

APPLICATION FOR ADMISSION

Name:									Date of Application	of Application:	
FIRST				MIDDLE		LA	AST		_		
Gend	er:	F	M	Date of Birth:				Age _	Marital Status:		
Addr	ess: _		ST	REET		CITY			STATE	ZIP	
							Ethnic	city:			
Birthp	rthplace: Citize				zensł	nip:			Primary Languag	e:	
S.S. #:				Former	Occi	ıpat	tion:		Approx. W	eight:	
Medi-(Cal#	(if a	pplic	able):							
Primary Insurance:						I.D. #:					
Second	lary/(Co-I	nsura	nnce:					I.D. #:		
Prescri	iption	Co	verag	ge:				I.	.D. #:		
Long T	Term	Car	e Ins	urance:				I.	D. #:		
Primary Care Physician:								_City:	Phone:		
Dentist	t:							_City:	Phone:		
Mortu	ary:_							City:	Phone:		
Is appl	icant	cap	able (of understanding hi	s/hei	cor	ndition	and mal	king decisions regardi	ng care? Y N	
Does a	pplica	ant l	have:								
	Adva	nce	Heal	th Care Directive?	Y	N	Agent	:			
	Finai	ncia	l Pow	er of Attorney?	Y	N	Agent	:			
	A Co	nse	rvato	rship?	Y	N	Agent	:			
Please	give a	a br	ief de	scription of current	heal	lth s	situation	n:			

APPLICATION FOR ADMISSION, page 2. Name of Person Receiving Billing Statement: Address: ______STREET CITY ZIP STATE Phone: DAY EVENING CELL Email: _______Relationship: _____ Relative/ Emergency Contact #1: Address: ______STREET CITY STATE ZIP Phone: DAY EVENING CELL Email: Relationship: Relative/Emergency Contact #2: ____ Address: CITY STATE ZIP

IN ADDITION TO THIS COMPLETED APPLICATION, PLEASE PRIVIDE THE FOLLOWING:

Phone: DAY EVENING

Confidential Financial Statement (included in this packet)

CELL

Copies of all insurance cards

Copy of Advanced Health Care Directive

Medical records documenting current diagnosis/diagnoses

List of current medications

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\$
<u>CURRENT ASSET AMOUNTS</u>
Bank Accounts
CD's, Money Market
Other Property
Annuities
Personal or Business loans made to others
Other
TOTAL NET WORTH <u>\$</u>
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 trustRevocableIrrevocable
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:

Grace Home Inc. 13435 Peach Ave Livingston, CA 95334 Phone: 209-394-2440 Fax: 209-233-3045