Hughes Health & Rehabilitation

Caring for loved ones. *Family style*

YOU HAVE CONTACTED THIS NURSING HOME AND INDICATED A DESIRE TO BE ADMITTED AS A RESIDENT TO THIS FACILITY. BECAUSE OF THIS, YOU HAVE ALREADY BEEN ISSUED A RECEIPT INDICATING THE DATE AND TIME OF YOUR INITIAL REQUEST AND YOUR NAME HAS BEEN PLACED ON OUR DATED LIST OF APPLICATIONS OR INQUIRY LIST.

PLEASE FIND ENCLOSED THIS FACILITY'S WRITTEN APPLICATION FORM. AS SOON AS YOU SUBSTANTIALLY COMPLETE AND RETURN THE FORM TO THE FACILITY, YOUR NAME WILL BE PLACED ON OUR WAITING LIST FOR ADMISSION TO THE FACILITY. YOUR NAME WILL BE PLACED ON OUR WAITING LIST ONLY AFTER YOU SUBSTANTIALLY COMPLETE AND RETURN THIS WRITTEN APPLICATION FORM TO US.

Hughes Health and Rehabilitation, Inc.

Application for Admission

Full name: ____________________
First Middle Last

Present address: ____________________

____________________ Telephone: ____________________

Social security number: __________ Date of birth: __________ Place of birth: __________

Primary language: ____________________ Do you speak English? __________

Are you an United States Citizen? ____ Yes ____ No Do you have a Green Card? ____ Yes ____ No

Green Card Number: ____________________ Green Card Exp Date: ____________________

Marital status: ________ Name of spouse: ____________________ (If Living)

Military service (Applicant or spouse): ____________________ Please specify branch: ____________________

Do you have a service-connected disability? ____ Yes ____ No

Veteran's service number and/or claim number: ____________________

Please check preferred contact:

1st Emergency Contact: ____________________ Relationship: ____________________

Address: ____________________

____

Phone: ____________________ (preferred) ____________________ (other)

Email: ____________________

2nd Emergency Contact ____________________ Relationship ____________________

Address: ____________________

____

Phone: ____________________ (preferred) ____________________ (other)

Email: ____________________

3rd Emergency Contact ____________________ Relationship ____________________

Address: ____________________

____

Phone: ____________________ (preferred) ____________________ (other)

Email: ____________________

Are you or your spouse currently working? ____ Yes ____ No

Your occupation (before retirement): ____________________ Date retired: __________

Your education: ____________________ Where have you lived most of your life? ____________________

Current living arrangements: ____________________

Your religion: ____________________ Active: ____ Yes ____ No

Church/Synagogue: ____________________

Funeral home: ____________________ Cemetery: ____________________

Name and address of present physician: ____________________

Will this physician continue your care if you are admitted? ________ Yes ________ No

Do you have any specialist physicians? If so, who? ____________________

____

____

Hospital preference: ____________________

Please give dates and nature of any major illnesses or operations you have experienced: ____________________

____

____

Have you been seen within the last two (2) years by an opthalmologist or an optometrist for vision testing? ________

If yes, please state who and when: ____________________

Have you ever lived in a place like Hughes Health and Rehabilitation before? ________ Yes ________ No

If yes, please state where and when: ____________________ from ________ to ________

Have you ever been treated for any nervous or emotional disorder?

If yes, please state where and when: ____________________ from ________ to ________

Have you ever been treated for: Alcohol abuse ________ Drug abuse ________ Other ________

If yes, please state where and when: ____________________ from ________ to ________

Can you completely care for yourself without assistance? ________ Yes ________ No

If not, in what way do you need assistance? ____________________

____

Medicaid number: ____________________ Worker's name: ____________________

Medicare number: ____________________ ☐ Part A ☐ Part B

Med D company: ____________________ Med D ID number: ____________________

Other insurance: ____________________ ____________________
Name Number

Do you have a long-term care insurance policy? ________ Yes ________ No

If yes: ____________________ ____________________
Name Number

Name of person responsible for the account: ____________________

Mail bills to: ____________________

____

________ (H): ________ (W) ________ (Cell)

How were you referred to Hughes Health and Rehabilitation, Inc.? ____________________

Other remarks:

Hughes Health and Rehabilitation, Inc.
Confidential Financial Statement

Resident's Name

HUGHES HEALTH AND REHABILITATION, INC. needs a complete accounting of the following information in order to ensure that timely decisions are made concerning payment for your care.

FINANCIAL INFORMATION

Social Security #: ____________ Medicare #: ____________ Medicaid (TXIX) #: ____________

Does applicant have an application pending for State Medicaid (TXIX)? Yes: ________ No: ________

If so, who is the Caseworker? ____________________ What DSS office? ____________

Other Medical/Hospital Insurance

Name of Company	Subscriber/Group #	Type of Insurance

Life Insurance

List all life insurance policies face amounts and cash surrender value amounts.

Name of Policy	Face Amount	Cash Surrender Value
	$	$
	$	$

Funeral Account

Has the applicant established an irrevocable burial account? Yes: ______ No: ______

If so, with what Funeral Home? ____________________

Amount currently in Funeral Account $ ____________________

Income

Social Security $ ________ /Mo. Check is being mailed or direct deposit to: ____________

Pensions $ ________ /Mo. Check is being mailed or direct deposit to: ____________

Source ____________________

$ ________ /Mo. Check is being mailed or direct deposit to: ____________

Source ____________________

VA Benefits $ ________ /Mo. Check is being mailed or direct deposit to: ____________

Annuities $ ________ /Mo. Check is being mailed or direct deposit to: ____________

Source ____________________

Interest $ ________ /Mo. Check is being mailed or direct deposit to: ____________

Source ____________________

Dividends $ ________ /Mo. Check is being mailed or direct deposit to: ____________

Source ____________________

Other Income $ ________ /Mo. Check is being mailed or direct deposit to: ____________

Source ____________________

Trusts

Do you receive income from or have any interest in any trust? Yes: ______ No: ______

If yes, please describe and provide a copy of the trust instrument. ____________________

Assets

If any asset is jointly held, please give name of joint owner. ______________________

Real Estate

Does applicant own any real estate? Yes: _______ No: _______

Address of Property	Description of Property	Approximate Value	Name(s) on Deed
		$	
		$	

Are there any liens or mortgages against the property? Yes: _______ No: _______

If so, please list which property, amount of Lien and the name of Lien-holder. ______________________

Was this real estate your home prior to entering to nursing home? Yes: _______ No: _______

Is your spouse now living in the home? Yes: _______ No: _______

Do you have a "life use" of any real estate? Yes: _______ No: _______

If so, what address and who owns the property now? ______________________

Cash Assets

Please list all assets including but not limited to: Savings and Checking Accounts, Stocks, Bonds, C.D's

Name of Institution	Account #	Present Balance
		$
		$
		$
		$

Transfer of Assets

Within 60 months prior to the date of this application, have you given away assets of any kind (cash, securities, real estate, etc.) or transferred assets of any kind (cash, securities, real estate, etc.)? Yes: _______ No: _______

If yes, please describe fully all such gifts or transfers of $1,000 or more, including the asset transferred, names, addresses and relationship to you of the person to whom the gift or transfer was made, and the value of the gift or transfer. ______________________

Within 60 months prior to the date of this application, have you created any trusts or placed funds or any other assets in a trust that already existed? Yes: _______ No: _______

If yes, please describe and provide a copy of the trust instrument. ______________________

I hereby certify that this is a true and complete statement of the applicant's current income and assets and any gifts or transfers of $1,000 or more and any trusts created or transfers of assets to any trust that they have made within the 60 months (5 years) prior to the date of this application.

Resident's Signature

Responsible Party's Signature

Date

Date

HUGHES HEALTH REHABILITATION, INC.

Required Admission Information

Please supply the following information either prior to or on the day of admission:

1. Power of Attorney (copy)
2. Conservator (copy)
3. Emergency contact person - name, address, telephone number(s)
4. Medicare Card or copy (both sides)
5. Social Security Card or copy (both sides)
6. Any other current Insurance Cards or copies (both sides)
7. Health care Directives or copies:
   - Living Will
   - Health Care Agent
   - Durable Power of Attorney
8. Military Service Information. It is important that information on the application regarding Military Service is answered. (It may mean additional benefits for the applicant)