PERSONAL DATA

APPLICATION FOR ADMISSION AS A RESIDENT

PERSONAL / FAMILY

Applicant's Full Name	Social Security #	Telephone

Street Address	Number of years at this address _________ Previous Address:

City, State, Zip Code

Date of Birth	Age	Marital Status	Sex

Name of Nearest Relative	Relationship

Address	Telephone

MEDICAL / SOCIAL

Presently at

Name of Medical Doctor

Current Diagnosis

Does the Applicant have any infections and /or communicable diseases?

Yes ☐ No ☐ Explain:

Brief Description of Applicant's recent Health History

Current Care Needs (include any special equipment needs)

Height	Weight

Any Psychiatric History or Abnormal Behavior Patterns?

Yes ☐ No ☐ Explain:

Previous stay at long-term care facility Yes ☐ No ☐ Name of Facility ______________________________

ADVANCED DIRECTIVES

Living Will?	Yes ☐	No ☐	Power of Attorney?	Yes ☐	No ☐
Health Care Agent?	Yes ☐	No ☐	Conserved?	Yes ☐	No ☐

FINANCIAL DATA

FINANCIAL INFORMATION

APPLICANT'S NET WORTH

- ☐ $-0- to $ 15,500
- ☐ $15,501 to $ 50,000
- ☐ $50,001 to $100,000
- ☐ $100,001 to $250,000
- ☐ Over $250,000

MEDICARE / MEDICAID INFORMATION

MEDICARE #	BC/BS #	MEDICAID #

Part A: Yes ☐ No ☐ BC/BS 65 L: Yes ☐ No ☐

Part B: Yes ☐ No ☐ BC/BS 65 H: Yes ☐ No ☐

Pending As Of	DSS Worker & Phone #

Other Medical Insurance	Policy #

Veteran	Service Branch	Service #	Spouse of Veteran
Yes ☐ No ☐			Yes ☐ No ☐

We require copies of all insurance / benefit cards. Copies can be made at the facility at no charge.

INCOME SOURCE

Income Source	Benefits #
Social Security $	Benefits #
VA Benefits $	Benefits #
Pension (company) $	Benefits #
SSI $	Benefits #
CD's $	Benefits #
Annuities $	Benefits #
Dividends $	Benefits #
Interest $	Benefits #
Other Income $	

Do you receive income from or have an interest in any trusts? Yes ☐ No ☐

If yes, please provide a copy of the trust instrument.

Within the past sixty (60) months, have you created any trusts or placed funds or any other assets in a trust that already existed?

Yes ☐ No ☐

BANK ACCOUNT

NAME OF BANK	ADDRESS	NAME ON ACCOUNT	TYPE OF ACCOUNT	BALANCE

REAL ESTATE

TYPE OF REAL ESTATE	WHERE LOCATED	OWNERSHIP NAME	EST. VALUE

OTHER ASSETS

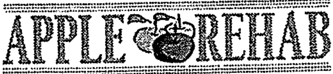
i.e. STOCKS, BONDS, MUTUAL FUNDS, ETC.

Item	Amount
Item	Amount
Item	Amount
Item	Amount

LIFE INSURANCE

Does the applicant have life insurance? Yes ☐ No ☐

Company	Death Benefits	Cash Value
Company	Death Benefits	Cash Value
Company	Death Benefits	Cash Value



ASSETS / PAYMENT DATA

TRANSFER OF ASSETS

Has the applicant said or transferred any motor vehicles, property, stocks, bonds, cash or other significant assets in the past 60 months?

Yes ☐ No ☐

AMOUNT TRANSFERRED	TO WHOM	REASON

Did he/she receive fair market value (cash or other type of payment) in return for the asset? Yes ☐ No ☐

PAYMENT INFORMATION

PRIVATE PAY

Person to Handle Billing	
Street Address	Home Phone #
City, State, Zip Code	Business Phone #

Does the applicant have insurance coverage for long term care? Yes ☐ No ☐

If yes, then complete below:

Name of Company or Plan	Policy # Phone #

MEDICAID APPLICANTS ONLY

If there are any bank books, who holds them?	Relationship to Applicant
Street Address	Home Phone #
City, State, Zip Code	Business Phone #
Who currently receives the applicants social security and/or retirement and other sources of income?	

Would you permit the nursing facility to handle the applicant's personnel fund? Yes ☐ No ☐

Would you permit the nursing facility to become the payee for income that MUST be applied to the applicant's care? Yes ☐ No ☐

The undersigned hereby directs and authorizes ______________________ to change and agrees to cooperate with the facility in changing addresses so that checks are delivered directly to the facility each month and the undersigned agrees to endorse and turn over to ______________________ all checks which constitute applied income.

Does the applicant have a burial contract? Revocable ☐ Irrevocable ☐ None ☐

If yes, then complete below:

Name of Funeral Home	
Cemetary Plot	Amount
Funeral Home Preferred (if no arrangements have been made)	

The answers given by me in completing this application are, to the best of my knowledge, true and complete.

______________________ Applicant's Signature or Mark (X) / Date

______________________ Witness' Signature if signed with an X / Date

______________________ Responsible Party

______________________ Date

______________________ P.O.A. Conservator, Durable Power of Attorney

______________________ Home Phone #

______________________ Business Phone #

______________________ Street Address

______________________ City, State, Zip Code

______________________ Date