RESIDENT APPLICATION

GREEN HILLS INN
6559 US 68 SOUTH
WEST LIBERTY, OH 43357

Please answer all questions as completely as possible. The information is held in strict confidence. Please print or type.

APPLICANT INFORMATION

Full Name_________________________________ Social Security Number________________

Present Living Arrangement ____

Present Address__________________________________ Phone Number_________________
Street

____
City State Zip Code

Date of Birth___________________ Age________ Birthplace___________________________

Marital Status: Single______ Married___________ Widowed__________(date)_______

Separated________________ Divorced________________

List your children, other close relatives, or close friends.

1) ____
Name Relationship Phone

____
Address

2) ____
Name Relationship Phone

____
Address

3) ____
Name Relationship Phone

____
Address

4) ____
Name Relationship Phone

____
Address

5) ____
Name Relationship Phone

____
Address

6) ____
Name Relationship Phone

____
Address

PREFERENCES

Preference of type of apartment:

Efficiency____________________________One bedroom__________________________________

Preferred moving date________________

If application is for two persons, please submit forms for both persons.

HEALTH HISTORY AND INFORMATION:

Name of local personal physician: ____

____
Address Phone

Name of other physician familiar with your health history: ________________________________

____
Address Phone

Have you ever had major surgery, a serious mental or physical disease, or other major health problems? _____________ If so, please describe briefly: _______________________________
____
____
____

Briefly describe any current health problems or disabilities: ____________________________________
____
____
____
____

 Individual Providing Information Initials________

List of Current Medications:

___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________

Do you have prescription drug coverage? Yes_________No_________

Do you have the Medicare D Plan? ____

Other: ____

Name of your pharmacy: ____

NOTE: **Please keep us informed of any changes in prescription medications, Medicare D coverage (prescription drug coverage), pharmacy, etc.**

Miscellaneous health information:

Do you have diabetes?_________________ Do you take insulin?_______
Are you on a special diet?_______________ Any diet restrictions?_______
Do you have a contagious disease?______________ If yes, please explain:______
____
Do you have high blood pressure?______________ Arthritis___________
Do you smoke?___________
Cigarettes__________ Cigar________ Pipe_______________
Do you use alcoholic beverages?________________ Never______________
Rarely_______ Occasionally________ Frequently__________
Are you currently under psychiatric care?_________

Insurance information:

Medicare Number________________________________ (provide copy of Medicare card)

Other medical insurance:
Company_________________________________(provide copy of card)
Policy number_______________________

Long term care insurance:
Company_________________________________(provide copy of card)
Policy number_______________________

Preference of funeral home: ____
(Name) (Phone Number)

PERSONAL INFORMATION:

What is your present or former occupation?_______________________________________

Name of Spouse:________________Where have you lived most of your life?________________

Do you? Walk for exercise________ Read newspaper__________ Watch television__________
Listen to the radio_______ Attend group/club meetings_________________________

Do you drive a car?______________ Do you plan to continue using your car?________________

Check the areas in which you now need some assistance:

Meal Preparation__________ Toileting________________
Housekeeping____________ Medications______________
Laundry_________________ Shopping________________
Dressing_________________ Transportation____________
Grooming________________ Handling finances_________
Bathing__________________

Do you use any of the following?
Glasses____________ Hearing aid______________ Cane______________
Wheelchair_________ Walker__________________ Scooter____________

What is your religious preference?____
Church name and address____
Pastor________________________________ Phone number__________________

What level of education have you completed?
Elementary_______________ High School________ College____________
Graduate school___________ Professional________ Other______________

What hobbies/interests do you enjoy at this time?
Sewing______ Embroidering_______ Weaving_____ Exercise_____
Music_______ Indoor Plants_______ Games______ Knitting_____
Crafts_______ Entertainment_______ Lectures_____ Painting_____
Church______ Woodworking ______ Gardening____ Ceramics_____
Parties ______ Traveling__________ Crocheting___ Reading_____
Other____

 Individual Providing Information Initials_______

List two references that may be contacted:

1) ____

Name Phone

____

Address

2) ____

Name Phone

____

Address

FINANCIAL DISCLOSURE/ MEDICAID SCREENING FORM

We thank you for considering _____________________ (Facility Name). To aid us in assessing whether we can meet your financial needs, we would like to review your financial resources to pay for care. Once determined, we can then establish a clear understanding of the financial responsibility you will be undertaking.

We require this information of all residents, regardless of their method of payment or length of stay. Completing this form before admission day will aid us in helping you make the best decisions, and will expedite the admission process. All information will be kept confidential, and if you choose our facility, this form will become part of your admission agreement.

General Information:

Prospective Resident's Name: ____

If you are not the prospective resident:

Your Name: ___________________________________ Relationship ____________________________

Legal Representatives (if any):

Please provide agreements, by attaching a copy to the Financial Disclosure Form, designating each legal representative. (Example: Legal guardian, POA, DPOA, Guarantor, Responsible party)

Type of legal representative: Financial POA __________Guardian______Health Care POA_____________

Representative's Name: ______________________ Telephone (Day): ___________________

(Eve): ___________________

Address: ___________________________________

City, State & Zip:____________________________ Title or relationship to resident: _______

____

Type of legal representative Financial: POA __________Guardian______Health Care POA____________

Name: ____

Telephone (Day): ___________________
(Eve):___________________

Address: ______________________________________

City, State & Zip:______________________________

Title or relationship to resident: _______
____

Other Responsible Party (if any)

Name: ____

Telephone (Day): ___________________
(Eve):___________________

Address: ______________________________________

City, State & Zip:______________________________

Title or relationship to resident: _______
____

Financial Information:

Does the resident have any insurance that will cover care provided in a long-term care facility, or residential care facility? YES___ NO ___

If yes, please identify:

Company: ________________________________ Policy #: ________________________________

Address of Insurance Company: ____

Agent's Name: ____________________________ Telephone #: ______________________________

Monthly Income:

Salary $ ___________________ **Social Security check** $ ___________________

*Source*______________________________ *Source*____________________________________

Pension $ ___________________ **IRA** $ ___________________

*Source*______________________________ *Source*____________________________________

Annuity $ ___________________ **Disability check** $ ___________________

*Source*______________________________ *Source*____________________________________

Rental income $ ___________________ **Other** $ ___________________

*Source*______________________________ *Source*____________________________________

401(K) or other similar account(s) $_______________

*Source*______________________________

*Source*______________________________

Total income – All sources $ _________________________________

Cash Assets:

Bank (1) __________________________ Location _________________________________

Checking account # _________________ Balance in account $ ____________

Savings account # ___________________ Balance in account $ ____________

Certificates of Deposit? YES ___ NO _____ If yes, approximate amount $ ____________

Bank (2) __________________________ Location ________________________________

Checking account # _________________ Balance in account $ ____________

Savings account # __________________ Balance in account $ ____________

Certificates of Deposit? YES ___ NO _____ If yes, approximate amount $ ____________

Bank (3) __________________________ Location ________________________________

Checking account # _________________ Balance in account $ ____________

Savings account # __________________ Balance in account $ ____________

Certificates of Deposit? YES ___ NO _____ If yes, approximate amount $ ____________

OTHER ASSETS/ LOCATION AMOUNT

__________________________________ $_______________________________________

__________________________________ $_______________________________________

(If additional space is still required, please list the location of these assets and the amount on a separate sheet and attach to this financial disclosure.)

Total of all cash assets listed $_________________________________

Real Estate Assets:

Does the resident own a home? YES ___ NO _____ If yes, approximate value $ _________________

Home Address (1)____

Does the resident own a second home? YES ____ NO____ If yes, approximate value$________________

Home Address (2)____

Does resident own any other property YES ___ NO _____ If yes, approximate value $ ___________
(farm, commercial real estate, etc.)?

If yes, what is it and indicate the address of the property?_______________________________________

____

Total value of all Real Estate owned $ ___________________________

Life Insurance Cash Value:

Does resident have life insurance policies with cash value? YES ___ NO ___

Company Name(1): _______________ Approximate Cash Value $ _________________

_________________________________ Face Value $_____________________________

Agent Name: ______________________ Telephone #_____________________________

Address____

Annuities $ _________________________

Company Name (2): _______________ Approximate Cash Value $ _________________

_________________________________ Face Value $_____________________________

Agent Name: ______________________ Telephone #_____________________________

Address____

Annuities $ _________________________

(If life insurance is held by more than one agent, please list agents and the amount they handle below.)

____

____

Total of all Life Insurance Cash Values only listed $ ___________________

Securities:

Does the resident have stocks and bonds? YES ____ NO ____

Approximate current market value of all securities $ _______________________________

Agent Name ___________________________________ Telephone # _______________

Address: ____

(If more than one agent holds securities, please list these agents and the amount they handle below.)

____

____

If no agent, please list the securities that are held below.

____

____

Individual Providing Information Initials________

Total of all Securities listed $ ______________________

Prepaid Burial Accounts:

Does the resident have a prepaid burial account or plot? YES __________ NO________

Is the account for the resident only or for the resident and his/ her spouses?

Resident Only ____________ Resident and Spouse _______________

Account # ________________________ Value: ____________________

Cemetery Name & Address : ____

Account # ________________________ Value: ____________________

Cemetery Name & Address : ____

Total of all Burial Account Values listed $ ______________________

Automobiles:

Does the resident own an automobile(s)? YES________ NO________

Please indicate the following information.

Auto (1): ________________________ Make/ Model:___________________________

Year:____________________________ Estimated Value:________________________

Auto (2): ________________________ Make/ Model:___________________________

Year:____________________________ Estimated Value:________________________

Auto (3): ________________________ Make/ Model:___________________________

Year:____________________________ Estimated Value:________________________

Total of all Auto Values listed $ ______________________

Other:
Are there any other sources of income that have not been identified above? YES ___ NO ____

Please identify the source(s): (Business Interests, Loans to Family Members, etc.) ____________

____

____

Individual Providing Information Initials________

Total of all current market value of these sources listed $ ______________

Total available sources of income:

Monthly income $ ____________________
Annuities $ ____________________

Total sources of income $ ___________________ (A)

Total available sources of assets:

Total Bank Value $ ____________________
Real Estate Assets $ ____________________
Life Insurance Cash Value $ ____________________
Securities $ ____________________
Burial Accounts $____________________
Automobiles $____________________
Other $ ____________________

Total Assets $ ___________________ (B)

Total Income and Assets $ ___________________ (C)

From what source(s) does the resident plan to pay for services at the Facility (named on agreement)?

____

____

If necessary, would the resident be willing to liquidate his/her assets to pay for services at the facility?
YES ____ NO ____

If the resident's resources become insufficient to meet total expenses while residing at the Facility, are there other persons or organizations that could help pay for services? If yes, please specify.

____

____

Are there any safeguards to ensure that your resources are used only for the resident's benefit? If yes, please specify.

____

____

During the past five years, has the resident given or transferred any cash, property or other assets (valued at more than $1,000) to any person or organization? If yes, please specify when, to whom, what assets and what their total value was at the time of transfer.

____

____

Who will handle the resident's financial affairs while he/she is a resident at the Facility (named in agreement)?

Name: ____________________________ Relationship ____________________________________

Address: __________________________ Legal Relationship ______________________________

____________________________ Telephone ______________________________________

In the past seven years has the resident declared bankruptcy or had judgments against them?
YES ____ NO ____

If yes, please specify: ____

____

Liabilities:

Please list any balance owed by the resident on the items below:

House Loans/ Mortgage Balance **$ ___________________ (D)**

Name of Credit Card

Credit Cards(1) _____________________ $ ___________________

Credit Cards(2) _____________________ $ ___________________

Credit Cards(3) _____________________ $ ___________________

Credit Cards(4) _____________________ $ ___________________

Credit Cards(5) _____________________ $ ___________________

TOTAL Credit Card Balance $ ___________________ (E)

Automobiles Balance Owed (1) $ ___________________

Automobiles Balance Owed (2) $ ___________________

Automobiles Balance Owed (3) $ ___________________

TOTAL Auto Balance **$ ___________________ (F)**

OTHER ____________________ **$ ___________________ (G)**

Unpaid Medical Expenses:

Physician $ ___________________

Prescriptions $ ___________________

Hospital or other Medical Facility $ ___________________

TOTAL Past Medical Expenses **$ ___________________(H)**

TOTAL LIABILITES $ ________________________________ (I)

Other monthly ongoing medical expenses not covered by Medicare, Medicaid or other Insurance. $___________________

Estimate of residual assets:

Monthly Income $ ________________________________ (A)

Total Assets $ ________________________________ (B)

- Total Liabilities $________________________________ (I)

Residual Assets $ ________________________________

Authorization:

I hereby state that to the best of my knowledge, the information on this form is true, accurate and complete. I understand that if any information has been falsely represented, it may be sufficient cause for denying admission or discharging the resident from the Inn. I authorize the Facility (named in the agreement) to investigate financial and credit records through any investigative or credit agency(s) of it's choice.

Resident: ____ Date: _______________

Legal Representative: _____________________________________ Date: _______________
Legal Guardian, POA, DPOA

Responsible Party/Agent: ___________________________________ Date: _______________

Facility Representative: ____________________________________ Date: _______________

Witness*: ____ Date: _______________

Witness*: ____ Date: _______________

*** Required only if resident is unable to sign his/her full name.**

 Individual Providing Information Initials________