GOLDEN VIEW
HEALTH CARE CENTER
A Non-Profit Community

Assisted Living, Long-Term Living and Rehabilitation Care
Application for Admission

Today's Date: _____

General Information

Resident's Name: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ / _____ / _____ SS#: _____ - _____ - _____

Home Phone: (_____)_____ - _____ Cell Phone: (_____) _____ - _____

Do you have Advance Directives? ☐ Yes ☐ No Living Will? ☐ Yes ☐ No (*if yes, please attach copies)*

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Civil Union ☐ Widowed ☐ Divorced ☐ Separated

Current Living Situation: ☐ Alone ☐ With spouse ☐ With family: _____ ☐ Other: _____

What type of housing do you currently live in?

☐ Apartment ☐ Single family ☐ Multi-family ☐ Condo ☐ Other: _____

Previous Occupation: _____

Are you or your spouse a US Veteran? ☐ Yes ☐ No

Do you own an automobile? ☐ Yes ☐ No If yes, make, model & year: _____

Do you intend to maintain a car? ☐ Yes ☐ No If yes, license plate #: _____

Do you have prepaid burial arrangements? ☐ Yes ☐ No If yes, where: _____

Health Care Professional Information

Primary Care Physician's Name: _____ Phone: (_____) _____ - _____

Specialty Physician's Name: _____ Phone: (_____)_____ - _____

Specialty: _____

Specialty Physician's Name: _____ Phone: (_____)_____ - _____

Specialty: _____

Specialty Physician's Name: _____ Phone: (_____)_____ - _____

Specialty: _____

Are you currently using any community services at this time?

Community Services	**Agency**	**Frequency of Services**
☐ Visiting Nurse	_____	_____
☐ Private Duty Nursing	_____	_____
☐ Meals on Wheels	_____	_____
☐ Housekeeping	_____	_____
☐ Other: _____	_____	_____
☐ Other: _____	_____	_____

Insurance Information

Please list all of your medical insurance coverage, including supplemental and long-term care:

Insurance: _____ Policy #: _____

Insurance: _____ Policy #: _____

Insurance: _____ Policy #: _____

Insurance: _____ Policy #: _____

Long-term Care Insurance Company: _____ Policy #: _____

Phone #: _____ Benefit Amount: $_____

Financial Information

This information is used for pre-admission screening process only and is kept confidential.

Monthly Income:

	Recipient's Name	**Monthly Amount**
☐ Social Security	_____	$ _____
☐ Retirement Pension	_____	$_____
☐ V.A. Pension	_____	$ _____
☐ Disability	_____	$ _____
☐ Annuities	_____	$ _____
☐ Other: _____	_____	$ _____

Cash Assets:

Bank: _____ Location: _____
Checking Account #: _____ Balance in Account: $_____
Savings Account #: _____ Balance in Account: $_____

Certificates of Deposit? ☐ Yes (please complete below) ☐ No
Institution: _____ Balance in Account: $_____
Institution: _____ Balance in Account: $_____
Institution: _____ Balance in Account: $_____

Securities:

Does the Resident have stocks and bonds? ☐ Yes ☐ No
Approximate Amount of all Securities: $_____
Agent Name: _____ Phone: (_____)_____ - _____

Real Estate Assets:

Does the Resident own? ☐ Yes ☐ Yes, jointly with _____ ☐ No
Approximate Value: $_____
Does the resident own any other property? ☐ Yes ☐ Yes, jointly with _____ ☐ No
Approximate Value: $_____

Life Insurance with Cash Value:

Does the Resident have life insurance with cash value? ☐ Yes ☐ No
Company Name: _____ Approximate Cash Value: $_____

Emergency Contacts

Responsible/Billing Party (where statements are to be mailed):

Name: _____ Relationship: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ - _____ Work Phone: (_____) _____ - _____ ext. _____

Cell Phone: (_____)_____ - _____ Email: _____

☐ Emergency Contact ☐ DPOA-Health ☐ DPOA-Financial ☐ Guardian ☐ Other: _____

Emergency Contact #1:

Name: _____ Relationship: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ - _____ Work Phone: (_____) _____ - _____ ext. _____

Cell Phone: (_____)_____ - _____ Email: _____

☐ Emergency Contact ☐ DPOA-Health ☐ DPOA-Financial ☐ Guardian ☐ Other: _____

Emergency Contact #2:

Name: _____ Relationship: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ - _____ Work Phone: (_____) _____ - _____ ext. _____

Cell Phone: (_____)_____ - _____ Email: _____

☐ Emergency Contact ☐ DPOA-Health ☐ DPOA-Financial ☐ Guardian ☐ Other: _____

Emergency Contact #3:

Name: _____ Relationship: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ - _____ Work Phone: (_____) _____ - _____ ext. _____

Cell Phone: (_____)_____ - _____ Email: _____

☐ Emergency Contact ☐ DPOA-Health ☐ DPOA-Financial ☐ Guardian ☐ Other: _____

Please list additional family members or friends you wish to have on our mailing or emailing contact list on the back of the application.

Referral Information

How did you hear about Golden View?

☐ Newspaper ☐ Radio ☐ Golden View Sign ☐ Family/Friend: _____

☐ Golden View Website ☐ Other Website: _____ ☐ Other: _____

Which staff member assisted you in your inquiry? _____

Authorization

I hereby state that to the best of my knowledge the above information is true, correct and complete. I understand that Golden View Health Care Center may check my bank references and credit history and I authorize this. I also understand this information is considered a continuing statement of financial condition and agree to notify the facility of any substantial changes in the future. I agree that a photocopy shall have the full force and effect as the original. **All information will be kept strictly confidential.**

Signature of Resident: _____ Date: _____

Signature of Responsible Party: _____ Date: _____