SITRIN
NeuroCare

SitrinNeuroCare.com

HOW TO APPLY FOR LONG-TERM RESIDENCE

We understand that the process of applying to a long-term residence facility can be a challenging time for families. We are committed to helping in the process as much as we can. If you have any questions regarding the admissions process, please call us at 1-888-578-8807, Option #4.

Step 1 - Application

To apply for admission to The NeuroCare Program at the Center, please complete and submit the enclosed Application for Admission. We ask that you provide all of the information requested, including the financial information, and print clearly. Once your Application for Admission has been received, the assessment can begin.

To help us expedite the admission process, please include with your Application for Admission:

- Four Authorization forms (enclosed) signed by the Applicant or Durable Power of Attorney (we will gather the applicantôs medical records)
- Completed Financial Guaranty form (enclosed)
- Copies of health insurance cards (both sides)
- Copy of Durable Power of Attorney (if applicable)
- Copy of Health Care Proxy or Living Will (if applicable)
- Copy of Guardianship Decree (if applicable)
- Verification for all assets listed in financial page of application (i.e., bank statements, Trust documents, etc.)

Please send your Application for Admission and the materials listed above to:

Sitrin Health Care Center
NeuroCare Admission
2050 Tilden Ave.
New Hartford, NY 13413

Step 2 - Assessment

Once we have received your completed Application for Admission, we will contact you and arrange for a meeting with the applicant, as well as his or her family. During this meeting, our staff will complete an assessment of the applicantôs current and projected care needs. All efforts will be made to accommodate a home visit, but alternate arrangements may be necessary.

Step 3 - Admission

Once the assessment is completed and you have been approved for admission, there may be a period of time before you can actually transfer to the Sitrin Health Care Center. Please keep in mind that there is a high demand for the quality of care provided at the Center and that we anticipate operating at close to maximum occupancy throughout the year. This period of time can vary greatly depending on bed availability; however, we will do everything we can to advance the process.

When a space does become available, the Admissions Office will contact you. It is expected that the applicant will be admitted within 1-2 weekdays of the offer for admission. If this is not possible, the applicant or family may choose to pay the current daily rate to hold the bed until the applicant is ready for admission. If the applicant chooses not to accept a bed offer, he/she will return to our waiting list.

Sitrin Health Care Center
2050 TILDEN AVE. | NEW HARTFORD, NY 13413
PHONE 1-888-578-8807, OPTION #4 | FAX 315-797-6955

APPLICATION FOR ADMISSION

APPLICANT INFORMATION FOR NEUROCARE PROGRAM

Applicant Name (First, Middle, Last)			Gender M F
Street Address and Apt. #			
City	State	Zip	
Residence Type: House Apartment With Family Senior Housing Assisted Living Nursing Home Other			
If at a temporary location (e.g., hospital or rehab setting) please provide name and location:			
Social Security Number	Phone Number ( )		
Date of Birth / Age / Birthplace			US Citizen Yes No
Ethnicity African American Asian Caucasian Hispanic Native American Other			
Religion	Primary Language		
Marital Status Single Married Widowed Divorced Separated			Spouseôs Name (if applicable)
Name of person completing this application			Relationship to applicant
How did you learn about Sitrin?			

Office Use Only
Date recôd: _____ SW: _____ Applicant #: _____
Copy to Fiscal: _____ MCD packet MCD Transition Forms G&R Form Date:_____

MEDICAL INFORMATION

Please provide name, address & phone numbers of applicant's medical care providers:

PHYSICIAN NAME	SPECIALTY	ADDRESS/ZIP	PHONE NUMBER
	Primary Care		

Does the applicant have a pacemaker? Yes No
If yes, please indicate physician managing pacemaker:

PHYSICIAN NAME	ADDRESS/ZIP	PHONE NUMBER

Please list any hospital admissions in the past 5 years, including psychiatric and nursing home admissions:

HOSPITAL	DATES	ADDRESS/ZIP	REASON FOR HOSPITALIZATION

Health Insurance Information

You must submit copies of all health insurance cards including *Medicare, HMOs, other insurance, and notices of eligibility for state or federally funded programs.*

MEDICARE INFORMATION	
Medicare Number	Are you enrolled in a Medicare HMO (e.g. Excellus Medicare Blue, Humana, United Health Care? Yes No
Do you have Medicare Part A? Yes No Part B? Yes No	Do you have Medicare Part D? Yes No Insurance I.D.# BIN #: PCN #: Group No.#: Effective Date:
If you are not eligible for Medicare, please explain:	

SUPPLEMENTAL INSURANCE		
Plan Name:	Policy #	
Company Name, Address and Phone Number (e.g., Blue Cross, AARP):		
Who is the insured? Patient Spouse	Name on Policy (if other than applicant)	
Policy Type Individual Group	Group Name (if applicable)	Group # (if applicable)

MEDICAID		
Medicaid Number	State of Origin	
Date Medicaid Application Filed	Location Filed	
I am not already enrolled on Medicaid, but I believe I may be eligible for Medical Assistance/Medicaid Yes No		

FINANCIAL INFORMATION

(CONFIDENTIAL)

INCOME	MONTHLY AMOUNT
Social Security	$
SSI	$
Pension	$
Trust	$
Other Monthly Income	$

ASSETS	DESCRIPTION	AS OF (DATE)	VALUE
Real Estate Owned			$
Savings Account			$
Checking Account			$
Retirement Account			$
Stocks and Bonds			$
Other Assets			$
Total Assets: Submit verification/s (recent statements) for above			**$**

Transferred Assets: Have you transferred any assets in the past 60 months? Yes, Date: __/__/__ No
If ñYes:ò Submit Verifications with this application.

Long Term Care Insurance Yes No (if yes, please provide copy of policy)

Pre-Need Burial Contract or Trust established Yes No

Person responsible for the applicant's financial matters:

Name _____

Address _____

Phone _____

Relationship to Applicant _____

IMPORTANT, PLEASE READ CAREFULLY: **MEDICARE Part A and Part B does not pay for "long-term care, such as custodial care in a nursing home."** Room and board long-term care is paid with private assets and income, long-term care insurance benefits, and/or Medicaid. We must know the source of payment in advance of admission. As an applicant, if you think you may be eligible for Medicaid on admission or within six months after admission, it is Sitrin Health Care Center policy that you complete a ***Medicaid*** application prior to admission.

CONTACT INFORMATION

Please list the names and addresses of family members and friends who should be contacted with information and/or in case of an emergency. We will be using this information both pre-admission and once the applicant has been admitted.

CONTACT #1		
Contact Name Mr. Mrs. Ms.		
Street Address and Apt. #		
City	State	Zip
Relationship to Applicant		
Role(s) *Check all that apply* Accountant Attorney Durable Power Of Attorney Elder Advocate Health Care Proxy Trustee Legal Conservator Legal Guardian Power of Attorney Paralegal Temporary Guardian		
Home ( )	Work ( ) Ext.	
Cell ( )	Pager ( )	
Fax ( )	Email	
SEASONAL ADDRESS (IF APPLICABLE)		
Address		
City	State	Zip
Dates From / To /	Phone ( )	

CONTACT #2		
Contact Name Mr. Mrs. Ms.		
Street Address and Apt. #		
City	State	Zip
Relationship to Applicant		
Role(s) *Check all that apply* Accountant Attorney Durable Power Of Attorney Elder Advocate Health Care Proxy Trustee Legal Conservator Legal Guardian Power of Attorney Paralegal Temporary Guardian		
Home ( )	Work ( ) Ext.	
Cell ( )	Pager ( )	
Fax ( )	Email	
SEASONAL ADDRESS (IF APPLICABLE)		
Address		
City	State	Zip
Dates From / To /	Phone ( )	

*Please note the #1 contact will be our main contact and alternates will be notified if contact #1 is not available, and so on.

CONTACT INFORMATION CONTINUED

CONTACT #3		
Contact Name Mr. Mrs. Ms.		
Street Address and Apt. #		
City	State	Zip
Relationship to Applicant		
Role(s) *Check all that apply* Accountant Attorney Durable Power Of Attorney Elder Advocate Health Care Proxy Trustee Legal Conservator Legal Guardian Power of Attorney Paralegal Temporary Guardian		
Home ( )	Work ( ) Ext.	
Cell ( )	Pager ( )	
Fax ( )	Email	
SEASONAL ADDRESS (IF APPLICABLE)		
Address		
City	State	Zip
Dates From / To /	Phone ( )	

CONTACT #4		
Contact Name Mr. Mrs. Ms.		
Street Address and Apt. #		
City	State	Zip
Relationship to Applicant		
Role(s) *Check all that apply* Accountant Attorney Durable Power Of Attorney Elder Advocate Health Care Proxy Trustee Legal Conservator Legal Guardian Power of Attorney Paralegal Temporary Guardian		
Home ( )	Work ( ) Ext.	
Cell ( )	Pager ( )	
Fax ( )	Email	
SEASONAL ADDRESS (IF APPLICABLE)		
Address		
City	State	Zip
Dates From / To /	Phone ( )	

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The next four (4) forms are Authorization forms. These forms authorize Sitrin Health Care Center to request medical records from doctors and/or hospitals on your behalf.

Please ONLY fill out the applicant's name, date of birth and social security number. **IF POSSIBLE, PLEASE HAVE THE APPLICANT SIGN THESE FORMS.** If you are signing as Health Care Agent, please include a copy of the Health Care Proxy. Some medical facilities will not accept documents signed by Health Care Agents unless there is also a written statement from an MD stating the Proxy has been invoked.

If you have a copy of the Durable Power of Attorney, that should be sent as well.

If you have any questions, feel free to contact us at 1-888-578-8807, Option #4.

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AUTHORIZATION FORM

For the Release of Protected Health Information to Sitrin

Patient/Resident Name (Please Print) _____

Date of Birth_____ **Social Security Number**_____

By signing this Authorization Form, I understand that I am giving my authorization to Sitrin's designated medical record or database custodians to request my protected health information (PHI) from the following person(s) or organization(s) named below:

_____

Name of Health Care Provider

_____

Street address

_____

City, State, and zip code

_____ _____

Telephone number Fax number

I specifically authorize the use and disclosure of the following PHI:
(Please provide a description of the particular data, such as doctors' notes, nurses' notes, etc., and period of time you are requesting).

_____

The information to be used or disclosed pursuant to this Authorization Form may include information relating to behavioral and mental health observations, which are part of the medical record.

I may revoke this authorization at any time by notifying Sitrin in writing to the Medical Records Department, 2050 Tilden Ave., New Hartford, NY 13413 of my intent to revoke this authorization. A Revocation Form can also be obtained by contacting the Medical Records Department. However, I also understand that such a revocation will not have any effect on any information already disclosed to Sitrin before HSL received my written notice of revocation.

Unless earlier revoked, this authorization will expire on the 180th day of the signing or as otherwise specified below:

_____

If neither federal nor state privacy laws apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by privacy laws.

I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization Form. Please make such intentions clear to the Medical Records Custodian when submitting this Authorization Form.

This Authorization is voluntary and I may refuse to sign this form.

I understand that I am not required to sign this Authorization Form in exchange for receiving treatment from Sitrin.

X_____ _____

Signature of patient/resident or Durable Power of Attorney **Date**

_____

Printed name of patient or resident

_____

Printed name of Durable Power of Attorney (if applicable)

_____

Relationship giving representative authority to act for patient/resident

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