Each applicant must provide a copy of:

- [ ] PHOTO ID (IF EXPIRED WILL STILL BE ACCEPTED)
- [ ] SOCIAL SECURITY CARD
- [ ] MEDICARE CARD
- [ ] MEDICAID CARD (IF APPLICABLE)
- [ ] ALL HEALTH INSURANCE BENEFITS CARDS
- [ ] FUNERAL HOME MUST BE SELECTED

LaSalle County Nursing Home Application for Admission

Please Select: Mr.☐ Mrs.☐ Miss☐ Admission Date: _____ Admission No. _____

Full Name: _____

Preferred Name or Nickname: _____

Address: _____

City: _____ Zip Code: _____ Home Phone: _____

Male: ☐ Female: ☐ Cell Phone: _____

Age: _____

Date of Birth: _____ Place of Birth: _____

Mother's Maiden Name: _____ Father's Name: _____

Marital Status: _____ Spouse's Name: _____ If wife, her Maiden Name: _____

Military Service: Yes ☐ No ☐ Branch of Military Service: _____

Social Security Number: _____

Medicare Number: _____

Medicare part D Prescription Drug Plan Policy Number: _____

Medicaid Number: _____

In Case of Illness Notify: _____ Relationship: _____

Address: _____

City: _____ Zip Code: _____ Phone: _____

Please Understand that documents for power of attorney for both finance and health care must be provided to the Admissions Coordination Staff within the first five days of admission to the facility.

Designated Healthcare POA (to receive Care Plan Invitations)

Name: _____

Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Durable Power of Attorney for Health care: Yes ☐ No ☐

Designated Financial POA (to receive invoices, nursing home/pharmacy bills)

Name: _____

Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Physician: _____

Address: _____

Phone: _____

Dentist: _____

Address: _____

Phone: _____

Religious Affiliation: _____

Parish / Church Name: _____

Would you like for us to contact your Clergyman: Yes ☐ No ☐

Financial Information

Present means of financial support: _____

Name of Financial Institution: _____

Checking: _____

Savings: _____

CD's: _____

Stocks/Bonds: _____

Have you the means of financial support during your stay at the nursing home:

Yes ☐ No ☐ Estimated Number of Years _____

Do you receive a monthly payment from Social Security: Yes ☐ No ☐

Amount: _____

Do you receive a monthly pension: Yes ☐ No ☐

Amount: _____

Do you receive a pension from your spouse: Yes ☐ No ☐

Amount: _____

Do you currently receive Public Aid (Medicaid) assistance: Yes ☐ No ☐

Amount: _____

Supplemental Insurance Name: _____

Agent's Name: _____

Address: _____

Phone: _____

Policy Numbers: _____

DECLARATION OF INCOME & ASSETS

Name: _____

MONTHLY EARNED INCOME	**CLIENT**	**SPOUSE**
1.Before tax wages or salary	_____	_____
2.Before tax income from Self-employment	_____	_____

ALL OTHER INCOME		
1.Social Security	_____	_____
2.SSI/SSI-E	_____	_____
3.Veteran's Pension	_____	_____
4.Pensions/Annuities	_____	_____
5.Interest/Dividend Income	_____	_____
6.Other: (i.e., estates/trusts,	_____	_____
Net rental income,	_____	_____
Workman's compensation,	_____	_____
Unemployment	_____	_____
compensation,Alimony, etc.	_____	_____

TOTAL ALL OTHER INCOME _____

COMBINED ASSETS OF CLIENT AND SPOUSE

Consider assets over the protected limits.
Do not count your home, furnishings, or car.

1. Cash on hand _____
2. Savings _____
3. Checking _____
4. IRA _____
5. Certificates of Deposit _____
6. Money Market _____
7. Other: (ie, stocks, bonds, trusts-excluding funeral trusts under $2000, money owed to you and any property not used for any of the following:the person's homestead, a business farming operation or rental income, a vehicle to go to work, to medical providers or for normal participation in community living.)

_____

_____

_____

8. Life insurance, cash value if face value is more Than $1500 _____

TOTAL ASSETS _____

Income received for children in the home (i.e., child support, social security, SSI, etc.) _____

EXPENSES

Child support or family support ordered to be paid monthly: Yours _____ Spouse's _____

Maintenance or alimony court ordered to be paid monthly: Yours _____ Spouse's _____

List average monthly out-of-pocket expenses which could be considered medically related to the person's condition. Medically related expenses should be interpreted broadly. The following are examples of what should be counted, but the list is not complete: Medications, medical supplies, equipment, payments on outstanding medical bills, caregivers, excess energy costs related to a medical condition, health insurance premiums, doctor/dentist/hospital bills (not covered by a third party), MA co-payments, hearing aids, wheelchair expenses, diapers, bed pads, etc.

_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have an irrevocable funeral trust fund? Yes ☐ No ☐

Have you or your spouse sold or given away property (such as land, stocks, bonds, cash, etc.,) within the last thirty months including transfers of property to children, relatives, or other persons? Yes ☐ No ☐

I have tried to give true and accurate information. I understand that the agency may request more detailed and documented information later.

Date _____ Signature (and relationship to participant) _____

LaSalle County Nursing Home
Ottawa, IL 61350

I, (we), warrant the statement and answers, as written in this application to be true and complete. When admitted to the LaSalle County Nursing Home, I, (we), agree to abide and be governed by all articles and conditions set forth in the manual of policies admission and procedures governing residence at the LaSalle County Nursing Home, and will assist in cultivation of a Happy Congenial Spirit among the residents by Friendly Behavior, Kindliness, and Compassion. I have been informed of my Resident Rights and Responsibilities applying to residence in the Lasalle County Nursing Home.

_____

Signature of Applicant

_____

Signature of Sponsor