Lakeland Health Care Center
Financial Information

This Long Term admission application should be completed by all residents admitting to Lakeland Health Care Center who are anticipating a long term stay, as well as any current, short term residents interested in remaining long term at Lakeland Health Care Center.

Resident: _____Screen Date:_____

PAY SOURCE UPON ADMISSION:

Private Pay_____ Medicare Part A_____ Medicaid_____ Applying for Medicaid____

MEDICAID (T19):

Currently receiving or applying for Medical Assistance through _____ County. Case Worker's Name: _____

Medicaid #: _____

MEDICARE (check all that apply):

Part A _____ Part B _____ Part D _____

Medicare #: _____

OTHER INSURANCE INFORMATION:

Name of Insurance Company: _____
Address: _____
Policy #: _____
Name of Insured: _____
Is this a retirement plan? _____ If so, Employer: _____

LONG TERM CARE POLICY:

Name of Insurance Company: _____
Address: _____
Policy #: _____

PRESCRIPTION DRUG PLAN:

Name of Drug Plan: _____

(copies of all insurance cards are required prior to admission)

ALL SOURCES OF INCOME:

Social Security	Resident _____ Spouse _____
Supplemental Security Income (SSI)	Resident _____ Spouse _____
Pension	Resident _____ Spouse _____
Employment	Resident _____ Spouse _____
Veterans Benefits	Resident _____ Spouse _____
Stock/Bond Income	Resident _____ Spouse _____
Annuities	Resident _____ Spouse _____
Other	Resident _____ Spouse _____

ASSETS:

Life Insurance

Policy Issuer _____

Policy Number _____

Checking/Savings Accounts

Name of Institution(s) _____

Account Number(s) _____

Other Authorized Account Holder? Yes _____ No _____

Name/Relationship to Resident _____

Cash _____

Stocks & Bonds

Name of Company/Issuer _____

Number of Shares _____

Share Account Number (if any) _____

Maturity Date (if bond) _____

CDs

Name of Institution Where Held _____

Maturity Date _____

Account Number (if any) _____

Name/Relationship of any Additional Holders on CD _____

Real Estate
Address _____

Type of Property Rental _____ Primary Residence _____

Other _____

Asset Valuation _____

Automobile Make/Model _____

Assets sold or given away in the last 5 years: _____

FINANCIALLY RESPONSIBLE PERSON (if other than the resident):

Name: _____Relationship: _____

Address: _____

_____

Is this person the Power of Attorney for Finance? _____ (activated) _____

Is this person a legal guardian? _____

If the responsible party has control of, or access to, the resident's income and/or assets, the responsible party agrees that these funds shall be used for the resident's welfare, including, but not limited to making prompt payment in accordance with the Admission Agreement.

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 Lakeland Health Care Center is relying on the above information. I further give Lakeland Health Care Center permission to verify the information provided herein. I believe I have adequate resources to meet my financial responsibilities, including those that will attach if I am admitted into the Facility.

If admitted for short term rehab, I understand that I will be discharged when short term goals are met.

Resident's Signature: _____ Date: _____

Responsible Party's Signature: _____ Date: _____

Authorized Representative: _____ Date: _____

Witness: _____ Date: _____