Please Print

ST. PAUL'S
A Continuing Care Community

Application for Residency or Home Based Services

Personal Information			
Name			Date
Address			
City		State	Zip
D.O.B. (MM/DD/YYYY)	Age	SS# (XXX-XXX-XXXX)	Marital Status ☐Married ☐Widowed ☐Single ☐Divorced
Home Phone #		Cell Phone #	
Work Phone #		E-Mail	

Emergency Contacts			
Name			Relationship
Address			
City		State	Zip
Home Phone #		Cell Phone #	
Work Phone #		E-Mail	
Name			Relationship
Address			
City		State	Zip
Home Phone #		Cell Phone #	
Work Phone #		E-Mail	
Name			Relationship
Address			
City		State	Zip
Home Phone #		Cell Phone #	
Work Phone #		E-Mail	

Billing Information (to whom sent)			
Name			Relationship
Address			
City		State	Zip
Home Phone #		Cell Phone #	
Work Phone #		E-Mail	

Brief Current Medical/Physical Health Information

In the preparer's own words write a short description of the applicant's condition (impairments, special problems needs).

_____

_____

_____

Are you or your spouse a Veteran? Y N

Primary Care Physician (PCP)	Phone # Fax #
Medicare #	HMO/PPO ☐Y ☐N
Primary Insurance	Policy #
Secondary Insurance	Policy #
Do you or your spouse have Long Term Care Insurance Y N	Policy #
☐PACE ☐PACENET ☐Med D	Policy #

Transfer of Assets

Have you transferred any property, cash, negotiable papers, real estate, etc. to any person within the past 5 years? ☐Y ☐N

If yes, description and amount: _____

_____

Power of Attorney

Living Will/DPOAHC (Durable Power of Attorney for Health Care) ☐Y ☐N	Person Holding POA

Religious and Social Affiliations

Church Membership

Resident Disclosure

I have ☐* have not ☐ been convicted of a felony in the past 20 years, and/or been required to be registered for commission of a sexual offense.

* If you marked "have" above, please briefly explain: _____

_____

Signature of Applicant or Responsible Party

_____ Date _____

The Villas Only

Our average daily rate is $290.00. Knowing this rate, and to help facilitate the Medical Assistance Application process, how many months/years can the prospective resident pay privately?

_____

_____

_____

ST. PAUL'S FINANCIAL QUESTIONNAIRE

Confidential Financial Data

APPLICANT'S NAME(S):_____

_____

Area of interest - check all that apply:

_____COLONY _____HERITAGE _____RIDGEWOOD _____WITHOUT WALLS

As part of the application process and as needed thereafter, the following financial eligibility information is required. Please provide copies of statements and documents with this application.

QUESTIONS

1. Do you have a health insurance plan?
    a. If yes, with what company?_____
2. Do you have a Medicare D plan? Y N
    a. If yes, with what company?_____
3. Are you or your spouse a Veteran? Y N
    a. If yes, did you serve during active wartime? Y N
4. Do you have Long Term Care Insurance? Y N
5. Do you have life insurance? Y N
6. Do you have a prepaid funeral? Y N
7. Do you have PACE or other pharmacy card? Y N
8. Do you have a Medicaid Access card? Y N
9. Does your monthly income include distributions from assets such as an IRA? Y N
10. Do you own real estate?
    a. If yes, describe the property and location:_____

    _____

    _____

11. Have you transferred any assets during the past five years?

    a. If yes, describe:_____

12. Are any family members willing to help with the cost of your care (where applicable)?_____

MONTHLY INCOME

1. Total monthly income (after Medicare deduction): $_____

   Please list sources of monthly income: (i.e. Social Security, pension, railroad retirement, Veteran's benefits, annuities, rental property, etc.)_____

2. Monthly income from a trust $_____

REAL ESTATE

1. Value of Real Estate, of any $_____

2. Balance of Mortgage and/or Line of Credit $_____

VALUE OF ASSETS

1. Value of checking and savings accounts $_____
2. Value of retirement assets (certificates of deposit, stocks, bonds, etc.) $_____
3. Cash value of life insurance policy $_____
4. Value of Trust $_____
5. Value of IRA $_____
6. Value of 401K $_____

7. Other Assets (Please describe) $_____

_____

_____

_____

MONTHLY EXPENSES

1. Health Insurance: $_____
2. Pharmacy: $_____
3. Long Term Care Insurance Premiums $_____
4. Other monthly expenses $_____

Please detail your other monthly expenses_____

_____

_____

_____

CERTIFICATION OF FINANCIAL INFORMATION

I affirm I have completed this information and to the best of my knowledge and have not withheld any information requested and that statements I have made are true and correct. I also affirm that any misrepresentation regarding my financial assets or any concealment of any other facts as set forth in this application shall be sufficient reason for the rejection of my application or my expulsion from St. Paul Homes, if accepted as a resident or Without Walls client. I further certify that all of these assets will be available for the costs of care and expenses at St. Paul Homes. Any major reduction of assets will be verified before my residency at St. Paul Homes.

Signature of Person Completing Application_____

Relationship_____ Phone #_____ Date_____