HALES CORNERS
CareCenter
Caring For Our Community

APPLICATION FOR RESIDENCY

The information in this application is required of all applicants and will be kept in the strictest of confidence. HALES CORNERS CARE CENTER will not discriminate based upon the information furnished in this document. Please complete and return this document to our Admissions Office. Should any question arise while filling it out, please do not hesitate to call us at 529-6888.

PLEASE RETURN TO:

Admission Coordinator Name	Telephone Number	Fax Number

PLEASE PRINT

PERSONAL INFORMATION

Applicant Full Name	Age	Sex	Marital Status

Address	Phone Number

City	State	Zip Code	County

Applicant Is Presently At:	Accommodations Desired: ❒ Semi- Private ❒ Private ❒ Private Suite

Has Applicant Previously Resided in a Skilled Nursing Facility?
❒ No ❒Yes If yes, indicate facility name and dates of stay:

Date of Birth	Place of Birth (City)	State	County

Country of Citizenship	Primary Language	Highest Level of Education

Military Service ❒ No ❒ Yes	Dates of Service	Has Applicant Been a Federal, State, County, or Municipal Employee? ❒ No ❒ Yes If yes, name:

Lifetime Occupation:	Religion	Clergy/Church Name	Telephone

Application is For: ❒ Short Term Stay (30 days or less) ❒ Long Term Stay (30 Days or Longer)

Name of person completing this form (if other that applicant)

Social Security Number	Medicare Number

Insurance Company Name

Address	City	State	Zip Code

Phone Number	Policy Number	Group Number

Does your Insurance policy listed above include nursing home benefits coverage? ❒ No ❒ Yes	Does the applicant have Medicaid (Title 19)? ❒ No ❒ YesMedicaid number _____ If no, is there a Title 19 appointment pending? ❒ No ❒ Yes Appointment Date?_____

NOTIFICATION OF CHANGES

Please indicate relatives/friends to be notified in case of emergency in the following order:

EMERGENCY CONTACT #1			
Name:	Relation		
Address	City	State	Zip Code
Work Phone:	Home Phone:	Cell Phone:	
Responsibility (checkall that apply) ❒ POA Health ❒ POA Finances ❒ Court Appointed Guardian			

EMERGENCY CONTACT #2			
Name:	Relation		
Address	City	State	Zip Code
Work Phone:	Home Phone:	Cell Phone:	
Responsibility (check all that apply) ❒ POA Health ❒ POA Finances ❒ Court Appointed Guardian			

EMERGENCY CONTACT #3			
Name:	Relation		
Address	City	State	Zip Code
Work Phone:	Home Phone:	Cell Phone:	
Responsibility (check all that apply) ❒ POA Health ❒ POA Finances ❒ Court Appointed Guardian			

RESIDENT CHOICES FOR PROFESSIONAL SERVICES

My choices for professional service providers are listed below. I understand that if I do not indicate a choice, facility will assume that the facility professional listed is an acceptable provider.

1) ATTENDING PHYSICIAN		
Facility		
My-Choice-Name		
Address		
City/State	Zip	Phone ( )

6) DENTIST		
Facility		
My-Choice-Name		
Address		
City/State	Zip	Phone ( )

2) ALTERNATE PHYSICIAN/SPECIALIST		
Facility		
My-Choice-Name	Specialty	
Address		
City/State	Zip	Phone ( )

7) PODIATRIST		
Facility		
My-Choice-Name		
Address		
City/State	Zip	Phone ( )

3) PHARMACIST		
Facility		
My-Choice-Name		
Address		
City/State	Zip	Phone ( )

8) OPTOMETRIST/ORTHALMOLOGIST		
Facility		
My-Choice-Name		
Address		
City/State	Zip	Phone ( )

4) LABORATORY SERVICES		
Facility		
My-Choice-Name		
Address		
City/State	Zip	Phone ( )

9) THERAPY SERVICES		
Facility		
My-Choice-Name		
Address		
City/State	Zip	Phone ( )

5) HOSPITAL		
Facility		
My-Choice-Name		
Address		
City/State	Zip	Phone ( )

10) FUNERAL HOME		
Facility		
My-Choice-Name		
Address		
City/State	Zip	Phone ( )

Signature on Acknowledgement of Receipt of Admission Information designates acceptance.

REQUEST TO OPEN PERSONAL MAIL

I, the above-named resident, request that the Administrator of the facility or designee assist in the opening and/or reading of my personal mail. I further request the Administrator or designee to assist in opening financially related mail addressed to me, such as checks, medical bills or statements, Medicare and Medicaid correspondence.

I understand that I may revoke this request at any time by notice to the Administrator or designee.

❑ Opening of Personal Mail Requested ❑ Opening of Personal Mail Not Requested

❑ Opening of Financial Mail Requested ❑ Opening of Financial Mail Not Requested

Please send any Financial Mail, including bills to:

Name_____

Address_____

Phone_____

CONSENT FOR USE OF PHOTOGRAPHS, AUDIOVISUAL RECORDINGS, AND NEWSLETTER/NEWSPRINT

I, the above-named resident, consent to the use of my name and any photographs or audiovisual recordings of myself for display, publication or broadcast with no form of compensation. The photographs or recordings may be taken of me by the facility, employees, or persons outside the facility for the use in the facility and/or in the public media and/or publications used by the facility or its subsidiary. I understood that I may rescind this authorization at any time, and that I am to be consulted with on each occasion.

❑ Consent Granted ❑ Consent Not Granted

SELECTION FOR LAUNDRY SERVICES

Hales Corners Care Center is pleased to offer you a personal laundry service at no additional charge. The facility provides this service on a daily basis and will deliver the clean clothes to the residents room within 24 hours. In order for the staff to properly identify the residents clothing, it is imperative that the clothing is marked. If you wish to mark the clothes, we recommend that you use a Laundry marker and mark the residents name on the inside of the clothing, near the tag. If you would like the facility to mark the clothing, please make us aware so that the clothes do not get sent to laundry without a name. Your cooperation with the clothing policy will allow us to safeguard each resident's personal belongings and to prevent lost items.

❑ I would like HCCC to do the personal laundry.

❑ I will take full responsibility for the laundering and dry cleaning for the above named resident's personal clothing, and will provide a washable hamper for soiled clothing. I will pick up soiled laundry and will return cleaned clothing on a weekly basis, or more often as needed.

Name:_____

Phone:_____

Relation to Resident:_____

Resident, and or Responsible Party, is obligated to make full and complete disclosure regarding all financial resources and income during the application process. Failure to identify all resources and income, or the submission of false information may result in the termination of the Admission Agreement.

FINANCIAL INFORMATION		
SOURCES OF INCOME	**AMOUNT**	**HOW OFTEN DOES THE APPLICANT RECEIVE THIS INCOME?**
1.		❑ Weekly ❑ Monthly ❑ Quarterly ❑ Annually
2.		❑ Weekly ❑ Monthly ❑ Quarterly ❑ Annually
3.		❑ Weekly ❑ Monthly ❑ Quarterly ❑ Annually

ASSETS			
CURRENT VALUE DOLLAR AMOUNT	**APPLICANT OWNS**	**MARITAL PROPERTY**	**ASSET NAME LOCATION & ACCT. #**
Checking Account:	%	❑ Yes ❑ No	
Savings Account:	%	❑ Yes ❑ No	
Stocks:	%	❑ Yes ❑ No	
Bonds/Annuities, etc.	%	❑ Yes ❑ No	
CD's:	%	❑ Yes ❑ No	
Additional Assets:	%	❑ Yes ❑ No	
Home:	%	❑ Yes ❑ No	
Are there any restrictions on the right of the applicant to transfer the asset? (liens, mortgages, etc.) ❑ No ❑ Yes			
Has any real estate been sold or transferred within the last 30 months? ❑ No ❑ Yes			

EXPENSES		
TO WHOM IS THIS AMOUNT PAID?	**AMOUNT**	**HOW OFTEN IS THIS AMOUNT PAID?**
		❑ Weekly ❑ Quarterly ❑ Other ❑ Monthly ❑ Annually Specify_____
		❑ Weekly ❑ Quarterly ❑ Other ❑ Monthly ❑ Annually Specify_____
		❑ Weekly ❑ Quarterly ❑ Other ❑ Monthly ❑ Annually Specify_____

AUTHORIZATION OF RELEASE OF INFORMATION

By signing this form, I represent and warrant that the above information is true and correct, and accurately reflects the funds that are available to provide for my care. I understand the Facility is relying on the above information and providing false information may result in the termination of any agreement to provide care. I further authorize Hales Corners Care Center to make all inquiries deemed necessary to verify the accuracy of the statements made herein and to determine individual or joint positions.

Applicant's Signature

Legal Representative's Signature

Specify type of Authority (ex. POA)

Date