WELLS NURSING HOME, INC.

SKILLED NURSING FACILITY

Admission Application / Financial Disclosure

NAME _____DATE_____

BIRTH DATE_____ AGE _____ SEX M F

ADDRESS_____

_____ZIP CODE_____

TELEPHONE (H) _____ (W) _____ RELIGION_____

SOCIAL SECURITY # _____ VETERAN _____ SPOUSE OF VETERAN_____

MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐

US CITIZEN YES_____ NO _____ IF NO, GIVE ALIEN REGISTRATION # _____

PERSONS TO BE NOTIFIED

NAME _____ ADDRESS_____

RELATIONSHIP_____TELEPHONE # _____

NAME _____ ADDRESS_____

RELATIONSHIP_____TELEPHONE # _____

NAME _____ ADDRESS_____

RELATIONSHIP_____TELEPHONE # _____

NAME _____ ADDRESS_____

RELATIONSHIP_____TELEPHONE # _____

NAME _____ ADDRESS_____

RELATIONSHIP_____TELEPHONE # _____

Federal and State laws prohibit any facility from denying admission to anyone because of race, color, creed, age, national origin, sex, disability, marital status, advanced directives or sexual preference

Please note- Wells Nursing Home is a Smoke Free Facility

WELLS NURSING HOME, INC.

FINANCIAL SUMMARY / MONTHLY INCOME (CURRENT)

SOCIAL SECURITY $_____ VETERAN'S BENEFITS $ _____

PRIVATE PENSION $ _____ DIVIDENDS $ _____

INTEREST $_____ SSI $ _____

BANK ACCOUNT $ _____ BANK NAME _____

BANK ACCOUNT $ _____ BANK NAME _____

CHECKING ACCOUNT $ _____ BANK NAME _____

OTHER $ _____ LIFE INSURANCE (CASH VALUE) $ _____

OTHER $ _____

FINANCIAL QUESTIONS TO DETERMINE MEDICAID ELIGIBILITY

Have you transferred any assets within the last 5 years? Y _____ N_____

If so, please indicate the **date, type** and **value** of transfer(s):

DATE	TYPE	VALUE
1_____	_____	$_____
2_____	_____	$_____
3_____	_____	$_____
4_____	_____	$_____

Do you own your home? Y____ N____ Do you know its current market value? $_____

Do you have long term care insurance? Y _____ N _____

Who is it with?_____

WELLS NURSING HOME, INC.

HEALTH INSURANCE

Medicare # _____ Medicaid # _____

Blue cross/ Blue Shield # _____

Private Insurance Type _____ ID # _____

Senior Blue # _____

Nursing Home Insurance Rider (if applicable) _____

Medicare D Plan: Name and ID # _____

BURIAL ARRANGEMENTS

PERSON RESPONSIBLE _____

ADDRESS _____

TELEPHONE _____

FUNERAL HOME PREFERENCE_____

ADDRESS _____

TELEPHONE _____

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