

APPLICATION FOR ADMISSION

State and Federal laws prohibit discrimination based on Sex, Race, Creed, Color, National Origin, Sexual Preference, Marital Status, Blindness, Disability, Age, Source of Payment, or Sponsorship in admission, retention and care of residents.

I. PERSONAL INFORMATION

Full Name _____ Date _____
 Current Address _____ City _____ State _____
 County _____ Zip _____ Tel. No _____ SS# _____
 I have been residing at this address since: _____ DOB: _____ Place of birth: _____
If foreign born, please provide documentation of proof of citizenship.
 Medicare ID # _____ Part A: Yes No Part B: Yes No
 Medicaid ID# _____ Effective Date: _____ Medicaid County: _____
 Other Insurance: _____ ID # _____
 Maiden Name _____ Wife's maiden name _____
 Name of Father _____ Maiden name of Mother _____
 Have you or your spouse ever served in the United States Military: Yes No Branch _____
 Occupation or Trade _____ Religious Preference _____
 Marital status: Single Married Widowed Separated Divorced
 Name of spouse _____ Marriage Date _____ Spouse's deceased date _____

Personal Contacts

1. Name _____ Relationship _____
 Home Address _____ Zip _____
 Home Tel.# _____ Business Tel. # _____
 2. Name _____ Relationship _____
 Home Address _____ Zip _____
 Home Tel. # _____ Business Tel. # _____

II. ADVANCE PLANNING

1.) I have a Power of Attorney: Yes No *(If yes, please attach a copy of the document.)*
 Name of Attorney-in-Fact: _____
 Address and Phone Number: _____
 2.) I have a Health Care Proxy: Yes No *(If yes, please attach a copy of the document.)*
 Name of Health Care Agent: _____
 Address and Phone Number: _____
 3.) I have a Living Will: Yes No *(If yes, please attach a copy of the document.)*
 4.) I am working with an Elder Law or similar Attorney? Yes No
(If yes, please provide name, address, and phone number)

5.) Who is the Executor of your estate?

Name _____ Relationship _____ Tel.# _____
Address _____

6.) **Membership in Benevolent society:**

Name of Organization / Undertaker _____ Tel. _____
Address _____

I have a paid unpaid burial plot

Cemetery _____ Location _____

7.) Arrangements for organ donation/anatomical gift: Yes No (If yes, please attach a copy of documents).

8.) In the event of accident or death, I direct you to notify _____
Address and Tel. #, _____

III. APPLICANT'S FINANCIAL ASSETS AND INCOME

ASSETS: Attach photocopies of the current statements, reflecting all assets listed below. Be sure copies include bank branch, account number, and name (s) of account holders. (We may request additional financial information depending on each applicant's financial status). *If needed, attach an additional page(s).*

1. Bank accounts **NOT** contained in a Trust and are therefore available for care(*Indicate: savings, checking, money markets, IRA's CD's, Mutual Funds, etc). Please note, Medicaid considers joint accounts as belonging to the applicant at 100%.

A. Bank _____ Balance \$ _____ Type of account* _____ Names on Acct _____
B. Bank _____ Balance \$ _____ Type of account* _____ Names on Acct _____
C. Bank _____ Balance \$ _____ Type of account* _____ Names on Acct _____
D. Investment _____ Market Value \$ _____ Names on Acct _____
E. Investment _____ Market Value \$ _____ Names on Acct _____

2. Within the past 60 months, have you **gifted/transferred** any assets or property to family or friends valued at \$500 or more?

Yes No If yes, provide dollar amount or value and dates for each transfer.
Amount/Value: _____ Date: _____ Amount/Value: _____ Date: _____
Amount/Value: _____ Date: _____ Amount/Value: _____ Date: _____

3. Within the past 60 months, have you entered into any "**TRUST**" arrangements?

Yes No If yes, list value of assets involved and date of transfer. Also, provide a copy of the Trust.
Value: _____ Date: _____ Value: _____ Date: _____
Value: _____ Date: _____ Value: _____ Date: _____

4. I own the following real property: Yes No

Location: _____ Property Value: \$ _____

Type of property: Primary Residence Rental Vacation Commercial

Location: _____ Property Value: \$ _____

Type of property: Primary Residence Rental Vacation Commercial

If real estate is "Primary Residence," please answer the following.

a. Is property currently listed for sale? Yes No

b. Is applicant's intention to return to this property within six (6) months? Yes No

c. Is property currently occupied? Yes No

1. If yes, by whom? _____ Relationship to Applicant _____
d. Is there any mortgage on any of this property? Yes No If yes, amount remaining on mortgage: _____

5. I own life insurance and/or annuity contracts: Yes No
a. Name of Insurance Company _____ Policy _____
Present cash surrender value \$ _____

6. I own Stocks and/or Bonds: Yes No
Name of Investment: _____ Market Value: _____
Name of Investment: _____ Market Value: _____

7. Do you have Long Term Care Insurance? Yes No
If yes, provide the name and address of the insurance carrier and the daily benefit amount.
Name of Carrier: _____ Daily Benefit: \$ _____

8. Does anyone owe you money under any loan, note or mortgage? Yes No
If yes: Date of loan: _____ Total amount owed: \$ _____ Monthly Payment: \$ _____

INCOME PER MONTH: (Please attach documents to show proof of income)

- 1. Social Security \$ _____
- 2. Pensions:
 - a. Government \$ _____ ID _____
 - b. VA \$ _____ ID _____
 - c. Company \$ _____ Name of Company _____
 - d. Other \$ _____ Describe _____
- 3. Interest Income \$ _____ Describe _____
- 4. Trust Income \$ _____ Describe _____
- 5. Other Income \$ _____ Describe _____

Please provide a copy of your Social Security card, Medicare card, Medicaid card (if applicable), and any other health insurance card (s).

EXPENSES: Cost of any medical insurance premiums \$ _____

IV. PLAN OF PAYMENT FOR COST OF CARE AT DAUGHTERS OF SARAH

- 1. Own assets and/or income Family (Check all that apply)
- 2. Designated Representative Responsible for Payments on your behalf.
Name _____ Relationship _____ Phone _____
Address _____

We make important decisions based on the information contained herein, therefore, do you have future plans to amend what funds are available toward the cost of care? Yes No

To the best of my knowledge, all the information provided herein is complete, accurate and valid. The finances described above are available and will be used to pay for the cost of care. I hereby apply for admission to *The Massry Residence*.

Date: _____ Applicant's Signature: _____

If you cannot sign your name, please mark an X and have it witnessed.
Witnessed by _____ Date: _____