APPLICATION FOR RESIDENCY

(PLEASE CHECK) : Nursing Home ______ Community Based Residential Facility _____ Efficiency _____
1 Bedroom_____
2 Bedroom_____
Duplex _____

Waunakee Manor HCC INC
801 Klein Dr.
Waunakee, WI 53597
(608) 849-5016 / 256-8448
FAX: (608) 850-4689

Rest Haven HCC LLC
7672 Mineral Point Rd
Verona, WI 53593
(608) 833-1691
FAX: (608) 833-0492

Sun Prairie HCC LLC
228 W Main St
Sun Prairie, WI 53590
(608) 837-5959 / 251-1171
FAX: (608) 825-4390

This application must be fully completed in order to be placed on the waiting list for admission. Please complete application and return it to the Health Care Center of choice as soon as possible (faxed copies are acceptable). If there are any questions, please contact Social Services at the facility of choice.

GENERAL INFORMATION Date Completed: ________________

1. Applicant ____
   Last Name First Name Middle Name

2. Applicant's Permanent Address:
   ____
   Street
   ____
   City County State Zip
   ____
   Phone (Area Code)

3. Sex: _____M _____F 4. Birthdate __________ Age_______ 5. Birthplace __________

6. Marital Status ______________ 7A. Current/Previous Occupation ________________________
   Current/Previous Occupation of Spouse ________________________
   7B. If retired: Year Retired ________________________
   Year Retired Spouse ________________________

8. Medicare Health Insurance Number: ______________________________
   ***Note: Filing of private insurance is applicant's responsibility.

9. Social Security Number: ______________________________

10. Hospital Preference: ______________________________

HEALTH INFORMATION:

11. Physician ______________________________ Phone ____________________
    Address: ____
    Street City State Zip

12. Diagnosis: ____

13. Has applicant fallen in the last six (6) months? ____ Yes ____ No
    If Yes, when? ______________________________

14. Does applicant need assistance with:
    Dressing ____ Yes ____ No Bathing ____ Yes ____ No
    Feeding ____ Yes ____ No Ambulation ____ Yes ____ No

15. List any Nursing Home stays in the last 5 years (Including Dates):

    ____

    Were any of these nursing home stays Medicare covered? _____ Yes _____ No

    List any hospital stays in the last 12 months (Including Dates):

    ____

    Failure to report any hospital and/or nursing home dates of service can result in miscalculation of available Medicare days in which applicant/responsible party will be held liable for uncovered days.

16. In case of emergency notify: (List in order of priority)

    1. ____
       Name

       ____
       Address City State Zip

       ____
       Home Phone Business Phone Cell Phone Relationship

    2. ____
       Name

       ____
       Address City State Zip

       ____
       Home Phone Business Phone Cell Phone Relationship

    3. ____
       Name

       ____
       Address City State Zip

       ____
       Home Phone Business Phone Cell Phone Relationship

ADDITIONAL INFORMATION:

17. Dentist: Name ____ Phone __________________________

18. Religion: ____ None ____________
    Church: ____ Phone __________________________

19. Funeral Home: ____ Phone __________________________

20. Has applicant executed any Advance Directives (i.e., Power of Attorney – health care, finances, Declaration to Physician)? _______ Yes _______ No
    If Yes, please describe and list who the designated agent is: ________________________________

21. Is Power of Attorney activated? ____ Yes ____ No

22. Will applicant be handling his/her own financial matters while at the Health Care Center?
    _____ Yes _____ No (If No, to whom should billing be sent?)

    ____
    Name

    ____
    Address City State Zip

    ____
    Home Phone Business Phone Relationship

23. **FINANCIAL:** (THIS INFORMATION WILL BE KEPT CONFIDENTIAL.)

Do you rent _______ Own your home _______ Approximate Value $__________

MONTHLY INCOME IS:

1. SOCIAL SECURITY $_______________
2. PRIVATE PENSION $_______________ COMPANY ______________
3. ANNUITIES / TRUST FUNDS $_______________ COMPANY ______________

TOTAL MONTHLY $ _______________ x 12 MONTHS = $________________

YEARLY INCOME FROM OTHER SOURCE (S):

EARNINGS FROM SAVINGS ACCOUNTS AND CERTIFICATE OF DEPOSIT $ ___________

DIVIDENDS FROM STOCKS, BONDS AND MISC SECURITIES $ ___________

TOTAL APPROXIMATE YEARLY INCOME $ ___________

ASSETS:

STOCKS AND BONDS $ _______________

CASH (SAVINGS & CHECKING) $ _______________

REAL ESTATE (INCLUDING HOME) $ _______________

C.D.'s $ _______________

OTHER $ _______________

TOTAL ASSETS: $ ___________

LIABILITIES:

MORTGAGE $ _______________

PERSONAL LOANS $ _______________

OTHER OBLIGATIONS $ _______________

TOTAL LIABILITIES: $____________

NET WORTH $ ____________________

Irrevocable burial trust fund $ _______________

There are funds to pay for care (less than six mo.). (____ Mo.), (at least 1 yr.), (2 yrs.), (more than 2 yrs.)

Signature: ____ Date: ________________
(Guarantor/POA)

Has the applicant transferred any assets more than $5,000 in value such as real estate (including home, stock, bonds, or other assets to another person without consideration in the last 2 ½ years?
_____ Yes _____ No Please Explain: ____
____

Have you or anyone in the past two years made application for this person to be on Medicaid?
Yes _____ No_____
Does the applicant have an acceptance for Medicaid? Yes_____ No_____
Has the applicant been rejected from Medicaid? Yes_____ No_____
Have you filed an appeal? Yes_____ No_____

Please let us know who referred you to Waunakee Manor/Rest Haven/Sun Prairie Health Care Center:

____

WAUNAKEE MANOR/REST HAVEN/SUN PRAIRIE ARE NO SMOKING FACILITIES

In completing this application, I am aware that Waunakee Manor/Rest Haven/Sun Prairie Health Care Center will reply upon, and is entitled to reply upon, the accuracy of my statements. I understand that I may be requested to update this application when the Health Care Center considers it appropriate. Therefore, I DECLARE THAT THE INFORMATION GIVEN IN THIS APPLICATION IS TRUE, FULL, AND COMPLETE AND THAT THE ASSETS LISTED ARE AVAILABLE FOR MY CARE.

I give consent to verify information contained in this application.

I understand that medical information may be obtained as part of the pre-admission process and allow for the release of this information as needed.

Preparer's Signature ____ Date: __________________

Resident's Signature ____ Date: __________________

Waunakee Manor/Rest Haven/Sun Prairie Health Care Center reserves the right to accept or deny any applicant for admission. Guidelines for acceptance and participation in facility programs are the same for everyone without regard to race, color, religion, national origin, age, sex, or handicap.

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Received by: ____ Date: ___________________

Approved by: ____ Date: ___________________

Approved by: ____ Date: ___________________

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ADDENDUM

____ _________________________
Other Insurance Name Insurance Group #

____ _________________________
Other Insurance Address Subscriber ID #

____
Other Insurance Telephone #

Social Services will need copies of all insurance information. This includes copies of Medicare, Social Security, and private insurance.

If available, photo copy these cards onto the back of this page, otherwise please bring all the cards on the day of admission.

As stated on Page 1, filing of private insurance is the applicant's responsibility.

Thank you.