

HEARTHSTONE RETIREMENT HOME & IN-HOME CARE SERVICES

I. GENERAL

Applicant's Name: _____ Telephone: (____) _____

Permanent Address: _____ Zip: _____

Present Address (if different): _____ Zip: _____

How long at present address? _____ Birth Place: _____

Social Security Number: _____ Age: _____ Birth Date: _____

Current or former occupation: _____

Veteran? Yes: _____ No: _____ Military Branch: _____

Sex: Male _____ Female: _____ Religion: _____

I am: Married _____ Widowed _____ Separated _____ Divorced _____ Single _____

Name of Spouse: _____ Address: _____ Zip: _____

Date & Place of Marriage: _____

If Deceased, Date of Death: _____

How did you learn about our facility? _____

Person to Contact in Case of an Emergency, Serious Illness or Accident:

Name: _____ Relation: _____ Telephone: (____) _____

Address: _____ Zip: _____

Name: _____ Relation: _____ Telephone: (____) _____

Address: _____ Zip: _____

Name: _____ Relation: _____ Telephone: (____) _____

Address: _____ Zip: _____

Name: _____ Relation: _____ Telephone: (____) _____

Address: _____ Zip: _____

Name: _____ Relation: _____ Telephone: (____) _____

Address: _____ Zip: _____



HEARTHSTONE

RETIREMENT HOME & IN-HOME CARE SERVICES

II. LIVING ACCOMMODATIONS

Please describe your present living accommodations: _____

Please describe any special needs or concerns of which Hearthstone's staff should be aware:

Do you currently rely on a relative, friend or home health aide to live with and/or assist you?

Yes: _____ No: _____ Who? _____ Why? _____

Do you anticipate the need for either part-time or 24-hour personal care/assistance? Yes: _____ No: _____

Have you ever resided in another Personal Care Home, Assisted Living Facility and/or Nursing Home Facility?

Yes: _____ No: _____ Name of Facility: _____

Periods of Stay: From: _____ to: _____

Why did you leave that facility? _____

III. LEVEL OF DAILY ACTIVITY

	Good	Fair	Poor		Good	Fair	Poor
Housekeeping	_____	_____	_____	Shopping	_____	_____	_____
Transportation	_____	_____	_____	Laundry	_____	_____	_____
Taking Medication	_____	_____	_____	Fire Awareness	_____	_____	_____
Walking	_____	_____	_____	Budgeting	_____	_____	_____

Personal Strengths & Interests:

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IV. MEDICAL

Physician's Name: _____ Telephone: (____) _____

Address: _____ Zip: _____

How would you describe your current state of health? _____

How often do you presently see a physician? _____

Are you on medication(s) at this present time? Yes: _____ No: _____

If so, for what condition(s)? _____

Do you require assistance to administer medication? Yes: _____ No: _____

Current Pharmacy Utilize: _____ Address: _____

Do you smoke/drink alcohol? Yes: _____ No: _____ Do you have difficulty with stairs? Yes: _____ No: _____

Do you use a walker? Yes: _____ No: _____ Do you use a cane? Yes: _____ No: _____

Do you prepare your own meals? Yes: _____ No: _____ Are you on a special diet? Yes: _____ No: _____

History of Hospitalization, Institutionalization and/or Treatment for Psychiatric/Mental Diagnosis:

Date (s): _____

Where Treated: _____

Reason for Admission: _____

I am willing to provide any additional medical information as the Board of Directors/Administrator deems necessary to determine in the facilities of Hearthstone Retirement Home are adequate for me. I understand that Hearthstone Retirement Home is an independent retirement home and not a health care facility. Therefore, if I should ever need temporary or private personal care, I agree to pay the expenses of a special attendant or I agree to be removed to a hospital or like health care facility. In the event of serious illness, accident or a determination by the Board of Directors that my transfer to a hospital or like health care facility is necessary and advisable, I agree to assume responsibility for making the necessary arrangements. I understand that in the event of an unexpected medical event, the employees of Hearthstone Retirement Home will call 911, the Emergency Medical System.

Date: _____ Signature: _____

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V. MEDICAL INSURANCE INFORMATION

Do you have Medical Insurance? Yes: _____ No: _____ Medicare Number: _____

Long Term Care Insurance Number: _____ Name: _____

Other Health Insurance Number: _____ Name: _____

Life Insurance Name: _____ Beneficiary: _____

Approximate Value: _____ Face Value: _____

VI. DRIVING

Do you have a current, valid driver's license? Yes: _____ No: _____

Are you presently operating a vehicle? Yes: _____ No: _____

Do you plan on having an automobile at our facility? Yes: _____ No: _____

VII. LEGAL REPRESENTATIVES

Does anyone handle your Financial Affairs? Yes: _____ No: _____

If yes, who?

Name: _____ Relation: _____ Telephone: (____) _____

Address: _____ Zip: _____

Do you have a POA for Healthcare? Yes: _____ No: _____

If yes, who?

Name: _____ Relation: _____ Telephone: (____) _____

Address: _____ Zip: _____

Do you have Legal Guardianship? Yes: _____ No: _____

If yes, who?

Name: _____ Relation: _____ Telephone: (____) _____

Address: _____ Zip: _____

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VIII. FUNERAL

Do you have arrangements for interment? Yes: _____ No: _____

Name of Funeral Home: _____

Person responsible for the Arrangements & Finances:

Name: _____ Relation: _____ Telephone: (____) _____

Address: _____ Zip: _____

VIII. FINANCIAL

Assets

Cash/Market Value

Bank Accounts:

Name of Company: _____ Address: _____

Checking: \$ _____
Cash/Market Value

Savings: \$ _____
Cash/Market Value

Name of Company: _____ Address: _____

Checking: \$ _____
Cash/Market Value

Savings: \$ _____
Cash/Market Value

Certificates of Deposit: \$ _____
Cash/Market Value

Stocks & Bonds: \$ _____
Cash/Market Value

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1. Name of Company: _____ Address: _____

401 (k)/IRA: \$ _____
Cash/Market Value

2. Name of Company: _____ Address: _____

Life Insurance Policy: \$ _____
Cash/Market Value

Automobiles Owned \$ _____ Make: _____ Year: _____

\$ _____ Make: _____ Year: _____

Other Major Assets: \$ _____

Name of Company: _____ Address: _____

TOTAL ASSETS \$ _____

Real Estate Assets:

Do you own your own home? Yes: _____ No: _____ Approximate Value: \$ _____

Is this Property Mortgaged? Yes: _____ No: _____

Monthly Payments: \$ _____ Unpaid Balance: \$ _____

Property Location: _____

Are there other occupants of the primary dwelling? Yes: _____ No: _____

Do you own other homes? Yes: _____ No: _____ Approximate Value: \$ _____

Is this Property Mortgaged? Yes: _____ No: _____

Monthly Payments: \$ _____ Unpaid Balance: \$ _____

Property Location: _____

TOTAL REAL ESTATE ASSETS \$ _____

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Asset Transfers

Have any of your assets, either solely or jointly owned, been transferred, sold, or given as a gift: trust, annuities, life, estate, mortgages or otherwise to others in the last five (5) years? Assets include real estate, personal property, or cash in excess of \$ 1,000.00

Yes: _____ No: _____ If yes, complete the following:

Item Transferred: _____

Approximate Value: _____

To Whom: _____

Date of Transfer: _____

Item Transferred: _____

Approximate Value: _____

To Whom: _____

Date of Transfer: _____

Liabilities

Amount Owed

Home Mortgage \$ _____

Other Loans \$ _____

TOTAL LIABILITIES: \$ _____

The logo features the word "HEARTHSTONE" in a large, black, serif font. Above the letters "A", "R", and "T" are three overlapping red hearts. Below "HEARTHSTONE" are the words "RETIREMENT HOME" and "& IN-HOME CARE SERVICES" in a smaller, black, serif font.

HEARTHSTONE RETIREMENT HOME & IN-HOME CARE SERVICES

Please describe the nature of your financial resources:

Employment Income: \$ _____

Pension Income: \$ _____

Family Assistance: \$ _____

Social Security Income: \$ _____

Interest Income: \$ _____

Other: \$ _____

Rental Income: \$ _____

TOTAL FINANCIL RESOURCES: \$ _____

Declarations

Are there any outstanding judgments against you? Yes: _____ No: _____

Have you been declared bankruptcy within the past 7 years? Yes: _____ No: _____