



## 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.