RESIDENT APPLICATION

GREEN HILLS INN
6559 US 68 SOUTH
WEST LIBERTY, OH 43357

Please answer all questions as completely as possible. The information is held in strict confidence. Please print or type.

APPLICANT INFORMATION

Full Name_____ Social Security Number_____

Present Living Arrangement _____

Present Address_____ Phone Number_____
Street

_____
City State Zip Code

Date of Birth_____ Age_____ Birthplace_____

Marital Status: Single_____ Married_____ Widowed_____(date)_____

Separated_____ Divorced_____

List your children, other close relatives, or close friends.

1) _____
Name Relationship Phone

_____
Address

2) _____
Name Relationship Phone

_____
Address

3) _____
Name Relationship Phone

_____
Address

4) _____
Name Relationship Phone

_____
Address

5) _____
Name Relationship Phone

_____
Address

6) _____
Name Relationship Phone

_____
Address

PREFERENCES

Preference of type of apartment:

Efficiency_____One bedroom_____

Preferred moving date_____

If application is for two persons, please submit forms for both persons.

HEALTH HISTORY AND INFORMATION:

Name of local personal physician: _____

_____
Address Phone

Name of other physician familiar with your health history: _____

_____
Address Phone

Have you ever had major surgery, a serious mental or physical disease, or other major health problems? _____ If so, please describe briefly: _____

_____

_____

_____

Briefly describe any current health problems or disabilities: _____

_____

_____

_____

_____

Individual Providing Information Initials_____

List of Current Medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have prescription drug coverage? Yes_____No_____

Do you have the Medicare D Plan? _____

Other: _____

Name of your pharmacy: _____

NOTE: **Please keep us informed of any changes in prescription medications, Medicare D coverage (prescription drug coverage), pharmacy, etc.**

Miscellaneous health information:

Do you have diabetes?_____ Do you take insulin?_____
Are you on a special diet?_____ Any diet restrictions?_____
Do you have a contagious disease?_____ If yes, please explain:_____
_____
Do you have high blood pressure?_____ Arthritis_____
Do you smoke?_____
Cigarettes_____ Cigar_____ Pipe_____
Do you use alcoholic beverages?_____ Never_____
Rarely_____ Occasionally_____ Frequently_____
Are you currently under psychiatric care?_____

Insurance information:

Medicare Number_____ (provide copy of Medicare card)

Other medical insurance:
Company_____(provide copy of card)
Policy number_____

Long term care insurance:
Company_____(provide copy of card)
Policy number_____

Individual Providing Information Initials_____

Preference of funeral home: _____
(Name) (Phone Number)

PERSONAL INFORMATION:

What is your present or former occupation?_____

Name of Spouse:_____ Where have you lived most of your life?_____

Do you? Walk for exercise_____ Read newspaper_____ Watch television_____
Listen to the radio_____ Attend group/club meetings_____

Do you drive a car?_____ Do you plan to continue using your car?_____

Check the areas in which you now need some assistance:

Meal Preparation_____ Toileting_____
Housekeeping_____ Medications_____
Laundry_____ Shopping_____
Dressing_____ Transportation_____
Grooming_____ Handling finances_____
Bathing_____

Do you use any of the following?

Glasses_____ Hearing aid_____ Cane_____
Wheelchair_____ Walker_____ Scooter_____

What is your religious preference?_____
Church name and address_____
Pastor_____ Phone number_____

What level of education have you completed?

Elementary_____ High School_____ College_____
Graduate school_____ Professional_____ Other_____

What hobbies/interests do you enjoy at this time?

Sewing_____ Embroidering_____ Weaving_____ Exercise_____
Music_____ Indoor Plants_____ Games_____ Knitting_____
Crafts_____ Entertainment_____ Lectures_____ Painting_____
Church_____ Woodworking _____ Gardening____ Ceramics_____
Parties _____ Traveling_____ Crocheting___ Reading_____
Other_____

Individual Providing Information Initials_____

List two references that may be contacted:

1) _____
Name Phone

_____
Address

2) _____
Name Phone

_____
Address

FINANCIAL DISCLOSURE/ MEDICAID SCREENING FORM

We thank you for considering _____ (Facility Name). To aid us in assessing whether we can meet your financial needs, we would like to review your financial resources to pay for care. Once determined, we can then establish a clear understanding of the financial responsibility you will be undertaking.

We require this information of all residents, regardless of their method of payment or length of stay. Completing this form before admission day will aid us in helping you make the best decisions, and will expedite the admission process. All information will be kept confidential, and if you choose our facility, this form will become part of your admission agreement.

General Information:

Prospective Resident's Name: _____
If you are not the prospective resident:

Your Name: _____ Relationship _____

Legal Representatives (if any):

Please provide agreements, by attaching a copy to the Financial Disclosure Form, designating each legal representative. (Example: Legal guardian, POA, DPOA, Guarantor, Responsible party)

Type of legal representative: Financial POA _____Guardian_____Health Care POA_____

Representative's Name: _____ Telephone (Day): _____
(Eve): _____

Address: _____

City, State & Zip:_____ Title or relationship to resident: _____

_____

Individual Providing Information Initials_____

Type of legal representative Financial: POA _____Guardian_____Health Care POA_____

Name: _____ Telephone (Day): _____
(Eve):_____

Address: _____

City, State & Zip:_____ Title or relationship to resident: _____
_____

Other Responsible Party (if any)

Name: _____ Telephone (Day): _____
(Eve):_____

Address: _____

City, State & Zip:_____ Title or relationship to resident: _____
_____

Individual Providing Information Initials_____

Financial Information:

Does the resident have any insurance that will cover care provided in a long-term care facility, or residential care facility? YES___ NO ___

If yes, please identify:

Company: _____ Policy #: _____

Address of Insurance Company: _____

Agent's Name: _____ Telephone #: _____

Monthly Income:

Salary **$** _____ **Social Security check** **$** _____

*Source*_____ *Source*_____

Pension **$** _____ **IRA** **$** _____

*Source*_____ *Source*_____

Annuity **$** _____ **Disability check** **$** _____

*Source*_____ *Source*_____

Rental income **$** _____ **Other** **$** _____

*Source*_____ *Source*_____

401(K) or other similar account(s) **$**_____

*Source*_____

*Source*_____

Total income – All sources $ _____

Cash Assets:

Bank (1) _____ Location _____

Checking account # _____ Balance in account $ _____

Savings account # _____ Balance in account $ _____

Certificates of Deposit? YES ___ NO _____ If yes, approximate amount $ _____

Individual Providing Information Initials_____

Bank (2) _____ Location _____

Checking account # _____ Balance in account $ _____

Savings account # _____ Balance in account $ _____

Certificates of Deposit? YES ___ NO _____ If yes, approximate amount $ _____

Bank (3) _____ Location _____

Checking account # _____ Balance in account $ _____

Savings account # _____ Balance in account $ _____

Certificates of Deposit? YES ___ NO _____ If yes, approximate amount $ _____

OTHER ASSETS/ LOCATION AMOUNT

_____ $_____

_____ $_____

(If additional space is still required, please list the location of these assets and the amount on a separate sheet and attach to this financial disclosure.)

Total of all cash assets listed $_____

Real Estate Assets:

Does the resident own a home? YES ___ NO _____ If yes, approximate value $ _____

Home Address (1)_____

Does the resident own a second home? YES ___ NO____ If yes, approximate value$_____

Home Address (2)_____

Does resident own any other property YES ___ NO _____ If yes, approximate value $ _____
(farm, commercial real estate, etc.)?

If yes, what is it and indicate the address of the property?_____

_____

Total value of all Real Estate owned $ _____

Individual Providing Information Initials_____

Life Insurance Cash Value:

Does resident have life insurance policies with cash value? YES ___ NO ___

Company Name(1): _____ Approximate Cash Value $ _____

_____ Face Value $_____

Agent Name: _____ Telephone #_____

Address_____

Annuities $ _____

Company Name (2): _____ Approximate Cash Value $ _____

_____ Face Value $_____

Agent Name: _____ Telephone #_____

Address_____

Annuities $ _____

(If life insurance is held by more than one agent, please list agents and the amount they handle below.)

_____

_____

Total of all Life Insurance Cash Values only listed $ _____

Securities:

Does the resident have stocks and bonds? YES ____ NO ____

Approximate current market value of all securities $ _____

Agent Name _____ Telephone # _____

Address: _____

(If more than one agent holds securities, please list these agents and the amount they handle below.)

_____

_____

If no agent, please list the securities that are held below.

_____

_____

Individual Providing Information Initials_____

Total of all Securities listed $ _____

Prepaid Burial Accounts:

Does the resident have a prepaid burial account or plot? YES _____ NO_____

Is the account for the resident only or for the resident and his/ her spouses?

Resident Only _____ Resident and Spouse _____

Account # _____ Value: _____

Cemetery Name & Address : _____

Account # _____ Value: _____

Cemetery Name & Address : _____

Total of all Burial Account Values listed $ _____

Automobiles:

Does the resident own an automobile(s)? YES_____ NO_____

Please indicate the following information.

Auto (1): _____ Make/ Model:_____

Year:_____ Estimated Value:_____

Auto (2): _____ Make/ Model:_____

Year:_____ Estimated Value:_____

Auto (3): _____ Make/ Model:_____

Year:_____ Estimated Value:_____

Total of all Auto Values listed $ _____

Other:
Are there any other sources of income that have not been identified above? YES ___ NO ____

Please identify the source(s): (Business Interests, Loans to Family Members, etc.) _____

_____

_____

Individual Providing Information Initials_____

Total of all current market value of these sources listed $ _____

Total available sources of income:

Monthly income	$ _____
Annuities	$ _____

Total sources of income $ _____ (A)

Total available sources of assets:

Total Bank Value	$ _____
Real Estate Assets	$ _____
Life Insurance Cash Value	$ _____
Securities	$ _____
Burial Accounts	$ _____
Automobiles	$ _____
Other	$ _____

Total Assets $ _____ (B)

Total Income and Assets $ _____ (C)

From what source(s) does the resident plan to pay for services at the Facility (named on agreement)?

_____

_____

If necessary, would the resident be willing to liquidate his/her assets to pay for services at the facility?
YES ____ NO ____

If the resident's resources become insufficient to meet total expenses while residing at the Facility, are there other persons or organizations that could help pay for services? If yes, please specify.

_____

_____

Individual Providing Information Initials_____

Are there any safeguards to ensure that your resources are used only for the resident's benefit? If yes, please specify.

_____

_____

During the past five years, has the resident given or transferred any cash, property or other assets (valued at more than $1,000) to any person or organization? If yes, please specify when, to whom, what assets and what their total value was at the time of transfer.

_____

_____

Who will handle the resident's financial affairs while he/she is a resident at the Facility (named in agreement)?

Name: _____ Relationship _____

Address: _____ Legal Relationship _____

_____ Telephone _____

In the past seven years has the resident declared bankruptcy or had judgments against them?
YES ____ NO ____

If yes, please specify: _____

_____

Liabilities:

Please list any balance owed by the resident on the items below:

House Loans/ Mortgage Balance **$ _____ (D)**

Name of Credit Card

Credit Cards(1) _____ $ _____

Credit Cards(2) _____ $ _____

Credit Cards(3) _____ $ _____

Credit Cards(4) _____ $ _____

Credit Cards(5) _____ $ _____

TOTAL Credit Card Balance **$ _____ (E)**

Individual Providing Information Initials_____

Automobiles Balance Owed (1) $ _____

Automobiles Balance Owed (2) $ _____

Automobiles Balance Owed (3) $ _____

TOTAL Auto Balance **$ _____ (F)**

OTHER _____ **$ _____ (G)**

Unpaid Medical Expenses:

Physician $ _____

Prescriptions $ _____

Hospital or other Medical Facility $ _____

TOTAL Past Medical Expenses **$ _____(H)**

TOTAL LIABILITES $ _____ (I)

Other monthly ongoing medical expenses not covered by Medicare, Medicaid or other Insurance. $_____

Estimate of residual assets:

Monthly Income $ _____ (A)

Total Assets $ _____ (B)

- Total Liabilities $_____ (I)

Residual Assets $ _____

Individual Providing Information Initials_____

Authorization:

I hereby state that to the best of my knowledge, the information on this form is true, accurate and complete. I understand that if any information has been falsely represented, it may be sufficient cause for denying admission or discharging the resident from the Inn. I authorize the Facility (named in the agreement) to investigate financial and credit records through any investigative or credit agency(s) of it's choice.

Resident: _____ Date: _____

Legal Representative: _____ Date: _____
Legal Guardian, POA, DPOA

Responsible Party/Agent: _____ Date: _____

Facility Representative: _____ Date: _____

Witness*: _____ Date: _____

Witness*: _____ Date: _____

*** Required only if resident is unable to sign his/her full name.**

Individual Providing Information Initials_____