

St. Mary's Nursing Center, Inc.

ADMISSION APPLICATION

NAME:		DIAGNOSIS:			
CURRENT ADDRESS:		DATE OF BIRTH:	AGE:	SEX:	MARITAL STATUS
		VETERAN STATUS:		RELIGION / RACE	
SOC. SEC. #	MEDICARE #		ADMITTED FROM:		
	MEDICAID #				
RESPONSIBLE PARTY:				RELATIONSHIP:	
ADDRESS:				PHONE:	
				(HOME)	
EMAIL ADDRESS:				(CELL)	
				(WORK)	
IN CASE OF EMERGENCY					
1. NAME:		RELATIONSHIP:			
ADDRESS:		PHONE: (HOME)			
		(CELL)			
		(WORK)			
2. NAME:		RELATIONSHIP:			
ADDRESS:		PHONE: (HOME)			
		(CELL)			
		(WORK)			
3. NAME:		RELATIONSHIP:			
ADDRESS:		PHONE: (HOME)			
		(CELL)			
		(WORK)			
POWER OF ATTORNEY / LIVING WILL:					
EDUCATION:			OCCUPATION:		
PLACE OF BIRTH / CITIZENSHIP:			PATIENT AWARE OF PLACEMENT:		
ATTENDING PHYSICIAN:			ALLERGIES:		
DR.:					
MORTUARY:	PHONE:		LAUNDRY: <input type="checkbox"/> Yes <input type="checkbox"/> No		
SECONDARY INSURANCE INFORMATION:					
COMMENTS:					
APPLICATION DATE:	ADMISSION DATE:	LOCATION:	TYPE:	PATIENT NUMBER:	
SIGNATURE: _____			DATE: _____		

FINANCIAL QUESTIONNAIRE

Applicant Name: _____

I. INCOME Amount

Social Security _____/mo.

Pension _____/mo.
(Company Name _____)

VA Pension _____/mo.
(Claim #: _____)

Dividends and Interest _____/mo.

Other _____/mo.
(Monthly Income E.G. Rental, Land Contract)

II. ASSETS

Balance of Checking Account: _____

1. Name and Address of Bank:

2. Name and Address of Bank:

Balance of Savings Account: _____

1. Name and Address of Bank:

Balance of Certificates of Deposit & Other Securities:

Balance of Savings Bonds: _____

Balance of Stocks & Bonds: _____

1. Company and Amount:

2. Company and Amount:

Cash on Hand: _____
(Home, Safety Deposit Box)

Have any assets been transferred/sold/or disposed of within 5 years? Yes No

III. REAL ESTATE

(Ownership: _____)

Does the applicant own real estate? Yes No

If yes, location:

What is the approximate value of the property?

\$ _____

Are there any liens or judgements against the property?

Yes No

Does the applicant own rental property?

Yes No

If yes, name and address of property:

IV. LIFE INSURANCE

Company: _____

Policy #: _____

Face Value: _____

Cash Surrender Value: _____

Beneficiary: _____

Other funds set aside for burial: Yes No

Specify: _____

Prepaid burial? Yes No

If yes, specify the amount and Funeral Home:

V. Does any party (other than applicant) have access and control of the aforementioned income assets?

Yes No

If yes, please specify name and address:

VI. I, the undersigned, hereby acknowledge that the information as provided herein is correct. Failure to disclose accurate financial information may be grounds for legal action in accordance with prevailing Federal, State, and Local Statutes and regulations.

Signature of Applicant

Date

Signature of Responsible Party

Date