

Application for Admission

M.M. Ewing Continuing Care Center

APPLICANT INFORMATION

Name _____
LAST FIRST MIDDLE INITIAL

Social Security # _____

Address _____

City _____ State _____ ZIP _____

Phone _____

Date of Birth _____ Age _____ Male Female Religious Preference _____

Marital Status: Single Married Widow Divorced Separated

Spouse: _____
LAST FIRST MIDDLE INITIAL

If deceased, spouse's date of death _____

PRIMARY CARE PHYSICIAN

If applicant is currently hospitalized or has been hospitalized within the last 30 days, list below:

HOSPITAL _____ ADMISSION DATE _____ DISCHARGE DATE _____

If applicant has had a previous skilled-nursing facility stay within the past year, please list the location and time frame below:

FACILITY _____ ADMISSION DATE _____ DISCHARGE DATE _____

Application for Admission

M.M. Ewing Continuing Care Center

HEALTH INSURANCE

Please provide copies of all insurance cards with the application.

MEDICARE INFORMATION Medicare number _____ Part A Part B

OTHER INSURANCE (e.g. Blue Choice, MVP, United Health) Plan name and number _____

MEDICAID Medicaid number _____ County _____

Caseworker name _____ Caseworker phone _____

PRESCRIPTION COVERAGE Plan name and number _____

LONG TERM CARE INSURANCE Plan name and number _____

Contact name _____ Phone _____

CONTACT INFORMATION

Primary Contact

Is contact Power of Attorney? Yes No

Is contact Health Care Proxy? Yes No

Name _____ Relationship _____

LAST

FIRST

MIDDLE INITIAL

Address _____

City _____ State _____ ZIP _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

Email Address _____

Designated Representative

Is contact Power of Attorney? Yes No Check here if it's the same as Primary Contact

Is contact Health Care Proxy? Yes No

Name _____ Relationship _____

LAST

FIRST

MIDDLE INITIAL

Address _____

City _____ State _____ ZIP _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____



FINANCIAL INFORMATION

PERSONAL FINANCIAL STATEMENT

MONTHLY INCOME SOURCE	APPLICANT	SPOUSE	TOTAL
Social Security	_____	_____	_____
SSI (Social Security Supplemental Income)	_____	_____	_____
Pension/Retirement	_____	_____	_____
Veterans Benefits	_____	_____	_____
Interest/Dividends/Annuity Income	_____	_____	_____
Other	_____	_____	_____
Total Monthly Income	_____	_____	_____

MONTHLY EXPENSE	APPLICANT	SPOUSE	TOTAL
Health Insurance Premiums	_____	_____	_____
Mortgage	_____	_____	_____
Other	_____	_____	_____
Total Monthly Expense	_____	_____	_____

Does the applicant have a financial adviser/attorney? Yes No
 Name _____ Phone _____

Has the applicant or spouse established and funded a trust? Yes No
 Date trust was established _____ Value of trust _____ Date of last transaction _____

Has applicant transferred any assets in past 60 months (i.e., money, stock, real estate)? Yes No
 Describe transfer _____ Date of transfer _____ Value of transfer _____

Liquid Assets owned by applicant and/or spouse

ASSETS	DESCRIPTION	NAME(S) ON ASSETS	CURRENT VALUE
Savings Account	_____	_____	_____
Checking Account	_____	_____	_____
Retirement Account	_____	_____	_____
Stocks and Bonds	_____	_____	_____
Other Assets	_____	_____	_____
Life Insurance	<input type="checkbox"/> Term <input type="checkbox"/> Whole Life	_____	_____

TOTAL ASSETS _____

Funeral Arrangements Does the applicant have prepaid funeral arrangements Yes No

Name and location of funeral home: _____

Phone: _____

Real Estate Property

ADDRESS	NAME(S) ON PROPERTY	CURRENT VALUE
_____	_____	_____
_____	_____	_____

Is there a spouse, disabled adult or child living in the home? Yes No

Current Liabilities (mortgages, taxes, loans and other debts)

NAME OF LIABILITY	OUTSTANDING BALANCE
_____	_____
_____	_____

THE RESIDENT AND/OR THE RESIDENT'S FINANCIAL GUARANTOR IS RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MEDICARE OR OTHER INSURANCE CARRIERS

State and federal laws prohibit discrimination in admission, retention and care of residents on the basis of race, creed, color blindness, marital status, disability, national origin, sex, sexual preference, source of payment, sponsorship, or age.

I declare (pursuant to 28 U.S.C. Section 1746) under penalty of perjury that the foregoing is true and correct, and I certify that all information on this application is accurate, true and complete.

Applicant's Signature _____ Date _____

Designated Representative _____ Date _____