Application for Admission

Trego County Lemke Memorial Hospital Long Term Care and Assisted Living

Resident's Name				Today's Date

Resident's Current Address	Date of Birth	Date of Birth

Home Phone	Cell Phone	Email Address

Marital Status	Spouse Name	Months at Current Address	Place of Birth

Emergency Contact

Financial Responisble Party	Relationship	Circle One
		POA CONSERVATOR
Financial Responisble Party Address		
		GUARDIAN DPOA N/A

Home Phone	Cell Phone	Email Address

Bank Name	Location

Checking Account Balance	Savings Account Balances

Certificate of Deposit	Value	Maturity Date

Does the Resident Own a Home?	If yes, Provide the Address	Value of Home
YES NO		

Does the Resident own other Property?	If yes, Provide the Address	Value of Property
YES NO		

Does the Resident have rental income?	If yes, amount per month	Value of mortages encumbering any owned real estate
YES NO		

Have you transferred or given away any real estate or assets within the last 5 years? If so, describe.

Does the resident have life insurance with cash value?	If yes, please provide the value
YES NO	

Does the resident have annuities?	If yes, please provide the value
YES NO	

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Does the resident have Social Security?	Does the resident have disability?
YES NO AMOUNT:	YES NO AMOUNT:
Does the resident have Pension?	Does the resident have annuities/Retirement plans?
YES NO AMOUNT:	YES NO AMOUNT:
Does the resident have Long Term Care insurance?	Does the resident have any other monthly income?
YES NO AMOUNT:	YES NO AMOUNT:

Does the resident have mortgage or rent?	Does the resident have loans?
YES NO AMOUNT:	YES NO AMOUNT:
Does the resident have a car payment?	Does the resident have credit cards?
YES NO AMOUNT:	YES NO AMOUNT:
Does the resident have any other monthly liablities?	Other??
YES NO AMOUNT:	YES NO AMOUNT:

YES	NO	Medicare Part A	Policy Number:	
YES	NO	Medicare Part B	Policy Number:	
YES	NO	Managed Care:	Name:	Policy Number:
YES	NO	Medicare Part D	Name:	Policy Number:
YES	NO	Veterans Benefit	Policy Number:	
YES	NO	Other Insurance	Name:	Policy Number:
YES	NO	Other Insurance	Name:	Policy Number:
YES	NO	Medicaid	Policy Number:	

Primary Care Physician	Address	Phone Number
Hospital	Address	Phone Number
Last Hospitalization date	How Long hospitalized?	Why was resident hospitalized
Dentist	Address	Phone Number
Optometrist	Address	Phone Number
Pharmacy	Address	Phone Number
Mortuary	Address	Phone Number

Has the Resident fallen in their home in the past year?	If yes, when?	Were they injured?
YES NO		
Has the Resident had a CARE Assessment completed?	If yes, when?	
YES NO		

I (we) make this application for residence of my (our) own free will and accord. I (we) declare the information provided to the foregoing questions to be true, complete, and an accurate financial account to the best of my (our) knowledge at time of completion.

Resident Responsible Party Signature: ______________________________

CFO Signature ______________________________

Director Of Nursing - LTC Signature: ______________________________