ST. JOSEPH'S MINISTRIES, INC.

APPLICATION FOR RESIDENCY

To apply for admission to St. Joseph's Ministries, Inc., please complete the following application, sign, and return it to the Admissions Office before admission. This application will become a part of the 'Resident Agreement' and should be completed in its entirety. All information submitted is confidential. ***Please enclose all required documents. IE: Advanced Directives, Healthcare Cards, Living Will and/or Healthcare Agent.***

Please note: St. Joseph's Ministries, Inc. is a smoke-free campus.

I. GENERAL INFORMATION

Date of Application: _____ **Social Security #:** _____

Name of Prospective Resident: _____ **Sex:** _____ **Age:** _____

Home Address, If Coming From Residence_____
(Street Address) (City) (State) (Zip Code)

Name of Spouse: _____ **Phone:** _____

Address: _____

Date of Birth: _____ **Marital Status:** ___ Single ___ Married ___ Widowed ___ Divorced ___

Religion: _____ **Name of Clergy:** _____ **US Citizen:** _____

Were you in the Armed Forces? _____ **Occupation before Retirement:** _____

Education - Years Completed: _____**Primary Language:** _____

Skilled Nursing Facility: _____ **Admission Date:** _____

Discharge Date: _____

Address of Facility: _____
(Street Address) (City) (State) (Zip Code) (Phone #)

Current Physician: _____
(Name) (Phone #)

_____
(Street Address) (City) (State) (Zip Code)

Current Dentist: _____
(Name) (Phone #)

_____
(Street Address) (City) (State) (Zip Code)

Medicare #: _____ (Please Provide Copy of Card) **Part A Part B**

Does Prospective Resident Have Any Other Health or Long Term Care Insurance?

_____ Yes _____ No _____
(If yes, provide name of insurance company, policy number and a copy of the insurance card.)

Does Prospective Resident Have Pre-Paid Burial Plans? _____
(Name)

_____
(Address)

Was Prospective Resident Admitted to Hospital During the Last 30 Days?

_____ Yes _____ No Dates _____

If yes, provide name of the facility and telephone number: _____
(Name) (Phone #)

Diagnosis? _____

If resident is unable to make financial/medical decisions, who is responsible?

Name _____ Relationship _____

Address _____
(Street Address/P.O. Box) (City) (State) (Zip Code)

Telephone # (Home) _____(Work) _____

Additional Relatives/Significant Others:

Name _____ Relationship _____

Telephone # (Home) _____(Work) _____

Name _____ Relationship _____

Telephone # (Home) _____(Work) _____

II. FINANCIAL INFORMATION

To process your application, the following information is needed concerning the prospective resident's finances. Please indicate the resources which are available to pay for the cost of care. The information supplied will be strictly confidential and will be used to assist you in your long-term planning.

Person who will be financially responsible for the cost of care (the "resident agent"). (The person whose name is listed here must also sign this application.):

Name _____ Relationship _____
(Last) (First) (M.I.)

Address _____
(Street Address/P.O. Box) (City) (State) (Zip Code)

Telephone # (Home) _____ (Work) _____

Has Anyone Been Appointed Power of Attorney/Guardian? _____ Yes (Provide Copy) _____ No

If yes, who? _____ _____ Financial Decisions _____ Medical Decisions

Has the resident applied, or will the resident soon be applying for State Medical Assistance?

_____ Yes _____ No _____
(If yes, provide Medical Assistance Number)

If the resident has applied, what was the date? _____ Where (County)? _____

Department of Social Services Representative _____ Telephone Number _____

Prospective Resident's Monthly Income

Salary	$ _____
Social Security	_____
Pensions/Annuities	_____
IRA	_____
Interest/Dividend Income	_____
Rental Income	_____
Other (*Specify*) _____	_____
Total Monthly Income	$ _____

Prospective Resident's Assets

Cash assets in Banks, Credit Unions, Savings, and Financial Institutions:

Institution Name _____ Balance in Account $ _____
Institution Name _____ Balance in Account $ _____
Institution Name _____ Balance in Account $ _____

Securities (Stocks, Bonds, IRAs) *Specify* _____

Real Estate Assets
Does resident own home? ___ Yes ___ No Approximate Value $ _____
Does resident own additional property? ___ Yes ___ No Approximate Value $ _____

Life Insurance Cash Value--Any policies with Cash Value?

_____ Yes _____ No Company Name _____ Value $ _____

Other Assets (Automobiles, Business Interests) *Specify* _____ Value $ _____

Total Assets **$** _____

Prospective Resident's Liabilities

Home Mortgage $ _____
Credit Cards/Charge Accounts _____
Loans _____
Other Debts (*Specify*) _____
Taxes Owed _____
Total Liabilities _____

Net Worth (Total Assets - Total Liabilities) **$** _____

III. PAYMENT TERMS

It is the policy of St. Joseph's Ministries, Inc. to collect the equivalent of one month's room charges in advance and at the beginning of each subsequent month. Resident bills are owed monthly and the amount due is payable upon receipt. Amounts unpaid by the end of the month will be subject to late charges as provided in the admissions agreement.

Please Sign Below

I hereby affirm that, to the best of my knowledge, the financial information provided is accurate and complete and that the assets listed are, in fact, available to pay for the resident's care at St. Joseph's Ministries, Inc. The nursing center has my permission to obtain a credit report of the applicant or contact any of the financial institutions listed herein. I understand that the nursing center will rely upon the accuracy and completeness of the financial information included on this application in making an admission decision.

_____ _____

Health Care Agent's Signature ***Date***

_____ _____

Signature of Resident or Legal Guardian ***Date***

IV. FACILITY REVIEW

_____ _____

Admissions Director's Signature ***Date***

In addition to the complete application, a single copy of the following must be presented:

- ***Medicare Card***
- ***Private Insurance Card/Information***
- ***Legal Documents--POA/Living Will***