Application for Residency

Guidelines

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1. Tour our community: Waunakee Manor's living options are viewable online at www.WaunakeeManor.com, but even more details are available during a tour of our campus. If you haven't already taken a tour, we encourage you to come visit us! To schedule an appointment, call **608-849-5016**.

2. Apply: This document may be printed and filled out by hand, **or your answers may be typed into the fillable PDF and then printed**. You will want to be equipped with the following information regarding the applicant(s):

- *Numbers for Social Security and Medicare*
- *Policy information for health insurance and long-term care*
- *Contact information for the applicant's primary care physician*
- *Contact information for healthcare power of attorney, if applicable*
- *Information regarding income, assets, liabilities, and financial institution(s)*

3. Submit: Mail, fax, or deliver your completed application to:

Waunakee Manor
Attn: Marketing Director
801 South Klein Drive
Waunakee, WI 53597

PHONE: (608) 849-5016
FAX: (608) 850-4689

or email your application to marketing@waunakeemanorhc.com

Applications are reviewed by the Executive Director. Acceptance of an application does not guarantee placement, and all prospective residents of Waunakee Manor will be subject to a pre-admission assessment.

Thank you for your interest in Waunakee Manor!

Application for Residency

(PLEASE CHECK): Nursing Home _____ AL (CBRF)_____ Studio _____
IL_____ AL (RCAC)_____ 1 Bedroom_____
2 Bedroom_____
Duplex _____

How did you hear about us? Billboard _____ Online _____
Print Ad_____ Friend/Family_____
TV_____ Radio _____
Other_____

This application must be fully completed in order to be placed on the waiting list for admission. Please complete application and return it to the community as soon as possible (faxed copies are acceptable). If there are any questions, please contact the Marketing Director at Waunakee Manor.

GENERAL INFORMATION Date Completed: _____

1. Applicant_____
Last Name First Name Middle Name

2. Applicant's Permanent Address:

_____
Street

_____
City County State Zip

_____
Phone (Area Code)

3. Gender:_____ 4. Birthdate _____ Age_____ 5. Birthplace _____

6. Marital Status _____ 7A. Current/Previous Occupation _____
7B. If retired: Year Retired _____

8. Medicare Number: _____
Other Insurance Name: _____
Insurance Group #: _____ Subscriber ID #: _____
Other Insurance Phone #: _____

***Note: Filing of private insurance is applicant's responsibility.

9. Social Security Number: _____
10. Hospital preference: _____

11. Education level: _____

HEALTH INFORMATION:

12. Physician _____ Phone _____

    Address: _____
    Street City State Zip

13. Diagnosis: _____

14. Has applicant fallen in the last six (6) months? ____ Yes ____ No
    If Yes, when? _____

15. List any Nursing Home stays in the last 5 years (Including Dates):
    _____

    Were any of these nursing home stays Medicare covered? _____ Yes _____ No

    List any hospital stays in the last 12 months (Including Dates):
    _____

    Failure to report any hospital and/or nursing home dates of service can result in miscalculation of available Medicare days in which applicant/responsible party will be held liable for uncovered days.

16. In case of emergency notify: (List in order of priority)
    1. _____
       Name
       _____
       Address City State Zip
       _____
       Home Phone Business Phone Cell Phone Relationship
    2. _____
       Name
       _____
       Address City State Zip
       _____
       Home Phone Business Phone Cell Phone Relationship

    Will applicant be handling his/her own financial matters while at the Health Care Center?
    _____ Yes _____ No

    Will an emergency contact be handling applicant's financial matters while at the Health Care Center?
    _____ Contact 1 _____ Contact 2 _____Other

ADDITIONAL INFORMATION:

17. Dentist: Name _____ Phone _____

18. Religion: _____ None _____
    Church: _____ Phone _____

19. Funeral Home: _____ Phone _____

20. Has applicant executed any Advance Directives (i.e. Power of Attorney – health care, finances, Declaration to Physician)? _____ Yes _____ No

If Yes, please describe and list who the designated agent is: _____

21. Has the Health Care Power of Attorney been activated and/or applicant been declared incapacitated by two doctors? _____ Yes _____ No

22. **FINANCIAL:** (this information will be kept confidential)

Do you rent _____ Own your home _____ Approximate value $_____

Monthly income is:

1. Social security $_____
2. Private pension $_____ Company _____
3. Annuities / trust funds $_____ Company _____

Total Monthly $_____ x 12 months = $_____

Yearly income from other source(s):

Earnings from savings accounts and certificate of deposit $ _____

Dividends from stocks, bonds and misc. securities $ _____

Total approximate yearly income $ _____

Assets:

Stocks and bonds $ _____

Cash (savings & checking) $ _____

Real estate (including home) $ _____

C.D.s $ _____

Other $ _____

Total assets: $ _____

Liabilities:

Mortgage $ _____

Personal loans $ _____

Other obligations $ _____

Total liabilities: $ _____

Net worth: $ _____

Irrevocable burial trust fund $ _____

Signature: _____ Date: _____
(Guarantor/POA)

Has the applicant transferred any assets more than $5,000 in value such as real estate (including home, stock, bonds, or other assets to another person without consideration in the last 2 ½ years?
_____ Yes _____ No Please Explain: _____

____

Have you or anyone in the past two years made application for this person to be on Medicaid?
Yes _____ No_____
Does the applicant have an acceptance for Medicaid? Yes_____ No_____
Has the applicant been rejected from Medicaid? Yes_____ No_____
Have you filed an appeal? Yes_____ No_____

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In completing this application, I am aware that Waunakee Manor will reply upon, and is entitled to reply upon, the accuracy of my statements. I understand that I may be requested to update this application when the Community considers it appropriate. Falsified information may result in denial of application. Therefore, I DECLARE THAT THE INFORMATION GIVEN IN THIS APPLICATION IS TRUE, FULL, AND COMPLETE AND THAT THE ASSETS LISTED ARE AVAILABLE FOR MY CARE.

I give consent to verify information contained in this application.

I understand that medical information may be obtained as part of the pre-admission process and allow for the release of this information as needed.

Preparer's Signature _______________________________________ Date: __________________

Applicant's Signature _______________________________________ Date: __________________

Waunakee Manor reserves the right to accept or deny any applicant for admission. Guidelines for acceptance and participation in Waunakee Manor programs are the same for everyone without regard to race, sex, religion, sexual orientation, national origin or ancestry, age, disability, marital status or physical appearance, or any other basis prohibited by local, state or federal laws, rules or regulations. Waunakee Manor is an Equal Housing Opportunity community which adheres to all state and federal fair housing laws. Waunakee Manor is a smoke-free community.

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Received by: ____ Date: ___________________

Approved by: ____ Date: ___________________