Tabor Hills

APPLICATION FOR ADMISSION

Original Date: _____
Update: _____
Update: _____
For Office Use Only

Please complete this form in its entirety and return it to the Administrative Representative

RESIDENT

Last Name, First Name, Middle Initial:			Preferred Name:
Date of Birth:	Social Security Number:	Medicare Number:	Medicaid Number:
Mailing Address		City, State, Zip:	
Phone Number:	Cell Phone Number:	Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced	
U.S. Citizen ☐ Yes ☐ No		U.S. Veteran ☐ Yes ☐ No	

SPOUSE

Last Name, First Name, Middle Initial			
Date of Birth:	Social Security Number:	Medicare Number:	
Mailing Address		City, State, Zip:	
Home Phone Number:	Cell Phone Number:	Work Number	Fax Number:
Email Address:		Best Method and Time to Reach You:	

CONTACT

Name:		Address, City, State, Zip:	
Home Phone Number:	Cell Phone Number:	Work Number	Fax Number:
Email Address:		Best Method and Time to Reach Your Contact:	

POA HC

Power of Attorney for Healthcare: (if available)		Address, City, State, Zip:	
Home Phone Number:	Cell Phone Number:	Work Number	Fax Number:
Email Address:		Best Method and Time to be Reached:	

POA FIN.

Power of Attorney for Finance: (if available)		Address, City, State, Zip:	
Home Phone Number:	Cell Phone Number:	Work Number	Fax Number:
Email Address:		Best Method and Time to be Reached:	

1. Except for personal effects, list all assets owned by you and your spouse, including the cash surrender value of life insurance stocks, bonds, vehicles, life estates and pensions, with the value as of the date of admission into the facility. **(*Attach supporting documents*)**

Description of Asset	Value of Asset
a.	
b.	
c.	
d.	

2. Did the agent or attorney-in-fact listed under financial power of attorney assist you with making any of the transfers or gifts referenced below in section number 4 below, or benefit or receive any of the assets transferred or gifted? If yes, please explain.

3. List all debts owed by you and your spouse, with values as of the date of admission into the facility.

Debtor	Description of Debt	Amount of Debt
a.		
b.		
c.		

4. List all transfers or gifts of assets within the **PAST FIVE YEARS** by you and your spouse, including transfers of a remainder interest in real property.

Date of Transfer	Description of Asset	Recipient	Value of Asset
a.			
b.			
c.			
d.			
e.			
f.			

5. List all pre-paid burial contracts, burial accounts, and pre-paid burial or funeral items owned by you or your spouse or by a third party for the benefit of you or your spouse.

Description	Owner	Value
a.		
b.		

Funeral Home Name: **Phone Number:**

Address:

6. List all sources of income for you and your spouse, including but not limited to rental payments, CRP income, long-term care insurance benefits, Social Security benefits, veteran's benefits, and employment income.

Description of Income	Date or Frequency of Payment	Amount of Payment
a.		
b.		
c.		
d.		
e.		
f.		

7. List all health and pharmacy insurance for you and your spouse.

Name of Insurer	Name of Insured	Description of Insurance	Monthly Premium Amount
a.			
b.			
c.			
d.			

8. Do you have Long Term Care Insurance? ☐ Yes ☐ No

Company Name: **Phone Number:**

9. Were any of the assets described in section number 4 above transferred or gifted to or from a trust? If yes, explain the nature of the transaction and identify the trust involved.

10. Have you previously applied for Medicaid? If yes, provide the date and county in which the application was made.

11. Do you or your spouse reside on a farm?

12. Are you actively engaged in farming or any other trade or business? If yes, describe the nature of the business.

13. Are you or your spouse employed by another or self-employed? If yes, provide the name of the employer or the nature of the self-employment, the hours worked, and the wage or salary earned.

14. Are you or your spouse the beneficiary of any trust?

15. Do you have any pending legal action from which you may receive money or medical benefits, including inheritance? If yes, describe.

16. Do you have any Life Insurance Policies?

Name of Company:	**Face Value of Policy:**	**Type of Policy:**	**Right to Change Beneficiary:** ☐ **Yes** ☐ **No**

By my signature below, I hereby authorize Tabor Hills to contact the county social services for information regarding my Medicaid application and eligibility, and I hereby release and authorize the county social services to release any information to the nursing home. I also authorize Tabor Hills to contact any and all of the above-identified financial institutions to obtain information regarding my assets and income, and I hereby release and authorize the financial institutions to release any information to Tabor Hills. I further authorize Tabor Hills to release to its attorneys any information regarding my application for admission.

I understand that providing false information could result in discharge and/or denial of my application. The answers provided herein are true and correct to the best of my knowledge and information.

_____ _____

Signature of Resident/Responsible Party **Date**