Sunset Retirement Communities and Services
Brookcrest

APPLICATION FOR NURSING HOME RESIDENCY

Date: _____

☐ Immediate Need

☐ Future Need

Please complete this form in its entirety and return it to the facility representative.

Applicant/Resident Identification			
Last name, First Name, Middle Initial			Date of Birth:
Place of Birth:	SS#		US Citizen: Yes ☐ No ☐
Street address:	City, State, Zip:		
Phone number:	Cell Number:		Best method to reach you:
Sex: Male ☐ Female ☐	Veteran: Yes ☐ No ☐ Veteran #		Church Affiliation:
Medicare #:	Medicaid #:	Supplemental Insurance:	
Does the applicant have additional long-term care insurance that would apply to nursing home care? Yes ☐ No ☐			Insurance Co. Name:
Recent hospitalization: Yes ☐ No ☐	Hospital:	Date Admitted:	Date Discharged:
Is there a history of metal illness or retardation? Yes ☐ No ☐			Diagnosis of Dementia? Yes ☐ No ☐
Is the applicant currently on medication for treatment of mental illness, e.g., depression, anxiety, etc.? Yes ☐ No ☐			
Is the applicant currently on medication for treatment of insomnia Yes ☐ No ☐			
What is the applicant's current health problem/diagnosis?			
Physician:		Phone:	
Street Address:		City, State, Zip:	
Applicant/Resident's Spouse Identification (If married)			
Last name, First name, Middle Initial:			
Date of Birth:		Spouse's SS#:	
Street address, if different:		City, State, Zip:	
Phone Number:	Cell Number:	Best method to reach Spouse:	
Applicant/Resident's Legal Guardian or Durable Power of Attorney Identification (Please attach a copy hereto.)			
Last Name, First Name, Middle Initial:		Relationship to Applicant, if any:	
Street address:		City, State, Zip:	
Phone number:	Cell number:	Work number:	Email:

Applicant/Resident's Health Care Power of Attorney Identification (Please attach a copy hereto.)			
Last Name, First Name Middle Initial:		Relationship to Applicant, if any:	
Street address:		City, State, Zip	
Phone number:	Cell number:	Work number:	Email:
Please note if Applicant/Resident is unable to manage his or her own affairs but has no guardian or power or attorney enabled to act on his or her behalf, the appointment of a guardian and/or conservator must be obtained.			
Applicant/Resident's Immediate Family Members Identification (Please list any Additional Contacts)			
Last Name, First Name, Middle Initial:		Relationship to Applicant, if any:	
Street address:		City, State Zip:	
Phone number:	Cell number:	Work number:	Email:

Last Name, First Name, Middle Initial:		Relationship to Applicant, if any:	
Street address:		City, State Zip:	
Phone number:	Cell number:	Work number:	Email:

Last Name, First Name, Middle Initial:		Relationship to Applicant, if any:	
Street address:		City, State Zip:	
Phone number:	Cell number:	Work number:	Email:

Last Name, First Name, Middle Initial:		Relationship to Applicant, if any:	
Street address:		City, State Zip:	
Phone number:	Cell number:	Work number:	Email:

Last Name, First Name, Middle Initial:		Relationship to Applicant, if any:	
Street address:		City, State Zip:	
Phone number:	Cell number:	Work number:	Email:

APPLICANT/RESIDENT'S CONFIDENTIAL FINANCIAL INFORMATION

1. Except for personal effects with a value of less than $500, list assets owned by you and your spouse, including checking accounts, savings accounts, certificates of deposit, the cash surrender value of life insurance policies, stocks, bonds, vehicles, real estate, land contracts, rental property, life estates, antiques, and collectibles, with the value as of the date of admission into the nursing home. (Attach additional pages if needed.)

Owner of Asset	Description of Asset	Value of Asset
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		

2. List all debts owed by you and your spouse, including mortgages, credit cards, personal loans, and co-signed notes or obligations, with values as of the date of admission into the nursing home.

Debtor	Description of Debt	Amount of Debt
a.		
b.		
c.		
d.		
e.		
f.		
g.		

3. List all transfers of gifts or assets within the past five years by you and your spouse, including transfers of a remainder interest in real property (e.g., lady bird deed).

Date of Transfer	Description of Asset	Recipient	Value of Asset
a.			
b.			
c.			
d.			
e.			
f.			

4. List all pre-paid burial contracts, burial accounts, and pre-paid burial or funeral items owned by you or your spouse or by a third party for the benefit of you or your spouse.

Description	Owner	Value
a.		
b.		
c.		
d.		
e.		

5. List all sources of income for you and your spouse, including but not limited to rental payments, pension income, long-term care insurance benefits, Social Security benefits, veteran's benefits, and employment income.

Description of Income	Date or Frequency of Payment	Amount of Payment
a. Social Security		
b. Interest		
c. Dividends		
d. Pension		
e. Annuities		
f. Veterans Benefits		
g. Insurance		
h. Trust Funds		

6. List all health and pharmacy insurance for you and your spouse.			
Name of Insured	**Name of Insurer**	**Description of Insurance**	**Monthly Premium Amount**
a.			
b.			
c.			
d.			
e.			

7. Did your agent or attorney-in-fact listed above assist you with making any of the transfers or gifts referenced in section number 3 above, or benefit or receive any of the assets transferred or gifted? If yes, please explain.

8. Were any of the assets described in section number 3 above transferred or gifted to or from a trust? If yes, explain the nature of the transaction and identify the trust involved?

9. Have you previously applied for Medicaid? If yes, provide the date and county in which application was made.

10. Do you (or your agent or attorney-in-fact listed above) intend to transfer assets in the future? If yes, provide details concerning asset to be transferred, method of transfer, and value of the asset as of the date of admission to the nursing home.

11. Are you or your spouse the beneficiary of a trust? If yes, identify the trust.

12. Do you have any pending legal action from which you may receive money or medical benefits, including inheritance? If yes, describe.

This questionnaire complies with state and federal law. By my signature below, I hereby authorize the nursing home to contact the county social services for information regarding my Medicaid application and eligibility, and I hereby release and authorize the county social services to release any information to the nursing home. I also authorize the nursing home to contact any and all of the above-identified financial institutions to obtain information regarding my assets and income, and I hereby release and authorize the financial institutions to release any information to the nursing home. I further authorize the nursing home to release to its attorneys any information regarding my application for admission.

I understand that providing false information could result in discharge and/or denial of my application. The answers provided herein are true and correct to the best of my knowledge and information.

Signature: _____ Date: _____