



Delaware Nursing & Rehabilitation Center Admission Application

1014 Delaware Avenue
(716) 883-6782
Admissions Coordinator – (716) 619 - 5775

Buffalo NY 14209
FAX (716) 883-6932

*All information contained in this application will be kept in the strictest confidence.
This information will become part of the Admission agreement if the applicant is admitted to Delaware Nursing & Rehabilitation Center.*

Short Term Rehabilitation _____ Long Term Skilled Nursing Care _____

Name of Applicant _____ Male _____ Female _____

Address _____ Telephone _____
Work _____

City _____ State _____ County _____

Birth date _____ Age _____ Birthplace _____

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____

Name of Spouse _____ Telephone _____
Work _____

Address _____ City _____ State _____

Social Security # _____ Medicare # _____ A ___ B ___

Medicaid # _____ County _____ Effective Date _____

Other Insurance _____ Policy # _____

Eligible for Veterans Benefits _____ VA # _____

Has Applicant Previously Had a Nursing Facility Stay? _____

If Yes, Name of Facility _____ Dates of Stay _____

If currently in hospital _____
Name of Hospital _____ Admission Date _____

Responsible Party for Applicant

Does applicant have Power of Attorney _____ Guardian _____ other _____

Name _____ Relationship _____

Address _____ Telephone _____
Work _____

City _____ State _____

The responsible party shall be obligated to pay **from the applicant's resources**, any expenses incurred while at Delaware Nursing & Rehabilitation Center which are not covered by Medicare, Medicaid or other health insurance. They are also responsible to make application for Medicaid financial assistance as it becomes necessary.

CONFIDENTIAL FINANCIAL INFORMATION

Statement of Resources (Monthly)

	<u>Applicant</u>		<u>Spouse</u>
Income	\$ _____		\$ _____
Social security	\$ _____		\$ _____
Other income	\$ _____		\$ _____
_____			_____
Source of Other income			Source of Other income
Pension	\$ _____		\$ _____
_____			_____
Source of Pension			Source of Pension

Liabilities

Mortgage	\$ _____	Balance Owed \$ _____
Loans	\$ _____	Balance Owed \$ _____

Do you own your home? _____ Do you own any real estate? _____

_____	_____
Location	Location
Checking Account? _____ Bank: _____	Balance: _____
Savings Account? _____ Bank: _____	Balance: _____

I make this Application for Admission to Delaware Nursing & Rehabilitation Center of my own free will and accord. I declare the answers to the foregoing questions to be true, full and complete to the best of my knowledge.

APPLICANT AND / OR RESPONSIBLE PARTY SIGNATURE (required)

_____ Date: _____
APPLICANT

_____ Date: _____
RESPONSIBLE PARTY