APPLICATION FOR RESIDENCY

Thank you for your interest in joining our community at Willowbrook Assisted Living. Please complete and return this application to 3508 Washington Road, Kenosha, WI 53144. Upon receipt of your completed application, a member of our staff will contact you. All information will be kept confidential.

GENERAL INFORMATION — Please print

Name: _____ Social Security # _____
First Middle Last

Address: _____ City: _____ State:_____ Zip: _____

Telephone: (h) _____ (c) _____ Email: _____

Birthdate: _____/_____/_____ Current/Former Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

CURRENT LIVING SITUATION

Where do you currently live?

☐ Senior Complex ☐ Assisted Living Facility ☐ Skilled Nursing Facility ☐ Group Home

If you live in one of these, please indicate where: _____

☐ Apartment ☐ House/Condo (Do you own your home or rent? ☐ Own ☐ Rent)

Do you currently live alone?

☐ No: Who do you live with? _____

☐ Yes: Do you use any supportive services (e.g. Meals on Wheels, home health care, transportation)?

Please indicate services you use, if applicable: _____

Why are you considering assisted living? _____

_____

EMERGENCY CONTACTS

Name #1: _____ Relationship: _____

Address: _____ Phone: (_____)_____

Name #2: _____ Relationship: _____

Address: _____ Phone: (_____)_____

DAILY LIVING

How do you enjoy spending your time? What hobbies do you have? _____

_____

Please describe yourself in the following areas in whether you need none, some, or full assistance:

	None	*Some*	*Full*		*None*	*Some*	*Full*
Bathing……	☐	☐	☐	Laundry……	☐	☐	☐
Dressing……	☐	☐	☐	Shopping……	☐	☐	☐
Eating……	☐	☐	☐	Toileting……	☐	☐	☐
Finances……	☐	☐	☐	Transportation…	☐	☐	☐
Housekeeping…	☐	☐	☐	Walking……	☐	☐	☐

What other assistance do you feel you need? _____

What special equipment or devices do you require? _____

MEDICAL AND INSURANCE INFORMATION

Primary Care Physician's Name: _____ Phone: (_____)_____

What medical/health conditions do you have? _____

What medications are you taking at this time? _____

_____

Do you require others to assist you with your medications by:

Reminding you to take medications?	☐ Yes	☐ No
Setting up your medications for you?	☐ Yes	☐ No
Helping administer your medications?	☐ Yes	☐ No

Do you require assistance with a special diet? Yes ☐ No ☐ Describe: _____

Do you smoke? Yes ☐ No ☐ Note: Willowbrook Assisted Living is a non-smoking facility/property.

Please list all your medical insurances, including supplemental and long term care:

_____

_____

Have you previously been admitted to a residence facility? ☐ Skilled Nursing (Nursing Home)

☐ Mental Health/Psychiatric ☐ Rehabilitation ☐ Developmentally Disabled ☐ Other

Name of facility, if applicable: _____

Dates of stay: _____ Reason: _____

Have you had a hospital stay within the previous 6 months? Yes ☐ No ☐

If yes: Hospital: _____ Dates of stay: _____

Reason: _____

LEGAL RESPONSIBILITY (Check all that apply)

☐ Power of Attorney for Health Care (Durable)

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

_____ _____

Responsible Agent (Primary) Responsible Agent (Alternate)

☐ Power of Attorney for Finances (Durable)

_____ _____

Responsible Agent (Primary) Responsible Agent (Alternate)

☐ Court Appointed Guardian Name of Guardian: _____

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

FINANCIAL INFORMATION

Willowbrook Assisted Living has a monthly rate between $4,995 and $7,095 plus the cost of additional services and fees. Applicants are responsible for providing financial information demonstrating that they have sufficient financial resources available to allow residency for two years minimum. Willowbrook does not accept Medicaid waiver programs, such as Family Care, Family Care Partnership, IRIS, Community Options Program Waiver (COP), or Community Integration Program Waiver (CIP). We do accept long-term care insurance.

Please complete the attached Confidential Financial Statement and submit with this application.

I understand and agree that this application is neither a contract nor a reservation for residence. Nothing contained in this document obligates or entitles me to a room at Willowbrook Assisted Living until a Residency Agreement has been signed by all parties involved. I certify that all of the information that I have given on this application is correct and complete and hereby authorize Willowbrook Assisted Living to make any inquiries necessary to evaluate my eligibility to reside at Willowbrook Assisted Living.

Signature of Applicant: _____ Date: _____

Is there someone helping you with your application? If so, may we contact them? Yes ☐ No ☐

Name: _____ Relationship: _____

Address: _____ Email: _____

Phone: (_____)_____ Cell: (_____)_____ Work: (_____)_____

CONFIDENTIAL FINANCIAL STATEMENT

For purposes of applying for admission to **WILLOWBROOK** ("Facility"), I am providing the following complete and accurate description of my financial condition.

Name: _____

Date of Birth: _____

Address: _____

Marital Status: _____ If married, name of spouse:_____

INCOME: Please identify your monthly income. If you are married, include the income of your spouse. If you receive a type of income that is not listed, use the "other" category to identify this income. Unless expressly noted, you represent that all income is available to pay for your care and/or services. All boxes should be completed. If a source of income is not applicable, mark "N/A" in the box. Please use additional pages as necessary.

Monthly Income	*Applicant (per month)*	*Spouse (per month)*
Social Security	$	$
Veterans Benefits	$	$
SSI (Supplemental Security Income)	$	$
Alimony	$	$
Unemployment Compensation	$	$
Pension	$	$
Retirement Plans	$	$
Disability Plans	$	$
Income from Stocks and Bonds	$	$
Rental Income Paid to You	$	$
Annuities	$	$
Trust Fund	$	$
Interest Income from Savings	$	$
Other: _____	$	$
Total Monthly Income	$	$

ASSETS. Please list your current assets. If an asset is owned by a trust, indicate the name and type of trust in the owner column. If an asset is jointly owned, identify the other owners and your percentage of ownership. Unless expressly noted, you represent that the listed assets are available to pay for your care and/or services. All boxes should be completed. If an asset type is not applicable, mark "N/A" in the owner and amount box. Please use additional pages as necessary.

Assets	*Owner* (applicant, spouse, jointly, trust) If jointly, identify co-owner. If trust, identify name of trust.	*Amount*
Checking Account Name of Bank:_____ Interest Bearing: Yes No Account #_____		$
Additional Checking Account Name of Bank:_____ Interest Bearing: Yes No Account #_____		$
Savings Account Name of Bank:_____ Account #:_____		$
Additional Savings Account Name of Bank:_____ Account #:_____		$
Cash on Hand		$
Stocks Description:_____		$
Bonds Description:_____		$
Certificates of Deposit		$
Money Owed to You		$
Real Estate Owned Description:_____		$
Land Contract		$
Farm Equipment		$
Livestock		$
Vehicles		$
Burial Trust		$
Other: _____		$

TRANSFER OF ASSETS: Please identify any assets or other financial resources worth over $5,000 that you have given away or sold for less than fair market value within the last five years. Please use additional pages as necessary.

Description of What Was Sold or Given Away: _____

By Whom:_____

To Whom:_____

Date of Gift or Sale:_____

Total Market Value:_____

Amount Received:_____

LIABILITIES: Indicate any significant liabilities that you owe. All boxes should be completed. If a liability is not applicable, mark "N/A" in the amount box. If a liability type is not listed, please use the "other" category to identify those liabilities. Please use additional pages as necessary.

Liabilities	Amount
Credit Cards	$
Taxes	$
Medical Bills	$
Mortgage	$
Loans: Describe: _____	$
Health Insurance Costs	$
Other: Describe: _____	$

POWER OF ATTORNEY FOR FINANCES:

Do you have a Power of Attorney for Finances: Yes___ No___

If yes, please provide name of agent:_____

MEDICARE:

Are you enrolled in Medicare Part A? Yes __ No __

If you are not eligible, do you have an equivalent insurance policy? Yes __ No __

Do you have a supplemental Medicare policy ("Medigap")? Yes, describe: _____ No ___

LONG-TERM CARE INSURANCE:

Do you have long-term care insurance? Yes __ No __

If yes, provide name of insurance company:_____

Primary Insurance:_____ Secondary Insurance:_____

LIFE INSURANCE:

Do you have life insurance? Yes __ No __ If yes, provide the following:

Cash Value: _____

Face Value: _____

Company Name: _____

Date Issued: _____

ACKNOWLEDGEMENT:

By signing this form, I represent and warrant that the above information is true and correct and accurately reflects my financial condition and the resources that are available to pay for my care and/or services. I understand that Facility will be relying on the information provided herein and may terminate any and all agreements with me if I provide false or misleading information. I further give Facility permission to verify the information provided herein. I also understand that I may be required to provide supporting documentation regarding the financial data I have provided and provide updated financial information and agree to do so upon request. I believe I have adequate resources to meet my financial responsibilities, including those that will attach if I am accepted into Facility.

_____ _____

Signature of Prospective Resident Date

If prospective resident is unable to sign, complete the following:

Name of Resident Representative: _____

Authority to Act: _____

Address: _____

Home Telephone Number: _____

Work Telephone Number: _____

_____ _____

Signature of Resident Representative Date

FOR OFFICE USE ONLY:

Received on _____

By _____