

Through joint programming, the Center develops and maintains relationships with a variety of Jewish communal organizations and synagogues. The programs are essential to building Jewish continuity and strengthening the connection for our residents with the community-at-large.

Please take a moment to tell us about the applicant's prior association.

Is the applicant a current or former member of any of the following organizations?

- Hadassah Unit _____ Brith Sholom ORT B'nai Brith
 National Council of Jewish Women Jewish War Veterans Other _____

Congregation _____

Activities _____

Do you grant permission to the Residence to notify the synagogue and/or organization of the applicant's new residency? Yes No

INSURANCE

In order to process the application, please include a copy of all insurance cards

Medicare # _____

Effective Date - Part A _____

Part B _____

Name of Supplemental Health Insurance Company _____

ID # _____

Group _____

HMO _____

ID# _____

Primary Care Physician _____

Has the applicant had any admissions to other nursing/rehabilitation centers prior to this application?

NO YES If yes, please list name of facility and dates of service _____

Private Long Term Care Insurance - *In order to process the application, please attach copy of policy*

Company Name _____

Policy # _____

Address _____

Life Insurance

Company Name _____

Policy # _____

Policy Holder _____

Face Value _____

Cash Value _____

Has the applicant appointed the following?

Power of Attorney – *Financial*

NO YES ***Please include copy***

Name _____

Power of Attorney – *Health Care*

NO YES ***Please include copy***

Name _____

Does the applicant have a *Living Will* or other medical directive?

NO YES ***Please include copy***

FINANCIAL DISCLOSURE*All information provided will be held in strict confidence.*

In order to process this application, please attach a copy of the last five (5) years of account statements for the items listed below and the last five (5) years of 1040 tax returns. Current financial information must be provided on or about the time of move-in.

INCOME:

		<u>Applicant</u>	<u>Spouse</u>
Social Security	Gross Amount per Month	\$ _____	\$ _____
Pension(Specify Type)_____	Gross Amount per Month	\$ _____	\$ _____
Disability(Specify Type)_____	Gross Amount per Month	\$ _____	\$ _____
Interest, Rentals, Dividends	Gross Amount per Month	\$ _____	\$ _____
Other Income(Specify)_____	Gross Amount per Month	\$ _____	\$ _____
TOTAL MONTHLY INCOME		\$ _____	\$ _____

ASSETS:

	Institution	Account #	<u>Applicant</u>	<u>Spouse</u>
Savings Account	_____	_____	\$ _____	\$ _____
Checking Account	_____	_____	\$ _____	\$ _____
Certificates	_____	_____	\$ _____	\$ _____
Stocks	_____	_____	\$ _____	\$ _____
Bonds	_____	_____	\$ _____	\$ _____
Mutual Funds	_____	_____	\$ _____	\$ _____
Trust Funds	_____	_____	\$ _____	\$ _____
Retirement Accts	_____	_____	\$ _____	\$ _____
Real Estate Attach Copy of Deed	_____	_____	\$ _____	\$ _____
Other Resources Please Specify	_____	_____	\$ _____	\$ _____
TOTAL ASSETS			\$ _____	\$ _____

SHELTER COSTS:

excluding utilities i.e. Rent, Mortgage, real estate taxes, home equity loans, homeowner insurance, etc. \$ _____

Please check Utility services:

Heat & Air condition Electricity Telephone

LIABILITIES:

	Description	Payable to Bank, Person, etc.	Amount per Month
Mortgage	_____	_____	\$ _____
Loans	_____	_____	\$ _____
Notes	_____	_____	\$ _____
Unpaid Bills	_____	_____	\$ _____
Other	_____	_____	\$ _____
TOTAL LIABILITIES			\$ _____

NET ASSETS

\$ _____

Have contributions been made to any of the above assets by anyone other than the applicant?

NO YES If yes, by whom and amount _____

Transfer of Assets

The Department of Public Welfare states that any applicant shall be ineligible, if within 60 months prior to the date of application for Medical Assistance, he/she had made a transfer or other disposition of assets for less than fair market value for the purpose of qualifying for Medical Assistance.

Within the past five years, has the applicant transferred money, insurance, real estate, or personal property?

NO YES If greater than \$500, please specify:

Amount	To Whom	When

Trust

Does the applicant receive income from or have a trust? NO YES

Within the past five years, has the applicant transferred money into, or established a trust? NO YES

Amount \$ _____ **If yes, please attach a copy of the Trust Agreement.**

Trustee _____ Phone _____

Address _____

Funeral/Burial Arrangements

Have funeral/burial arrangements been made? NO YES

If yes, are arrangements paid in full and irrevocable? NO YES

Funeral Home _____ Cemetery _____

Institution with burial reserve account _____

Are you represented by an attorney?

NO YES If yes, please provide the following information.

Attorney _____ Phone _____

Address _____

PAYMENT

Monthly care charges are to be paid by (please check all applicable boxes):

Applicant's own resources Other (specify) _____

State Medical Assistance (Medicaid)

Has the application been initiated? NO YES

If yes, date initiated _____ caseworker _____

Please include any paperwork relevant to the Medicaid application.

So that we have accurate contact information, including email address and are able to inform children, grandchildren and friends of the many activities and religious life programs, please provide us with the following information.

FAMILY AND FRIENDS

Name _____ Relationship _____ Spouse _____

Address _____

Phone _____

Home

Office

Cell

Email

Congregation _____

Contact for Medical Decisions YES NO Contact for Financial Decisions YES NO



Name _____ Relationship _____ Spouse _____

Address _____

Phone _____

Home

Office

Cell

Email

Congregation _____

Contact for Medical Decisions YES NO Contact for Financial Decisions YES NO



Name _____ Relationship _____ Spouse _____

Address _____

Phone _____

Home

Office

Cell

Email

Congregation _____

Contact for Medical Decisions YES NO Contact for Financial Decisions YES NO

FAMILY AND FRIENDS *(continued)*

Name	Relationship	Spouse
Address		
Phone		
Home	Office	
Cell	Email	
Congregation		
Contact for Medical Decisions	YES NO <input type="checkbox"/> <input type="checkbox"/>	Contact for Financial Decisions YES NO <input type="checkbox"/> <input type="checkbox"/>



Name	Relationship	Spouse
Address		
Phone		
Home	Office	
Cell	Email	
Congregation		
Contact for Medical Decisions	YES NO <input type="checkbox"/> <input type="checkbox"/>	Contact for Financial Decisions YES NO <input type="checkbox"/> <input type="checkbox"/>

CERTIFICATION

I understand that no application is considered for move-in to the Abramson Residence until all requested information is furnished.

I certify that each and every statement set forth above, including any accompanying financial records, is true and correct. I understand that the Abramson Center for Jewish Life's agreement to admit applicant to the Abramson Residence is expressly made in reliance on the information contained herein. I understand that any material omissions or misrepresentations shall constitute a breach of the Admission Agreement and may result in termination of residency.

Applicant Signature	Date
Responsible Party Signature	Date