



Please complete all information and return to us as soon as possible. There are no financial obligations made as a result of filling out this application.

## PERSONAL DATA

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_

Current Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Education Level: \_\_\_\_\_

Former Occupation: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

US Citizen: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_ Veteran/Spouse of a Veteran: \_\_\_\_\_

Resident Representative: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship of Resident Representative: \_\_\_\_\_

Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Please Circle if the Applicant has any of the following: POA HCP DNR Living Will MOLST

**The Admissions Department will need copies of these documents prior to admission**

Will the Applicant be utilizing the furniture provided by Heather Heights? \_\_\_\_\_

Has the Applicant ever been convicted of a felony or a sexual offense? If yes, please explain \_\_\_\_\_

## MEDICAL DATA

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

1st Hospital Preference \_\_\_\_\_ 2nd Preference \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Case Number: \_\_\_\_\_ County: \_\_\_\_\_

Other Medical Insurance: \_\_\_\_\_

Prescription Card Number: \_\_\_\_\_

Will the applicant be using Heather Heights' contracted Pharmacy? \_\_\_\_\_ Y \_\_\_\_\_ N

# FINANCIAL INFORMATION

All information is treated as highly confidential. Please only list the applicant's resources.

Social Security: \$ \_\_\_\_\_

Pension (Source & Amount): \$ \_\_\_\_\_

Annuities, Dividends, Interests: \$ \_\_\_\_\_

**Total Monthly Income :** \_\_\_\_\_

**Real Estate** (If owned individually, joint names, or as tenants in common, please indicate):

Address: \_\_\_\_\_

Owner of Property: \_\_\_\_\_

**Value of Property:** \_\_\_\_\_

## Bank Accounts:

| Name of Bank(s): | Current Balance: |
|------------------|------------------|
|                  |                  |
|                  |                  |

## Stocks & Bonds:

| Issuer Name: | Owner: | Number of Shares: | Value: |
|--------------|--------|-------------------|--------|
|              |        |                   |        |
|              |        |                   |        |

## Long Term Care Insurance:

| Company: | Owner: | Benefit: |
|----------|--------|----------|
|          |        |          |

By signing this application, I agree that all of the above information is accurate. Providing inaccurate information shall result in denial of admission to Heather Heights.

Resident: \_\_\_\_\_ Date: \_\_\_\_\_

Resident's Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_



HEATHER HEIGHTS<sup>INC.</sup>  
— SENIOR LIVING —