Confidential Application

The information on this form ensures that there are funds available to care for the resident. As you know, the care associated with a resident in a Senior Living Community can be costly and time consuming. As a private facility, we want to be assured that there is a clear understanding of the financial responsibilities being undertaken by the resident and the responsible party. This information will be kept strictly confidential.

Community applying to_____

1. **General Information**

   Name (of Resident-to-Be)_____

   Social Security #_____ **Date of Birth**: _____

   Name (of Resident-to-Be)_____

   Social Security #_____ **Date of Birth**: _____

   Current Address_____ **Phone #**_____

   _____

2. **Responsible Party** (Individual responsibility for paying bills, POA, or nearest relative)

   Name_____ Phone # (H) _____

   Relationship _____Phone # (C) _____

   Address_____

   Email _____

3. Has anyone been appointed **Durable Power of Attorney or Guardian**? Yes____ No _____

   If "yes" complete the following: Name_____

   Address_____

   What is the extent of their authority? _____

Referred by: _____

4. Is a **Living Will and/or Advanced Health Care Directive** in place? Living Will: Yes___ No ___

   Advanced Health Care Directive: Yes___ No ___

5. **Primary Care Physician**

   Physician's Name_____ Phone Number_____

   Address_____

6. **Insurance Information**

   Medicare # _____ Part A _____ Part B _____

   Other Health Insurance_____ Policy # _____

   Any long term care policies that cover Assisted Living/Residential Care or Supportive Services? Yes____ No____

   If yes, list company_____ Policy # _____

   Amount paid for services if known $_____

   Has the resident been in the hospital or another facility in the last 60 days?

   Yes_____ No_____ If yes, facility name _____

   Has the resident applied, or will they be applying, for State Medicaid assistance?

   Yes _____ No_____ Medicaid number (if known) _____

7. **Financial**

   Please be aware that we may ask you to verify some or all of the assets shown in the form of bank statements, quarterly reports, etc. Assets shown are available to be used towards residing in one of our communities.

   Income/Assets

   Social Security: gross monthly $_____

   Retirement/Pension $ _____ Company_____

   Address_____

   Annuities/Investments $_____ Company_____

   Address_____

   Trust Account $_____ Company_____

   Address_____

   Approximate Total Value $_____

Real Estate

Rental Income $_____ Mortgage $ _____

Address_____

Does the resident own a residence? Yes___ No___ Does the potential new resident(s) plan to use the asset of the residence towards their assets? Yes___ No____

If so, value of home $ _____ Mortgage $ _____

Address_____

Value of other real estate assets $_____ Mortgage $ _____

Address_____

Approximate Total Value $_____

Bank Accounts

Bank_____ Type of Account_____

Address_____ Current Balance $_____

Bank_____ Type of Account_____

Address_____ Current Balance $_____

Bank_____ Type of Account_____

Address_____ Current Balance $_____

Approximate Total Value $_____

Other

Value of other assets $_____ Description: _____

_____

Value of other assets $_____ Description: _____

_____

8. **Monthly Expenses**

Health Insurance $_____ Medication Expenses $_____

Credit Card Bills $_____ Car Payment $_____

Other $_____ Description_____

Any debts, mortgages or other financial obligations that would affect the income assets

_____

_____

_____

I understand and agree that this application is neither a contract nor a reservation for residence. Nothing contained in this document obligates or entitles me to an apartment at Pillsbury Senior Communities until a lease has been signed by all parties involved.

I hereby state that, to the best of my knowledge, the information given here is accurate and true. I understand that if any of this information has been falsely represented, this will be sufficient grounds to terminate this application for admission. I also understand that any change in financial condition will promptly be communicated to the facility management, so that we may assist the resident in seeking assistance or making alternate plans.

I hereby authorize my physician and others having access to my Private Health Information (PHI) to release this information from my health records.

_____ _____

Signature of Applicant Date

_____

Responsible Party / Guardian / POA

To protect the confidential nature of this form, please return it in a specially marked envelope addressed to:

Marketing Office
Pillsbury Senior Communities
20 Harbor View Road
South Burlington, VT 05403

If you deliver this information in person, please submit in a sealed envelope to the charge nurse on duty at Pillsbury Manor North or South only. Your confidential information is kept in a locked file in our billing office.