

APPLICATION FOR RESIDENCY

Name: Ms _____ Phone: _____
Mrs. _____
Mr. _____

Address: _____

Email Address: _____

Date of Birth: _____ Age: _____ County of Residence: _____

Name of Spouse: _____ if deceased, when? _____

Anniversary Date: _____ Email address: _____

U.S. Citizen? Yes ___ No ___ Served military duty? Yes ___ No ___ What branch? _____

Social Security # _____ - _____ - _____ Medicare # _____ - _____ - _____

Primary Language: _____ Secondary Language: _____

Supplemental Insurance Company(s) _____

I.D. # _____ Acct. # _____ Code: _____

Long Term Care Insurance Company s)

I.D. # _____ Acct. # _____ Code: _____

LIST OF CONTACTS

Name: _____ Relationship: _____

Address: _____

Phone # _____ Cell # _____ Work # _____

Email Address: _____

Name: _____ Relationship: _____

Address: _____

Phone # _____ Cell # _____ Work # _____

Email Address: _____

Name: _____ Relationship: _____

Address: _____

Phone # _____ Cell # _____ Work # _____

Email Address: _____

Name: _____ Relationship: _____

Address: _____

Phone # _____ Cell # _____ Work # _____

Email Address: _____

Whom do you wish notified in the event of emergency?

Name: _____ Relationship: _____

Address: _____

Phone # _____ Cell # _____ Work # _____

MEDICAL HISTORY

1. Do you have any chronic illnesses? Yes No (circle one)

2. Have you had any serious illness in the past 5 years? Yes No (circle one)
If yes, please list:

3. List the current medications you are taking:

4. Do you use tobacco, alcohol, or narcotics in any form? Yes No (circle one)

5. Do you see your physician regularly? Yes No (circle one)

When was your last visit? _____

Your Physician: Name _____ Phone # _____

Address: _____

Your Dentist: Name _____ Phone# _____

Address: _____

Your Pharmacy: Name _____ Phone # _____

Address: _____

Hospital Preference: _____

Funeral Home preference:

Name _____ Phone # _____

Address: _____

SOCIAL SERVICE INFORMATION

1. What are your current living arrangements? _____

2. How long can these arrangements continue? _____

3. What are your reasons for desiring to live at Hubbard Hill?

4. With what other facilities do you have application for admission?

5. Your profession or occupation?

Year of Retirement _____

6. Have you been a resident in any other facility? Yes No (circle one)

If yes, give name:

7. Church membership or affiliation: _____

Clergyman: _____ Phone: _____

Hobbies, interests, or talents: _____

Clubs, memberships or civic organizations you are involved in: _____

NECESSARY FINANCIAL INFORMATION

Will you or the resident be paying for the services provided out of own funds? Yes ___ No ___

If the resident is paying out of own funds, the resident must qualify financially. It is important, in the interest of prospective residents, as well as the facility, to determine in advance whether an applicant is able to pay the cost of residency at Hubbard Hill. The following information is needed for such an evaluation. If you should desire not to disclose your financial status, a statement from your banker, financial planner, or trust officer assuring the facility that you will have adequate resources to meet your monthly obligations, will be accepted.

1. Approximate monthly income is: _____

2. Cash Assets:

Bank: _____ Location: _____

Checking Account #: _____ Savings Account #: _____

Balance in Account: _____ Balance in Account: _____

Certificates of Deposit? Yes _____ No _____

If yes, identify the bank or institution where held and amount:

(Institution)	(Amount)
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(Institution)	(Amount)
---------------	----------

(Institution)	(Amount)
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Safe Deposit Box? Yes _____ No _____

If yes, indicate location. Bank Name: _____

Real Estate Assets: Do you own your home? Yes _____ No _____

Approximate value: \$ _____ Mortgage balance: \$ _____

Is it your intention to use proceeds from that sale of your home to pay for your living expenses at Hubbard Hill? Yes _____ No _____

Do you own any other property? Yes _____ No _____

Do you own any Life Estates? Yes _____ No _____

If yes, where is the property located? _____

Do you have any "rental" income? Yes _____ No _____

How much per month? \$ _____ per year \$ _____

3. Life insurance Cash Value:

Do you have life insurance policies with cash value? Yes _____ No _____

The approximate amount of cash value? _____

Annuities: \$ _____

Company Name: _____

Agents Name: _____ Agents telephone #: _____

Is there a Burial Trust Fund? Yes _____ No _____

If yes, where? _____

4. Securities:

Do you have stocks and/or bonds? Yes _____ No _____

Approximate value of all securities: \$ _____

Agent handling securities: Name: _____

Address: _____

Telephone Number: _____

5. Other Income:

Social Security Check: \$ _____ Disability Check: \$ _____

Pension: \$ _____ From: _____ Other: \$ _____

Annuity: \$ _____ From: _____

Identify who receives each monthly check: _____

7. The Hubbard Hill monthly statement should be mailed to:

Name: _____

Address: _____

Phone # _____ Relationship: _____

AUTHORIZATION AND CONSENT FOR APPLICATION

Everything stated in this application is true and correct. I understand that Hubbard Hill Estates, Inc. will check my bank references and credit history and I authorize this. I also understand Hubbard Hill Estates, Inc., considers this application as a continuing statement of financial condition and I agree to notify the facility in writing of any substantial change in financial condition. All this information will be kept strictly confidential by the facility. I agree that a photocopy shall have the full force and effect as the original of this application. By submitting my email address(s), I authorize Hubbard Hill to send me notifications and newsletters and understand I may unsubscribe at any time.

Signature of Resident: _____ Date: _____

Sponsor/Responsible Party: _____ Date: _____

I heard about Hubbard Hill from: _____

NONDISCRIMINATION POLICY

As a recipient of Federal financial assistance, Hubbard Hill does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, sexual orientation or on the basis of disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Hubbard Hill directly or through a contractor or any other entity with which Hubbard Hill arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Provider Name: Hubbard Hill Estates, Inc.

Contact Person/Patrick Pingel

Telephone number: 574-295-6260

Thank You for choosing



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