Samson *Nursing Center*
A COMMUNITY OF MENORAH LIFE

APPLICATION FOR ADMISSION

Please complete **all** items.

PERSONAL HISTORY

NAME:_____
LAST FIRST MIDDLE/MAIDEN

CURRENT ADDRESS: _____

_____PHONE: _____
CITY STATE ZIP CODE

DATE OF BIRTH: _____SOCIAL SECURITY #: _____AGE: _____

MARITAL STATUS: MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐

U.S. CITIZEN? YES ☐ NO ☐ PLACE OF BIRTH: _____

☐BY BIRTH ☐BY NATURALIZATION

FORMER OCCUPATION: _____

IF MARRIED, SPOUSE'S NAME: _____ PHONE: _____

CURRENT LIVING ARRANGEMENT: ALONE ☐ WITH RELATIVES ☐ RELATIONSHIP:_____

NAME:_____ADDRESS:_____PHONE:_____

☐ OWN HOUSE ☐ CONDO ☐ NURSING HOME:_____

☐ RENT ☐ ASSISTED LIVING FACILITY:_____

YEARS OF RESIDENCE IN ANY OF THE FOLLOWING COUNTIES:

_____PINELLAS _____HILLSBOROUGH _____SARASOTA _____MANATEE ____PASCO _____POLK

____OTHER FLORIDA AREAS (SPECIFY): _____

RELIGIOUS PREFERENCE:_____

FAMILY

PLEASE LIST FAMILY MEMBERS:

1. NAME: _____ SPOUSE'S NAME: _____

ADDRESS: _____ PRIMARY PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ OCCUPATION: _____

CELL PHONE: _____ WORK PHONE: _____

EMAIL: _____ ☐ *CHECK HERE TO OPT OUT OF EMAIL CORRESPONDENCE*

RELATIONSHIP: _____ SPOUSE'S PHONE: _____ ☐ WORK ☐ CELL

☐ CONTACT FOR HEALTH CARE MATTERS ☐ CONTACT FOR FINANCIAL MATTERS

☐ HEALTHCARE SURROGATE ☐ POWER OF ATTORNEY

☐ OTHER _____

2. NAME: _____ SPOUSE'S NAME: _____

ADDRESS: _____ PRIMARY PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ OCCUPATION: _____

CELL PHONE: _____ WORK PHONE: _____

EMAIL: _____ ☐ *CHECK HERE TO OPT OUT OF EMAIL CORRESPONDENCE*

RELATIONSHIP: _____ SPOUSE'S PHONE: _____ ☐ WORK ☐ CELL

☐ CONTACT FOR HEALTH CARE MATTERS ☐ CONTACT FOR FINANCIAL MATTERS

☐ HEALTHCARE SURROGATE ☐ POWER OF ATTORNEY

☐ OTHER _____

3. NAME: _____ SPOUSE'S NAME: _____

ADDRESS: _____ PRIMARY PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ OCCUPATION: _____

CELL PHONE: _____ WORK PHONE: _____

EMAIL: _____ ☐ *CHECK HERE TO OPT OUT OF EMAIL CORRESPONDENCE*

RELATIONSHIP: _____ SPOUSE'S PHONE: _____ ☐ WORK ☐ CELL

☐ CONTACT FOR HEALTH CARE MATTERS ☐ CONTACT FOR FINANCIAL MATTERS

☐ HEALTHCARE SURROGATE ☐ POWER OF ATTORNEY

☐ OTHER _____

PLEASE SUBMIT COPIES OF POWER OF ATTORNEY AND/OR HEALTH CARE SURROGATE PAPERS.

CONFIDENTIAL FINANCIAL REPORT

MEDICARE NUMBER: _____ MEDICAID NUMBER: _____

SUPPLEMENTAL HEALTH INS. COMPANY: _____

ADDRESS: _____ POLICY #: _____

LIFE INSURANCE: COMPANY_____POLICY #: _____

ADDRESS:_____AMOUNT: _____ BENEFICIARY:_____

PREPLANNED FUNERAL? ☐YES ☐NO FUNERAL HOME_____PHONE #: _____

IF YOU HAVE NOT MADE FUNERAL ARRANGEMENTS, PLEASE INDICATE WHICH FUNERAL HOME YOU WOULD WANT US TO CONTACT SHOULD THE NEED ARISE. NAME_____ PHONE #: _____

RESERVED PLOT? ☐ YES ☐NO NAME OF CEMETERY? _____PHONE #_____

REGULAR MONTHLY INCOME

	Applicant	Spouse
Social Security	$_____	$_____
Pension	$_____	$_____
Dividends	$_____	$_____
Interest	$_____	$_____
Property Income	$_____	$_____
IRA Income	$_____	$_____
Trust Income	$_____	$_____
Other Income	$_____	$_____
Total	$_____	$_____

Total Regular Monthly Income $ _____

ASSETS

Cash (Savings & Checking)	$_____	$_____
CDs, Money Markets, etc.	$_____	$_____
Stocks & Bonds	$_____	$_____
IRAs/ Annuities	$_____	$_____
House or Condo	$_____	$_____
Other Real Estate	$_____	$_____
Trust Fund	$_____	$_____
Life Insurance	$_____	$_____
Other Asset(s)	$_____	$_____
Total	$_____	$_____

Total Capital Asset $ _____

IF RESOURCES HAVE BEEN TRANSFERRED WITHIN 5 YEARS PRIOR TO THIS APPLICATION, ATTACH A SEPARATE PAGE WITH THE PARTICULARS. ALL APPLICANTS MUST SUBMIT MOST RECENT TAX RETURN.

HEALTH INFORMATION

CURRENT PRIMARY CARE PHYSICIAN (NAME): _____

PHONE: _____ FAX: _____

ADDRESS: _____

PSYCHIATRIST/PSYCHOLOGIST: _____

PHONE: _____ FAX: _____

ADDRESS: _____

SPECIALISTS (OTHER): _____

REASON FOR APPLYING TO SAMSON NURSING CENTER: _____

_____

_____

_____

_____

I HEREBY VOLUNTARILY MAKE APPLICATION FOR RESIDENCY AT SAMSON NURSING CENTER. I AND MY IMMEDIATE FAMILY WHO HAVE SIGNED BELOW, AFFIRM THAT ALL INFORMATION PROVIDED IS FACTUAL TO THE BEST OF OUR KNOWLEDGE AND AGREE TO ABIDE BY THE RULES AND REGULATIONS OF SAMSON NURSING CENTER.

DATE: _____

APPLICANT'S SIGNATURE: _____

SIGNATURES OF IMMEDIATE FAMILY AND/OR HEALTH CARE SURROGATE OR POWER OF ATTORNEY:

_____

_____

_____

_____

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