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.