COMMUNITY WELLNESS PARTNERS

Confidential Application for Admission

COMMUNITY OF INTEREST: (CHECK ALL YOU MAY WISH TO APPLY TO)

SKILLED NURSING/REHABILITATION

☐ Katherine Luther Residential Health Care & Rehabilitation Center

ADULT HOME/ASSISTED LIVING

☐ Lutheran Home of Central New York
☐ Presbyterian Residential Community
☐ Lutheran Home Cottages

OTHER SERVICES

☐ Katherine Luther -Adult Medical Day Health Care
☐ Presbyterian Residential Community - Adult Day Care Program Social
☐ Lutheran Home of Central New York - Adult Day Care Program Social
☐ Preswick Glen - Independent Living
☐ ESSHI - Independent Living @ The Meadows
☐ Home & Community Based Services

In the admission, retention and care of residents, Community Wellness Partners' communities do not discriminate in the provision of services with regard to race, color, blindness, gender, sexual preference, sponsorship, national origin, disability, age, marital status or any other protected class. All of the following information is necessary for admission and will be kept confidential. Any questions regarding this application may be answered by calling the Admissions Office at: **315.235.7132**

How soon would you like to enter the facility? _____

PERSONAL INFORMATION

Applicant's Name: _____ Phone Number: _____
Home/Previous Address: _____
Present Location/Address: _____
If a medical facility, date of admission: _____
Date of Birth:_____ Age:_____ Birthplace:_____ Religion_____
Marital Status:_____ Previous Occupation _____Education_____
Hobbies/Interests (Past & Present) _____Veteran (spouse of) Yes No
_____Veteran Service #_____
_____Branch of Service_____

Primary Contact Person_____ Relationship_____
Address:_____
Telephone Days:_____ Telephone Evenings_____
POA: _____POA Telephone: _____
Conservator: _____Estate_____ (include documentation)
Other Involved Parties:
Name _____Relationship _____
Address:_____
Telephone: Days _____Evenings_____

Name_____ Relationship_____
Address:_____
Telephone: Days_____ Evenings _____
Name of Health Care Proxy: _____Telephone:_____

MEDICAL INFORMATION

Name/address of current physician_____
_____Phone # _____
Names/phone number of all other medical providers (specialists)
Name: _____ Phone #:_____
Name: _____ Phone #:_____
Name: _____ Phone #:_____
Recent hospitalizations? (List Name of Hospital and dates hospitalized): _____
_____
Is applicant receiving community services? If so, please list agencies & contact information:
_____
Reason placement is needed _____
Attitude towards placement: Applicant _____Family_____
Anticipated length of stay_____
Diagnosis_____
Medications_____
What assistance does applicant require with personal care (i.e. dressing, eating, walking, etc.)?
_____
_____

Please list mental limitations or behavioral difficulties and successful management techniques.

_____

_____

FINANCIAL INFORMATION

Social Security #_____ Medicare #_____ Part A_____
Part B_____

NY State Medicaid (State Assistance) #_____
Does applicant have an application pending for State Medical Assistance (Title 19)?_____
If yes, date application submitted_____ Name of Office Caseworker _____
Is an attorney handling your application? _____ If yes, please provide attorney name and contact number. _____
Do you need assistance applying for Medicaid? _____
Does the applicant have a Long Term Care policy? _____ If yes, please provide the name, policy number and address. _____

_____

Other Medical/Hospital Insurance:

Name of Company	Subscriber/Group #	Type of Insurance
_____	_____	_____
_____	_____	_____

Life Insurance. (List only policies having a cash surrender value and give approximate cash surrender value): _____

Burial Information
Has applicant established an irrevocable burial account?_____
If so, name of funeral home and amount_____
Funeral home to be contacted in the event of death:

_____
Name Address Phone

INCOME

Social Security	$_____	VA Benefits	$_____
Pensions	$ _____/Mo.	Source	_____
Annuities	$ _____ /Mo.	Source	_____
Interest	$ _____ /Mo.	Source	_____
Dividends	$ _____ /Mo.	Source	_____
Other	$ _____/Mo.	Source	_____

Do you receive income from or have any interest in any trust?_____

If yes, please describe and provide a copy of the trust instrument._____

_____

ASSETS (If any asset is jointly held, please give name of joint owner).

Real Estate

Does applicant own any real estate? Yes No

Description of Property	Approximate Value	Name(s) on Deed

Are there any liens or mortgages against the property? Yes No
If yes, in the amount of $ _____ Payable to _____

Was this real estate your home prior to entering the nursing home? Yes No
Is your spouse now living in the home? Yes No

Do you have a "life use" of any real estate (any ownership interest, in full or in part, for your lifetime, or the right to occupy property for your lifetime)? Yes No
If yes, please describe _____

Cash Assets

Please list all assets including but not limited to: Savings Accounts, Checking Accounts, Stocks, Bonds, C.D.'s

Name of Institution and Account	Account #	Present Balance	Name on Account

Transfer of Assets

Within sixty (60) months prior to the date of this application, have you given away assets of any kind (cash, securities, real estate, etc.) or transferred assets of any kind (cash, securities, real estate, etc.) for less than fair market value? If so, please describe fully all such gifts or transfers, including the asset transferred, names, addresses and relationship to you of the person to whom the gift or transfer was made, and the value of the gift or transfer.

Gifts or transfers within 60 months: Yes No
Please describe _____

Within sixty (60) months prior to the date of this application, have you created any trusts, placed funds or any other assets in a trust that already existed, taken out any loans, mortgages, leases, or lines of credit ? Yes No
If yes, please describe and provide a copy of the trust instrument. _____

Does the applicant have any recurring financial obligations that will affect their ability to pay the private pay rate or their personal liability? Yes No
If yes, please attach a separate sheet detailing monthly expenses.

Applicants requesting long term care placement, adult home or assisted living are asked to provide 18 months bank and/or investment statements to verify assets; the first two pages of your most recent IRS forms 1040, the interest and dividend schedule from our most recent tax return.

I hereby certify that this is a true and complete statement of the applicant's current income and assets and any gifts or transfers for less than fair market value in excess of $1,000 and any trusts created or transfers of assets to any trust that they have made within the sixty (60) months prior to the date of this application.

Applicant : _____

Responsible Party: _____

NOTE: This application will be reviewed in accordance with the policies and procedures of the affiliates of Community Wellness Partners. The act of filing an application does not guarantee placement. Misrepresentation or falsification of any information provided in this application may result in the automatic denial of this application or may necessitate the subsequent discharge of the applicant from the Community Wellness Partners affiliate in which they are residing.

Revised: May 2026