The GreenFields
Continuing Care Community

Confidential Data Application

All Information Will Be Held Confidential

Check Appropriate Facility:

☐ **GreenField Health/Rehabilitation Center** - *Skilled Nursing*
5949 Broadway Lancaster, NY 14086 (716) 684-3000

☐ **GreenField Terrace** - *Assisted Living & Memory Care*
5979 Broadway Lancaster, NY 14086 (716) 684-8400

☐ **GreenField Court** - *Assisted Living*
5951 Broadway Lancaster, NY 14086 (716) 684-8400

☐ **GreenField Manor** - *Residential Living*
5953 Broadway Lancaster, NY 14086 (716) 684-8400

Please Print Clearly or Type

Applicant Name:_____
Last First Middle

U.S. Citizen ☐ Yes ☐ No
Veteran ☐ Yes ☐ No
Spouse Veteran ☐ Yes ☐ No

Address: _____
Street

_____
City State Zip Code

Phone #: Home (_____)_____-_____ Cell (_____)_____-_____

E-mail Address:_____

Birth Date: _____/_____/_____ Social Security #: _____-_____-_____
Month Day Year

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Spouse/2nd Person Name:_____
Last First Middle

U.S. Citizen ☐ Yes ☐ No
Veteran ☐ Yes ☐ No
Spouse Veteran ☐ Yes ☐ No

Address (*if different*): _____
Street

_____
City State Zip Code

Phone #: Home (_____)_____-_____ Cell (_____)_____-_____

Birth Date: _____/_____/_____ Social Security #: _____-_____-_____
Month Day Year

Applicant's Additional Information (If applying for skilled nursing care or assisted living)

Health Care Proxy ☐ Yes ☐ No Living Will ☐ Yes ☐ No Do Not Resuscitate Order ☐ Yes ☐ No

Medicare ☐ Yes ☐ No; If Yes # _____ Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No

Medicaid: ☐ Yes ☐ No ☐ Pending; If yes, ID #:_____County:_____Eff. Date:_____

SSI: ☐ Yes ☐ No

Health Insurance:_____ Policy #: _____

Other Health Insurance:_____ Policy #: _____

Prescription Drug Plan:_____ Effective Date: _____/_____/_____

Rx ID_____ Rx Group _____ Rx Bin_____ Rx PCN _____

Other Prescription Plan:_____ Policy #: _____

Long Term Care Insurance:_____ Policy #: _____

Dates of last hospital stay: From_____ To_____ Where:_____

Dates of last nursing home stay: From_____ To_____ Where:_____

Return to present residence if nursing home care is no longer needed? _____Possible _____Not Possible

Health Condition (**must be completed**):_____

_____

_____

Primary Physician's Name: _____

Office Address: _____
Street

_____
City State Zip Code

Office Phone #: (_____) _____-_____ Fax #: (_____) _____-_____

Consultant Physician's Name: _____ Specialty _____

Office Address: _____
Street

_____
City State Zip Code

Office Phone #: (_____) _____-_____ Fax #: (_____) _____-_____

Spouse/2nd Person Additional Information (If applying for skilled nursing care or assisted living)

Health Care Proxy ☐ Yes ☐ No Living Will ☐ Yes ☐ No Do Not Resuscitate Order ☐ Yes ☐ No

Medicare ☐ Yes ☐ No; If Yes # _____ Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No

Medicaid: ☐ Yes ☐ No ☐ Pending; If yes, ID #:_____County:_____Eff. Date:_____

SSI: ☐ Yes ☐ No

Health Insurance:_____ Policy #: _____

Other Health Insurance:_____ Policy #: _____

Prescription Drug Plan:_____ Effective Date: _____/_____/_____

Rx ID_____ Rx Group _____ Rx Bin_____ Rx PCN _____

Other Prescription Plan:_____ Policy #: _____

Long Term Care Insurance:_____ Policy #: _____

Dates of last hospital stay: From_____ To_____ Where:_____

Dates of last nursing home stay: From_____ To_____ Where:_____

Return to present residence if nursing home care is no longer needed? _____Possible _____Not Possible

Health Condition (**must be completed**):_____

_____

_____

Primary Physician's Name: _____

Office Address: _____
Street

_____
City State Zip Code

Office Phone #: (_____) _____-_____ Fax #: (_____) _____-_____

Consultant Physician's Name: _____ Specialty _____

Office Address: _____
Street

_____
City State Zip Code

Office Phone #: (_____) _____-_____ Fax #: (_____) _____-_____

Must be completed for all levels of care

Pre-Paid Funeral Arrangements

Applicant: Funeral Home _____

Phone #: (_____) _____-_____

Spouse/2nd Person: Funeral Home _____

Phone #: (_____) _____-_____

Emergency Contacts/Financial Representative/Power of Attorney/Health Care Agent/Guardian

1. Name:_____ Bill To: ☐ Yes ☐ No
Last First Middle Power of Attorney: ☐ Yes ☐ No
Health Care Agent: ☐ Yes ☐ No
Guardian/Conservator ☐ Yes ☐ No

Address: _____
Street

_____
City State Zip Code

Relationship: _____ E-mail Address: _____

Phone #: Home (_____)_____-_____ Work (_____)_____-_____ Cell (_____)_____-_____

2. Name:_____ Bill To: ☐ Yes ☐ No
Last First Middle Power of Attorney: ☐ Yes ☐ No
Health Care Agent: ☐ Yes ☐ No
Guardian/Conservator ☐ Yes ☐ No

Address: _____
Street

_____
City State Zip Code

Relationship: _____ E-mail Address: _____

Phone #: Home (____)_____-_____ Work (_____)_____-_____ Cell (____)_____-_____

Trust Applicant: ☐ Yes ☐ No If yes, ☐ Revocable ☐ Irrevocable
Spouse/2nd Person: ☐ Yes ☐ No If yes, ☐ Revocable ☐ Irrevocable

Life Estate Applicant: ☐ Yes ☐ No Spouse/2nd Person: ☐ Yes ☐ No

Annuity Applicant: ☐ Yes ☐ No If yes, ☐ Structured ☐ Liquid
Spouse/2nd Person: ☐ Yes ☐ No If yes, ☐ Structured ☐ Liquid

Please provide copy(s) of trust and/or life estate documents.

Financial Statement

Must be completed for each individual

Assets must be in individual's name and joint holdings must be so noted with percentage of interest

ALL INFORMATION WILL BE HELD CONFIDENTIAL

REGULAR MONTHLY INCOME	1st Person	2nd Person
Social Security/SSI	$	$
VA Pension	$	$
Pension* From_____	$	$
Dividends	$	$
Mortgage/Rental Income	$	$
IRA Income	$	$
Annuity Income	$	$
Trust Income	$	$
Other Monthly Income (specify)	$	$
Total Monthly Income	$	$

*Upon death of spouse, what percent/amount of the pension will surviving spouse receive? _____

CAPITAL ASSETS	1st Person	2nd Person
Cash - Savings Bank Name_____ Bank Name_____	 $ $	 $ $
Cash - Checking Bank Name_____ Bank Name_____	 $ $	 $ $
CD's, Money Markets, etc.	$	$
Stocks and Bonds	$	$
IRA's	$	$
Annuities	$	$
House (value in applicant(s) name) Address_____ _____	$	$
Other Real Estate Type_____ Address_____ _____	$	$
Trust Fund (attach copy)	$	$
Other Assets (specify)	$	$
Total Assets	$	$

CAPITAL ASSETS Cont.	1st Person	2nd Person
Life Insurance (cash value)	$	$

LIABILITIES	1st Person	2nd Person
Credit Card(s) - Total Balance Due	$	
Mortgage	$	
Auto Loan(s) - Total Balance Due	$	
Other Liabilities (specify)	$	
Total Liabilities	$	

Have you transferred any asset valued over $1,000 in the past five (5) years? Yes_____ No_____

If yes, please indicate the specifics below. NLHS reserves the right to request official documentation of any such transfer. Your failure to disclose this information may affect your admission application.

Asset Transferred	Amount	Name Asset Was Transferred To	Date of Transfer

I hereby declare that all statements made herein are true according to my best knowledge and belief. In witness whereof, I have hereunto set my hand to this application this _____ day of _____ 20_____.

_____ _____

Signature of 1st Person/POA/Responsible Party Signature of 2nd Person/ POA/Responsible Party

****NOTE: Please enclose copies of any POWER OF ATTORNEY, GUARDIANSHIP and/or HEALTH CARE PROXY FORMS, SOCIAL SECURITY CARD, ALL INSURANCE CARDS (front and back), MONTHLY INCOME CHECKS, LONG TERM CARE INSURANCE POLICY and TRUST FUND.**

State and federal laws prohibit discrimination because of age, race, creed, gender, marital status, disability, sexual preference, national origin, payer source or having/not having an advance directive.

EQUAL HOUSING OPPORTUNITY

Revised June 2017

Frequently asked questions
GreenFields Continuing Care Community

What levels of care are offered?

- Independent Living
- Assisted Living
- Assisted Living-memory care
- Assisted Living-enhanced
- Skilled Nursing
- Rehabilitation- Inpatient
- Rehabilitation- Outpatient therapy
- Respite care

What are the financial qualifications to move-in to the GreenFields?
Each facility has its own financial guidelines and requirements. When you come for a tour, we will discuss the appropriate level of care for your needs and the financial guidelines for that level of care.

What forms do I have to fill out to be considered for GreenField Manor, Court, or Terrace?
You will be asked to fill out a Confidential Data Application. You will also be asked to disclose any Life Estate, VA Benefits, Long Term Care Insurance, and Trusts.

What happens if I am a resident and need to move to a different level of care? Am I guaranteed a place?
No, we do not guarantee a place at the other levels of care, however we do want you to remain on our campus if at all possible and will give you priority access to the other levels of care if you meet the criteria. Because each facility has its own financial guidelines and requirements, if you need to move from one level of care to another, you will be asked to fill out a updated application. Your assets/income will be compared against the financial requirements of the facility you are moving to. We will take into consideration the length of time you have lived on our campus, if you had any transfer of property or assets, etc. when we evaluate the updated application.
When you submit an application, we are relying on this information being accurate and complete. Providing incomplete or untruthful information may jeopardize your continued stay at the facility or prevent you from moving to a different level of care.

What happens to my apartment/room if I temporarily go to the hospital or to a Rehabilitation Center?
Your Manor, Court, or Terrace apartment/room will be kept for you as long as you are out of the facility, as you are still occupying the apartment/room. You will have to pay the monthly fee, in addition to the charges incurred at the hospital/rehabilitation center. If you chose to give up your apartment/room please let us know. Charges will continue until the apartment/room is fully vacated and keys are returned, if applicable.

Per my signature, I acknowledge that the above information has been reviewed with me and my questions have been answered:

_____	_____	_____
Applicant Name	Applicant Signature	Date
_____	_____	_____
Applicant Name	Applicant Signature	Date