

*the* **ANDERSON**  
**APPLICATION FOR RESIDENCY**

To apply for admission, please complete this questionnaire, and return it to the Case Management Team. All information will be held in confidence. A more complete medical history and physical exam will be recorded on another form. This application will become a part of the "Resident Agreement".

**Name of Applicant:** Mr. Mrs. Ms. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No: \_\_\_\_\_

Religion: \_\_\_\_\_ Church: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ State: \_\_\_\_\_

Social Security No: \_\_\_\_\_ Marital Status:  Single  Married  Widowed  
(Please attach a copy of the card)

Medicare No: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
(Please attach a copy of front and back of card)

Medicaid No: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
(Please attach a copy of the card)

Coinsurance Policy Co. & No: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
(Please attach a copy of front and back of card)

Funeral Home: \_\_\_\_\_ Prepaid:  Yes  No

**Name of person completing this form:** \_\_\_\_\_

Relationship to resident: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**How did you hear about the Anderson?**

Newspaper

Brochure

Friend

Social Worker

Physician

Hospital

Other Nursing Facility

Other

**Have you visited any other nursing facilities?**  Yes  No

If yes, which ones? \_\_\_\_\_

## MEDICAL AND PERSONAL DATA

Diagnoses: \_\_\_\_\_

Resident's Current Physician: \_\_\_\_\_ Telephone No: \_\_\_\_\_

<input type="checkbox"/> Mentally Alert	<input type="checkbox"/> Forgetful	<input type="checkbox"/> Confused
<input type="checkbox"/> Eats Independently	<input type="checkbox"/> Requires Help with Feeding	<input type="checkbox"/> Requires Special Diet
<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Walks with Assistance	<input type="checkbox"/> Chair-Ridden
<input type="checkbox"/> Bed-Ridden	<input type="checkbox"/> Requires Bed Rails	
<input type="checkbox"/> Continent	<input type="checkbox"/> Incontinent	

Admission Date desired: \_\_\_\_\_

Resident now residing at: \_\_\_\_\_

Reason for seeking admission: \_\_\_\_\_

### I give permission for my (applicant's) doctor/hospital to release Medical Information

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

### The names(s) of the person(s) who will be financially responsible for the cost of the care (the "Guarantor")

Name(s): \_\_\_\_\_ Telephone No: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Has a Trust Account been established?  Yes  No

If yes, please detail and attach a copy \_\_\_\_\_

Has a Durable Power of Attorney been appointed for financial affairs?  Yes  No

If yes, please attach a copy of the document.

Has a Legal Guardian been appointed?  Yes  No

If yes, please attach a copy of the guardianship papers.

Has a Living Will been executed?  Yes  No

If yes, please attach a copy of the document.

Has a Durable Medical Power of Attorney been appointed?  Yes  No

If yes, please attach a copy of the document.

## FINANCIAL DATA

To process your application, the following information is needed. The information supplied is confidential and allows us to assist you in your long term financial planning. Your cooperation is appreciated in order to expedite the admission.

### Monthly Income:

Salary	\$ _____
Social Security	\$ _____
Pensions/Annuities	\$ _____
IRA	\$ _____
Interest/Dividend	\$ _____
Rental Income	\$ _____
Investments/Other	\$ _____

**Total:** \$ \_\_\_\_\_

### Assets/Description:

### Account #:

### Value:

Cash (please list bank names and account #'s):

_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Securities (stocks bonds):

_____	_____	\$ _____
_____	_____	\$ _____

Real Estate (description and location): (Example: 3 bedroom house; Jones St., Anyplace OH 99999)

_____	_____	\$ _____
_____	_____	\$ _____

### Other Assets:

### Description:

### Value:

Cash value of Life Insurance	_____	\$ _____
Vested Pension Benefits	_____	\$ _____
Business Interest	_____	\$ _____
Automobiles	_____	\$ _____
Other	_____	\$ _____

**Total Assets:** \$ \_\_\_\_\_

## FINANCIAL DATA (Continued)

**Liabilities:**

Home Mortgage \_\_\_\_\_ \$ \_\_\_\_\_

Credit Cards/Charge Account \_\_\_\_\_ \$ \_\_\_\_\_

Loans \_\_\_\_\_ \$ \_\_\_\_\_

Other Debts \_\_\_\_\_ \$ \_\_\_\_\_

Taxes Owed \_\_\_\_\_ \$ \_\_\_\_\_

**Total Liabilities:** \$ \_\_\_\_\_

**NET WORTH** (Assets - Liabilities): \$ \_\_\_\_\_

**Please sign below:**

I hereby affirm that, to the best of my knowledge, the information provided on this application is accurate and complete.

\_\_\_\_\_  
Resident Signature Date

\_\_\_\_\_  
Guarantor's Signature Date

Reviewed by: \_\_\_\_\_  
Case Management Date

\_\_\_\_\_  
Administrator Date

\_\_\_\_\_  
Accounting Date