GraceHome

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: _____

_____

_____

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Name of Person Receiving Billing Statement: _____

Address: _____
STREET CITY STATE ZIP

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: _____
STREET CITY STATE ZIP

Phone: _____
DAY EVENING CELL

Email:_____ **Relationship:**_____

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

Confidential Financial Statement (included in this packet)

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$_____

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 ($379.00 a day for a shared room and $399.00 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:**_____

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