



## 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](http://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](mailto: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!**



## 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: \_\_\_\_\_