170 Murray Street
Auburn, NY 13021
(P) 315-253-2755
(F) 315-252-9970

Northbrook Heights Assisted Living Application for Admission

Application Date: _____

Applicant's Name: _____
(First) (Middle) (Last) (Suffix)

Date of Birth: _____ Social Security Number:_____
(MM/DD/YYYY)

Current Home Address:_____
_____

Home Phone:_____
Cell Phone: _____
Email:_____

Marital Status:_____
Name of Spouse:_____
(please give name of spouse-even if deceased)

Health Insurance Coverage (Please provide copies of proof of any Insurance listed below)
Please list Medicare or Medicaid and provide copies of your card(s) if applicable.

Insurance Name	Policy Number	Group &/or Plan Number

Do you intend to apply for Medicaid? (Y) (N)
Anticipated date of application: _____

Northbrook Heights requires a $250.00 Non-refundable application fee.
Please submit with your application.
Checks should be made payable to Northbrook Heights.

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship:_____
Home Address:_____
_____
Home Phone:_____
Cell Phone: _____
Email:_____

□ Representative
□ Next of Kin
□ Legal Guardian
□ POA
□ HCP

2. Name: _____ Relationship:_____
Home Address:_____
_____
Home Phone:_____
Cell Phone: _____
Email:_____

□ Representative
□ Next of Kin
□ Legal Guardian
□ POA
□ HCP

MEDICAL/HEALTH CARE PROVIDERS

Primary Care Provider:_____ Phone:_____
Address:_____
_____

Consulting Provider:_____ Phone:_____
Address:_____
_____

Consulting Provider:_____ Phone:_____
Address:_____
_____

Consulting Provider:_____ Phone:_____
Address:_____
_____

Consulting Provider:_____ Phone:_____
Address:_____
_____

Will Family transport to medical appointments? (Y) (N)
If yes, who will be the primary transport? _____

Immunizations:

Last INFLUENZA (FLU) date:_____ Last PNEUMOVAX (PNEUMONIA) date:_____
Date of First Covid Vaccine Shots: _____ Date of Second Covid Vaccine Shot:_____

FINANCIAL DISCLOSURE

Source	Applicant	Spouse
Social Security		
Veteran's Pension		
Other Pensions		
Annuities		
Interest Income		
Other Income		
Total Monthly Income		

Notes:

Asset Type	Institution Name	Account #	Current Balance or Cash Value
Checking Account			
Savings Account			
CD (Maturity Date)			
Annuities			
Life Insurance Policies			
Pre-paid Burial			
Total Cash Assets			

Notes:

REAL ESTATE/OTHER

1. Property Address:_____

_____

Appraised or Market Value: _____

2. Property Address:_____

_____

Appraised or Market Value: _____

Have you transferred any assets to another person within the past five (5) years? (Y) (N)

If yes, please state the value of the asset, to whom it was transferred, and the date of the transfer: _____

_____

_____

_____

Has the applicant or spouse retained the services of an attorney to obtain Medicaid eligibility? (Y) (N)

If yes, please state the current status of the eligibility process: _____

_____

_____

Please List current debt/financial obligations:

Business or Organization Name	**Type of Debt**	**Account Balance**	**Monthly Payments**

Burial Information

Funeral Home:_____ Address:_____

_____

Cemetary: _____ Address:_____

Grave: _____ _____

Instructions:_____

CERTIFICATION

I hereby certify that the information provided by me to Northbrook Heights is and will be correct. I agree to pay any expense due to Northbrook Heights because of incorrect information provided by me.

Name of Responsible Party (Person responsible for making payment to Northbrook Heights)
Name: _____ Relationship if other than Resident:_____

Address: _____
_____

Home Phone:_____
Cell Phone: _____
Email:_____

Signature: _____ Date: _____

Acknowledgement

I acknowledge and agree as follows:
I am financially responsible for any and all charges for care services provided to _____ (Name of Resident) by Northbrook Heights that are not covered by a third party insurer such as Medicaid.

- At all times I will be responsible for meeting the requirements of the third party insurer.
- I shall not assert any claim that I was relieved of financial responsibility in the absence of any express written agreement stating such.
- In the event litigation is filed for nonpayment charges, I agree to pay all expenses incurred by Northbrook Heights because of such litigation, including reasonable attorney's fees.

Name of Responsible Party (Person responsible for making payment to Northbrook Heights)
Name: _____ Relationship if other than Resident:_____

Address: _____
_____

Home Phone:_____
Cell Phone: _____
Email:_____

Signature: _____ Date: _____

Please proceed to next page

Please include the following items, as applicable, when returning completed application:

□ Non-refundable Application Fee
□ Copy of Social Security card
□ Copy of Medicare card(s)
□ Copy of Health Insurance card(s)
□ Copy of Medication/Part D Plan card(s)
□ Copy of Medicaid card(s)
□ Copy of EPIC card(s)
□ Copy of Picture ID
□ Copy of Social Security Award Letter/SSI Award Letter
□ Copy of VA Award Letter
□ Copy of Health Care Proxy
□ Copy of POA
□ Copy of Living Will
□ Copy of DNR
□ Copy of Burial
□ Copy of Life Insurance Policy(ies) including the Cash Value
□ Three (3) months of bank statements for all accounts: checking and savings
□ Verification of Property and Approximate Value
□ Verification of all resources: Bonds, Stock, CD's, 401k etc.
□ Verification of completed Medicaid Application, name of worker, and county applied in

If Northbrook Heights will be assisting in the Medicaid Application process, please provide the following documents as well as the above listed:
□ Six (6) months of bank statements for all accounts: checking and savings
□ Copy of Birth Certificate
□ Copy of Marriage Certificate
□ Copy of Spouse's Death Certificate
□ Vehicle Registration
□ Verification of all resources with the individuals name attatched to it

THANK YOU FOR CHOOSING NORTHBROOK HEIGHTS.
HOW DID YOU HEAR ABOUT US?

○ Family/Friend/Aquaintance ○ Newspaper ○ Radio ○ Television

○Website ○Brochure ○Open House/Community Event

○Church or social club ○ Social Worker/Case Worker

○ Other:_____