Sunnyside Care Center
Application For Admission

Name: ____

Address: ____
____

Phone: ____
Email: ____

DOB: ____

Has this individual applied for Long Term Care Medicaid? _______ YES _______ No
If yes, through which County? ____

POA Name ____
POA Phone # ____

INSURANCE INFORMATION

Primary Insurance ____
Policy #____

Secondary Insurance ____
Policy# ____

Additional Insurance ____
Policy#____

LTC Insurance Plan ____

FINANCIAL INFORMATION

Social Security Income ____
Spouse Social Sec Income ____
Alimony ____
Veterans Benefits ____

Homeowner ______ Yes ______No

Wages ____
Self-Employment ____
Workers Comp ____
Private Disability ____

Pensions/Annuities ____
Dividends/Interest Income ____
Stocks/Bonds, Mutual Funds Name____
Approximate Value______________________________
Name____
Approximate Value______________________________

Rental Income ____
Rental Property Value ____
Liens on Property ____

Bank Info Name____
Approximate Balance ____________________________

Name____
Approximate Balance ____________________________

Name____
Approximate Balance ____________________________

Life Insurance Company_____________________________________
Cash Value_____________________________________

Please submit with a PRI (Patient Review Instrument) and Screen* to:
Director of Admissions
FAX 315-656-7394
EMAIL smahony@sunnysidecare.com

***(A PRI must be ordered by a physician/primary care provider)**