



APPLICATION FOR ADMISSION

This application is for: Immediate Need Future Need: Months/Years
Applying for: Apartments Cottages Personal Care Personal Care Memory Support
 Skilled Care Skilled Care Memory Support

How did you hear about St. Anne's Retirement Community? _____

Name: _____ Social Security #: _____
Address: _____ Home Phone: _____
Email: _____ Cell Phone: _____
Date of Birth: _____ Place of Birth: _____ Male: Female:
Marital Status: _____ Spouse's Name: _____

Please circle the appropriate answer:

Do you have an Advance Directive/Living Will? Yes No
Do you have a Durable Power of Attorney (POA) for Health Care? Yes No
Do you have a Will? Yes No

If yes, who is the Executor? _____

Power of Attorney's Name: _____ Phone Number: _____
Address: _____
Email: _____
Type of POA: Financial: Medical:

Children/Significant Other (Please list individuals in the order they should be contacted if unable to reach POA)

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Address: _____ Email: _____

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Home Phone: _____ Work Phone: _____ Cell Phone: _____
Address: _____ Email: _____

To Be Admitted From (check one): Residence Hospital Health Facility
If Hospital – Name and Unit: _____

List Inpatient Stay Dates for Past Year (Hospital, Other Facility Transitional Care, etc.): _____

Long Term Goal

Return Home Transfer to another Facility/Level of Living Remain at St. Anne's

Primary Health Insurance (Medicare, Advantage Plan, PPO)

Insurance Company: _____

Policy/ID Number: _____ Group Number (if applicable): _____

Address: _____

Phone Number: _____

If Health Insurance is Medicare:

Part A Effective Date: _____ Part B Effective Date: _____

Secondary Health Insurance

Carrier Name: _____ Insured Name: _____

Address: _____

Phone Number: _____

Policy/ID #: _____ Group Number (if applicable): _____

Annual cost for insurance is: _____

Do you have Long Term Care Insurance? Yes: ____ No: ____

Policy # _____ Daily Personal Care Benefit _____ Daily Skilled Nursing Benefit _____

If Yes, Carrier _____

Address: _____

Phone Number: _____

Do you have Life Insurance? Yes: ____ No: ____

If Yes, Company _____

Face Value: _____ Cash Value: _____

Beneficiary: _____

Have you applied for Medical Assistance (MA): Yes: ____ No: ____

If Yes, when? _____ MA #: _____

Are you a veteran/spouse of a veteran: Yes: ____ No: ____

Branch of Service: _____

Do you take prescription medicines Yes: ____ No: ____ Average Monthly Cost is: _____

Do you receive medication from the VA? Yes: ____ No: ____

Do you have a prescription card? Yes: ____ No: ____ Type: _____

Community Physician: _____ Phone Number: _____

Church: _____ Address: _____

Phone Number: _____

Clergy: _____

Funeral Home: _____ Address: _____

Phone Number: _____

Do you have a Burial Trust/Prepaid Funeral?: Yes: ____ No: ____

Financial Information

Have you, or your Power of Attorney, received financial planning services? ___ Yes ___ No

If yes, Name(s) of financial planning service employed by you, or your Power of Attorney _____

Do you, or your Power of Attorney, have an attorney assisting you? ___ Yes ___ No

If yes, Name of Attorney _____ Phone # _____

Have you disposed of, or gifted, real estate or personal property within the last 5 years? Yes: ___ No: ___

If Yes, list date and explain: _____

Please supply copies of your latest statement for the assets listed below. Please identify if the asset, liability or monthly income are joint or individual, by selecting I (individual) J (joint) or S (spouse) in the corresponding column.

Please enter totals unless otherwise specified.

ASSETS		I	S	J
Cash				
Checking				
Savings				
Certificates of Deposit				
Individual Retirement Accounts, 401k				
Mutual Funds				
Annuities				
Stocks and Bonds				
Real Estate				
Trust Accounts				
Loans to Others				
Total Assets	\$			

LIABILITIES		I	S	J
Rent				
Credit Card Debt				
Other Debts				
Mortgage Balance				
Total Liabilities	\$			

Monthly Income		I	S	J
Social Security				
Pension				
Annuities				
Investment Income				
Rental Income				
VA Benefits				
Total Monthly Income	\$			

Real Estate Owned

Street Address	City	State	Zip Code	Estimated Value	Mortgage Balance

Other Assets

Asset	Fair Market Value	Joint/Individual

I represent the resources listed above are and will remain available for payment of services I may receive at St. Anne's Retirement Community.

Have you ever been convicted of a crime other than a summary offense? Yes: ____ No: ____

If Yes, What was the Date of the Conviction? _____

If Yes, Please describe the Conviction: _____

AGREEMENT

I have applied for admission to St. Anne’s Retirement Community. In doing so, I understand that St. Anne’s Retirement Community has a special obligation to clients, Residents and staff with respect to their personal property and safety. I hereby give St. Anne’s Retirement Community the right to make a thorough investigation into my previous employment, education, references, and character, and I release from all liability all persons supplying such information. The investigation is not limited to the above, and criminal checks both–State and Federal–can be required. I authorize all public officials or persons involved in reference for admission to furnish information necessary for residency at St. Anne’s Retirement Community. Records obtained will be confidential.

I hereby certify that the information and financial statements provided in this application are correct and complete to the best of my knowledge. I understand that any misrepresentation could result in the forfeiture of my application or status as a resident of St. Anne’s Retirement Community, Inc. I understand that this application does not obligate St. Anne’s Retirement Community, Inc., in any way and is submitted to be placed on file, and that the above information is strictly confidential.

In the event a resident becomes a danger to themselves and/or others, as in the judgment of the attending physician and Administrator, to jeopardize the health and/or safety of other residents or constitutes a hazard to himself/herself, St. Anne’s Retirement Community shall cooperate with the relative or responsible party in finding the most appropriate placement for the Resident.

I agree to sign using an electronic signature.

By checking above, I acknowledge the electronic signature below is the legal equivalent of my manual/handwritten signature.

Electronic Signature of Applicant/Responsible Party

Date

Signature of Administration

Date

Signature of Approval

Date of Approval

