WMC Health | Schervier Pavilion

Westchester Medical Center Health Network

Thank you for considering Schervier Pavilion!

In order for the Admission process to be completed, we will require the following documentation:

1. A signed, completed application.
2. Copies of bank statements or other proof of assets/income.
3. Patient Review instrument (PRI) & screen completed by a certified screener and completed within the last 90 days. Mandatory for Skilled Nursing & Rehabilitation residents.
4. Copy of Medicare card, Medicaid card, and any other insurance cards including all prescription plans. Please provide a copy of the front & back of all cards.
5. Advanced Directives that may currently be in place, such as DNR, MOLST form, Health Care Proxy, Living Will and/or Power of Attorney should be presented either before or at the time of admission.

Schervier Pavilion provides a laundry service of washable clothing for all residents. Any clothing entering the facility must be left with the front desk to be sent to the Laundry department for labeling. **Clothing MUST be labeled by our Laundry department in order to prevent loss.** Please leave clothing with our receptionist in plastic bags in the lobby at the time of admission.

If you have any questions, we can be reached at 845-987-5750. If we are not available please leave a voice message and we will return your call. Thank You.

Sincerely,

Betty Tiedemann, RN Clinical Liaison
Cortney Wright, Admissions Coordinator

SCHERVIER PAVILION
22 VAN DUZER PLACE
WARWICK, NY 10990
845-987-5750

SKILLED NURSING AND REHABILITATION

FEE SCHEDULE

ACCOMMODATIONS:

PRIVATE ROOM	$407.00 PER DAY + 6.8% TAX
SEMI-PRIVATE ROOM	$369.50 PER DAY + 6.8% TAX

WMC Health | Schervier Pavilion

Westchester Medical Center Health Network

Admission Application

This application must be completed and returned within 3 business days.

Date:_____ Care Manager: _____

Patient Name:_____ MR Number:_____

Contact Person:_____

Relationship:_____

Contact Phone Numbers: Cell:_____Home:_____

Best Time to Call: _____

Power of Attorney: _____

If you are in need of post-hospital care before returning home, consideration for admission to a nursing facility requires clarification of a payment source. Coverage of your insurance varies based on your individual benefit and more importantly the type of care you may require upon admission to a nursing facility. Every patient's eligibility for coverage by insurance is different. If you are in need of custodial care, which is help with walking, feeding, bathing, taking medication and other daily activities, this is often not covered by insurance. We will inform you if you appear to need custodial care. If you have skilled needs some of your stay in a nursing facility may be covered by your health insurance. However, insurance coverage frequently has time limits. Even if you are covered upon admission, the period of coverage is continually evaluated by your insurance carrier. Since the nursing facility does not know how long you will need to stay or if your benefit will cover some or all of your stay, ensuring a payment source is absolutely necessary. We know this may be hard to understand, but all facilities need to anticipate the payment source for all admissions, short or longer term stays.

Can this patient pay 6 months or longer at approximately $400-$450/day for room and board?

_____Yes _____ No (This $ amount can vary depending on the facility)

If yes, please provide copies of most recent banking statements. If no, more specific information will be required about your finances. An application for Medicaid may also need to be completed. Your Care Manager will guide you through the process.

The remainder of this application will need to be completed. If you do not return this Universal Application, we will help you arrange services for a discharge home when your physician indicates you are medically stable.

UNIVERSAL APPLICATION

General Information:

Patient's Name: _____ Sex: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Name of husband or wife and address if living: _____

US Citizen: YES or NO Place of Birth: _____

Social Security #: _____ Religion: _____

With whom does the patient currently live? _____

Current Address: _____

Primary Language: _____ Secondary Language: _____

Reads: _____ Writes: _____

Education Level: _____ Occupation: _____

Present Facility: _____ Room #: _____

Primary Care Physician: _____

Advanced Directives: _____Yes _____No (Please attach living will, DNR, DNI, etc.)

Next of Kin: _____ Relationship: _____

Next of Kin address: _____

Next of Kin Contact Numbers: Home/Cell/Work

H: _____ C: _____ W: _____

Insurance Information:

Medicare Part A: Yes No ID Number: _____ Effective Date: _____
Medicare Part B: Yes No ID Number: _____ Effective Date: _____

Medicare Supplement Plan: Yes No Plan Name: _____
ID Number: _____ Group Number: _____
Effective Date: _____ Phone Number: _____

Do you have a Managed Medicare Plan? Yes No IF YES, name of plan: _____

Other Supplemental Insurance? _____

Have you applied for Medicaid? YES NO Has all the information been provided? YES NO

Application Date: _____ Effective Date: _____

Medicaid ID Number: _____ County: _____

Do you have a Managed Medicaid Plan? Yes No If yes, Name of plan: _____

Do you have Long Term Care Insurance? Yes No If yes, Name of plan: _____

Policy #: _____ Phone Number: _____

Please circle:
Do you or your spouse have Life Insurance? Yes No If yes, what is the current cash value? _____

Please circle:
Are you or your spouse Veteran Service Connected? Yes No
Are you receiving Veteran Pension Benefits? Yes No
Are you receiving other Veteran's financial benefits? Yes No

Please circle:
Do you have a Power of Attorney? Yes No Name & Phone Number: _____

Do you have a Healthcare Proxy? Yes No Name & Phone Number: _____

Financial Information:

Please provide applicant's monthly income and if married the combined income:

Social Security: $_____ Private Pension: $_____

Annuity: Total Amount: $_____ Veteran's Pension: $_____

Trusts: $_____ Railroad Pension: $_____

Rental Property: $_____ Stocks/Bonds: $_____

Interest Payments: $_____ Other Income: $_____

Are you a party to a Promissory Note? Yes No

Checking Account: Joint? Yes No With whom? _____

Bank: _____ Balance: $_____ Date: _____

Bank: _____ Balance: $_____ Date: _____

Savings Account: Joint? Yes No With whom? _____

Bank: _____ Balance: $ _____ Date: _____

CDs:

Bank: _____ Balance: $ _____ Date: _____

Stocks:
Name of Stock: _____ Number of Shares: _____ Market Value: _____

(Please list any other assets not mentioned here on a separate sheet of paper)

Property:
Does the applicant own a home? Yes No Estimated Value: $_____

Is the home jointly owned with anyone? Yes No With whom? _____

Other real estate holdings? Yes No Estimated Value: $_____

Any lien, mortgages, or home equity loans on above property? Yes No

Miscellaneous Assets:

Has the applicant gifted or given away any funds, property, or assets to anyone in the last 60 months (5 years)? (This includes birthday, wedding, graduation gifts, charitable gifts, etc.)

_____No _____Yes If yes, when_____ How much was given? $_____

To whom was it given? _____

Has an estate trust been established? Yes No If yes, when? _____

Is the Trust Revocable or Irrevocable? _____ What was placed in the Trust? _____

Has anything been transferred into the Trust since its inception (particularly within the past 5 years)? Yes No

If Yes, when? _____ How much? _____

(Please be prepared to provide a copy of the trust should it be needed.)

Funeral Arrangements:

Funeral Home: _____

Address & Phone Number: _____

Prepaid burial? Yes No Amount: $_____

To the best of my knowledge, all of the information provided in this application is correct. I fully understand that the information contained in this form will be shared with the nursing facility. Federal and State Law prohibit this facility from denying admission to anyone because of race, creed, national origin, marital status, religion, sex, handicap, sexual preference or sponsorship.

_____ _____
Signature of applicant or responsible party Date

_____
Printed name of applicant or responsible party