Sun Prairie
HEALTH CARE CENTER

Application for Residency

Guidelines

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1. Tour our community: Sun Prairie Health Care Center's living options are viewable online at www.SunPrairieHC.com, but even more details are available during a tour of our campus. If you haven't already taken a tour, we encourage you to come visit us! To schedule an appointment, call **608-837-5959**

2. Apply: This document may be printed and filled out by hand, **or your answers may be typed into the fillable PDF and then printed**. You will want to be equipped with the following information regarding the applicant(s):

- *Numbers for Social Security and Medicare*
- *Policy information for health insurance and long-term care*
- *Contact information for the applicant's primary care physician*
- *Contact information for healthcare power of attorney, if applicable*
- *Information regarding income, assets, liabilities, and financial institution(s)*

3. Submit: Mail, fax, or deliver your completed application to:

Sun Prairie Health Care Center
Attn: Marketing Director
228 West Main Street
Sun Prairie, WI 53590

PHONE: (608) 837-5959
FAX: (608) 825-4390

or email your application to marketing@sunprairiehc.com

Applications are reviewed by the Executive Director. Acceptance of an application does not guarantee placement, and all prospective residents of Sun Prairie Health Care Center will be subject to a pre-admission assessment.

Thank you for your interest in Sun Prairie Health Care Center!

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HEALTH CARE CENTER

Application for Residency

(PLEASE CHECK): Nursing Home _____
IL_____
AL (RCAC)_____

Studio _____
1 Bedroom_____
2 Bedroom_____

How did you hear about us?

Billboard _____
Print Ad_____
TV_____

Online _____
Friend/Family_____
Radio _____
Other_____

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 community as soon as possible (faxed copies are acceptable). If there are any questions, please contact the Marketing Director at Sun Prairie Health Care Center.

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. Gender:_____ 4. Birthdate _____ Age_____ 5. Birthplace _____

6. Marital Status _____ 7A. Current/Previous Occupation _____
   7B. If retired: Year Retired _____

8. Medicare Number: _____
   Other Insurance Name: _____
   Insurance Group #: _____ Subscriber ID #: _____
   Other Insurance Phone #: _____

***Note: Filing of private insurance is applicant's responsibility.

9. Social Security Number: _____

10. Hospital preference: _____
11. Education level: _____

HEALTH INFORMATION:

12. Physician _____ Phone _____

    Address: _____
    Street City State Zip
13. Diagnosis: _____

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

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

    Will applicant be handling his/her own financial matters while at the Health Care Center?
    _____ Yes _____ No

    Will an emergency contact be handling applicant's financial matters while at the Health Care Center?
    _____ Contact 1 _____ Contact 2 _____Other

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. Has the Health Care Power of Attorney been activated and/or applicant been declared incapacitated by two doctors? _____ Yes _____ No

22. **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 $ _____

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_____

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In completing this application, I am aware that 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 Community considers it appropriate. Falsified information may result in denial of application. 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: ___________________

Applicant's Signature ____ Date: ___________________

Sun Prairie Health Care Center reserves the right to accept or deny any applicant for admission. Guidelines for acceptance and participation in Sun Prairie programs are the same for everyone without regard to race, sex, religion, sexual orientation, national origin or ancestry, age, disability, marital status or physical appearance, or any other basis prohibited by local, state or federal laws, rules or regulations. Sun Prairie Health Care Center is an Equal Housing Opportunity community which adheres to all state and federal fair housing laws. Sun Prairie Health Care Center is a smoke-free community.

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Received by: ____ Date: ____________________

Approved by: ____ Date: ____________________