BROOKSIDE CARE CENTER
LONG TERM CARE APPLICATION AND CONFIDENTIAL FINANCIAL DISCLOSURE

Name:_____ Date of Birth: _____
First Middle Last

☐ Never Married ☐ 1st Marriage ☐ 2nd + Marriage ☐ Widowed ☐ Divorced

Current Residence Address:_____
Street City State Zip Code

☐ House ☐ Condo ☐ Apartment ☐ Senior Apartment

☐ Assisted Living Facility _____ ☐ Skilled Nursing Facility _____

Landline Phone:_____ Mobile Phone:_____ Work Phone:_____

E-mail:_____

CONTACTS/RESPONSIBLE PARTY:

1) Name:_____ Relationship:_____

Home Address:_____
Street City State Zip Code

Landline Phone:_____ Mobile Phone:_____ Work Phone:_____

E-mail:_____

☐ Responsible Party ☐ Billing Contact ☐ POA Health Care ☐ POA Finance

2) Name: :_____ Relationship:_____

Home Address:_____
Street City State Zip Code

Landline Phone:_____ Mobile Phone:_____ Work Phone:_____

E-mail:_____

☐ Responsible Party ☐ Billing Contact ☐ POA Health Care ☐ POA Finance

LEGAL RESPONSIBILITY (check all that apply):

☐ Power of Attorney for Health Care (Durable)

_____ _____
Primary Agent Alternate Agent

Activated: ☐ Yes ☐ No If yes, date activated:_____

☐ Power of Attorney for Finances (Durable)

_____ _____
Primary Agent Alternate Agent

☐ Court Appointed Guardian _____
Name of Guardian

Copies of applicable documents must be presented at time of admission.

MEMBERS OF HOUSEHOLD:

☐ I live alone (completion of this section is not necessary) ☐ I live with others.

Enter the name and relationship of all people living in your household. Check yes or no to identify if they contribute to payment of household expenses.

Name	Relationship	This person assists with expenses	
		Yes	No

EMPLOYER:

☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Disabled ☐ Retired

Employer:_____

Address:_____ Phone:_____
Street City State Zip Code

BENEFITS INFORMATION:

Social Security #:_____

☐ Medicare
☐ Primary ☐ Secondary

Medicare#:_____

Do you have Medicare Part A? ☐ Yes ☐ No Medicare Part B? ☐ Yes ☐ No

Do you have Medicare Part D? ☐ Yes ☐ No If no, other prescription coverage? ☐ Yes ☐ No
If yes, name of prescription plan:_____

☐ Medicare Supplement

Provider:_____ Identification#:_____ Group #:_____

☐ Medicare Advantage/Replacement

Provider:_____ Identification#:_____ Group #:_____

☐ Commercial Insurance
☐ Primary ☐ Secondary

Provider:_____ Identification#:_____ Group #:_____

☐ Title 19 (Medicaid)
☐ Primary ☐ Secondary

If yes: Title 19 #:_____ Effective Date:_____
If no, have you applied for Title19 or made an appointment to apply? ☐ Yes ☐ No
If yes: Appointment Date:_____ Case Worker Name:_____

☐ Veteran's Administration Primary Plan
Brookside Care Center is not a VA contracted provider.

☐ Long Term Care Insurance

Provider:_____
Address:_____
Street City State Zip Code
Phone Number:_____
Identification#:_____ Group #:_____

INCOME/ASSETS:

Monthly Itemized Gross Household Income	Applicant	Spouse/Other
Salaries and Wages		
Pension		
Retirement Funds		
Interest and Dividends		
Social Security		
Disability		
Public Assistance		
Rental Payments (rent from property you own)		
Other: _____		
Total Monthly Gross Income		

Savings/Checking/Investments	Name of Institution/Company	Current Value	Ownership
Savings Account			☐ Self ☐ Joint
Checking Account			☐ Self ☐ Joint
CD			☐ Self ☐ Joint
Pension, Retirement Accounts, IRA, Deferred Compensation, 401K, etc.			☐ Self ☐ Joint
Total Savings/ Checking/Investments			

Real Estate Assets	Fair Market Value	Mortgage Balance	Net Value	Ownership
Primary Residence				☐ Self ☐ Joint ☐ Trust
Business Property				☐ Self ☐ Joint ☐ Trust
Income Property				☐ Self ☐ Joint ☐ Trust
Other				☐ Self ☐ Joint ☐ Trust
Total Real Estate Net Value				

If real estate assets are held in a trust, is the trust revocable or irrevocable? _____
Are any real estate assets bound by a reverse mortgage? ☐ Yes ☐ No

Business Interest/Ownership	Type of Business	Ownership	% Ownership
		☐ Self ☐ Joint ☐ Trust	
		☐ Self ☐ Joint ☐ Trust	

Life Insurance Company	Cash Surrender Value	Face Value (Death Benefit)	Beneficiary
Have you pre-paid funeral arrangements? ☐ Yes ☐ No			

LIABILITIES:

Lender		Balance Due	Ownership
			☐ Self ☐ Joint
			☐ Self ☐ Joint
			☐ Self ☐ Joint
Total Liabilities			

TRANSFER/DISPOSAL OF PROPERTY/ASSETS:

Have you disposed of (sold, given away or destroyed) any assets (real estate, automobiles, cash, investments, etc.) in the last 5 years? ☐ Yes ☐ No

If yes, record transactions below:

Property/Asset	Date of Disposal	Fair Market Value on Date of Disposal	Ownership
			☐ Self ☐ Joint
			☐ Self ☐ Joint
			☐ Self ☐ Joint
Total Transfer/Disposal of Property/Assets			

BANKRUPTCY/LITIGATION:

Have you ever filed for bankruptcy? ☐ Yes ☐ No

If yes, provide current status _____

Are you a party in any lawsuit or litigation? ☐ Yes ☐ No

If yes, identify the lawsuit of litigation _____

DECLARATION:

Each undersigned represents and warrants that the information provided is true and correct and authorizes Brookside Care Center to make all inquiries deemed necessary to verify the accuracy of the statements made herein and to determine individual or joint financial position. The Financial Agent is not held liable by Brookside Care Center to any extent other than to provide financial information.

Signed: _____

Applicant Date

Signed: _____

Spouse (if applicable) Date

Signed: _____

Financial Agent (if applicable) Date