Application for Residency Date:_____________

General Information

Customer's Name:____

Current Address:____

City:_________________________ County:______________ State:_________ Zip:___________

Home Phone:______________________________ E-Mail:________________________________

Date of Birth:_____________________ Age:__________ Sex: Male Female

Marital Status:_______________________________ Religion:_____________________________

Previous Occupation:______________________________ Military Service:__________________

Medical Provider Information

Primary Care Physician:____

Address:____

Phone Number:_______________________________ Fax Number:__________________________

Responsible Party Information

Is the customer his/her own responsible party? YES NO

If no, please complete the following:

Name of Responsible Party:___________________________ Relationship:___________________

Address of Responsible Party:____

City:_____________________ State:________________________ Zip:_______________________

Home Phone:_______________ Cell Phone: __________________Email:_____________________

Has this person been appointed guardianship by the court? YES NO

Does this person have a documented power of attorney? YES NO

If yes, to what extent? Financial Medical Durable

Legal Information

Do you have an attorney? Yes   No Name:____

City:___________________________ Phone Number:_____________________________________

Financial Power of Attorney (Name):____

Medical Power of Attorney (Name):____

Does the customer have advanced directives? YES NO

If so, please circle which apply:

Living Will Health Care Instructions DNR

Note: We will need copies of all forms upon admission to our facility

Emergency Contact Information

1.) Name:____________________________________ Relationship:__________________________

Address:____

City:____________________________ State:_____________________ Zip:______________________

Home Phone:_______________ Cell Phone:______________ Email:__________________________

2.) Name:____________________________________ Relationship:__________________________

Address:____

City:____________________________ State:______________________ Zip:_____________________

Home Phone:_______________ Cell Phone:_______________ Email:_________________________

Financial Information

A. Insurance Information

Social Security Number:________________________________

Medicare Number:_______________________________ Effective Date:___________ A ________B_________

Medicare Supplemental Insurance:____________________________ Policy #:_________________________

Other Insurance:_______________________ Policy#:___________________ Group#:_____________________

Has the customer applied or will be applying for medical assistance? YES NO

If yes, please list following:

Date of application:______________ Medicaid Number: __________________County:_________________

Department of Social Services Representative:____

Long Term Care Insurance: _____________________________Policy#:_______________________________

Other Insurance: _______________________________________Policy #:______________________________

B. Monthly Income

Social Security $______________ Civil Service Retirement $_______________

V. A. Pension $_______________ Military Retirement $___________________

Rental Income $_______________ Railroad Retirement $___________________

Interest Earnings $_____________ Other $_________________________________

C. Bank Accounts

Checking Account Bank Name:____

Approximate Balance:__________________ Names on Account:____________________________________

Savings Account Bank Name:____

Approximate Balance:___________________ Names on Account:___________________________________

Other Account Bank Name:____

Approximate Balance:___________________ Names on Account:___________________________________

D. Real Estate Assets

Does the customer own a home? YES NO Approximate Value:____________________________________

If so, is the property jointly owned? YES NO Names of Owners:__________________________________

Does the customer own any additional property? YES NO Value:________________________________

E. Life Insurance Information

Does the customer have life insurance policies with cash value? YES NO

If yes, what is the company's name? ____________________________ Value:_______________________

F. Funeral Arrangements

Has the customer made pre-paid funeral arrangements? YES NO

Burial Account Amount:_________________________

Funeral Home Preference:____

City:_________________________ State:_________________ Phone Number:______________________

G. Other Assets

Please list company name

CD's:____ Value:_________________________

Stocks:____ Value:_________________________

Bonds:____ Value:_________________________

Annuities:____ Value:_________________________

Vehicles:____ Value:_________________________

Other: ____Value:__________________________

I hereby certify that to the best of my knowledge and belief, the above information is true, correct and complete. I understand that if any information has been falsely represented, this will be sufficient cause for voiding my application for admission.

Customer Signature:____ Date:________________

Responsible Party Signature:____ Date:_________________