your family member's employer:

_____

_____

_____

_____*No.*

5. Does the employer that sponsors *the* GHP employ 100 or more employees?

___ Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

_____

_____

_____

Policy identification number *(this number is sometimes referred to as the health insurance benefit package number)*: _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient):

_____

Name of policyholder*/named insured*: _____

Relationship to patient: _____

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

Part VI - ESRD

1. Do you have group health plan (GHP) coverage?

*If yes, n*ame and address of GHP:

_____

_____

_____

Policy identification number *(this number is sometimes referred to as the health insurance benefit package number*: _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient):

_____

Name of policyholder */named insured*: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

_____

_____

___ No. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

___ Yes. Date of transplant: *MM/DD/CCYY*

___ No.

3. Have you received maintenance dialysis treatments?

___ Yes. Date dialysis began: *MM/DD/CCYY*

If you participated in a self-dialysis training program, provide date training started: CCYY/MM/DD

___ No

4. Are you within the 30-month coordination period *that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis. If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)*

___ Yes

___ No. **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

___ Yes.

___ No.

6. *Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?*

___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

___ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement?

___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

___ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

If no MSP data are found in *the Common Working File (*CWF*)* for the beneficiary, the provider still asks the *types of* questions *above* and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.