

REGENCY VILLAGE

APPLICATION FOR RESIDENCY

To apply for admission, please complete this questionnaire, and return it to the Case Management Team. All information will be held in confidence. A more complete medical history and physical exam will be recorded on another form. This application will become a part of the "Resident Agreement".

Name of Applicant: Mr. Mrs. Ms. _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone No: _____

Religion: _____ Church: _____

Date of Birth: _____ Place of Birth: _____ State: _____

Social Security No: _____ Marital Status: ___ Single ___ Married ___ Widowed
(Please attach a copy of the card)

Medicare No: _____ Effective Date: _____
(Please attach a copy of front and back of card)

Medicaid No: _____ Effective Date: _____
(Please attach a copy of the card)

Coinsurance Policy Co. & No: _____ Effective Date: _____
(Please attach a copy of front and back of card)

Funeral Home: _____ Prepaid: ___ Yes ___ No

Name of person completing this form: _____

Relationship to resident: _____ Telephone No: _____

Address: _____ City: _____ State: _____ Zip: _____

How did you hear about us?

___ Newspaper

___ Brochure

___ Friend

___ Social Worker

___ Physician

___ Hospital

___ Other Nursing Facility

___ Other

Have you visited any other nursing facilities? ___ Yes ___ No

If yes, which ones?

MEDICAL AND PERSONAL DATA

Diagnoses: _____

Resident's Current Physician: _____ Telephone No: _____

<input type="checkbox"/> Mentally Alert	<input type="checkbox"/> Forgetful	<input type="checkbox"/> Confused
<input type="checkbox"/> Eats Independently	<input type="checkbox"/> Requires Help with Feeding	<input type="checkbox"/> Requires Special Diet
<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Walks with Assistance	<input type="checkbox"/> Chair-Ridden
<input type="checkbox"/> Bed-Ridden	<input type="checkbox"/> Requires Bed Rails	
<input type="checkbox"/> Continent	<input type="checkbox"/> Incontinent	

Admission Date desired: _____

Resident now residing at: _____

Reason for seeking admission: _____

I give permission for my (applicant's) doctor/hospital to release Medical Information

Name: _____ Signature: _____

The names(s) of the person(s) who will be financially responsible for the cost of the care (the "Guarantor")

Name(s): _____ Telephone No: _____

Address: _____ City: _____ State: _____ Zip: _____

Has a Trust Account been established? Yes No

If yes, please detail and attach a copy _____

Has a Durable Power of Attorney been appointed for financial affairs? Yes No

If yes, please attach a copy of the document.

Has a Legal Guardian been appointed? Yes No

If yes, please attach a copy of the guardianship papers.

Has a Living Will been executed? Yes No

If yes, please attach a copy of the document.

Has a Durable Medical Power of Attorney been appointed? Yes No

If yes, please attach a copy of the document.

FINANCIAL DATA

To process your application, the following information is needed. The information supplied is confidential and allows us to assist you in your long term financial planning. Your cooperation is appreciated in order to expedite the admission.

Monthly Income:

Salary	\$ _____
Social Security	\$ _____
Pensions/Annuities	\$ _____
IRA	\$ _____
Interest/Dividend	\$ _____
Rental Income	\$ _____
Investments/Other	\$ _____

Total: \$ _____

Assets/Description:

Account #:

Value:

Cash (please list bank names and account #'s):

_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Securities (stocks bonds):

_____	_____	\$ _____
_____	_____	\$ _____

Real Estate (description and location): (Example: 3 bedroom house; Jones St., Anyplace OH 99999)

_____	_____	\$ _____
_____	_____	\$ _____

Other Assets:

Description:

Value:

Cash value of Life Insurance	_____	\$ _____
Vested Pension Benefits	_____	\$ _____
Business Interest	_____	\$ _____
Automobiles	_____	\$ _____
Other	_____	\$ _____

Total Assets: \$ _____

FINANCIAL DATA (Continued)

Liabilities:

Home Mortgage _____ \$ _____

Credit Cards/Charge Account _____ \$ _____

Loans _____ \$ _____

Other Debts _____ \$ _____

Taxes Owed _____ \$ _____

Total Liabilities: \$ _____

NET WORTH (Assets - Liabilities): \$ _____

Please sign below:

I hereby affirm that, to the best of my knowledge, the information provided on this application is accurate and complete.

Resident Signature Date

Guarantor's Signature Date

Reviewed by: _____
Case Management Date

Administrator Date

Accounting Date