THE NOTTINGHAM
CONFIDENTIAL DATA APPLICATION

PERSONAL INFORMATION

Applicant's Name: ____

First Middle Last

Present Address: ____

Street City State Zip

Home Phone Number: ____________________ Date of Birth: ____________________

Cell Phone Number: ____________________

Social Security Number: # ____

Marital Status: *(circle one)* SINGLE MARRIED WIDOWED DIVORCED

Name of Spouse: ____________________ Date of Birth: ____________________

(even if deceased)

Spouse's Social Security Number: ____

HEALTH INSURANCE COVERAGE *(Please Provide Copies of Any Marked "Yes")*

	APPLICANT		*SPOUSE*	
MEDICARE Part A *(circle one)*	YES	NO	YES	NO
MEDICARE Part B *(circle one)*	YES	NO	YES	NO
Medicare Number:	# ____________		# ____________	

SECONDARY INSURANCE CARRIER *(circle one)*	YES	NO	YES	NO

Address: ____

Street City State Zip

Group/Plan Number:	# ____________	# ____________

EMERGENCY INFORMATION

Notify:

1) Name: ______________________ Relationship: ______________________

Address: ____
Street City State Zip

Home Phone Number: ______________________ Work Phone Number: ______________________

Email Address: ______________________ Cell Phone Number: ______________________

2) Name: ______________________ Relationship: ______________________

Address: ____
Street City State Zip

Home Phone Number: ______________________ Work Phone Number: ______________________

Email Address: ______________________ Cell Phone Number: ______________________

PHYSICIANS:

Primary Care Physician: ____

Phone Number: ____

Address: ____
Street City State Zip

OTHER HEALTH/MENTAL HEALTH PROVIDERS:

Name: ______________________ Care Specialty: ______________________

Address: ______________________ Phone Number: ______________________
Street City State Zip

Name: ______________________ Care Specialty: ______________________

Address: ______________________ Phone Number: ______________________
Street City State Zip

HOSPITAL PREFERENCE: ____

ADVANCED DIRECTIVES:

HEALTH CARE PROXY	***LIVING WILL***	***NON-HOSPITAL D.N.R.***
YES NO	YES NO	YES NO

Please Provide Copies of any Marked "YES"

BURIAL INSTRUCTIONS (optional): ____

FINANCIAL DISCLOSURE STATEMENT *(Must be completed by each individual; joint holdings must be so noted)*

Please attach copy of recent account statements, or last year's income tax statements.

Sources of *Current* monthly income (record actual amount)

	APPLICANT	***SPOUSE***
Social Security:	______________	______________
Veterans Pension:	______________	______________
Other Pension Number:	______________	______________
Dividends:	______________	______________
Interest:	______________	______________
IRA/TDA/TSA:	______________	______________
Trust:	______________	______________
Other Income: (list sources)	______________	______________
Total Monthly Income:	$______________	$______________

Sources of *Cash* Assets (record actual amount)

	APPLICANT	***SPOUSE***
Savings:	______________	______________
Checking:	______________	______________
CDs:	______________	______________
Maturity Date:	______________	______________
Stocks & Bonds:	______________	______________
IRA/Annuities:	______________	______________
Life Insurance:	______________	______________
Cash Value:	______________	______________
Total Cash Assets:	$______________	$______________

Has the Applicant and/or spouse created a Trust? Yes ______No ________

Date Established: ____________________________ Attorney Name: ____

Is the applicant or spouse currently working with an attorney? Yes____ No

If yes, Attorney Name: ________________________ Phone Number: ____

Transfer of Assets within the last five years:

Asset Transferred	$ Amount or Value	Date of Transfer	Receiver Name

LONG TERM CARE INSURANCE

Company: ____ ____

Daily Benefit: $_______________________________________ $_______________________________________

Maximum Benefit: $_______________________________________ $_______________________________________

Real Estate: *(Please Provide Addresses)*: ____ Value: $________________

____ Value: $________________

Rental Property: YES NO Located at: ______________________________ Monthly Rental Income: $_________________

List all Debt and Obligations: ____

____

____

____

LEGAL INFORMATION:

PERSON RESPONSIBLE FOR FINANCES: *(who writes the checks)*

Name: ______________________________ Relationship: ______________

Address: ____

Street City State Zip

Home Phone Number: ____________________ Work Phone Number: ______________

Cell Phone Number: ____________________

POWER OF ATTORNEY: *(must furnish copy)*

Name: ______________________________ Relationship: ______________

Address: ____

Street City State Zip

Home Phone Number: ____________________ Work Phone Number: ______________

Cell Phone Number: ____________________

FINANCIAL DISCLOSURE STATEMENT:

PLEASE NOTE:

Both Federal and State laws impose severe penalties for obtaining Medicaid fraudulently. Therefore, you must provide an accurate and complete financial disclosure statement, which is required to decumbent the nature and use of your assets. This complete section of The Nottingham Residency Application and Financial Disclosure Statement may be used in the future, if necessary, to substantiate your request and application for Medicaid.

Please be advised that Federal Law prohibits the transfer of most assets for 60 months (5 years) prior to applying for Medicaid.

DEPOSIT AND APARTMENT RENTAL

1. A nonrefundable administrative processing fee of $________ is required at the time of application.

2. Upon application approval and acceptance of unit offered, the following will become payable and due:
   (All fees will be charged at rates existing at time of move-in.)

   First month's rent, in the amount of $_________________, will be payable prior to move-in.

3. Based on the financial information provided in this application, the applicant is approved / not approved for admission to the Nottingham's Residential Health Care Facility.

I hereby declare that all statements made herein are true to the best of my knowledge. I authorize you to verify financial information through credit checks and inquiry to financial institutions.

Applicant's Signature:____ Date: __________________

Spouse's Signature:____ Date: __________________
(if applicable)

The Nottingham Executive Director's Signature:____ Date: ________________

An approved application does not guarantee residency.

A Senior Living Community

1301 Nottingham Road • Jamesville, New York 13078 • (315) 445-9242

A Loretto Managed Community

www.thenottingham.org