



- Autumn View Health Care Facility
- Northgate Health Care Facility
- Garden Gate Health Care Facility
- Brookhaven Health Care Facility
- Harris Hill Nursing Facility

ADMISSION QUESTIONNAIRE
For Scheduled Short-Term Care

DATE: _____

I. APPLICANT DEMOGRAPHICS:

- A Name of Applicant _____
- B Home Address _____
City _____ County _____ State _____ Zip _____
- C Telephone # _____ Religion _____
- D Social Security # _____ Gender M F
- E Date of Birth _____ Place of Birth _____
- F U.S. Citizen Yes No If yes, is proof available? Yes No
- G Marital Status _____
If married, name and location of spouse _____
- H Location of Applicant _____
- I Previous Nursing Home stays Yes No
If yes, Facility name and dates of stay _____

II. APPLICANT DEMOGRAPHICS:

- A Financial / Designated Representative (manages finances for applicant)
Name _____ Relation _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Bank POA: Yes No Durable POA: Yes No Conservator/Guardian: Yes No
(If yes, please provide proof)
- B Other Contacts
Name _____ Relation _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____

III. INSURANCE COVERAGE:

- A Veteran Yes No Spouse Veteran Yes No
- B Medicare # _____
- C Medicaid CIN# _____ Effective Date _____
If Medicaid Pending, Interview Date _____
- D Long-Term Care Insurance Yes No Provider _____
- E Other Medical Insurance (BC/BC, IHA, HCP, Univera, EPIC, No Fault)
Provide copies of all insurance cards
Company / Insurer _____ ID # _____ Prescription Card Yes No
- F Medicare Part D Provider _____

IV. STATEMENT OF INCOME:

	Applicant	Spouse
A Social Security	\$ _____	\$ _____
SSI	\$ _____	\$ _____
Retirement / Pension	\$ _____	\$ _____
Veteran's Pension	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Other Income (Specify)	\$ _____	\$ _____

Consent to change of address for Monthly Income Yes No

V. ASSETS/RESOURCES:

A Real Estate Yes No

If yes, Location _____ Value \$ _____

Location _____ Value \$ _____

B Life Insurance Yes No If yes, Face Value \$ _____ Cash Value \$ _____

Face Value \$ _____ Cash Value \$ _____

C Prepaid Funeral Yes No Location _____

D Trust Yes No If yes, Name _____ Date Established _____

E Additional Assets / Resources - Applicant or Joint with Applicant -
(Checking, Savings, CD's, stocks, bonds, annuities, money market, etc)

Account Name	Type of Account	Balance
_____	_____	_____
_____	_____	_____
_____	_____	_____

* Are any of the above annuitized? Yes No

Total Balance \$ _____

VI. LIABILITIES:

A Home Mortgage: Yes No If yes, amount owed \$ _____

B Loans: Yes No If yes, amount owed \$ _____

C Credit Cards: Yes No If yes, amount owed \$ _____

D Other (home equity, etc): Yes No If yes, amount owed \$ _____

E Has applicant / financial representative transferred assets or property in the last 60 months
 Yes No If yes, Value \$ _____ Date of Transfer _____

F Additional Financial Information _____

I, _____ do solemnly swear or affirm that the information on this form is true and accurate to the best of my knowledge. I assure payment of all expenses incurred to the extent of the applicant's resources.

Resident Signature _____ Date _____

Designated Rep Signature _____ Date _____