Applicants Health Information:

Current Diagnosis_____ Date of Onset_____
Secondary Diagnosis_____

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

TOTAL INDIVIDUAL CASH ASSETS $_____

1. Checking Account #_____ Bank _____

   Branch _____ Account Balance $ _____

2. Savings Account #_____ Bank _____

   Branch _____ Account Balance $_____

3. CD/IRA? _____YES_____NO Approximate Amount $_____

4. Burial Account _____YES_____NO Where? _____

TOTAL JOINT CASH ASSETS $_____

1. Checking Account #_____ Bank _____

   Branch _____ Account Balance $_____

   Name and Address of Joint Owner_____

2. Savings Account #_____ Bank _____

   Branch _____ Account Balance $_____

   Name and Address of Joint Owner_____

3. CD/IRA(s)? _____YES_____NO Approximate Amount$_____

   Name and Address of Joint Owner_____

TRANSFERS

Date: _____ Amount: _____To: _____

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

Does the Applicant have a Trust? _____YES_____NO If so, when was it created? _____

INSURANCE

Does the Applicant have a Life Insurance with Cash Value? _____YES _____NO

Company Name_____ Approx. Cash Value $_____

Annuities: _____Company Name _____

Identify Insurance Expected to Cover Facility Costs:

Company_____Policy #_____

Case Managers Name: _____Phone # ( ) _____

Medicare D Drug Plan _____

REAL ESTATE ASSETS

Does Applicant Own a Home _____YES_____NO Market value $ _____

Location(s)_____

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? $_____

SECURITIES

Does Applicant have Stocks and Bonds? _____YES_____NO

If jointly owned, name, address, and relation to Joint Owner_____

_____

_____

Approximate value of all Securities $ _____

INCOME

Social Security $ _____Disability $ _____

Pension $ _____Other $ _____

Does applicant have an Elder Care Attorney or Representative? _____YES _____NO
If so, please provide a letter of representation.

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:_____

Date:_____

Signature of Responsible Party: _____

Date:_____

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