

**Application for Admission**

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Last non-institutional address \_\_\_\_\_  
Street Apt. City State Zip Code

Sex: M / F Date of Birth \_\_\_\_\_ Birthplace \_\_\_\_\_ US Citizen YES / NO

Marital Status: M  S  W  Sep.  D  Name of Spouse \_\_\_\_\_

Maiden Name \_\_\_\_\_ Former Occupation \_\_\_\_\_

Religion \_\_\_\_\_ Church/Pastor \_\_\_\_\_

**Person(s) to notify in case of an emergency:**

- 1) \_\_\_\_\_  
Name Address (including Zip Code) Phone Number Relationship
- 2) \_\_\_\_\_  
Name Address (including Zip Code) Phone Number Relationship
- 3) \_\_\_\_\_  
Name Address (including Zip Code) Phone Number Relationship

**Financial:**

Social Security Number \_\_\_\_\_ Medicare Number \_\_\_\_\_ Hospital  Medical

Blue Cross/Blue Shield \_\_\_\_\_ Medical Assistance Number \_\_\_\_\_

Other Health Insurance \_\_\_\_\_

**Present Monthly Income:** (SS, SSI, PENSION, VA, PUBLIC ASSISTANCE, ETC.)

Source \_\_\_\_\_ \$ \_\_\_\_\_ /month

Source \_\_\_\_\_ \$ \_\_\_\_\_ /month

Source \_\_\_\_\_ \$ \_\_\_\_\_ /month

**Assets:**

Name of Financial Institution \_\_\_\_\_

Savings/Checking Account # \_\_\_\_\_ \$ \_\_\_\_\_ /value

Real Estate \_\_\_\_\_ \$ \_\_\_\_\_ /value

Investments \_\_\_\_\_ \$ \_\_\_\_\_ /value  
Describe (Stocks, Bonds, Certificate)

Other \_\_\_\_\_ \$ \_\_\_\_\_ /value  
Describe

Applicant will be: Medicare  Private Pay  Medical Assistance  County \_\_\_\_\_

**Life Insurance:**

Name of Company	Policy	Value	Beneficiary	Name of Policy	Paid up (yes or no)
1)					
2)					
3)					

*Note: Verification of Income must be submitted with application*

**Social**

Applicant presently at:

\_\_\_\_\_  
Name Address (including zip code) Phone Number

If above is an institution complete the following:

Date of Admission \_\_\_\_\_ Reason for Admission \_\_\_\_\_

Is applicant covered under Medicare in the above facility? \_\_\_\_\_

Reason for requesting transfer from above facility \_\_\_\_\_

Social Worker to contact on above facility \_\_\_\_\_

If not presently in an institution complete the following:

Resides with someone \_\_\_\_\_ with whom \_\_\_\_\_ Lives alone \_\_\_\_\_

Hospitals, nursing homes, or other institutions applicant has been in within the last six months:

\_\_\_\_\_  
Name of Institution Address (including zip code) Date From to

\_\_\_\_\_  
Name of Institution Address (including zip code) Date From to

Reason for requesting admission to St. Ignatius Nursing Home \_\_\_\_\_

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Power of Attorney \_\_\_\_\_  
Name Address (including zip code) Phone Number

Will \_\_\_\_\_  
Lawyer/Executor Address (including zip code) Phone Number

Funeral Director \_\_\_\_\_  
Name Address (including zip code) Phone Number

Cemetery \_\_\_\_\_ Burial Lot \_\_\_\_\_ Holder of Deed \_\_\_\_\_

A non-discrimination policy as to race, color, national origin, ancestry, age sex, and religious creed is observed at St. Ignatius Nursing Home.

All residents agree to abide by the rules of the home. A resident who, for any reason, does not comply with the policies of this facility will be discharged.

I agree to attend the business affairs for the applicant by seeing the monies due St. Ignatius are paid in accordance with its current policies.

Name of responsible party \_\_\_\_\_

Address \_\_\_\_\_ Phone Number ( \_\_\_\_\_ )

Signature \_\_\_\_\_ Date \_\_\_\_\_