

You have contacted this facility and indicated a desire to be admitted as a resident. You have already been issued a receipt, indicating the date and time of your initial request and your name has been placed on our Inquiry List. This is Avon Health Center's Application Form. As soon as you have substantially completed and returned this form, your name will be placed on our Waiting List.

ADMISSION APPLICATION

I. VITAL STATISTICS

Applicant's Name: _____
Home Address: _____ Phone: _____
Present Location: _____ If hospital, date of admit: _____
Date of Birth: _____ Birthplace: _____
Marital Status: _____ Religion: _____
Former Occupation: _____

II. RESPONSIBLE PARTIES

Person Managing Finances: _____
Address: _____
Phone: (home) _____ (work) _____

Emergency Contacts:

Name: _____ Relationship: _____
Address: _____
Phone: (home) _____ (work) _____
Name: _____ Relationship: _____
Address: _____
Phone: (home) _____ (work) _____

III. MISCELLANEOUS

Hospital Preference: _____
Community Physician: _____ Phone: _____
Dentist: _____ Podiatrist: _____
Optometrist: _____ Other: _____
Funeral home preferred: _____
Have arrangements been made? Yes _____ No _____
Has funeral been prepaid? Yes _____ No _____

FINANCIAL DISCLOSURE

All information supplied shall remain confidential. The Application for Admission cannot be processed without this form.

I. INSURANCE

Applicant's Name: _____
Social Security Number: _____ Medicare Number: _____
Medicare D Plan: _____ ID Number: _____
Other Medical Insurance: _____ Policy Number: _____
Phone Number: _____
Medicaid Number: _____ If Pending, Case Worker: _____
Were you or your spouse a member of the United States Armed Forces? Yes ___ No ___
Do you own a partnership-approved Long-Term Care Insurance Policy? Yes ___ No ___
If Yes, name of company and policy number: _____
How will your stay be financed? Please circle one of the following: 1. MEDICARE 2. INSURANCE ONLY
3. INSURANCE & PRIVATE FUNDS 4. PRIVATE FUNDS 5. MEDICAID
Anticipated Length of Stay: Rehab ___ Hospice ___ Respite ___ Long-Term ___

II. INCOME AND ASSETS

Current Total Monthly Income from all sources: \$ _____
Current Liquid Assets (*Checking and Savings Accounts and Securities*): \$ _____
Current Non-Liquid Assets (*Stocks, Bonds, and IRA'S*): \$ _____
PROPERTIE:
Type and Location: _____
Names on Deed: _____ Estimated Value: \$ _____
MORTGAGE NOTES HELD ON PROPERTIES
Mortgagee: _____ Amount: \$ _____
Matures: _____ Other: _____
Has there been any transfer of Liquid or Non-Liquid Assets within the past 36 months? Yes ___ No ___
If Yes, please specify Amount and To Whom: \$ _____ To _____
Where is Social Security Check mailed? _____

III. LIVING ACCOMMODATIONS

Where has the applicant been within the past 60 days? _____
Please describe the applicant's current living arrangements: _____
Has placement been discussed with the applicant? Yes ___ No ___
Has the applicant used any *Home Care Services* in the past? Yes ___ No ___
If Yes, what agency? _____
Will the applicant's prior living arrangements be available after placement? Yes ___ No ___

IV. DOCUMENTS

Does applicant have a **LIVING WILL**? Yes ___ No ___ **POWER OF ATTORNEY**? Yes ___ No ___
CONSERVATOR? Yes ___ No ___
Is applicant an **ORGAN DONOR**? Yes ___ No ___
We will need copies of the following documents (we can make copies, if desired):
 Medicare Card Insurance Card(s) Living Will & Health Care Agent
 Power of Attorney Conservatorship Documents

Thank you for taking the time to complete this application.

Signature: _____ **Date:** _____