GENERAL INFORMATION

Applicant's Name: _____

Home/Previous address: _____

How long at this address? _____ Applicant residing now at: Home _____ Hospital _____ Nursing Home _____

Date of Birth: _____/_____/_____ Age: _____ Social Security Number: _____-_____-_____

Marital Status: _____ If Married/Widowed, Name of spouse: _____

Is Spouse living? YES _____ NO _____ If No, please provide Date of Death _____/_____/_____

Is Applicant or Spouse a Veteran? YES _____ NO _____ If yes, Branch & Years of Service? _____

Medicare #: _____ Medicare D Drug Plan: _____

Other Health Insurance: _____ Insurance #: _____

PLEASE PROVIDE COPY OF INSURANCE CARDS, INCLUDING DRUG PRESCRIPTIONS CARD

LONG TERM CARE INSURANCE

Company_____ Policy #_____

Case Managers Name: _____ Phone # ( ) _____

CONTACTS

Name and address of Responsible Party/POA: _____

_____

Email Address: _____

Home Phone # ( ) _____ Cell # ( ) _____ Office # ( ) _____

Name and Address of All Applicant's Living Children:

_____

_____

_____

Primary Physician: _____ Phone # ( ) _____

Address: _____

Financial Information

Will applicant pay for stay out of his/her own private funds? YES _____ NO _____
*If yes, applicant must qualify financially. All questions must be answered completely and accurately.
ANSWERS ARE SUBJECT TO VERIFICATION

INCOME

Social Security	$_____/MO	
Pensions	$_____/MO	
VA Benefits	$_____/MO	
Annuities	$_____/MO	
Interest	$_____/MO	
Dividends	$_____/MO	
Other	$_____/MO	Source _____

Does the Applicant have a Trust? YES _____ NO _____ If so, when was it created? _____

Do you receive income from or have any interest in any trust? _____

If yes, please describe and provide a copy of the trust instrument.

_____

_____

_____

TOTAL INDIVIDUAL CASH ASSETS $_____

Please list all assets including but not limited to: Savings, Checking, Stocks, Bonds, Cds, Annuities

Name of Institution	Account #	Present Balance	Joint/individual account
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____

***Please attach separate sheet for additional accounts or other financial resources. ***

Does the Applicant have a Life Insurance with Cash Value? YES _____ NO _____

Company Name_____ Approx. Cash Value $_____

REAL ESTATE ASSETS

Does Applicant own any real estate? YES _____ NO _____ Market value $_____

Location(s)_____

Does the applicant have a reverse mortgage? YES _____ NO _____

Name and Address of Joint Owner(s) _____

_____

Other Property Owned? YES _____ NO _____ Market Value $ _____

Does the applicant have a Life Estate? YES _____ NO _____
Locations: _____

Name and Address of Joint Owners(s): _____
_____

Does Applicant Receive Rental Income? YES _____ NO _____ How much? $_____

Approximate value of all Securities $ _____

Does applicant have an Elder Care Attorney or Representative? YES _____ NO _____
If so, please provide a letter of representation.

TRANSFERS

Within sixty (60) months prior to the date of this application, have you given away assets of any kind (cash, securities, real estate, Etc.) or transferred assets of any kind (cash, securities, real estate, Etc.) for less than fair market value? If so, please describe fully all such gifts or transfers, including the asset transferred, names, addresses and relationship to you of the person(s) to whom the gift or transfer was made, and the value of the gift or transfer.

Gifts or transfers within 60 months: YES _____ NO _____

Please describe any transfers: _____
_____
_____
_____

LEGAL AUTHORIZATION

Everything I have stated in this application is true and correct. I understand and agree that Central Island Healthcare may rely on the accuracy and completeness of the information herein in considering the applicant for admission. I authorize Central Island Healthcare to check all financial and credit history. I understand that Central Island Healthcare considers this application as a continuing statement of financial condition and I agree to notify Central Island Healthcare in writing of any substantial change in information. Information herein will be kept strictly confidential by Central Island Healthcare. I understand that photocopies of relevant section of this application may be used for verification purposes.

Signature of Applicant/ Responsible Party: _____

Date: _____

***PLEASE PROVIDE CENTRAL ISLAND WITH 5 YEARS OF BANKING**