



Interest from Bank Accounts \$  
Stock Dividends \$  
Other Income (Please specify.) \_\_\_\_\_ \$  
Total Monthly Income \$

**ASSETS:**

**Checking Account(s):**

Bank: \_\_\_\_\_ Balance: \$  
Is this a joint account? \_\_\_ yes \_\_\_ no  
Bank: \_\_\_\_\_ Balance: \$  
Is this a joint account? \_\_\_ yes \_\_\_ no

**Savings Account(s):**

Bank: \_\_\_\_\_ Balance: \$  
Is this a joint account? \_\_\_ yes \_\_\_ no  
Bank: \_\_\_\_\_ Balance: \$  
Is this a joint account? \_\_\_ yes \_\_\_ no

**Certificates of Deposit:**

Bank/Financial Institution \_\_\_\_\_ Amount: \$

**Real Estate:**

Does applicant own a home or other property? \_\_\_ Est. Value: \$  
Is the home jointly owned with anyone? \_\_\_ yes \_\_\_ no  
Does applicant plan to sell home or other real estate to pay for nursing home costs? \_\_\_ **yes** \_\_\_ **no**

**Other Assets (Stocks, etc.) Please list.**

(1) \_\_\_\_\_ \$  
(2) \_\_\_\_\_ \$

**Have any assets been transferred in the last 36 months?** \_\_\_ **yes** \_\_\_ **no**

If \_\_\_\_\_ yes, \_\_\_\_\_ please \_\_\_\_\_ describe:

**Has an estate trust been established?** \_\_\_ yes \_\_\_ no If yes, please provide a copy.

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**III. INSURANCE INFORMATION**

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Social Security # \_\_\_\_\_ Medicare # \_\_\_\_\_ Part A: \_\_\_ Part B: \_\_\_  
Medicaid #: \_\_\_\_\_ County: \_\_\_\_\_  
Medicaid Application Pending? \_\_\_ yes \_\_\_ no If yes, date submitted: \_\_\_\_\_ Other \_\_\_\_\_

Hospitalization and Medical Insurance:

Name of Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #:

Prescription Card?  yes  no Name of Ins. Co.: \_\_\_\_\_ Card #:

**Note: Please attach a copy of all insurance cards with this application.**

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**IV. PLAN OF PAYMENT:**

Own assets  Medicaid

Other (Please specify.)

Person who will handle or assist with the financial affairs of the applicant:

Name: \_\_\_\_\_ Relationship:

Address:

Phone #: Home \_\_\_\_\_ Work \_\_\_\_\_

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To the best of my knowledge, all of the information provided herein is correct and valid. I understand that the accuracy of the information contained on this application form will be used for the purpose of determining when the resident may need financial assistance. I hereby give Good Samaritan Lutheran Health Care Center permission to verify information supplied on the Application for Admission and further agree that the funds listed will be for the care of the applicant during his/her residency at Good Samaritan Lutheran Health Care Center.

*The information provided shall remain confidential and shall be made available only to authorized Good Samaritan Lutheran Health Care Center personnel.*

*In accordance with Federal and State Law, Good Samaritan Lutheran Health Care Center shall not discriminate on the basis of race, creed, color, national origin, handicap, age, blindness, sex, sexual preference, or sponsorship in the admission, retention and care of residents*

**Signature of Applicant or Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_