



## Application for Residency

- Village on the Square** - Independent Living       **MasonWoods** - Independent Living (Cecil, WI)  
 **Compass Point** - Catered/Assisted Living       **Riverside Lodge** - Memory Care  
 **Masonic Center for Health & Rehab** - 24 Hour Skilled Nursing

Date of Application: \_\_\_\_\_ Name: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Cell \_\_\_\_\_

Currently reside at: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

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Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Medicare Number: \_\_\_\_\_

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Supplemental Medical Insurance: \_\_\_\_\_

Long Term Care Insurance: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed      Wedding Date: \_\_\_\_\_

List Masonic Affiliations: \_\_\_\_\_ Religion/Church Affiliation: \_\_\_\_\_

\_\_\_\_\_

Clergy to Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

Funeral Home Preference: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have a Health Care Power of Attorney (HCPOA)? \_\_\_\_\_

Do you have a Durable Power of Attorney (DPOA)? \_\_\_\_\_

Do you have a Living Will/Declaration to Physician? \_\_\_\_\_

Primary/Former Occupation: \_\_\_\_\_

What are your hobbies/interests? \_\_\_\_\_

\_\_\_\_\_

Do you have a Durable Power of Attorney    Yes:     No:

Do you have a Health Care Power of Attorney    Yes:     No:     If yes, from which state? \_\_\_\_\_

Has your Health Care Power of Attorney been activated?    Yes:     No:     If yes, activation date: \_\_\_\_\_

**If your Health Care Power of Attorney has been activated, please include the activation date and a copy of the Determination of Incapacity.**

## ***Health Information***

Name of Current Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## ***Emergency Contacts***

Please designate Health Care Power of Attorney (HCPOA) and Durable Power of Attorney (DPOA)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Please designate:  HCPOA  DPOA  
Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: H \_\_\_\_\_ W \_\_\_\_\_ Please designate:  HCPOA  DPOA  
Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: H \_\_\_\_\_ W \_\_\_\_\_ Please designate:  HCPOA  DPOA  
Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

## ***Family History***

Do you have children?  Yes  No If yes, how many? \_\_\_\_\_ Sons \_\_\_\_\_ Daughters

Please list name(s) and addresses of children if not listed previously:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: H \_\_\_\_\_ W \_\_\_\_\_  
Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: H \_\_\_\_\_ W \_\_\_\_\_  
Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: H \_\_\_\_\_ W \_\_\_\_\_  
Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Frequency of contact with your children:  Daily  Weekly  Monthly  Yearly

**Financial Information** (Note: Joint column to be used for income not specific to applicant or spouse.)

MONTHLY INCOME (\$)	APPLICANT	SPOUSE	JOINT
Social Security Benefit			
Annuity <sup>1</sup>			
Pension			
Investment Income			
Other Income (describe)			
<b>Total Income (\$)</b>			

<sup>1</sup>Annuity Information: Are there survivor benefits?  Yes  No Can payment amounts change?  Yes  No  
 Is there a termination date?  Yes  No If so, when: \_\_\_\_\_

MONTHLY EXPENSES (\$)	APPLICANT	SPOUSE	JOINT
Rent/Mortgage			
Automobile (indicate if you do not own)			
Supplemental Insurance			
Medications			
Utilities			
Other (describe)			
<b>Total Expenses(\$)</b>			

ASSETS (\$)	APPLICANT	SPOUSE	JOINT
Cash/Checking*			
Saving & Certificates of Deposits*			
Stocks, Bonds & Mutual Funds*			
Others Investments*			
Trusts*			
Residence (net market)			
Real Estate (other)			
Cash Surrender Value of Life Insurance Policies			
Vehicles			
Funeral Trust			
Other Assets (describe)			
<b>Total Assets (\$)</b>			

**\*Please attach most recent financial documentation with application.**

Is your residence currently on the market?  Yes  No

How much are your annual property taxes and insurance? \_\_\_\_\_

If you included Trust assets on the application, please describe the nature of the Trust:

\_\_\_\_\_

<b>Please complete:</b> Have you divested (given away) any assets? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how much \$ _____ when? _____ and to whom? _____
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LIABILITIES (\$)	APPLICANT	SPOUSE	JOINT
Mortgage			
Other Loans			
Credit Card Debt			
Other Obligations (describe)			
<b>Total Liabilities (\$)</b>			

The information given in this application is accurate to the best of my knowledge and ability.

Signature of applicant \_\_\_\_\_ Date \_\_\_\_\_

Signature of applicant \_\_\_\_\_ Date \_\_\_\_\_

Completed for the applicant by \_\_\_\_\_ Date \_\_\_\_\_

Relationship to applicant \_\_\_\_\_

### ***Additional Information***

Prior to residency, please include copies of the following information:

- Social Security Card  Medicare Card  Supplemental Insurance Card (front & back)
- Health Care Power of Attorney (if applicable)  Durable Power of Attorney (if applicable)
- Living Will/Declaration to Physician (if applicable)

***How did you hear about Three Pillars?*** \_\_\_\_\_

<i>Notes</i> (For office use only)