vincentian

Nursing Care

APPLICATION

A Ministry of the Vincentian Collaborative System

GENERAL INFORMATION

Community of Interest ☐ **Vincentian Home** ☐ **Vincentian Marian Manor** ☐ **Vincentian de Marillac**
(Please check all interested in.)

Name of Applicant _____ Race _____ Age _____ Sex _____

Preferred Name _____ Phone Number _____

Address _____

Email _____

Birthdate _____ Birthplace _____ Citizenship _____

Religion _____ Church/Pastor_____Veteran: ☐ Yes ☐ No

Marital Status _____ Spouse's Name _____

Spouse's Address *(if different than applicant's)* _____

Referred by _____

Former Occupation _____ Education _____

Languages Spoken _____

IF YOU ARE PRESENTLY IN ANOTHER FACILITY, PLEASE COMPLETE

Facility Name _____

Address _____

Date of Stay *(from/to)* _____

Reason for transferring to Vincentian _____

PHYSICIAN

Current Physician _____ Phone _____

Primary Diagnosis _____ Secondary Diagnosis _____

Allergies _____

Cash Held in Financial Institutions	*All Belonging to Applicant?*	Amount
Retirement	☐ Yes ☐ No	$
Checking Account	☐ Yes ☐ No	$
Savings Account	☐ Yes ☐ No	$
Other	☐ Yes ☐ No	$
Other	☐ Yes ☐ No	$
TOTAL		$

Other Assets	Amount
Total *(current)* Value of Stocks	$
Total Value of Bonds	$
Total Value of Notes	$
Other Investments *(not including real estate)*	$
TOTAL	$

Income	Monthly
Social Security (first person)	$
Social Security (second person)	$
Pension (first person)	$
Pension (second person)	$
Interest	$
Dividends	$
Other	$
TOTAL	$

Real Estate Holdings	Amount
Current Value of Real Estate *(best estimate)*	$
How much do you owe in Real Estate?	$
TOTAL	$

EMERGENCY CONTACT

First Contact Name _____ Relationship _____

Please Mark Which Phone We Should Call First.

☐ Home Phone _____ ☐ Cell/Work Phone _____

Address _____

Second Contact Name _____ Relationship _____

Please Mark Which Phone We Should Call First.

☐ Home Phone _____ ☐ Cell/Work Phone _____

Address _____

Third Contact Name _____ Relationship _____

Please Mark Which Phone We Should Call First.

☐ Home Phone _____ ☐ Cell/Work Phone _____

Address _____

DESIGNATED PERSON

(The person you want to be notified in the event of emergency, termination of services, home closure or other situations)

Name _____ Relationship _____

Home Phone_____Cell/Work Phone_____

Address _____

POWER OF ATTORNEY / GUARDIAN / TRUSTEE

Type of Representation: ☐ Self ☐ Power of Attorney ☐ Guardian ☐ Next of Kin ☐ Other

Name _____ Relationship _____

Home Phone_____Cell/Work Phone_____

Address _____

Pre-Planned Funeral ☐ Yes ☐ No Is it ☐ Revocable? ☐ Irrevocable?

Funeral Home Name _____ Phone _____

Address _____

Prepaid Burial Account ☐ Yes ☐ No Cemetery Lot? ☐ Yes ☐ No

INSURANCE

Social Security # _____

Medicare # _____

Medicaid # _____

Insurance Company _____

Coverage Plan _____

Co-Insurance _____

Co-Insurance # _____

Co-Insurance Group _____

Life Insurance _____

Life Insurance Beneficiary _____

Life Insurance Value _____

I HEREBY VERIFY THAT THE ABOVE INFORMATION, TO THE EXTENT OF MY KNOWLEDGE, IS CORRECT. WE AGREE THAT THE APPLICANT'S ASSETS, HIS/HERS PORTION OF THE ASSENTS DECLARED ON THIS APPLICATION AND ON OTHER LEGAL DOCUMENTS WILL BE USED SOLELY FOR HIM/HER FOR EXPENSES HERE AT THIS FACILITY AND FOR OTHER PERSONAL FINANCIAL OBLIGATIONS AND FOR NO OTHER PURPOSE.

Applicant _____ Date _____