



**THE OAKS**  
AT MENORAH PARK

Date of Application: \_\_\_\_\_

Please circle desired level of care

- The Oaks
- The Inn
- Jewish Health & Rehabilitation Center

## Menorah Park Application for Residency

Please complete for Prospective Resident

Primary	Secondary Applicant (if applicable)		
Street Address	(only if different from primary)		
City	State	Zip	
Home Phone			
Cell Phone			
Social Security Number			
Medical Number			
Secondary Insurance			
Carrier			
Subscriber Number			
Date of Birth			

### Emergency Contact Information

Primary Emergency Contact			
Name			
Street Address			
City	State	Zip	
Home Phone			
Cell Phone			
Work Phone			

## Secondary Emergency Contact Information

Name

Street Address

City

State

Zip

Home Phone

Cell Phone

Work Phone

Email

## Primary Physician

Name

Address

Phone

Fax

Email

## Secondary Physician

Name

Address

Phone

Fax

Email

Hospital of Preference: \_\_\_\_\_

## Advanced Directives

Does Resident have any of the following completed? (If yes, please provide copies)

- Health Care Proxy? (HCP)                      YES                      NO
- Living Will    YES                      NO
- Do Not Resuscitate (DNR)                      YES                      NO
- Power of Attorney (POA)                      YES                      NO

Name and Address of POA

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Phone Numbers

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**Financial Information**

Income - Monthly Breakdown	Applicant	Secondary Applicant
Social Security		
Pension		
Other Pension		
Dividends		
Interest		
IRA		
Trust		
Rental Income		
Other Income		
<b>Total Monthly Income</b>		

Income - Monthly Breakdown	Applicant	Secondary Applicant	Bank/Investment Company
Total Real Estate			
List Addresses			

Checking Account		
Savings Account		
CD's		
Maturity Date		
Total Value of IRA or Annuity		
Cash Value of Life Insurance		
<b>Total Cash Assets</b>		

Please list any debts (including Mortgage balances)

Has the applicant (or Co-Applicant) created a Trust?                      YES                      NO

Date Trust was established?

Is the money in this trust available to pay for additional services for the Applicant or Co-Applicant?

YES                      NO

Please list any transfer of assets within the past five years:

Asset Transferred	Value of transferred Asset	Date of Transfer

Does Applicant (Co-applicant) have Long Term Insurance?      YES                      NO

Applicant (or POA) responsible to obtain claim form.

Carrier \_\_\_\_\_

Policy Number \_\_\_\_\_

Daily Benefit \_\_\_\_\_

Length of Coverage \_\_\_\_\_

To whom should the monthly bills be sent?

Name

Street Address

City

State

Zip

Home Phone

Cell Phone

Work Phone

Email

**Financial Disclosure Statement:**

Both Federal and State laws impose severe penalties for obtaining Medicaid fraudulently. Please note that Federal Law prohibits the transfer of most assets for 60 months prior to applying for Medicaid. This signed application represents accurate disclosure of all assets.

This Menorah Park Application for Residency may be used in the future to substantiate any future Medicaid application.

I hereby declare that the application represents true and accurate information; I understand that I may be asked to provide supportive documentation to verify this information. Menorah Park reserves the right to have this application updated at lease renewal or prior to a move into the Jewish Health and Rehabilitation Center.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Co-Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Menorah Park Administrator \_\_\_\_\_ Date \_\_\_\_\_