

INSURANCE INFORMATION:

Social Security No. _____

Medicare No. _____ Medicare: Part A (hospital) ____ Part B (medical) ____

Medicare Supplement _____ Tel# _____

Address _____

I.D.# _____ Group name _____ Group # _____

Do you have an HMO Provider? Yes / No If Yes please provide details to the admissions office.

Do you have long-term care insurance Yes / No Company _____
(Please include a copy of long-term care insurance policy)

Do you have a PACE Card? Yes / No Do you have a Medicare Part D plan? Yes / No

Name of Medicare Part D plan "or" any other pharmacy plan _____

PERSONAL HISTORY:

Lifetime Occupation: _____ Retirement Date: _____

Most recent employment _____ Veteran? Yes No

Where have you lived most of your life? _____

How did you heard about Fairmount Homes? _____

Briefly describe present living situation and why a move to Fairmount Homes is being considered: _____

Religious Affiliation _____ Specific Congregation _____
(Optional) (Optional)

Minister (Name, Address and Phone No.): _____
(Optional)

Fairmount Homes Retirement Community is a private non-profit organization whose policy is to serve all residents without regard to race, color, national origin, ancestry, age, sex, religious creed, handicap or disability.

I understand that this application is not binding on Fairmount Homes or me. It simply expresses my interest in becoming a resident and a desire for my name to be placed on file. All information is held in strict confidence.

To the best of my knowledge and belief the information in this application is true and correct. Although the application is not otherwise binding, I understand and agree that any misrepresentation or significant omission or misstatement of fact, including financial information may be considered grounds for refusal of admission or for dismissal (after admission) from Fairmount Homes. In making this application for admission I hereby declare that I have read and am familiar with the attached Fairmount Homes "Pre-admission Information Sheet," and agree to accept the said regulations and do make this application without reserve.

Applicant

Date

Representative of the resident (if unable to sign)

Date 02/06

FINANCIAL STATEMENT: (MUST BE COMPLETE FOR APPLICATION TO BE CONSIDERED)

Have you (or your spouse if you are married) transferred any assets to someone other than your spouse for less than full market value within the past three years? YES ____ NO ____

Have you (or your spouse if married) established a trust, or transferred any assets to a trust within the past 5 years? YES ____ NO ____.

If the answer to either question is yes, please use a separate sheet to describe any such transfer of assets valued at more than \$5,000.00. This information is being requested because transferring assets, without consideration, including transfers to and from trusts, can interfere with and delay eligibility for Medicaid.

***Please complete as accurately as possible filling in all blanks with figures or "0" for no assets of that type.

Assets:

Cash \$ _____
 Savings & Checking Account \$ _____
 Certificates of Deposit \$ _____
 Savings Bonds \$ _____
 Mutual Funds \$ _____
 Stocks & Bonds \$ _____
 IRA/403(b)/401(k) \$ _____
 Real Estate Value \$ _____
 Trust Fund \$ _____
 Annuities \$ _____
 Motor Vehicles \$ _____
 Boats, Snowmobiles, Trailers, and Other Vehicles \$ _____
 Value of Business \$ _____
 Loans to Others \$ _____
 Other \$ _____

Monthly Income (Applicant's Income Only):

Social Security \$ _____
 Pensions \$ _____
 Annuities \$ _____
 Interest/Dividends \$ _____
 IRA \$ _____
 Rental Income \$ _____
 Other \$ _____

TOTAL: _____

Liabilities:

Monthly Rent \$ _____
 Notes Payable \$ _____
 Mortgage \$ _____
 Credit Card Debt \$ _____
 Other Debt \$ _____

TOTAL: _____

TOTAL: _____

Real Estate Worksheet:

Description of Real Estate (house, land, property, etc.) and Location	Date Purchased	Purchase Price	Mortgage Remaining	Market Value (estimate)
1.				
2.				

MISCELLANEOUS FINANCIAL DATA:

Life Insurance: Yes ____ No ____ Cash Value \$ _____ Pre-paid Burial Reserve? Yes ____ No ____

Value \$ _____ Funeral Home of Choice _____

Burial Space? Yes ____ No ____ Location: _____

My Fairmount bill should be sent to: Name _____

Address: _____ Phone: () _____

I certify the above information to be complete and accurate and authorize Fairmount Homes to research any of the above information for verification. I understand that Fairmount may request proof of financial status.

Signature _____

Date _____ 08/05

RECORD OF PAST USE OF HEALTH CARE SERVICES:

HOSPITALIZATION RECORD:

Were you hospitalized in the last year? Yes ____, No ____.

Complete the following for any hospitalizations within the last year **or** for the two most recent hospitalizations.

Hospital	Inpatient/Outpatient	Dates of Hospitalization	Reason
1.			
2.			

Details on any other significant hospitalizations or surgeries:

Hospital of choice for any future hospitalizations _____

MENTAL HEALTH HISTORY:

Have you ever received treatment for a Mental Illness? Yes ____, No ____.

Give Details on any Previous Psychiatric Treatment:

Provider	Year	Inpatient/Outpatient	Treatment
1.			
2.			

PREVIOUS ADMISSION TO NURSING OR ASSISTED LIVING FACILITY:

Previous admission to a Nursing or Assisted Living Facility? Yes ____, No ____.

Which facility?	Dates of stay?	Reason for admission?	Therapies received?

THERAPIES/HOME HEALTH:

Please describe any in-home services you have used such as Occupational, Physical and/or Speech Therapy, Home Health Services, etc. (Please list provider, reason, details and dates and reason for treatments).

For Office Use Only:

Date application received: _____

Comments: