Our Lady of Consolation **Phone(631) 587-1600**
111 Beach Drive **Fax (631) 587-1640**
West Islip, NY 11795

FINANCIAL INFORMATION

Applicant's Name_____Date_____

Medicare No. (if applicable): _____ Suffix _____

Blue Cross SNF Coverage _____Yes _____No Supplemental _____Yes _____No
Group Contract No. _____ Certificate No. _____

Policy Holder's Name_____ Effective Date _____

Does applicant have any other Long Term Care Insurance? _____Yes _____No
If yes, Name of Insurance Co._____
Group_____
Address_____ Policy No._____
Name of Prescription Plan Coverage_____
Has MEDICAID been applied for? ____Yes ____No Type: _____Community _____Chronic Care
Name of Worker_____County_____Tel. No._____
Medicaid No._____Seq._____Date of Approval _____
If Other Hospital Insurance, please complete the following:
Name of Insurance Co._____
Group_____
Adress_____ Policy No._____
Will patient/resident pay privately? _____Yes _____No If yes, total amount available_____
Social Sec./Railroad Benefits $_____ Veterans Benefits$_____
Pension Benefit $_____ Company Name of Pension_____
Any Other Source of Income?
Annuities_____Stocks_____Bonds_____Dividends_____Other_____
If yes, give source and monthly dividend for each_____
_____
If Jointly Owned: Name/Address/Tel.No. of Joint Owner _____

Name of Bank **Amount**

Account No.

Checking: Joint____Yes____No

_____

Savings: Joint____Yes____No

_____

CD's: Joint____Yes____No

_____

Trusts: Joint____Yes____No

_____

Money Mkt:Joint____Yes____No

_____

Name/Address/Tel No. of Joint Owner

_____

Who holds Bank Books?

Name:_____Address_____

Does Applicant own property? (House, Condo, Etc.)

Location_____Value_____

Joint Owner's Name_____

Address_____

Has there been any transfer of funds or property within the past 60 months? ____Yes ____No

If yes, please explain_____

Does applicant receive rental income? _____Yes _____No Amount $_____

LIFE INSURANCE POLICIES

Company or Society **Policy No.** **Cash Value** **Beneficiary**

_____

_____

_____

_____

LEGAL AUTHORIZATION

Power of Attorney:

Name_____

Guardian (If applicable)_____

Who is responsible for paying monthly bills on the first of each month?

Name_____Relationship_____

_____

Address_____

_____

Signature of Applicant/Responsible Person_____Date_____

Our Lady of Consolation prohibits discrimination based on race, color, creed, national orgin, sex, sexual preference, age,

handicap, marital or veteran status, or source of payment as contained in the N.Y. State and Federal Laws. Revised 1/09