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
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: __________________

Bon Secours Health System, Inc. Good help to those in need 22 VanDuzer Place Warwick, NY 10990 845-987-5717
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)

Ben Secours Health System, Inc. Good help to those in need. 22 Van Duzer Place Warwick, NY 10990 845-987-5717
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