

SAINT SIMEON'S

APPLICATION: PERSONAL INFORMATION

Application Received

PLACEMENT

- | | |
|--|--|
| <input type="checkbox"/> COTTAGE LIVING | <input type="checkbox"/> HEALTH CARE CENTER |
| <input type="checkbox"/> ASSISTED LIVING | <input type="checkbox"/> Private <input type="checkbox"/> Semi-Private |
| <input type="checkbox"/> Studio <input type="checkbox"/> Suite | <input type="checkbox"/> ALZHEIMER'S/MEMORY |
| <input type="checkbox"/> One Bedroom | <input type="checkbox"/> Private <input type="checkbox"/> Semi-Private |

Please indicate any of the following documents that have been completed and provide a copy.

- D.N.R. CONSENT
- ADVANCED DIRECTIVE FOR HEALTHCARE (LIVING WILL)
- GUARDIANSHIP (NAME) _____
- POWER OF ATTORNEY (NAME) _____

PERSONAL INFORMATION

LAST NAME _____ FIRST _____ MIDDLE _____

SS# _____ MARITAL STATUS _____ SPOUSE'S NAME _____

HOME ADDRESS _____ CITY/ST _____ ZIP _____

TELEPHONE _____ DATE OF BIRTH _____ AGE _____ SEX _____

PREVIOUS OCCUPATION _____ EMPLOYER _____

HAVE ANY FAMILY MEMBERS RESIDED AT ST. SIMEON'S? Yes No

NAME _____ RELATIONSHIP _____

RELIGIOUS INFORMATION

RELIGIOUS AFFILIATION _____

NAME OF CHURCH, CLERGY _____ TELEPHONE _____

ADDRESS _____ CITY/ST _____ ZIP _____

NAME OF FUNERAL HOME _____ TELEPHONE _____

ADDRESS _____ CITY/ST _____ ZIP _____

IN CASE OF EMERGENCY (NEXT OF KIN)

FULL NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY/ST _____ ZIP _____

BUS. PHONE _____ HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

FULL NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY/ST _____ ZIP _____

BUS. PHONE _____ HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

MEDICAL INFORMATION

DIAGNOSIS _____

KNOWN ALLERGIES _____

ATTENDING PHYSICIAN _____ TELEPHONE _____

ADDRESS _____ CITY/ST _____ ZIP _____

DENTIST _____ TELEPHONE _____

PHARMACY _____ TELEPHONE _____

HOSPITAL PREFERENCE _____

EMSA TOTAL CARE Yes No

RESPONSIBLE PARTY

FULL NAME _____

ADDRESS _____ CITY/ST _____ ZIP _____

BUS. PHONE _____ HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

INSURANCE INFORMATION

MEDICARE NAME (FROM CARD) _____

MEDICARE NUMBER _____

SECONDARY INSURANCE _____

POLICY NUMBER _____ GROUP NUMBER _____

WHO REFERRED YOU TO SAINT SIMEON'S?

NAME _____

ADDRESS _____ CITY/ST _____ ZIP _____

BUS. PHONE _____ HOME PHONE _____ CELL PHONE _____

PLEASE INDICATE HOW YOU HAVE HEARD ABOUT SAINT SIMEON'S (circle all that apply)

- Physician Hospital Personnel Case Manager Church
- Website Yellow Page Listing Magazine Ad Radio Ad
- Friend Life Senior Services Newspaper Relative of a Resident
- Alzheimer's Association Other: _____

I certify that this Application is made of my own free will and volition and that the information is correct to the best of my knowledge. I authorize and request that my attending physician, surgeon or other persons having direct, professional knowledge of my physical or mental health, past or present, provide to the staff of Saint Simeon's Episcopal Home any and all information relative to this Application.

Applicant or Representative

Date

Relationship

SAINT SIMEON'S

APPLICATION: FINANCIAL INFORMATION

NAME OF APPLICANT _____
 FINANCES ADMINISTERED BY _____ SELF _____ OTHER _____
 NAME _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 PHONE _____ E-MAIL _____
 FINANCIAL INFORMATION AT _____, 20__

ASSETS	AMOUNT	LIABILITIES	AMOUNT
CASH		PAYABLES:	
SAVINGS		BANK LOANS	
CERTIFICATES OF DEPOSIT		CREDIT CARD	
NOTES RECEIVABLE		NOTES PAYABLE	
STOCKS & BONDS		OTHER	
REAL ESTATE		MORTGAGE	
PERSONAL PROPERTY		OTHER LIABILITIES	
OTHER ASSETS			
TOTAL		TOTAL	
		TOTAL ASSETS LESS LIABILITIES (NET WORTH)	

MONTHLY INCOME	AMOUNT	MONTHLY EXPENSES	AMOUNT
PENSION		MORTGAGE	
SOCIAL SECURITY		LOANS/NOTES PAYABLE	
TRUST INCOME		CREDIT CARD	
DIVIDENDS		MEDICATIONS	
OTHER:		OTHER:	
TOTAL		TOTAL	
		TOTAL MONTHLY INCOME LESS MONTHLY EXPENSES	

Do you have long-term care insurance: _____ YES _____ NO

If yes, what is the coverage amount and term:

I, THE UNDERSIGNED, HEREBY CERTIFY AND DECLARE THAT THE ABOVE FINANCIAL INFORMATION IS TRUE, CURRENT AND ACCURATE AT THE DATE OF THIS APPLICATION. SHOULD ANY OF THE INFORMATION LISTED ABOVE CHANGE PRIOR TO ADMISSION TO SAINT SIMEON'S, I WILL IMMEDIATELY MAKE THAT INFORMATION AVAILABLE TO SAINT SIMEON'S.

APPLICANT OR REPRESENTATIVE _____

DATE _____