

# Application for Admission

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Referred by: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Office Use Only: This application was received by the admitting office on: \_\_\_\_\_

## General Information

Applicant's Name: - - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Veteran: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Spouse of Veteran: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Marital Status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_

If Married, name of Spouse: \_\_\_\_\_ Age: \_\_\_\_\_

Presently Employed? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Last Date of Employment: \_\_\_\_\_

Do you have an Apartment in the Community? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Present Location: \_\_\_\_\_ If a Medical Facility, Date of Admission: \_\_\_\_\_

Were you in a skilled-nursing facility in the last year? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Primary (current) Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Anticipated Length of Stay: Short Term: \_\_\_\_\_ Long Term: \_\_\_\_\_

Will prior living accommodations be available upon discharge? \_\_\_\_\_

Person responsible for Applicant (if any): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Business Phone #: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_ Power of Attorney (POA): Yes: \_\_\_\_\_ No: \_\_\_\_\_

Conservator of Estate: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Conservator of Person: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Religion: \_\_\_\_\_ Parish Name, City: \_\_\_\_\_

### ***Final Arrangements:***

Funeral Home: \_\_\_\_\_ Phone #: \_\_\_\_\_ Plot #: \_\_\_\_\_

Address, City, State: \_\_\_\_\_

Do you have a prepaid burial account? Yes: \_\_\_\_\_ No: \_\_\_\_\_

**Health Benefits**

Are you entitled to Medicare coverage for nursing home care? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Medicare #: \_\_\_\_\_

Do you currently have Medicaid? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

Do you currently have private insurance that will pay for nursing home care? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Other Insurance: \_\_\_\_\_  
(Name & I.D. #)

**I hereby certify that the above information is true and correct to the best of my knowledge.**

\_\_\_\_\_  
**Signature of Resident**

\_\_\_\_\_  
**Date**

# Financial Disclosure

Date: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Office Use Only: This application was received by the admitting office on: \_\_\_\_\_

Applicant's Name: - - \_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_

Please make sure all information is complete and accurate including income, assets, long-term insurance, etc.

## Health Benefits

Medicare #: \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Other Insurance: \_\_\_\_\_  
(Name & I.D. #)

## *Applicant's Own Income (monthly)*

Social Security: \$ \_\_\_\_\_ Child Support: \$ \_\_\_\_\_

Pension: \$ \_\_\_\_\_ Alimony: \$ \_\_\_\_\_

Annuity: \$ \_\_\_\_\_ Interest: \$ \_\_\_\_\_

Dividends: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

Does the applicant receive income from, or have interest in, a trust? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If Yes, please describe in detail and provide a copy of the trust instrument.

\_\_\_\_\_  
\_\_\_\_\_

## *Applicant's Assets (NOTE: IF any assets are jointly held, please give nature of joint ownership.)*

**Real Estate: Provide Address:** \_\_\_\_\_

Please describe and give approximate value: \_\_\_\_\_

\_\_\_\_\_

Was this real estate the applicant's home prior to entering the nursing home? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Does anyone other than the applicant live in this home? Yes: \_\_\_\_\_ No: \_\_\_\_\_

## **Stocks and Bonds:**

Please describe and give approximate value: \_\_\_\_\_

\_\_\_\_\_

**Bank Accounts: Provide Bank Names** \_\_\_\_\_

Please describe and give approximate value: \_\_\_\_\_

**Life Insurance: Name of Company** \_\_\_\_\_

Please describe and give approximate face & cash surrender value: \_\_\_\_\_

**Other:**

Please describe and give approximate value: \_\_\_\_\_

Does anyone have a "life use" of any real estate (any ownership interest, in full or in part, for your lifetime, or the right to occupy property for lifetime)?

**Yes:** \_\_\_\_\_ **No:** \_\_\_\_\_

If yes, please describe:

**Transfers of Assets:**

Within sixty (60) months prior to the date of this application, have you or your spouse given away assets of any kind (cash, securities, real estate, etc.) or transferred assets of any kind for less than fair market value? If so, please describe fully all such gifts or transfers in excess of \$1,000.00, including the asset transferred, names, addresses and relationship to you of the person to whom the gift or transfer was made, the value of the gift or transfer, and the date of transfer.

Within sixty (60) months prior to the date of this application, have you or your spouse created any trusts or placed funds or any other assets in a trust that already existed?

**Yes:** \_\_\_\_\_ **No:** \_\_\_\_\_

If yes, please describe and provide a copy of the trust instrument: \_\_\_\_\_

I hereby certify that this is a true and complete statement of my current income and assets and any gifts or transfers for less than fair market value in excess of \$1,000.00 and any trusts created or transfers of assets to any trust that my spouse or I have made.

\_\_\_\_\_  
(Resident Signature)

*Note: The facility will not use any financial information disclosed on this form as the basis to deny admission of Medicaid-eligible residents based on source of payment. No applicant or resident shall be required to waive any rights to benefits under Medicare or Medicaid or to give oral or written assurance that the applicant or resident is not eligible for, or will not apply for, benefits under Medicare or Medicaid.*

