TRINITY CONTINUING CARE SERVICES
APPLICATION FOR ADMISSINON

This Application must be completely filled out and verified before resident will be considered for admission

HOW DID YOU LEARN ABOUT US____

INFORMATION CONCERNING PERSPECTIVE RESIDENT:

Residents Name_________________________ Age_____ Birthday___________ Sex____
Home Address____
City________________________________ State_____ Zip___________
Resident is now at ______________________________
Identify institution if applicable: Name_______________________________________
Address: ____________________________________
City____
Phone #._______________ How Long___________

List below those persons who should be contacted in the event of an emergency:
Name_______________________________________ Relationship________________________
Address____
Home Phone________________ Work Phone________________ Cell Phone_____________
Name_______________________________________ Relationship________________________
Address____
Home Phone________________ Work Phone_________________ Cell Phone____________
Legal Authority________________________ Responsible for Payment__________________

GENERAL INFORMATION:

Current Living Situation_____________________ Prior Living Situation___________________
If currently hospitalized, name of hospital and social worker____________________________
Dates of Stay___________________
Past Nursing Home and Hospital Placements including dates for the last 6 months
____
____
____
General State of Health____
____
____
____
Height______________ Weight______________
Personal Physician's Name__________________________ Phone Number__________________

Financial Information: So that we can better assist you in obtaining any possible coverage from Medicare, Medicaid, private insurance, other sources, please complete this financial information page.

1) Insurance:

Social Security Number ________________________________ Medicaid Number____________________

Medicare Number_______________________________________ Blue Cross Number_________________

Other Insurance Numbers____

2) Assets:	General Amount or Value
Checking Accounts	______________________________
Savings Accounts	______________________________
Stocks Bonds	______________________________
Other	______________________________
<u>Life Insurance</u>	
Whole Life	______________________________
Term Life	______________________________
Real Estate and Land Contracts Owned	______________________________
Mortgages Owned	______________________________

3) Income:	Monthly Income
Salary Income	______________________________
Pensions	______________________________
Social Security	______________________________
Supplemental Security Income	______________________________

4) General Information:

If application for Medicaid assistance has been made, name of social worker and office:

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Are assets held jointly? ________________________________ With whom? _______________________

I certify that the financial information contained above accurately represents my financial position as of this date. I authorize this health care center to release to the Family Independence Agency and/or the Social Security Administration, financial information relevant to application for Title XIX (Medicaid) or supplemental security income (SSI). I declare the information presented above is true and complete to the best of my knowledge and hereby authorize permission to the Nursing Care Center to verify any or all of the information and credit records.

Applicant's Signature or Responsible Party____

Date___________________