



Making each day count since 1914

APPLICATION FOR ADMISSION

GENERAL INFORMATION

NAME: _____
Last First Middle Maiden Name

HOME ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ COUNTY: _____ TELEPHONE: _____

APPLICANT'S CURRENT LOCATION: _____ DOB: _____

AGE: _____ BIRTHPLACE: _____ SS#: _____

RELIGION: _____ CHURCH: _____ PASTOR: _____

ATTENDING PHYSICIAN: _____

MEDICAL INSURANCE

MEDICARE NUMBER: _____ Part A: Yes ___ No ___ / Part B: Yes ___ No ___

Is your Medicare Traditional _____ or HMO _____

Are you/Applicant enrolled in a Medicare Advantage Plan? YES ___ NO ___

MEDICAID NUMBER: _____ STATE: _____ COUNTY: _____

OTHER INSURANCE: _____ ID#: _____

GROUP #: _____ PHONE #: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

OTHER INSURANCE: _____ ID#: _____

GROUP #: _____ PHONE #: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

❖ (COPIES -front and back - OF MEDICARE, MEDICAID, SOCIAL SECURITY AND INSURANCE CARDS REQUESTED)

SIGNIFICANT CONTACTS – In case of emergency contact:

1. <table><tr><td>Name</td><td>Relationship</td></tr><tr><td colspan="2">Address</td></tr><tr><td colspan="2">Home Telephone #: _____</td></tr><tr><td colspan="2">Work Telephone #: _____</td></tr></table>	Name	Relationship	Address		Home Telephone #: _____		Work Telephone #: _____		2. <table><tr><td>Name</td><td>Relationship</td></tr><tr><td colspan="2">Address</td></tr><tr><td colspan="2">Home Telephone #: _____</td></tr><tr><td colspan="2">Work Telephone #: _____</td></tr></table>	Name	Relationship	Address		Home Telephone #: _____		Work Telephone #: _____	
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DOES ANY PERSON OR FIRM HOLD A **POWER OF ATTORNEY**?

YES _____ (A COPY IS REQUESTED) NO _____

(Name) (Address) (Telephone Number)

BURIAL INFORMATION: (responsible Party is responsible for making burial arrangements and providing nursing home with the name and address of the funeral home or organ donation site)

❖ RESPONSIBLE PARTY FOR PLANNING: _____

TELEPHONE: _____

❖ FUNERAL HOME/ORGAN DONATION SITE: _____

TELEPHONE: _____ ADDRESS: _____

FINANCIAL INFORMATION:

<u>Monthly Income</u>		<u>(Current)</u>		<u>Stocks and Bonds</u>	
<u>Source</u>	<u>Amount</u>			<u>Name</u>	<u># of shares</u>
Social Security	\$ _____			_____	_____
Private Pension	\$ _____			_____	_____
Veteran's Benefits	\$ _____			_____	_____
Railroad Retirement	\$ _____			_____	_____
Dividends	\$ _____			_____	_____
Interest	\$ _____			_____	_____
SSI – OAA	\$ _____			_____	_____
Other _____	\$ _____			_____	_____
Other _____	\$ _____			_____	_____

Bank Accounts

<u>Name & Address of Bank</u>	<u>Account Number</u>	<u>Amount</u>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

IF YOU RECEIVE ANY FORM OF PUBLIC ASSISTANCE, PLEASE COMPLETE THE FOLLOWING:

NAME AND ADDRESS OF WELFARE CENTER : _____

NAME OF CASEWORKER: _____

TELEPHONE NUMBER: _____ ID #: _____

HAS THE APPLICANT DISPOSED OF ANY ASSETS WITHIN THE PAST FIVE YEARS?

YES ____ NO ____

IF YES, STATE THE AMOUNT AND REASON FOR SUCH DISPOSITION:

DOES THE APPLICANT MAINTAIN ANY ASSETS IN A SAFE DEPOSIT BOX?

YES ____ NO ____

IF YES, GIVE LOCATION AND NAMES OF PERSON(S) WHO ALSO HOLD A KEY TO THE BOX:

LOCATION: _____

KEY HOLDER(S) _____

DOES THE APPLICANT OWN A HOME: YES ____ NO ____

JOINTLY OWNED WITH ANYONE: YES ____ NO ____

BACKGROUND

PREVIOUS OCCUPATION(S): _____

HIGHEST LEVEL OF EDUCATION: _____

PREVIOUS AND CURRENT HOBBIES, INTERESTS, ACTIVITIES: _____

SPOUSE'S NAME: _____ DATE & LENGTH OF MARRIAGE: _____

LIVING OR DECEASED: _____

IF DECEASED, DATE & CAUSE: _____

MOTHER'S NAME (MAIDEN): _____ FATHER'S NAME: _____

