



## Admission Application

Merion Gardens considers all applicants without regard or discrimination for any legally protected class. Please complete this application in its entirety, as discrepancies or blanks may delay processing.

Date: \_\_\_\_\_ Name of applicant: (Last) \_\_\_\_\_

(First) \_\_\_\_\_ (Nickname/Preferred Name) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Marital Status: (check one) S M D W

Referred by: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Place of birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Religion: \_\_\_\_\_

Long term care insurance  No  Yes Carrier: \_\_\_\_\_

Veteran or qualified spouse of a veteran?  No  Yes

Medicare #: \_\_\_\_\_ A \_\_\_\_\_ B

Other medical insurance carrier & number: \_\_\_\_\_

Pharmaceutical insurance carrier & number: \_\_\_\_\_

Person(s) responsible for applicant (if applicable):

1. Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ State/Zip: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ State/Zip: \_\_\_\_\_

Where is the applicant currently residing? \_\_\_\_\_

If in health care facility what is the date of admission \_\_\_\_\_

Current Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Podiatrist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please list all other medical specialists treating applicant with name, specialty & phone# on back of page.

Does the applicant have an Advance Directive? (If yes, please provide a copy) Yes \_\_\_\_\_ No \_\_\_\_\_

Funeral Home preference: \_\_\_\_\_ Phone #: \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_

List all health care facilities where the applicant has received care in the past two years:

Facility	Admission Date	Discharge Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(List any additional admissions on back of this page)

1. Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Cell \_\_\_\_\_

2. Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Cell \_\_\_\_\_

3. Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Cell \_\_\_\_\_

## FINANCIAL DISCLOSURE

Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Cell \_\_\_\_\_

All residents must establish financial credibility with Merion Gardens. It is important that all financial resources be listed in order to meet all expenses incurred at Merion Gardens. Residents eligible for Medicaid are OBLIGATED TO SURRENDER to Merion Gardens the AMOUNT PRE-DETERMINED BY MEDICAID. Thank you for your cooperation in this matter.

	<u>Principle</u>	<u>Monthly Income</u>	<u>Bank/Institution</u>	<u>Account #</u>
Savings	_____	_____	_____	_____
Checking	_____	_____	_____	_____
Certificates	_____	_____	_____	_____
Trust Fund	_____	_____	_____	_____
Securities	_____	_____	_____	_____
Real Estate	_____	_____	_____	_____
Other	_____	_____	_____	_____
Total Assets	\$ _____		Total Liabilities	\$ _____

Gross Monthly Income (please include any deductions for insurance premiums or other deductions from monthly Social Security or pension payments):

Social Security: \_\_\_\_\_ Pension: \_\_\_\_\_ Insurance: \_\_\_\_\_

Other: \_\_\_\_\_ Total Monthly Income \$ \_\_\_\_\_

The undersigned hereby certify that I/we have read the above, that all statements made therein are true and complete to the best of my knowledge. The applicants authorize Mullica Gardens (or its agents) to verify the information contained herein. There are no liens, judgments, pending sales or bankruptcy proceedings against the applicant or the applicant's property. The applicant understands that Mullica Gardens, may at its option, cancel any admission granted if this application contains any false or misleading information, or if in its opinion, the credit investigation discloses an unsatisfactory record. Resident and sponsor agree to review the above financial information semi-annually or more often if needed to verify the continued ability to pay the account.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date: