

Snyder Village Health Center Application for Residency

1200 East Partridge St.
Metamora, Illinois 61548
(309) 367-4300

DATE _____

Please complete the following information for Applicant.

Applicant _____
First Middle Initial Last Maiden

Social Security # _____ Medicare # _____

Birth Date _____ Age _____ Sex _____ Marital Status: S ___ M ___ W ___ D ___

Birth Information: City _____ County _____ State _____

Present Home Address: _____
Street City/State Zip

Spouse (Even if Deceased): _____
First Middle Initial Last Maiden

Person Who Should Receive Statement (Guarantor):

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Name of Power of Attorney for Health Care _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name of Power of Attorney for Financial _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name of Legal Guardian _____ Phone _____

Address _____ City _____ State _____ Zip _____

Primary Emergency Contact:

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____

Alternate Emergency Contact:

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____

Medical Information

Current Primary Physician _____ Office Phone _____

Primary Physician While at S/V _____ Office Phone _____

Address _____

Specialist _____ Specialty _____

Address _____ Office Phone _____

Dentist _____ Office Phone _____

Eye Doctor _____ Office Phone _____

Hospital Preference _____ Phone _____

Funeral Home Preference _____ Phone _____

Do you have a living will? Yes _____ No _____

I DO _____ DO NOT _____ wish to have CPR procedures performed on me while a resident at Snyder Village.

Social Information

Have you ever been convicted of a felony? Yes ___ No ___

Race _____ U.S. Citizen Yes ___ No ___ U.S. Veteran Yes ___ No ___

Mother's Maiden Name _____ Father's Name _____

Lifetime Occupation _____ Date of Retirement _____

	<u>Grade School</u>	<u>High School</u>	<u>College</u>
Education: Highest Grade Completed:	1 2 3 4 5 6 7 8	9 10 11 12	1 2 3 4

Post Graduate _____ Tech/Trade School _____

Religion _____ Church Affiliation _____

Clergy _____ Phone _____

Has a Burial Trust been established? Yes ___ No ___ Value \$ _____

Insurance Information

• Do you have alternative Third Party Medicare coverage? Yes ___ No ___

Name of insurance company _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Policy # _____

• Do you have any Medicare Supplemental Health Insurance? Yes ___ No ___

Name of insurance company _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Policy # _____

• Do you have Medicare D coverage? Yes ___ No ___

Name of insurance company _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Policy # _____

• Do you have any employee provided insurance? Yes ___ No ___

Name of insurance company _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Policy # _____

• Do you have any Long-Term Care Insurance? Yes ___ No ___

Name of insurance company _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Policy # _____

Financial Information - all assets and income available for residency and care at Snyder Village

Sources of Income

Monthly

Social Security	Applicant	\$ _____
	Spouse	\$ _____
Pension	Applicant	\$ _____
	Spouse	\$ _____
Interest Income		\$ _____
Rental Income		\$ _____
Other sources of income		\$ _____

Bank Accounts

	Institution	Account #	Current Balance
Savings	_____	_____	\$ _____
	_____	_____	\$ _____
Checking	_____	_____	\$ _____
	_____	_____	\$ _____
CD/Money Market	_____	_____	\$ _____
	_____	_____	\$ _____
Trust	_____	_____	\$ _____
Other	_____	_____	\$ _____

Real Estate

Do you own your own home? Yes _____ No _____ How long? _____

Approximate Value \$ _____

Outstanding Mortgage \$ _____

Lender _____

Other real estate owned and approximate value _____

Financial Information (cont.)

Life Insurance policies

Company _____ Cash Value _____

Company _____ Cash Value _____

Stocks/Bonds, Mutual Funds, IRA's, 401K, Trusts, etc.

Company / Fund Name _____
Estimated Value \$ _____

Company / Fund Name _____
Estimated Value \$ _____

Company / Fund Name _____
Estimated Value \$ _____

Company / Fund Name _____
Estimated Value \$ _____

Trusts

Do you have a trust? Yes _____ No _____

If yes, is it revocable or irrevocable? Please circle and list amount \$ _____

Any Other Assets or Sources of Income

Description _____

Amount \$ _____

Obligations: (Please list any debts, mortgages, obligations, etc., affecting your income or assets.)

Amount \$ _____

Do the names of any other individuals appear on any of the above accounts? Yes _____ No _____

Within the past 60 months, have you or your spouse sold or given away assets, closed any bank accounts, or made any changes in the way an asset is held (such as adding a name to a house deed or creating a trust or annuity?) Yes _____ No _____

Within the past 60 months have you or your spouse: 1) Made any transfers from a revocable trust, or 2) created an irrevocable trust that does not permit payment to you? Do you or your spouse have an irrevocable trust that has stopped payment within the past 60 months? Yes _____ No _____

If you answer yes to either of these questions, please specify transactions made.

IMPORTANT: PLEASE BRING IN THE FOLLOWING FOR DUPLICATION, OR ATTACH A COPY

- | | |
|--|---|
| 1. Medicare Card (Red, white and blue card) | 4. Financial Power of Attorney, Guardianship
Conservatorship, or Bank Trust Papers |
| 2. Social Security Card | 5. Health Care Power of Attorney / Living
Will |
| 3. Other Health Insurance Identification Cards | |

AGREEMENT INFORMATION: HEALTH CENTER

I (we) further certify that all assets and income amounts are available for the use of the applicant(s) to be applied to expenses incurred by me (us) for any services provided by any entity of Snyder Village.

I (we) understand that my (our) submission of this application for residency at Snyder Village is not binding.

I (we) hereby give authorization to Snyder Village to review and discuss the intent of my (our) application with my family, physician and contact persons listed above.

I (we), the undersigned, do hereby certify that the answers to the foregoing questions are true, correct, and complete to the best of my (our) knowledge. I (we) do hereby authorize investigation of any statement contained in this application by Snyder Village or its agent. I (we) understand that a misrepresentation or omission of facts may be the basis for denying applicant(s) admission to or for discharge from Snyder Village. To insure payment to Snyder Village of any charges due, resident(s) or responsible party shall cooperate fully in furnishing Snyder Village any necessary financial, medical or other required information necessary for determination of eligibility for any aid or assistance program. I (we) or responsible party will further cooperate in the preparation, filing, signing, etc, of necessary applications, reports, or documents for any program or other purpose necessary or required by any government agency. Further, the I (we) or responsible party authorizes the release of information from any financial, housing or other institution necessary to make eligibility determinations.

Date

Applicant

Responsible Party

Snyder Village Health Center Release Form

TO WHOM IT MAY CONCERN:

The following paragraphs provide for the assignment of health insurance benefits and the release of certain information, which is required by Snyder village Health Center of Metamora, Illinois.

I acknowledge that this information will be considered confidential by Snyder Village and its agents and will not be transferred to any other person without first obtaining my written consent. I further declare that a photocopy of this authorization shall be considered as effective and valid as the original.

AUTHORIZATION FOR RELEASE OF INFORMATION AND MEDICAL RECORDS

I hereby authorize the release of all hospital and medical records including medical history, consultation or treatment, and other information regarding my condition as requested by Snyder Village Health Center of Metamora, Illinois.

AUTHORIZATION FOR RELEASE OF INFORMATION REGARDING INSURANCE BENEFITS

I hereby authorize my insurance company or companies to release information regarding the insurance benefits to which I am entitled for any medical, long term care, or supplemental health insurance benefits policy currently in effect. This information includes, but is not limited to, the scope and limits of coverage, possible exclusions, and effective date(s).

ASSIGNMENT OF BENEFITS

For any medical services or supplies provided to me by Snyder Village, I authorize Snyder Village Health Center to bill Medicare and/or my insurance on my behalf. I also assign all Medicare and/or health insurance benefits due or payable to me to be paid to Snyder Village Health Center from the date of my admission or from this date forward, whichever is applicable.

Signature of Applicant

Date

Legally Authorized Representative

**SNYDER VILLAGE HEALTH CENTER
2018 RATE SCHEDULE
EFFECTIVE JANUARY 1, 2018**

<u>CARE LEVEL</u>	<u>SEMI-PRIVATE ROOM RATE PER DAY</u>
SUB-ACUTE CARE	\$244
ADVANCED NURSING CARE	\$235
NURSING CARE	\$224
	<u>PRIVATE ROOM PER DAY</u>
	ADDITIONAL \$30.00

If a resident living in a semi-private room desires to buy-out the second bed to create a private room the buy-out room rate is 75% of the normal cost of the second bed. For example, if a resident's room rate is \$244/day; the buy-out rate would be \$427/day ($\$244 \times 75\% = \183 , so $\$244 + \$183 = \$427/\text{day}$).