Financial Application

Date: ________________________

Resident's Name: ____
Last First Middle

Home Address: ____

City: _______________________________________ State: ____________________ Zip: ________

Phone: __________ Date of Birth: _____________ Marital Status: ________ Sex ___M ___F

Is resident currently hospitalized? If so, date of hospitalization ___________________________

Physician: ____

Has the resident been admitted to another Nursing Home or hospital within the past year?

No _____ Yes _____ Where? ____

When? Admission Date: __________ Discharge Date: _________

AGENT INFORMATION

Agent: Name _____________________________ Relationship ______________________________

Address: ____

City: _______________________________________ State: ____________________ Zip: ________

Home Phone: ________________________________ Work Phone: _________________________

Is there a **Power of Attorney**? _____ No _____ Yes If yes, Please attach a copy.

Is there a **Legal Guardian**? _____No _____ Yes If yes, attach a copy of Court administration.

If so:

Name: ____

Address: ____

City: ________________________________ State: __________________ Zip: ________

Home Phone: ____________________________ Work Phone: _________________________

2nd Contact Person:

Name: ____

Address: ____

City: ________________________________ State: __________________ Zip: ________

Home Phone: ____________________________ Work Phone: _________________________

Monthly Statements should be sent to:

Name: ____

Address: ____

City: ________________________________ State: __________________ Zip: ________

Home Phone: ____________________________ Work Phone: _________________________

HEALTH INSURANCE INFORMATION

Social Security #: ____________________ Medicare #: ____________________________

Supplemental Insurance: ____

Group #: _________________________ Agreement #: ____________________________

RESIDENT NAME: ____________________ RESIDENT #: ___________________

Other Insurance:

Supplemental Insurance: ____

Group #: _________________________ Agreement #: ____________________________

Medicaid #: ___________________________ Please attach copies of all insurance cards.

Additional Family Members :

Name & Relationship:____

Address: ____

City: __________________________________ State: ____________________ Zip: ________

Home Phone: ______________________________ Work Phone: _________________________

Name & Relationship:____

Address: ____

City: __________________________________ State: ____________________ Zip: ________

Home Phone: ______________________________ Work Phone: _________________________

Name & Relationship:____

Address: ____

City: __________________________________ State: ____________________ Zip: ________

Home Phone: ______________________________ Work Phone: _________________________

Name & Relationship:____

Address: ____

City: __________________________________ State: ____________________ Zip: ________

Home Phone: ______________________________ Work Phone: _________________________

RESIDENT NAME: ____________________ RESIDENT #: ___________________

Name & Relationship:____

Address: ____

City: ______________________________________ State: ____________________ Zip: ________

Home Phone: ______________________________ Work Phone: __________________________

Social Security #: ____________________________ Date of Birth: ______________________

Expected Source of Payment:

_____ Medicare

_____ Medicaid (Date of Application _______)

_____ Private Pay

_____ Other ____________________________

_____ HMO Insurance

_____ Respite

RESIDENT'S CHOICE FOR HEALTH CARE PROVIDERS

Attending Physician

Facility Provider: ____

Specialty: ____

My choice – Name: ____

Address: ____

Telephone No.: ____

Dentist

Facility Provider: ____

My choice – Name: ____

Address: ____

Telephone No.: ____

RESIDENT NAME: ____________________ RESIDENT #: ___________________

Podiatrist

Facility Provider: ______________________________

My choice – Name: ______________________________

Address: ______________________________

Telephone No.: ______________________________

Pharmacy

Facility Provider: ______________________________

My choice – Name: ______________________________

Address: ______________________________

Telephone No.: ______________________________

Hospital (In the case of an Emergency you will be taken to the nearest hospital)

Facility Provider: ______________________________

My choice – Name: ______________________________

Address: ______________________________

Telephone No.: ______________________________

Funeral Home/Arrangements

(Resident / Agent agree that failure to designate their choice of a Funeral Home indicates their consent to using the Facility provider listed below).

Facility Provider: ______________________________

My choice – Name: ______________________________

Address: ______________________________

Telephone No.: ______________________________

Irrevocable Burial Trust Fund Account

Bank: : ______________________________

Address: ______________________________

Account No.: ______________________________

RESIDENT NAME: ____________________ RESIDENT #: ___________________

Church Affiliation

Facility Provider: ____

My choice – Name: ____

Address: ____

Telephone No.: ____

SOURCES OF INCOME

	Resident:	Spouse:
Social Security per month:	$________________	$________________
Supplemental Security:	$________________	$________________
Pension Payment per month:	$________________	$________________
VA Payment per month:	$________________	$________________
Dividends and Interest *:	$________________	$________________
Rental Property Income:	$________________	$________________
Alimony per month:	$________________	$________________
Trust Income:	$________________	$________________
Other Income. Specify:	$________________	$________________

* Give source of dividends and interest income: name of institution, address, account number, and title of account. ____

____

____

____

____

Does the resident have a representative payee on his/her Social Security check? If yes, who?

____

RESIDENT NAME: ____________________ RESIDENT #: ___________________

Is the Social Security check direct deposited? Yes__________ No __________

If direct deposit, state the following:

Institution Name: ____

Address: ____

Account #:______________________________

If the resident receives a Pension income, list the following:

Name of Company or Governmental Agency: ____

Address: ____

Account #: ______________________________

If resident receives a Pension check, is it direct deposited? Yes________ No __________

If direct deposit, state the following:

Institution Name: ____

Address: ____

Account#: ___________________________

Does the resident have a safety deposit box? _____ No _____ Yes Where?

____

____

ASSETS:

Checking Account

Bank: ____

Address: ____

Account #: __________________ Balance: $____________________________________

RESIDENT NAME: ____________________ RESIDENT #: ___________________

Savings Account

Bank: ____

Address: ____

Account #: ____________________ Balance: $________________________________

Other Accounts

Institution: ____

Address: ____

Account #: ____________________ Balance: $________________________________

Stocks/Bonds (fair market value). $ ______________________

Institution: ____

Address: ____

Account #: ____

Certificates of Deposit $ ____________________

Institution: ____

Address: ____

Account #: ____

IRA Account $ _____________________

Institution: ____

Address: ____

Account #: ____

Real Estate Owned

Address:____

(fair market value) …… $ ______________________

RESIDENT NAME: ____________________ RESIDENT #: ___________________

Life Insurance (face amount) $ ___________________________

(cash value) $ ___________________________

Policy Number: ____

Company Name: ____

Address: ____

Automobiles Owned

Make/Yr. _____ Fair Market Value .... $ ___________________________

Make/Yr. _____ Fair Market Value .... $ ___________________________

Other Assets: ____

____

Total Assets .... $ __________________

Have any assets been transferred to another party within the past sixty (60) months? If so, what asset was transferred and to whom: ________________________________

____

____

LIABILITIES:

Installment Debt

Creditor's Name:

____

Address: ____

Account #: ____

Balance .... $ _________________________________

RESIDENT NAME: ____________________ RESIDENT #: ___________________

Creditor's Name

____

Address: ____

Account #: ____

Balance ………. $ _________________________________

Real Estate Loans (Mortgages)

Institution: ____

Address: ____

Account #: ____

Name(s) on Deed: ____

Property Address: ____

Is anyone currently lining at the property? ___ Yes ___ No If yes, who: __________________

Balance ………. $ ______________________

Auto Loans

Institution: ____

Address: ____

Account #: ____

Balance …………… $ ______________________

Total Liabilities ……$ ______________________

Net Worth…………$ ______________________

ARE ANY OF YOUR ASSETS HELD JOINTLY OR IN SOMEONE ELES'S NAME?

_____ No _____ Yes

Which assets and with whom: ____

____

RESIDENT NAME: ____________________ RESIDENT #: ____________________

Do all jointly held assets belong to the resident? _____ No _____ Yes

If no, can the co-owner document contribution and ownership? _____ No _____ Yes

I certify that this financial summary is true and correct. The facility reserves the right to request verification of pertinent information as necessary.

Resident Signature: ________________________________ Date: ____________________

Agent Signature: __________________________________ Date: ____________________

Witness Signature: ________________________________ Date: ____________________