10101 West Wisconsin Avenue
Wauwatosa, WI 53226
(414) 259-6310

DATE: ______________________

St. Camillus campus application, please circle area you are applying for:

San Camillo Retirement Community   Assisted Living at St. Camillus   Memory Care

Skilled Nursing   Home Care   Hospice   St. Camillus at Home

Unit Preference: ____

Name: ____

Home Address: ____
Street   City   State   Zip

Home Phone: ______________ Marital Status: ____________ Email: ______________________

Gender: ______________ Age: ____________ Birthdate: ______________________

Social Security No.: ______________________ Medicare No.: ______________________

Title XIX No.: ______________ Long Term Care Insurance: ______________

Health Insurance: ______________ No.: ______________ Group #: ______________

Medicare Part D P.D.P.: ______________________ #: ______________

U.S. Citizen: ❑ Yes ❑ No

Veteran: ❑ Yes ❑ No   Dates of Service: ______________ Branch of Service: ______________

Lifetime Occupation: ____

Company retired from: ______________________ When: ______________

<u>*Please supply copies of Medicare and other insurance cards</u>.

Primary Care Physician: ____
Name   Phone

Address: ____

Dentist: ____
Name   Phone

Address: ____

<u>*UPON ADMISSION PLEASE PROVIDE THE FACILITY WITH COPIES OF THESE DOCUMENTS</u>:

Does the applicant have Advanced Directives? ❑ Yes ❑ No   POA HC Activated? ❑ Yes ❑ No

Does the applicant have a Do Not Resuscitate Order? ❑ Yes ❑ No   POA Finances? ❑ Yes ❑ No

Does the applicant have a Living Will? ❑ Yes ❑ No

<u>ST. CAMILLUS IS A SMOKE-FREE CAMPUS.</u>

List in order of preference persons to be notified in a medical emergency or change of condition. Also, please indicate type of **Legal Authority** such as Power of Attorney for Finances, Power of Attorney for Health Care or Guardianship.

1) ______________________________ ______________________________
Name Relationship Type of Legal Authority
______________________________ ______________________________
Address Home Phone Work Phone
______________________________ ______________________________
City / State / Zip Cell Phone Email

2) ______________________________ ______________________________
Name Relationship Type of Legal Authority
______________________________ ______________________________
Address Home Phone Work Phone
______________________________ ______________________________
City / State / Zip Cell Phone Email

3) ______________________________ ______________________________
Name Relationship Type of Legal Authority
______________________________ ______________________________
Address Home Phone Work Phone
______________________________ ______________________________
City / State / Zip Cell Phone Email

Please send all facility bills to: ______________________________
Name
____
Address City State Zip

Religion / Affiliation

Religion: ______________________ Church Name: ______________________

Funeral Home

Name: ______________________ Address: ______________________

City, State, Zip: ______________________ Phone: ______________________

Burial Trust ❑ Yes ❑ No Burial Plot ❑ Yes ❑ No

ST. CAMILLUS HEALTH CENTER, HOME CARE, AND HOSPICE APPLICANTS ONLY.

Hospital Preference (Required): ______________________

Hospitalization

Have you been hospitalized in the last 12 months? ❑ Yes ❑ No
If yes, please complete the following information:

Acute Hospital: ______________________ Admit Date: __________ Discharge Date: __________

Skilled Nursing Facility: ______________________ Admit Date: __________ Discharge Date: __________

Resident is now at: ______________________ Admit Date: __________

Plans to discharge within 3 months: ❑ Yes ❑ No ❑ Uncertain

I give my permission, and release St. Camillus from liability, that this information has been kept in resident/client file, is considered confidential, and available to appropriate staff, all medical care providers, Fire Department and/or Paramedics in the event of an emergency.

Resident / Client Signature: ______________________ Date: __________

Responsible Party Signature: ______________________ Date: __________

ALL APPLICANTS MUST COMPLETE THIS ENTIRE PAGE.

CONFIDENTIAL FINANCIAL STATEMENT OF:

Name(s): ____ Date: __________

***If applicant is married, spouse's assets must also be included.**

ACCOUNT: (Banks, Savings and Loans, Credit Unions, IRA's, Certificates of Deposit, Etc.)

Name of Institution	Amount	For each, indicate: Self, Joint*, Other

INVESTMENTS: (Stocks, Bonds, Mutual Funds, Annuities, Etc.)

Description	Number of Shares	Market Value	Assets Liquid?	For each, indicate: Ownership Self, Joint, Other
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	

If you own property, fill in this section. If you rent, mark with"N/A".

Description / Location	Market Value	Balance Due	Mortgage Holder	For each, indicate: Ownership Self, Joint, Other
Primary Residence:				
Other:				

RESOURCE-INCOME TRANSFER:

Sold any assets for less than fair market value: ❑ Yes ❑ No

Traded assets or income: ❑ Yes ❑ No

Transferred or gave away any assets: ❑ Yes ❑ No

TRUST FUNDS:

Are any of your assets held in revocable or irrevocable trust? ❑ Yes ❑ No

Are you the beneficiary of the Principle of the trust? ❑ Yes ❑ No

If so, please list estimated value: ______________________________

Are you the beneficiary of the income of the trust? ❑ Yes ❑ No

If so, please list monthly value: ______________________________

ALL APPLICANTS MUST COMPLETE THIS ENTIRE PAGE.

LIFE INSURANCE:

Company / Policy Number	Cash Surrender Value	Face Value (Death Benefit)	Beneficiary

LOANS: (Banks, Consumer, Life Insurance, Credit Cards, Etc.)

Lender	Account Number	Amount

ANY OTHER LOANS OR LIENS ON ASSETS: (Describe and List)

____

____

____

Has there been any sale of house or property gifts of money, or transfer of assets in the last 5 years? If any, please explain:

____

MONTHLY INCOME:

	Social Security Income
Applicant	
Spouse	

Pension: ______________________________

Other: ______________________________

____

Investments, Interest, Dividends, Rents Etc.: ______________

____

MONTHLY EXPENSES:

Medical: ______________________________

Other: ______________________________

Financial Conditions Acceptable:
Internal Use Only

Yes __________ No __________

By: ______________________________

Title: ______________________________

Date: ______________________________

Signature terms:

Each undersigned represents and warrants that the information provided is true and correct. St. Camillus is authorized to make all inquiries deemed necessary to verify the accuracy of the statement herein and to determine individual or joint financial position. Each undersigned is aware that additional information may be needed before application is considered complete.

Resident / Client Signature: ______________________________ Date: ______________

Responsible Party Signature: ______________________________ Date: ______________