COUNTRYSIDE HEALTH CARE OF MILFORD

APPLICATION FOR ADMISSION

* PERSONAL AND CONFIDENTIAL *

I. GENERAL INFORMATION CONCERNING PROSPECTIVE RESIDENT:

A. Resident's Name _____

Birhtdate _____ Place of birth (county/state) _____

Home Address _____

City _____ County _____ State/Zip Code _____

Marital Status _____ Religion _____ Church _____

Father's Name _____ Mother's Maiden Name _____

Previous Occupation _____ Military Service _____

Referred To Facility By _____

Resident is now at _____Home _____Hospital _____Nursing Home _____Other (specify)

Facility Information: Name _____

Telephone _____ Name _____

Date of Admission _____ Referral Source _____

Has the Resident ever been in another nursing center ? Yes _____ No _____

Is the Resident aware of the palcement decision? Yes _____ No _____

Personal Physician's Name _____

Address _____

Telephone _____

Will the resident's personal physician attend here ? Yes _____ No _____

B. INDIVIDUAL RESPONSIBLE FOR PAYING BILL:

Name _____ Relationship to Resident _____

Home Address _____

City _____ State/Zip Code _____

Telephone (home) _____ (business) _____

C. POWER OF ATTORNEY:

Has anyone been appointed Power Of Attorney or Guardian ? Yes _____ No _____

If so, who ? _____

To what extent ? _____

Has an advance directive been prepared ? Yes _____ No _____

Type _____

D. ADDITIONAL RELATIVES (Significant Others):

Name _____ Relationship to Resident _____

Home Address _____

City _____ State/Zip Code _____

Telephone (home) _____ (business) _____

Name _____ Relationship to Resident _____

Home Address _____

City _____ State/Zip Code _____

Telephone (home) _____ (business) _____

II. FINANCIAL INFORMATION CONCERNING RESIDENT:
All questions must be answered as completely and accurately as possible.

Social Security # _____ Medicare # _____ Date _____ Part A ___ Part B ___

Medex/Medigap # _____ Medicare supplemental insurance _____

Prescription Card _____ Policy # _____

Long Term Care Insurance _____ Policy # _____

Other Insurance _____ Policy # _____

A. MONTHLY INCOME

Recipient's Name — Monthly Amount

Social Security _____ $ _____

Civil Service Retirement _____ $ _____

V.A. Pension _____ $ _____

Military Retirement _____ $ _____

Railroad Retirement _____ $ _____

Rental Income _____ $ _____

Other (specify) _____ $ _____

_____ $ _____

B. CASH ASSETS IN BANKS, CREDIT UNIONS SAVINGS AND FINANCIAL INSTITUTIONS:

Institution Name _____ Location _____

Type of Account _____ Balance in Account $ _____

Names Listed on Account _____

Institution Name _____ Location _____

Type of Account _____ Balance in Account $ _____

Names Listed on Account _____

Institution Name _____ Location _____

Type of Account _____ Balance in Account $ _____

Names Listed on Account _____

C. LIFE INSURANCE CASH VALUE:

Does the Resident have life insurance policies with cash value ? Yes _____ No _____

Company Name _____

Approximate cash value $ _____ Annuities $ _____

D. REAL ESTATE ASSETS:

Resident Own Home ? Yes _____ No _____ Approximate Value $ _____

Is Property Owned Jointly ? Yes _____ No _____

Names Of Co-Owners _____

Resident own any additional property ? Yes _____ No _____

Approximate value $ _____

E. FUNERAL ARRANGEMENTS:

Has the Resident made pre-paid funeral arrangements ? Yes _____ No _____

Funeral home preference (name) _____ Telephone _____

Burial Account amount $ _____

F. OTHER ASSETS/INVESTMENTS (stocks, bonds, IRA's):

Company Name _____ Approximate value $ _____

Company Name _____ Approximate value $ _____

Company Name _____ Approximate value $ _____

Company Name _____ Approximate value $ _____

G. MEDICAID/TITLE XIX (19):

Has the Resident applied, or will the resident shortly be applying, for Medical Assistance?

Yes _____ No _____ Medicaid # _____

If the resident has applied, what was the date ? _____ Location of Office _____

Dept. of Medical Assistance representative _____ Telephone _____

I hereby certify that to the best of my knowledge and belief, the above stated information is true, correct and complete. I understand that if any information has been falsely represented, this will cause my allpication to be incomplete and result in a delay for admission. All of the information will be kept confidential by the facility.

Signature of Resident _____ Date _____

Signature of Sponsor _____ Date _____

Facility Representative _____ Date _____