

Rochester Regional health System Skilled Nursing  
Financial Resource Worksheet

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

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)                      Male                      Female	Are you receiving VA Medical Benefits:    Yes    No

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:	
<b>Copies of all insurance cards will need to be provided at time of admission</b>	

Prescription Insurance Information:

Insurance Plan Name:	Insurance Policy #
Insurance Address:	
Insurance Phone Number:	

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

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 All other property: (i.e. Land Rental Property Vacation Home Other)

Please specify type of Property: \_\_ Land Rental Property Vacation Home Other Location:

\_\_\_\_\_

Names(s) on Deed: \_\_\_\_\_

Estimated Value: \_\_\_\_\_

Please specify type of Property: \_\_\_\_\_ Land Rental Property Vacation Home Other Location:

\_\_\_\_\_

Names(s) on Deed: \_\_\_\_\_

Estimated Value: \_\_\_\_\_

E. Resident's Interest In a Business

Name of Business: \_\_\_\_\_

Address: \_\_\_\_\_

Type of Business: \_\_\_\_\_

Ownership Interest: \_\_\_\_\_

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):

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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 Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date