Confidential Data Application

All Information Will Be Held Confidential

Check Appropriate Facility:

☐ **GreenField Health/Rehabilitation Center** - *Skilled Nursing*
5949 Broadway Lancaster, NY 14086 (716) 684-3000

☐ **GreenField Terrace** - *Assisted Living & Memory Care*
5979 Broadway Lancaster, NY 14086 (716) 684-8400

☐ **GreenField Court** - *Assisted Living*
5951 Broadway Lancaster, NY 14086 (716) 684-8400

☐ **GreenField Manor** - *Residential Living*
5953 Broadway Lancaster, NY 14086 (716) 684-8400

Please Print Clearly or Type

Applicant Name:_____
Last First Middle

U.S. Citizen ☐ Yes ☐ No
Veteran ☐ Yes ☐ No
Spouse Veteran ☐ Yes ☐ No

Address: _____
Street

_____
City State Zip Code

Phone #: Home (_____)_____-_____ Cell (_____)_____-_____

E-mail Address:_____

Birth Date: _____/_____/_____
Month Day Year

Social Security #: _____-_____-_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Spouse/2nd Person Name:_____
Last First Middle

U.S. Citizen ☐ Yes ☐ No
Veteran ☐ Yes ☐ No
Spouse Veteran ☐ Yes ☐ No

Address (*if different*): _____
Street

_____
City State Zip Code

Phone #: Home (_____)_____-_____ Cell (_____)_____-_____

Birth Date: _____/_____/_____
Month Day Year

Social Security #: _____-_____-_____

Applicant's Additional Information (If applying for skilled nursing care or assisted living)

Health Care Proxy ☐ Yes ☐ No Living Will ☐ Yes ☐ No Do Not Resuscitate Order ☐ Yes ☐ No

Medicare ☐ Yes ☐ No; If Yes # _____ Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No

Medicaid: ☐ Yes ☐ No ☐ Pending; If yes, ID #:_____County:_____Eff. Date:_____

SSI: ☐ Yes ☐ No

Health Insurance:_____ Policy #: _____

Other Health Insurance:_____ Policy #: _____

Prescription Drug Plan:_____ Effective Date: _____/_____/_____

Rx ID_____ Rx Group _____ Rx Bin_____ Rx PCN _____

Other Prescription Plan:_____ Policy #: _____

Long Term Care Insurance:_____ Policy #: _____

Dates of last hospital stay: From_____ To_____ Where:_____

Dates of last nursing home stay: From_____ To_____ Where:_____

Return to present residence if nursing home care is no longer needed? _____Possible _____Not Possible

Health Condition (**must be completed**):_____

_____

_____

Primary Physician's Name: _____

Office Address: _____
Street

_____
City State Zip Code

Office Phone #: (_____) _____-_____ Fax #: (_____) _____-_____

Consultant Physician's Name: _____ Specialty _____

Office Address: _____
Street

_____
City State Zip Code

Office Phone #: (_____) _____-_____ Fax #: (_____) _____-_____

Spouse/2nd Person Additional Information (If applying for skilled nursing care or assisted living)

Health Care Proxy ☐ Yes ☐ No Living Will ☐ Yes ☐ No Do Not Resuscitate Order ☐ Yes ☐ No

Medicare ☐ Yes ☐ No; If Yes # _____ Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No

Medicaid: ☐ Yes ☐ No ☐ Pending; If yes, ID #:_____County:_____Eff. Date:_____

SSI: ☐ Yes ☐ No

Health Insurance:_____ Policy #: _____

Other Health Insurance:_____ Policy #: _____

Prescription Drug Plan:_____ Effective Date: _____/_____/_____

Rx ID_____ Rx Group _____ Rx Bin_____ Rx PCN _____

Other Prescription Plan:_____ Policy #: _____

Long Term Care Insurance:_____ Policy #: _____

Dates of last hospital stay: From_____ To_____ Where:_____

Dates of last nursing home stay: From_____ To_____ Where:_____

Return to present residence if nursing home care is no longer needed? _____Possible _____Not Possible

Health Condition (**must be completed**):_____

_____

_____

Primary Physician's Name: _____

Office Address: _____
Street

_____
City State Zip Code

Office Phone #: (_____) _____-_____ Fax #: (_____) _____-_____

Consultant Physician's Name: _____ Specialty _____

Office Address: _____
Street

_____
City State Zip Code

Office Phone #: (_____) _____-_____ Fax #: (_____) _____-_____

Must be completed for all levels of care

Pre-Paid Funeral Arrangements

Applicant: Funeral Home _____

Phone #: (_____) _____-_____

Spouse/2nd Person: Funeral Home _____

Phone #: (_____) _____-_____

Emergency Contacts/Financial Representative/Power of Attorney/Health Care Agent/Guardian

1. Name:_____ (Last / First / Middle)
   Bill To: ☐ Yes ☐ No
   Power of Attorney: ☐ Yes ☐ No
   Health Care Agent: ☐ Yes ☐ No
   Guardian/Conservator ☐ Yes ☐ No

   Address: _____ (Street)

   _____ (City / State / Zip Code)

   Relationship: _____ E-mail Address: _____

   Phone #: Home (_____)_____-_____ Work (_____)_____-_____ Cell (_____)_____-_____

2. Name:_____ (Last / First / Middle)
   Bill To: ☐ Yes ☐ No
   Power of Attorney: ☐ Yes ☐ No
   Health Care Agent: ☐ Yes ☐ No
   Guardian/Conservator ☐ Yes ☐ No

   Address: _____ (Street)

   _____ (City / State / Zip Code)

   Relationship: _____ E-mail Address: _____

   Phone #: Home (____)_____-_____ Work (_____)_____-_____ Cell (____)_____-_____

Trust Applicant: ☐ Yes ☐ No If yes, ☐ Revocable ☐ Irrevocable
Spouse/2nd Person: ☐ Yes ☐ No If yes, ☐ Revocable ☐ Irrevocable

Life Estate Applicant: ☐ Yes ☐ No Spouse/2nd Person: ☐ Yes ☐ No

Annuity Applicant: ☐ Yes ☐ No If yes, ☐ Structured ☐ Liquid
Spouse/2nd Person: ☐ Yes ☐ No If yes, ☐ Structured ☐ Liquid

Please provide copy(s) of trust and/or life estate documents.

Financial Statement

Must be completed for each individual

Assets must be in individual's name and joint holdings must be so noted with percentage of interest

ALL INFORMATION WILL BE HELD CONFIDENTIAL

REGULAR MONTHLY INCOME	1st Person	2nd Person
Social Security/SSI	$	$
VA Pension	$	$
Pension* From_____	$	$
Dividends	$	$
Mortgage/Rental Income	$	$
IRA Income	$	$
Annuity Income	$	$
Trust Income	$	$
Other Monthly Income (specify)	$	$
Total Monthly Income	$	$

*Upon death of spouse, what percent/amount of the pension will surviving spouse receive? _____

CAPITAL ASSETS	1st Person	2nd Person
Cash - Savings Bank Name_____ Bank Name_____	 $ $	 $ $
Cash - Checking Bank Name_____ Bank Name_____	 $ $	 $ $
CD's, Money Markets, etc.	$	$
Stocks and Bonds	$	$
IRA's	$	$
Annuities	$	$
House (value in applicant(s) name) Address_____ _____	$	$
Other Real Estate Type_____ Address_____ _____	$	$
Trust Fund (attach copy)	$	$
Other Assets (specify)	$	$
Total Assets	$	$

CAPITAL ASSETS Cont.	1st Person	2nd Person
Life Insurance (cash value)	$	$

LIABILITIES	1st Person	2nd Person
Credit Card(s) - Total Balance Due	$	
Mortgage	$	
Auto Loan(s) - Total Balance Due	$	
Other Liabilities (specify)	$	
Total Liabilities	$	

Have you transferred any asset valued over $1,000 in the past five (5) years? Yes_____ No_____

If yes, please indicate the specifics below. NLHS reserves the right to request official documentation of any such transfer. Your failure to disclose this information may affect your admission application.

Asset Transferred	Amount	Name Asset Was Transferred To	Date of Transfer

I hereby declare that all statements made herein are true according to my best knowledge and belief. In witness whereof, I have hereunto set my hand to this application this _____ day of _____ 20_____.

_____ _____

Signature of 1st Person/POA/Responsible Party Signature of 2nd Person/ POA/Responsible Party

****NOTE: Please enclose copies of any POWER OF ATTORNEY, GUARDIANSHIP and/or HEALTH CARE PROXY FORMS, SOCIAL SECURITY CARD, ALL INSURANCE CARDS (front and back), MONTHLY INCOME CHECKS, LONG TERM CARE INSURANCE POLICY and TRUST FUND.**

State and federal laws prohibit discrimination because of age, race, creed, gender, marital status, disability, sexual preference, national origin, payer source or having/not having an advance directive.

EQUAL HOUSING OPPORTUNITY

Revised December 2015