

APPLICATION FOR ADMISSION

APPLICANT INFORMATION

DATE: _____

NAME: _____ AGE: _____ DATE OF BIRTH: _____ SEX: _____

ADDRESS: _____ PHONE: _____

PREFERRED NAME: _____ MARITAL STATUS: _____ NAME OF SPOUSE: _____

RELIGIOUS AFFILIATION: _____

1) RESPONSIBLE PARTY NAME / RELATIONSHIP / ADDRESS: _____

_____ PHONE: _____

2) EMERGENCY CONTACT NAME / RELATIONSHIP / ADDRESS: _____

_____ PHONE: _____

3) EMERGENCY CONTACT: _____ PHONE: _____

PERSONAL INFORMATION

APPLICANT WILL BE ADMITTED FROM (home, hospital, etc.): _____ PHONE: _____

IF HOSPITAL - NAME AND DATES OF STAY: _____

FAMILY PHYSICIAN / ADDRESS / PHONE: _____

APPLICANT REFERRED BY: _____ PRIMARY LANGUAGE(S) SPOKEN: _____

POWER OF ATTORNEY: YES NO FINANCIAL: MEDICAL: GUARDIANSHIP:

NAME OF POWER OF ATTORNEY: _____ LIVING WILL: YES NO

FUNERAL HOME / ADDRESS / PHONE: _____

PERSONAL INFORMATION

SOCIAL SECURITY NO.: _____ MEDICARE NO.: _____ PAAD: _____

ADDITIONAL INSURANCE: _____ POLICY NO.: _____

IF APPLICABLE: MEDICAID NUMBER: _____

IF PENDING: DATE OF MEDICAID APPLICATION: _____ COUNTY: _____

CASE WORKER NAME: _____ PHONE: _____

FINANCIAL STATEMENT

Please use this form to give us an accurate accounting of the applicant's financial status. This information is necessary to determine the resources of the applicant in relation to the cost of nursing home care.

This statement must be completed and returned in order to be considered for admission to The McCarrick Care Center. Please include copies of bank statements where applicable to verify the information given. A signature is required on the back of this form from the applicant and/or responsible party.

NAME OF APPLICANT: _____

MONTHLY INCOME FROM:

Social Security _____
 Pension _____
 Interest _____
 Dividends _____
 Other _____

TOTAL INCOME \$ _____

LIABILITIES

Accounts due _____
 Bills due _____
 Unpaid taxes _____
 Mortgages _____
 Notes payable _____
 Other _____

TOTAL LIABILITIES \$ _____

ASSETS:

Provide documentation verifying name(s) and balance on accounts.

<u>Bank / Institution</u>	<u>Address</u>	<u>Additional names listed on account</u>	<u>Checking Savings / CD</u>	<u>Balance</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FINANCIAL STATEMENT

ITEMIZE REAL ESTATE:

<u>Address</u>	<u>Additional names listed on deed</u>	<u>Market Value</u>	<u>Balance on mortgage</u>

ITEMIZE SECURITIES:

Provide documentation verifying applicant's ownership.

<u>Issuer of Bonds</u>	<u>Additional names listed</u>	<u>Market Value</u>	<u>Annual Dividend</u>

<u>Issuer of Stocks</u>	<u>Additional names listed</u>	<u>Number of Shares</u>	<u>Market Value</u>	<u>Annual Dividend</u>

Have you transferred any assets within the past 36 months? Yes ____ No ____
If yes, please describe asset(s) transferred and amount received for transfer.

FINANCIAL STATEMENT

INSURANCE POLICIES:

Name of Insurance Company _____

Proceeds \$ _____ \$ _____

Cash Value \$ _____ \$ _____

Health Insurance:

Medicare number : _____

Is applicant covered under Medicare Parts A and B? _____

Insurance Company: _____ Policy Number: _____

Insurance Company: _____ Policy Number: _____

Does applicant have Medicaid? If yes, please provide:

Medicaid No.: _____ Date of eligibility: _____

Person responsible for allocating applicant's funds:

Name: _____

Address: _____

Phone: Home _____ Work _____

Certification:

This is to certify that all statements herein and in any supporting schedules are true and give a full and accurate showing of the financial condition of _____

Applicant's Name

Signature of Applicant/Responsible Party: _____

Date: _____

Date received: _____