ADMISSION APPLICATION

Please complete ALL of the following information: Date: _____

Applicant's Name: _____ (Last) _____ (First) _____ (Middle)

Home Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Telephone # ( )_____ Birthdate:_____ Age:_____ Citizen: _____ Sex:_____

Social Security:_____

Marital Status: Married____ Single____ Widowed____ Divorced____ Name of Spouse: _____

Number of Living Children: _____ Are you a Veteran: Yes_____ No_____

Religion:_____ Spouse a Veteran: Yes_____ No_____

Former Occupation:_____

_____

Present location of Applicant if other than his/her home: _____

_____

Most recent date of admission to hospital, Nursing Home, or rehabilitation center (if applicable) _____

Reason for admission to above: _____

_____

Medicare Number_____ Part A_____ Effective Date _____

Medicare Number_____ Part B_____ Effective Date _____

Medicaid Number_____ Effective Date _____

Do you have long-term or supplemental insurance?_____ If yes, please describe: _____

_____

Certificate #_____ Group #_____Class/Type _____

Certificate #_____ Group #_____Class/Type _____

Other Medical Insurance: _____

Prescription Insurance: _____

Applicant's attending Physician: _____

Funeral Home:_____ Funeral prepaid: _____

Persons to be notified in case of an emergency:

Name: _____ Relationship: _____

Address: _____ Telephone #: _____ Home

_____ Telephone #: _____ Business

Name: _____ Relationship: _____

Address: _____ Telephone #: _____ Home

_____ Telephone #: _____ Business

THIS IS A SMOKE FREE FACILITY

THIS FACILITY ACCEPTS ALL RESIDENTS WITHOUT REGARD TO RACE, CREED, COLOR, NATIONAL ORIGIN, HANDICAP, SEX, AGE, SPONSOR, MARITAL STATUS AND SEXUAL PREFERENCE

APPLICATION FINANCIAL REPORT (ALL INFORMATION IS CONSIDERED CONFIDENTIAL)

Applicant's Name _____

Power of Attorney for Estate or person responsible for bill (trust officer, lawyer, family member)

Name: _____

Address: _____

Monthly Income of Applicant:

Social Security or Disability _____

Pensions (Retirement, Railroad, Veterans) _____

Is income deposited directly into applicant's bank account? _____

If yes, specify account: _____

If not, how is income received? _____

Other Monthly Income (Example: Rental Income, Disability, etc) _____

Please explain: _____

Assets:

Savings Account (please provide copy of current bank statement)

Bank _____ Amount $_____

Bank _____ Amount $_____

Checking Account (please provide copy of current bank statement)

Bank _____ Amount $_____

Other (CD's, Money Market Fund, Living Trusts, Trusts: Amount $_____

Type of Trust (i.e. Income only) _____

Stocks, Bonds _____ Amount $ _____

Insurance Policies (Life or Medical) _____ Cash Value $ _____

Real Estate _____

Liabilities _____

AUTHORIZATION:

All financial information provided to this facility is complete and correct. I understand that this facility will verify my bank references and credit history, and I authorize this. I agree to notify the facility should there be any changes in the financial condition. I also understand this information will be kept confidential.

_____

Applicant's and/or Responsible Party's Signature (REQUIRED)

_____

Date

At the time of application, is there any real estate owned by the resident? Yes_____ No _____
If YES, please answer the following:

Address of real estate:

① _____

_____

_____

Homestead: Yes_____ No _____
Commercial Property: Yes_____ No _____

When was the property purchased?_____(Year)
Is it currently on the Market? Yes_____ No _____
Realtor?_____ Phone Number_____

Did the resident reside at this location before admission into the Nursing Home or Hospital? Yes_____ No _____

Is there a spouse in the community? Yes_____ No___
If YES, does the spouse reside at the above address? Yes_____ No _____

Value property assessed at:_____

Are there any known LIENS/JUDGMENTS/ BACK TAXES? Yes_____ No _____
If YES, amount of judgment filed against the property:_____

② _____

_____

_____

Homestead: Yes_____ No _____
Commercial Property: Yes_____ No _____

When was the property purchased?_____(Year)
Is it currently on the Market? Yes_____ No _____
Realtor?_____ Phone Number_____

Did the resident reside at this location before admission into the Nursing Home or Hospital? Yes_____ No _____

Is there a spouse in the community? Yes_____ No___
If YES, does the spouse reside at the above address? Yes_____ No _____

Value property assessed at:_____

Are there any known LIENS/JUDGMENTS/ BACK TAXES? Yes_____ No _____
If YES, amount of judgment filed against the property:_____

At the time of application, were there any transfers of property/funds within the past 60 months? Yes_____ No _____If YES, please answer the following:

When was it transferred?_____(need exact date)
Was it transferred to SPOUSE/CHILD/OTHER_____

Are there any living trusts? Yes_____ No _____
If YES, what is the Attorney's Name:_____
Address:_____
Phone Number:_____

AUTHORIZATION:

All financial information provided to this facility is complete and correct. I understand that this facility will verify my bank references and credit history, and I authorize this. I agree to notify the facility should there be any changes in the financial condition. I also understand this information will be kept confidential.

_____
Applicant's and/or Responsible Party's Signature (REQUIRED)

_____
Date