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 Curr	ent Address	Place of Birth	
Emergency Contact			•		•	
Financial Responisble Party				Relationship		Circle One
						POA CONSERVATOR
Financial Responisble Party Add	dress					
· · ·						
						GUARDIAN DPOA N/A
Home Phone	Cell Phone		Email Address			GOARDIAN DI GA NYA
Bank Name					Location	
Checking Account Balance				Savings Account B	alances	
				l	4.4.1000	
Certificate of Deposit			Value		Maturity Date	
Certificate of Deposit			Value		Watarity Bate	
Does the Resident Own a Home	2	If yes, Provide t	the Address			Value of Home
Does the Resident Own a nome		ii yes, i lovide t	ille Address			value of Florine
VEC	10					
YES N Does the Resident own other P	IO roporty?	If yes, Provide t	the Address			Value of Property
Does the Resident Own Other F	roperty:	ii yes, Flovide t	ille Address			value of Froperty
V						
	10	16		\/a af anta-a-a		and and and artes
Does the Resident have rental i	ncome?	If yes, amount	per month	value of mortages	encumbering a	ny owned real estate
	10	1	de de les es	216		
Have you transferred or given a	iway any real esta	ite or assets witr	nin the last 5 yea	ars? If so, describe.		
Does the resident have life insu	rance with cash v	alue?	If yes, please pi	rovide the value		
YES	NO					
Does the resident have annuitie	es?		If yes, please pi	rovide the value		
YES	NO					

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Does the resident have Social Security?				Does the resident have disability?					
	V/50		****	· -		V50		444011117	
Does the re	YES	NO Pension?	AMOUN	IT:	Does the resident h	YES	NO Retirement n	AMOUNT:	
Does the re	sident nave	1 611310111			Does the resident in	ave annuncies	y Ketirement p	10113:	
	YES	NO	AMOUN	IT:		YES	NO	AMOUNT:	
Does the re	sident have	Long Term Care	insuranc	e?	Does the resident h	ave any othe	r monthly inco	me?	
	YES NO AMOUNT:				YES	NO	AMOUNT:		
Does the resident have mortgage or rent?			Does the resident h	ave loans?					
YES NO AMOUNT:				YES	NO	AMOUNT:			
Does the resident have a car payment?				Does the resident h	ave credit ca	rds?			
	YES	NO	AMOUN	IT:		YES	NO	AMOUNT:	
Does the re	sident have	any other mont	hly liablit	ies?	Other??				
	YES	NO	AMOUN	IT:		YES	NO	AMOUNT:	
VEC	NO	Madisana Dank	^	Dalia Musakas					
	NO	Medicare Part A Policy Number:							
	NO	Medicare Part		Policy Number:					
	NO	Managed Care		Name:			Policy Numb		
YES	NO	Medicare Part D Name:					Policy Numb	per:	
YES	NO	Veterans Benef	it	Policy Number:					
YES	NO	Other Insurance	е	Name:	Policy Number:				
YES	S NO Other Insurance Name:			Policy Number:					
YES	NO	Medicaid		Policy Number:					
Primary Car	e Dhysician			Address				Phone Number	
Filliary Car	e Filysiciali			Address				Filone Number	
Hespital				Address				Phone Number	
Hospital		Address			Phone Number				
Last Hassite	-1:4:1	L-		Ham Lava basa	المدامية	\A/la	sident beenitelined		
Last Hospitalization date			How Long hospitalized?			Why was resident hospitalized			
Dentist				Address				Phone Number	
Optometris	t			Address				Phone Number	
Pharmacy			Address				Phone Number		
Mortuary			Address				Phone Number		
Has the Res	ident fallen	in their home ir	the past	year?	If yes, when?		Were they in	njured?	
Υ	'ES			NO					
			If yes, when?						
				NO					
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 fo							ovided 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:									