



APPLICATION FOR ADMISSION

Name: \_\_\_\_\_ Date of Application: \_\_\_\_\_
FIRST MIDDLE LAST

Gender: F M Date of Birth: \_\_\_\_\_ Age \_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_
STREET CITY STATE ZIP

Religion: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Citizenship: \_\_\_\_\_ Primary Language: \_\_\_\_\_

S.S. #: \_\_\_\_\_ Former Occupation: \_\_\_\_\_ Approx. Weight: \_\_\_\_\_

Medi-Cal # (if applicable): \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ I.D. #: \_\_\_\_\_

Secondary/Co-Insurance: \_\_\_\_\_ I.D. #: \_\_\_\_\_

Prescription Coverage: \_\_\_\_\_ I.D. #: \_\_\_\_\_

Long Term Care Insurance: \_\_\_\_\_ I.D. #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Mortuary: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Is applicant capable of understanding his/her condition and making decisions regarding care? Y N

Does applicant have:

Advance Health Care Directive? Y N Agent: \_\_\_\_\_

Financial Power of Attorney? Y N Agent: \_\_\_\_\_

A Conservatorship? Y N Agent: \_\_\_\_\_

Please give a brief description of current health situation: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_



**CONFIDENTIAL FINANCIAL STATEMENT**

**Failure to complete this document will automatically trigger private pay rate.**

**Applicant Name:** \_\_\_\_\_

**MONTHLY INCOME AMOUNT**

**SOURCE of INCOME (Enter a monthly average if not received monthly)**

**Social Security**-----

**Pensions, Annuities, Investment Earnings**-----

**Supplemental Security Income (SSI)** -----

**Other**-----

**MONTHLY INCOME TOTAL**\$ \_\_\_\_\_

**CURRENT ASSET AMOUNTS**

**Bank Accounts**-----

**CD's, Money Market**-----

**Other Property**-----

**Annuities**-----

**Personal or Business loans made to others**-----

**Other**-----

**TOTAL NET WORTH** \$ \_\_\_\_\_

**With the information and schedule of rates (\$365.00 a day for a shared room and \$385.00 for a private room), what would you estimate your pay status for Grace Home's services to be at this time? Check all that apply.**

\_\_\_\_ Use of personal funds for \_\_\_\_ 2+ years \_\_\_\_ 7 months to 2 years \_\_\_\_ 6 months or less

\_\_\_\_ Has a trust \_\_\_\_ Revocable \_\_\_\_ Irrevocable

\_\_\_\_ Is currently receiving Medi-Cal benefits.

\_\_\_\_ Will qualify for Medi-Cal upon admission to a Skilled Nursing Facility.

**If checked, have you contacted Medi-Cal? \_\_\_\_ Yes \_\_\_\_ No**

**To the best of my knowledge, the information is completely accurate and true in all respects. We may request verification of information with bank statements.**

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Spouse Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Designee/Conservator:** \_\_\_\_\_ **Date:** \_\_\_\_\_