CONFIDENTIAL APPLICATION

We thank you for considering our skilled nursing facility. To aid us in assessing whether we can meet your needs, we would like to review your medical needs and assess the financial resources available to pay for that care. Once determined, we can then establish a clear understanding of the services you will receive and the financial responsibility you will be undertaking.
We require this information of all residents, regardless of their method of payment or length of stay. Completing this form prior to admission day will aid us in helping you to make the best decisions, and will expedite the admission process.
All information will be kept confidential, and if you choose our facility, this form will become part of your admission agreement.

GENERAL INFORMATION CONCERNING PROSPECTIVE RESIDENT:

Resident Name:____
Date of Birth:__________________Place of birth (county/state)__________________
Home Address:____
City:__________________County________________State/Zip Code________________
Marital Status:______________Religion______________Church__________________
Father's Name:______________________Mother's Maiden Name:________________
Previous Occupation:______________________Military Service:________________
Referred to facility by:____
Resident is now at: ______ home______hospital______nursing home______Other (specify)
Facility Information: Name______________________________
Telephone ____________________ Name__________________________
Date of Admission _________________ Referral Source ____________________
Has the Resident ever been in another nursing center? Yes_____ No_____
Is the Resident aware of the placement decision? Yes_____ No_____
Personal physician's name____________________________
Address______________________________
Telephone______________________________
Will the Residents personal physician attend here? Yes_____ No _____

INDIVIDUAL RESPONSIBLE FOR PAYING BILL

Name ______________________________ Relationship to Resident ______________________
Home Address ____
City ______________________________ State/Zip Code ______________________________
Telephone (home) __________________________ (business) ______________________________

POWER OF ATTORNEY

Has anyone been appointed Power of Attorney or Guardian? Yes_____ No_____
If so, who? ____
To what extent? ____
Has an advance directive been prepared? Yes_____ No_____
Type ____

ADDITIONAL RELATIVES (SIGNIFICANT OTHERS):

Name ________________________________ Relationship to Resident _______________________
Home Address ____
City _________________________________ State/ Zip Code ______________________________
Telephone (home) ____________________________ (business) ____________________________

Name _______________________________ Relationship to Resident ________________________
Home Address ____
City _________________________________ State/ Zip Code ______________________________
Telephone (home) ____________________________ (business) ____________________________

FINANCIAL INFORMATION CONCERING RESIDENT:

* All questions must be answered as completely and accurately as possible.*

Social Security # ______________ Medicare #____________ Date _________ Part A _____ Part B ____
Medex/Medigap # _____________________ Medicare supplemental insurance ____________________
Prescription Card _____________________ Policy # ______________________
Long Term Care Insurance ______________ Policy # ______________________
Other Insurance ______________________ Policy # ______________________

MONTHLY INCOME

Recipient's name	Monthly Amount
Social Security __________________________	$________________________
Civil Service Retirement _____________________	$ ________________________
V.A. Pension ______________________________	$ ________________________
Military Retirement _________________________	$ ________________________
Railroad Retirement _________________________	$ ________________________
Rental Income _____________________________	$ ________________________
Other (specify) _____________________________	$ ________________________
______________________________	$ ________________________

CASH ASSETS IN BANKS, CREDIT UNION SAVINGS AND FINCIAL INSTITUTIONS

Institution Name ____________________________ Location _____________________________
Type of account _____________________________ Balance in Account $____________
Names listed on account ____

Institution Name ____________________________ Location _____________________________
Type of account _____________________________ Balance in Account $____________
Names listed on account ____

Institution Name ____________________________ Location _____________________________
Type of account _____________________________ Balance in Account $____________
Names listed on account ____

LIFE INSURANCE CASH VALUE

Does the Resident have life insurance policies with cash value? Yes ____ No ____

Company Name ____

Approximate cash value $______________________ Annuities $_________________

REAL ESTATE ASSETS

Resident Own Home? Yes _____ No_____ Approximate Value $______________

Is Property Owned Jointly? Yes _____ No_____

Name's of Co-Owners ____

Resident owns any additional property? Yes ______ No _____

Approximate value $_______________

FUNERAL ARRANGMENTS

Has the Resident made pre-paid funeral arrangements? Yes______ No______

Funeral home preference (name) _______________________ Telephone ________________

Burial Account amount $____________________

OTHER ASSETS/INVESTMENTS (stocks, bonds, IRA'S)

Company name ___________________________ Approximate value $___________________

Company name ___________________________ Approximate value $___________________

Company name ___________________________ Approximate value $___________________

Company name ___________________________ Approximate value $___________________

MEDICAID/TITLE XIX (19)

Has the Resident applied, or will the resident shortly be applying, for Medical Assistance?

Yes_____ No_____ Medicare # ______________________________

If the resident has applied, what was the date? _________________ Location of office ____________

Dept. of Medical representative ______________________________ Telephone _________________

AUTHORIZATION

I herby certify that to the best of my knowledge and belief, the above stated information is true, correct and complete. I understand that if any information has been falsely represented, this will cause my application to be incomplete and result in a delay of admission. All of the information will be kept confidential by the facility.

Signature of Resident _____________________________________ Date ____________________

Signature of Sponsor ______________________________________ Date ____________________

Facility Representative ____________________________________ Date ____________________

Palmer Healthcare Center
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