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

Phone Numbers

Financial Information

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

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		
Total Cash Assets		

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 _____