



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

Date of Birth: _____ Age: _____ Sex: Male Female

Social Security Number: _____ - _____ - _____ Medicare Number: _____

Social Security Number: _____ - _____ - _____ Medicare Number: _____

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: _____

Primary/Former Occupation: _____

What are your hobbies/interests? _____

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

Do you have a Living Will/Declaration to Physician? _____

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 ¹ | | | |
| Pension | | | |
| Investment Income | | | |
| Other Income (describe) | | | |
| Total Income (\$) | | | |

¹Annuity 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) | | | |
| Total Expenses(\$) | | | |

| 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) | | | |
| Total Assets (\$) | | | |

***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:

| |
|--|
| Please complete: Have you divested (given away) any assets? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how much \$ _____ when? _____ and to whom? _____ |
|--|

| LIABILITIES (\$) | APPLICANT | SPOUSE | JOINT |
|-------------------------------|-----------|--------|-------|
| Mortgage | | | |
| Other Loans | | | |
| Credit Card Debt | | | |
| Other Obligations (describe) | | | |
| Total Liabilities (\$) | | | |

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) |
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