



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 <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> 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 <input type="checkbox"/> Y <input type="checkbox"/> N
Primary Insurance	Policy #
Secondary Insurance	Policy #
Do you or your spouse have Long Term Care Insurance Y N	Policy #
<input type="checkbox"/> PACE <input type="checkbox"/> PACENET <input type="checkbox"/> 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) <input type="checkbox"/> Y <input type="checkbox"/> 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 \$395.00. 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? Y N

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

Please provide copies of statements and documents with this application.

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 _____