ROCHESTER REGIONAL HEALTH

Rochester Regional Health System Skilled Nursing Referral Form

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:	
Date of Birth: Age:	
Birthplace:	Veteran (circle one): Yes No
Sex (Circle one) Female Male	Are you receiving VA Medical Benefits: Yes No

Next of Kin Information

Name:	Relationship:
Is this person Power of Attorney?	Is this Person Health Care Proxy?
Phone:	Alternate Phone:
Address:	City/State/Zip
Name:	Relationship:
Is this person Power of Attorney?	Is this Person Health Care Proxy?
Phone:	Alternate Phone:
Address:	City/State/Zip

Medical Insurance Information

Medicare Policy (HIC) #:	Medicaid #: County:
Part A: Y N Effective Date:	Effective Date:
Part B: Y N Effective Date:	Medicaid Worker:
	Have you submitted an application for Medicaid: Yes
All Other Medical Insurance(s):	If yes, Date of application submission: _________
Name:	
Address:	Long Term Care Insurance: Y N
	Company Name:
Policy #: Eff. Date:	Address:
Name:	Phone #:
Address:	Daily Benefit Allowance of policy $:
Policy #: Eff. Date:	
Copies of all insurance cards will need to be provided at time of admission	

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Financial Resource Worksheet

Please supply financial and biographical information as requested below. Whenever possible, please produce supporting documentation. Rochester Regional Health reserves the right to request additional information and records in order to verify the data contained in this worksheet.

Statement of Potential Resident's Finances: Please provide a copy of your most recent statement for any and all monthly income, liabilities, debts and all other assets.

A. Monthly Income

Type of Income	APPLICANT	SPOUSE
Salary	$	$
Social Security	$	$
Retirement/Pension (401K)	$	$
Veteran's Pension	$	$
Railroad Pension	$	$
Annuities	$	$
Mortgages/Notes	$	$
Interest/Dividends (Stocks/Bonds)	$	$
Supplementary Security Income (SSI)	$	$
Other income: (Explain)	$	$
	$	$
TOTAL MONTHLY INCOME:	$	$

B. Assets

SOURCE	SELF/SPOUSE/JOINT	BANK	AMOUNT
Savings Account			$
Checking Account			$
Money Market Account			$
Cert. of Deposit (CD's)			$
Stocks/Bonds			$
IRA/401K/403B			$
Annuities			$

C. Life Insurance Policies:

COMPANY	FACE VALUE	CASH VALUE	NAME ON POLICY

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D. Real Estate

1. Primary Residence (location): ____

Names(s) on Deed:____

Estimated Value:____

Is the property currently listed for sale? (If yes, provide copy of listing or sale contract) _

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
4. Caretaker

c. Other dependent relative of applicant: ______________________________________

2. List and specify all other property: (i.e. Land, Rental Property, Vacation Home, Other)

Type: ____

Location: ____

Names(s) on Deed:____

Estimated Value:____

Type: ____

Location: ____

Names(s) on Deed:____

Estimated Value:____

E. Resident's Interest In a Business

Name of Business: ____

Address: ____

Type of Business: ____

Ownership Interest: ____

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F. **Trusts:** ____ Yes ____ No

If Yes, Name of Trustee: ____

Date Trust Established: ____

Has there been a transfer of applicant's money, stock, or other property for no fair consideration (a resource was transferred to another individual without taken into account the fair market value of transferred asset) within the last five (5) years?

______No _____Yes (Please Specify):

____

____

____

____

____

____

____

Name and Contact information of person completing this form:

Name:	Relationship:
Is this person Power of Attorney?	Is this Person Health Care Proxy?
Phone:	Alternate Phone:
Address:	City/State/Zip

I certify that the financial information provided is correct, and I understand that the Living Center is relying on this information to determine whether to admit the potential resident. If any of the above information changes, I agree to notify the Living Center immediately.

____ ____________
Resident Date

____ ____________
Financial/Designated Representative Date