



ADMISSIONS OFFICE
80 FAIRVIEW AVENUE
BINGHAMTON, NY 13904
PHONE: 607-724-2477 + FAX: 607-723-4724
WWW.GOODSHEPHERDCOMMUNITIES.COM

APPLICATION FOR ADMISSION

Good Shepherd Communities offers the following healthcare accommodations.
Please indicate the level for which you are applying:
(Please print in black ink)

Good Shepherd Village at Endwell

- Skilled Nursing Facility (SNF)
- Assisted Living Residence (ALR)*
- Special Needs Assisted Living Residence (SNALR)*

*Enhanced services available at both ALR and SNALR

Good Shepherd Fairview Home at Binghamton

- Skilled Nursing Facility (SNF)
- Assisted Living Program (ALP)
- Assisted Living Residence (ALR)*
- Apartments for Independent Living (APT)

*Enhanced services available at ALR

Chase Memorial

- Skilled Nursing Facility (SNF)

APPLICANT INFORMATION

Name in full:

- Ms. Miss Mrs. Mr.

Home Address (correspondence will be sent to applicant unless otherwise stated below):

Applicant's Mailing Address (if different than above):

Applicant's E-mail Address:

Telephone #: () _____

County of Residence: _____

Person to be contacted when an opening becomes available:

Telephone #: () _____

E-mail Address:



FINANCIAL INFORMATION

In accordance with Good Shepherds Communities' (GSC) Statement of Financial Responsibility, please complete the following personal financial information, which is required prior to admission and upon request after admission.

The information is needed to estimate the number of residents who will need financial assistance and to determine if the applicant has a source of payment, this information will be held in confidence and will not be released to any person, agency, or party other than the GCS and the GCSs advisors without the permission of the applicant.

List below all sources of individual income and/or individual assets, restricted or unrestricted. For joint ownership, please indicate the proportional value.

Please provide copies of all current bank and brokerage firm statements and list all amounts on this application. Please have available upon request a copy of HCP, POR, DMR and insurance card.

INCOME:

1. Social Security Income:

Presently receiving yearly
(after deductions for Medicare): \$ _____

2. Annuities or Endowment Income:

Company: _____
Plan of payment: _____
No. of years: _____
Per year: _____

Company: _____
Plan of payment: _____
No. of years: _____
Per year: _____

Company: _____
Plan of payment: _____
No. of years: _____
Per year: _____

3. Pension or Retirement Plans: (please indicate if applicant's or spouse's pension)

a. Is there a cost of living inflator and if so, how does it work?

b. If spouse's, what happens on death of a spouse?

Company: _____
Frequency of payment: _____
No. of years: _____
Amount per year: _____

Company: _____
Frequency of payment: _____
No. of years: _____
Amount per year: _____

Company: _____
Frequency of payment: _____
No. of years: _____
Amount per year: _____

4. Trust Funds: (You must provide a copy of the complete document, including any attachments, addendums and/or amendments)

Plan of Payment (For Life or No. of Years, etc.)
_____ Amount: \$ _____
_____ Amount: \$ _____

Who Administers: _____

Do you have access to the principal? Yes No

If yes, list amount \$: _____

5. Other Income

Source: Dividends & Interest – both taxable and non-taxable

Monthly: \$ _____ Yearly: \$ _____

Rental Income

Monthly: \$ _____ Yearly: \$ _____

Other (specify): _____

Monthly: \$ _____ Yearly: \$ _____

6. TOTAL YEARLY INCOME: \$ _____

PERSONAL INFORMATION

Date of Birth: _____

Birth Place: _____

Social Security Number: _____

Marital Status: Single Married Divorced
 Widowed

Name of Spouse (current or former): _____

Name of Spouse's Employer, if applicable:

Veteran Status: Yes No Branch: _____

Persons to contact if unable to contact applicant:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Hospital of Choice: _____

Church Affiliation: _____

Have you ever been a resident at Good Shepherd or another facility? Yes No

If yes to the above, please indicate where and when:

How did you hear about or choose Good Shepherd Communities? (check all that apply)

- Family/Friend Physician TV Radio
 Newspaper Internet Location Attorney
 Other (please describe):

Name of your personal physician:

Phone: _____

Name/address of attorney:

Name of person with access to any of your accounts:

Name of person with Power of Attorney for you:

Type of Power of Attorney: Durable General

Name of Healthcare Proxy:

Name of DSS (Medicaid) Caseworker:

HEALTH INSURANCE

Heath Insurance	Policy Number, Letter	Company Name
Medicare A/B		
Medicaid		
Supplemental Insurance		
Prescription/Medicare D		
Long-Term Care Insurance		
Commercial Insurance		

ASSETS:

- 7. Cash/Checking Accounts \$ _____
- 8. Savings Accounts \$ _____
- 9. Stocks \$ _____
- 10. Bonds/Treasuries \$ _____
- 11. Residence \$ _____
 - 11 a. Percent Owned % _____
- 12. Other Real Estate \$ _____
 - 12 a. Percent Owned % _____
- 13. CD & Mutual Funds \$ _____
- 14. Total Value of IRAs/TSAs \$ _____
- 15. Total Worth of Business Owned \$ _____
- 16. Automobile \$ _____
- 17. Life Insurance: face amount \$ _____
- 18. Net Cash Value \$ _____
- 19. Prepaid Funeral Account \$ _____
- 20. Where: _____
- 21. Other Assets \$ _____
- 22. TOTAL ASSETS** \$ _____

LIABILITIES

- 23. Installment Debts \$ _____
- 24. Insurance Premiums \$ _____
 - Long-Term Care \$ _____
 - Other \$ _____
- 25. Loan/Pledges against Stocks or Bonds \$ _____
- 26. Real Estate Loans \$ _____
- 27. Personal Notes, Loans, Guarantees \$ _____
- 28. Other Liabilities
 - _____ \$ _____
 - _____ \$ _____
 - _____ \$ _____
- 29. TOTAL LIABILITIES** \$ _____

- PLEASE NOTIFY GOOD SHEPHERD COMMUNITIES OF ANY SIGNIFICANT CHANGES TO THIS APPLICATION OR THE APPLICANT'S STATUS
- AT THE TIME AN OPENING OCCURS YOU MAY BE ASKED TO UPDATE THIS INFORMATION

Have you executed a trust for your own or someone else's benefit? Yes No

If yes, please provide a copy.

Have you gifted or transferred any assets to other persons or entities in the past 6 years? Yes No

If yes, please provide an explanation, dates, and amount. _____

Have you executed a promissory note or loan to other persons or entities in the past 6 years?

Yes No

If yes, please provide an explanation, dates, and amount. _____

Were you required to file a Federal or State Income Tax Return last year? Yes No

If yes, please provide a copy.

DECLARATION OF APPLICANT

In completing the application for admission, I/we understand that the filing of this application does not oblige the applicant to enter Good Shepherd Communities (GSC), nor does it guarantee admission to GSC, it merely places the applicant's name on the waiting list. I/we understand that I/we will be asked to update this information at such a time that the applicant may be considered for admission.

I/We, the undersigned, affirm that the answers to all the questions are complete and accurate to the best of my/our knowledge. I/We understand that any conveyance of a resident's assets without adequate consideration that renders the resident unable to pay GSC's bills as they become due, or that disqualifies the resident for Medicaid or SSI status for any period of time will be considered fraudulent by GSC. I/We will not, during residency, transfer or reduce resources needed to carry out my/our commitments to GSC.

Signature of Applicant:

Date: _____

Signature of Designee:

Date: _____