APPLICATION FOR ADMISSION for ALTERNATE Level of Care

Please Circle one: Short Term Rehab - Assisted Living - Skilled Nursing (LTC)

Applicant Name: _____ Social Security #: _____

Sex: __ M __ F Date of Birth: _____ Place of Birth: _____

Marital Status: _____ Name of Spouse: _____

Preferred Name: _____ Maiden Name: _____

Primary Language: _____ Secondary Language: _____

Home Address:_____

Present Location: _____

Primary Care Physician: _____ Phone#: _____

Religion: _____ Email: _____

Have you been hospitalized in the past 90 days: ___ Yes ___ No

If yes, where: _____

Placement discussed with resident on: (date) _____ by _____.

Reaction to discussion of placement:_____

Persons To Be Notified:

1..Name: _____ Relationship: _____ HCP: __ Yes __ No

Address:_____

Email address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

2. Name: _____ Relationship: _____ POA: __ Yes __ No

Address:_____

Email Address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

United States Citizen: ___ Yes ___ No

Education: _____

Previous Occupation:_____

Previous Employer(s): _____

Veteran Status: ___ Non-veteran ___ Veteran ___ Veteran Related

Does the Applicant have a prepaid funeral arrangement? □ Yes □ No

Funeral Home of Choice:

Cemetery Plot? ____ Yes or ____ No

Name of Cemetery: _____

Address: _____ Telephone Number: _____

Do you have a Health Care Proxy: ___ Yes ___ No * please note: HCP must be 1st contact.

If yes, name: _____ Telephone Number: _____

Do you have a Power of Attorney: ___Yes ___ No * Please provide a copy

If yes, Name: _____ Telephone Number: _____

Do you have a Guardian appointed by Court? _____Yes _____No. If yes, please provide name, address and telephone number: _____

Financial Information:

The reason that Financial information is being requested is you either ..do not have secondary insurance, or have limited coverage, or is suspected that the patient will be permanent placement.

Person who will manage All Financials: _____

Medicare #: _____ Medicaid #: _____ Medicaid Worker _____

County (or Counties of Residence): _____

Do you have a Medicaid appointment: ___ Yes ___ No If yes, date: _____

Long Term Care Insurance & Policy#: _____ Telephone Number: _____

Other Health Insurance & Policy#: _____ Telephone Number: _____

Prescription Insurance/Medicare D Plan/Policy#: _____

Do you need prior approval: ___ Yes ___ No

Monthly Income Source	Applicant	Spouse	Total Income
Monthly Social Security			
SSDI(Disability)			
SSI			
Pension/Retirement			
Veterans Benefits			
Interest/Dividends/Annuity Income			
Other (i.e. rental income)			
Total Monthly Income			

Monthly Expense	Applicant	Spouse	Total Expenses
Health Insurance Premiums			
Mortgage			
Other (taxes, utilities, cable, phone, etc.)			
Total Monthly Expense			

Does the Applicant have a Trust which he/she created or is the beneficiary of? ☐ Yes ☐ No

Date trust was established	Type of trust	Value of trust

Date the Trust was Funded : _____
(i.e. when the assets in the trust were transferred into trust)
Name of the Trustee: _____

Address: _____ **Phone #:** _____

*****A copy of the trust must be provided prior to admission.*****

Has the Applicant transferred any of his/her assets in the past 60 months (i.e. money, stock, real estate)? □ Yes □ No

Describe Transfer(s) (including gifts):

Date of Transfer(s) and Recipient of Transfer(s)	Asset(s) Transferred and Value(s)

*****If any of the Transfers has been made within the past 60 months, Applicant must provide copies of cancelled check(s), deed(s), or other evidence documenting the Transfer(s) prior to admission.*****

Applicant's Liquid Assets (include all checking, savings, CD's, IRA's, Annuities, Mutual Funds, Stocks/Bonds, Life Insurance, or any other investments) Please attach current copies of all.

Assets	**Financial Institution & Account Number**	**Name(s) on Assets**	**Current Value**
Savings			
Checking			
Retirement			
Stocks and Bonds			
Other Assets			
Life Insurance	□Term □ Whole Life		**Cash value:**
TOTAL			**$**

Real Property

(Must explain Applicant's and Spouse's Ownership, Joint Tenancy, Tenants in Common Interest)

Real Property Address	Owner (s) of Property	Current Value

Please be sure all questions have been answered.

Important Notice:

Please provide copies of bank and/or investment account statements to verify assets; the first two pages of most recent IRS Form 1040; the interest and dividend schedule from your most recent income tax return; and records or gifts in excess of $2,000 made by Applicant and Spouse within the last five years.

Copies of all Advance directives (HCP, POA, MOLST, Living Will, DNR), and All insurance cards, Social Security Card, LTC Policy, Divorce Decree, and Guardianship Papers, must be submitted with the Application.

The Long Term Care Facility relies on the information disclosed in this application in making decisions regarding admission. Unless otherwise stated, this application may be shared with any of submitted sister facilities affiliates.

Submission of an application does not guarantee admission or a spot on a wait list. Placement is offered only after an application is reviewed and approved by the Long Term Care Facility.

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I, _____, attest that the information reported in this application is true and accurate. I understand that Long Term Care Facility is relying on the information disclosed in this application in making decisions regarding admission of the Applicant herein. I agree to supplement this application if there are any changes to the asset, liability or income information disclosed in this application.

*Effective November 15, 2007, All Long Term Care Health Facilities are now Tobacco free. Individuals are not permitted to smoke on grounds. All tobacco, including electronic cigarettes are prohibited on facility grounds.

Signature of Person Completing Form: _____ Date: _____

Federal and State law prohibit the SNF from denying admission to anyone because of race, creed, color, national origin, sex, handicap, marital status, source of payment, sexual preference, or presence or absence.