NEW YORK STATE DEPARTMENT OF HEALTH
Office of Primary Care and Health Systems Management

Special Needs Assisted Living Voucher Demonstration Program for Persons with Dementia

Instructions: This application is to be completed by the resident or the resident's authorized representative.
Scan the completed form, and email to: **ALTCteam@health.ny.gov**

Or, mail to: **New York State Department of Health**
ALTC Team
Empire State Plaza
Corning Tower, Suite 1415
Albany, NY 12237

Section 1: Resident's Details

Name of Resident _____

Name of Facility _____

Facility Address _____
STREET

_____ NY _____
CITY STATE ZIP

County of Facility _____

When did the resident move into the Special Needs Assisted Living Residence? _____
MM/YY

When did the resident move into the Assisted Living Residence (if applicable)? _____
MM/YY

Resident's Date of Birth _____
MM/DD/YYYY

Gender
- ☐ Male
- ☐ Female
- ☐ Choose not to respond

Marital Status
- ☐ Married
- ☐ Widowed
- ☐ Divorced/Separated
- ☐ Single

Race/Ethnicity (mark all that apply)
- ☐ American Indian
- ☐ Asian
- ☐ Asian/Pacific Islander
- ☐ Black/African American
- ☐ Hispanic
- ☐ White/Caucasian
- ☐ Other _____

Diagnosis
- ☐ Alzheimer's Disease
- ☐ Dementia Unspecifed
- ☐ Mild Cognitive Impairment
- ☐ Vascular Dementia
- ☐ Frontotemporal Dementia
- ☐ Lewy Body Dementia
- ☐ Other _____

If Resident's Details were completed by the resident's representative, the representative must complete this section.

Representative's Details

Name of Representative _____

Relationship to Resident _____

Telephone _____ Email _____

Address _____
STREET

_____ _____ _____
CITY STATE ZIP

Section 2: Resident's Financial Details

What is your current monthly service fee per your residency agreement (including addenda)? $ _____

What is your current monthly payment to the facility (if different than above)? $ _____

What is your current total monthly household income? $ _____

Are the resident's resources less than or equal to six (6) months of the average regional monthly cost of a Special Needs Assisted Living Residence for the region where you reside (please refer to **Regional Costs of Care** chart below)? ☐ YES ☐ NO

Has the resident transferred resources or assets that equal more than three (3) months of the average regional monthly cost of a Special Needs Assisted Living Residence in the region where you reside within one year prior to this application date (please refer to **Regional Costs of Care** chart below)? ☐ YES ☐ NO

Is the resident on Medicaid and/or Medicaid eligible? ☐ YES ☐ NO

Regional Costs of Care

Region		Average Monthly Service Cost
Capital District	Albany, Columbia, Delaware, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie	**$7,118**
Central	Broome, Cayuga, Cortland, Chenango, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga, Tompkins, St. Lawrence	**$5,939**
Finger Lakes	Chemung, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Yates	**$6,079**
Hudson Valley	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	**$9,993**
Long Island	Suffolk and Nassau	**$9,089**
New York City	Bronx, Kings, New York, Queens, Richmond	**$10,602**
Northeast	Clinton, Essex, Franklin, Hamilton, Warren, Washington	**$5,800**
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Wyoming	**$6,401**

Certification

I, or my authorized representative, who has power of attorney, certify that, to the best of my or their knowledge, and under penalty of perjury, all the information on and attached to this application is true, correct, complete, and made in good faith. I, or my authorized representative, who has power of attorney, understand that false or fraudulent information on or attached to this application may be grounds for invalidating my application or disqualifying my eligibility. Further, I, or my authorized representative, who has power of attorney, understand that any information that is voluntarily provided on or attached to this application may be investigated. I, or my authorized representative, who has power of attorney, will update any and all information and notify the Department of Health immediately of any changes.

I, or my authorized representative, who has power of attorney, certify and consent that the Department of Health has a right to audit this application and have access to all information relevant to or submitted in or with this application.

I, or my authorized representative, who has power of attorney, understand that once approved, this application is valid for twelve (12) months only.

Signature _____ Date _____

Print Name _____