



APPLICATION FOR ADMISSION

DATE:							
APPLICANTS NAME:		TELEPHONE NO:					
STREET ADDRESS:							
CITY:		STATE:	ZIP:_		SSN#:		
DATE OF BIRTH:	PLAC	E OF BIRTH:			CITIZENSHIP:		
PLACE OF RESIDENCE (if	different from abo	ve):					
HOW LONG AT CURRENT	RESIDENCE?	YRS	_MOS.	EDUCATION	ON:		
MARITAL STATUS:	MARRIED	SINGLE_	WI	DOWED	SEPARATED	DIVORCED	
RELIGION:	PARIS	Н:			PASTOR:		
FORMER OCCUPATION:_		MILIT	ARY SVC	DATES:	BRANCH:_		
FATHER'S NAME:BIRTHPLACE:							
MOTHER'S MAIDEN NAM		BIRTHPLACE:					
SPOUSE OF APPLICANT:_			_OCCUP	ATION/DAT	TE OF DEATH:		
CHILDREN OF APPLICAN		DRESS & ZIP Creverse side if mo			PHONE NUMBERS		
BROTHERS/SISTERS OF A	PPLICANT AD	DRESS & ZIP C	<u>ODE</u>		PHONE NUMBERS		
NAME, ADDRESS, ZIP CO OR DEATH (PLEASE LIST		E NUMBERS OF	PERSONS	S TO NOTIF	FY IN CASE OF MEDICA	L EMERGENCY	
1							
2							

FINANCIAL STATEMENT

(Use additional sheet if necessary)

LIST OF MONTHLY SOURCES OF INCOME:

Social Security				\$		
Supplemental Security Incor	me			\$		
Pensions (give source)				\$		
Interest on Savings Accounts	s			\$		
Ground Rents				\$		
Annuities				\$		
Trust Funds (describe type)				\$		
Dividends				\$		
Other Income (state type)				\$		
		TOTAL MONTHI	LY INCOME	\$		
LIST ALL REAL ESTATE, L	OCATION, ASSESSED VALU	JE AND ENCUMBRANCES	<u>'</u> :			
LOCATION	NAMES ON DEED	VALUATION	N	EMCUMBRANCES		
RETIREMENT ACCOUNT						
		VALUE				
	VALUE					
STOCKS AND BONDS (Li	st by name, all co-owners, nu	mber of shares, and current	value)			
NAME	OWNERS	NO. OF SHARES	TOTA	L CURRENT VALUE		
CASH IN FINANCIAL INS	TITUTIONS (List bank nam	e and all co-owners, accoun	t no. and amount):			
•		N ACCOUNT	ACCOUNT NO	. AMOUNT		

FINANCIAL STATEMENT

(Use additional sheet if necessary)

LIFE INSURANCE POLICY NO. COMPANY PAID-UP PREMIUM FACE VALUE LOAN AMOUNTS CASH VALUE BENEFICIARY SUPPLEMENTAL LONGTERM INSURANCE BLUE CROSS/BLUE SHIELD NO. _____ PRE-PAID BURIAL AMOUNT & LOCATION _____ OTHER MEDICAL INSURANCE _____ MEDICARE NUMBER: PART A: ______PART B: ___ PERSON RESPONSIBLE FOR MEDICAL ASSISTANCE APPLICATION AND/OR RECERTIFICATION: MEDICAL ASSISTANCE NUMBER: EFFECTIVE DATE: OTHER PERSONAL PROPERTY (ARTICLES OF VALUE) HAVE YOU WITHIN THE LAST FIVE YEARS DISPOSED OF ANY PROPERTY, CASH OR OTHER ASSEST AND IF SO, HOW? EXPECTATION OF INHERITANCE (Specify): UNPAID DEBTS OR CLAIMS: TO WHOM AND AMOUNT: IS ANYONE HOLDING ANY CASH OR OTHER KINDS OF ASSETS FOR YOU? (List name, address, telephone no. and amount) NAME, ADDRESS AND TELEPHONE NUMBER OF PERSON HAVING POWER OF ATTORNEY: NAME, ADDRESS AND TELEPHONE NUMBER OF ATTORNEY:

DO YOU HAVE A WILL?	LOCATIO	N	
NAME, ADDRESS AND TELEPHONE NO. O	F EXECUTOR	:	
NAME, ADDRESS AND TELEPHONE NO. O	F PERSON HA	AVING DEED TO BURIAL OR CEMETERY LOT:	
LOCATION, DEED NUMBER, LOT & GRAVE	E NUMBER		
NAME, ADDRESS AND TELEPHONE NO. O	F PERSON WI	HO WILL MAKE ARRANGEMENTS FOR BURIAL:	
NAME, ADDRESS AND TELEPHONE NUME	BER OF PERSO	ONAL PHYSICIAN:	
NAME, ADDRESS & TELEPHONE NUMBER	OF PERSONA	AL DENTIST:	
SIGNATURE OF APPLICANT	DATE	SIGNATURE OF PERSON COMPLETING (if different from applicant)	DATE
SIGNATURE OF POWER OF ATTORNEY (FINANCIAL)	DATE	SIGNATURE OF POWER OF ATTORNEY (HEALTH CARE)	DATE
REVIEWED AND APPROVED BY BUSINES	SS OFFICE M	IANAGER	
SIGNED		DATE	

St. Elizabeth Rehabilitation and Nursing Center licensed by the State of Maryland as a comprehensive skilled care facility and is operated by Associated Catholic Charities. The Daughters of Charity provide administrative, staff and spiritual direction. Discrimination is prohibited based on race, color, sex, creed, age, religion, handicap, or national origin.

This non-discriminatory policy also applies to employment practice.