Admission Application

Woolwich Gardens considers all applicants without regard or discrimination for any legally protected class. Please complete this application in its entirety, as discrepancies or blanks may delay processing.

Date: _____ Name of applicant: (Last)_____

(First)_____ (Nickname/Preferred Name) _____

Address: _____ City: _____

County: _____ State: _____ Zip Code: _____

Phone #: _____ Marital Status: (check one) S☐ M☐ D☐ W☐

Referred by: _____

Birth date: _____ Age: _____ Place of birth: _____

Social Security #: _____ Religion: _____

Long term care insurance _____No _____Yes Carrier: _____

Veteran or qualified spouse of a veteran? _____ No _____Yes

Medicare #: _____ _____A _____B

Other medical insurance carrier & number: _____

Pharmaceutical insurance carrier & number: _____

Person(s) responsible for applicant (if applicable):

1. Name: _____ Relationship_____

Address: _____ City: _____

Phone: (H)_____ (W)_____ State/Zip: _____

2. Name: _____ Relationship_____

Address: _____ City: _____

Phone: (H)_____ (W)_____ State/Zip: _____
Where is the applicant currently residing? _____

If in health care facility what is the date of admission_____

Current Physician: _____ Phone #: _____

Podiatrist: _____ Phone #: _____

Please list all other medical specialists treating applicant with name, specialty & phone# on back of page.

Does the applicant have an Advance Directive? (If yes, please provide a copy) Yes____ No____

Funeral Home preference: _____ Phone #: _____

Hospital of Choice: _____

List all health care facilities where the applicant has received care in the past two years:

Facility	Admission Date	Discharge Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(List any additional admissions on back of this page)

1. Emergency Contact: _____ Relationship: _____

Address: _____

Phone: (H)_____ (W)_____ Cell_____

2. Emergency Contact: _____ Relationship: _____

Address: _____

Phone: (H)_____ (W)_____ Cell_____

3. Emergency Contact: _____ Relationship: _____

Address: _____

Phone: (H)_____ (W)_____ Cell_____

FINANCIAL DISCLOSURE

Responsible Party: _____ Relationship: _____

Address: _____

Phone: (H)_____ (W)_____ Cell_____

All residents must establish financial credibility with Woolwich Gardens. It is important that all financial resources be listed in order to meet all expenses incurred at Woolwich Gardens. Residents eligible for Med-icaid are OBLIGATED TO SURRENDER to Woolwich Gardens the AMOUNT PRE-DETERMINED BY MEDICAID. Thank you for your cooperation in this matter.

	Principle	Monthly Income	Bank/Institution	Account #
Savings	_____	_____	_____	_____
Checking	_____	_____	_____	_____
Certificates	_____	_____	_____	_____
Trust Fund	_____	_____	_____	_____
Securities	_____	_____	_____	_____
Real Estate	_____	_____	_____	_____
Other	_____	_____	_____	_____

Total Assets $_____ Total Liabilities $_____

Gross Monthly Income (please include any deductions for insurance premiums or other deductions from monthly Social Security or pension payments):

Social Security: _____ Pension: _____ Insurance: _____

Other: _____ Total Monthly Income $_____

The undersigned hereby certify that I/we have read the above, that all statements made therein are true and complete to the best of my knowledge. The applicants authorize Woolwich Gardens (or its agents) to verify the information contained herein. There are no liens, judgments, pending sales or bankruptcy proceedings against the applicant or the applicant's property. The applicant understands that Woolwich Gardens, may at its option, cancel any admission granted if this application contains any false or misleading information, or if in its opinion, the credit investigation discloses an unsatisfactory record. Resident and sponsor agree to review the above financial information semi-annually or more often if needed to verify the continued ability the pay the account.

_____ _____

Signature of applicant Signature of responsible party

_____ _____

Witness Date: