

APPLICATION FOR RESIDENCY

- Village on the Square** - Independent Living **Compass Point** - Catered/Assisted Living
 Masonic Center for Health & Rehab - 24 Hour Skilled Nursing **Riverside Lodge** - Memory Care or Assisted Living

Date of Application: _____ Name: _____

Telephone: Home _____ Cell _____

Currently reside at: _____

City: _____ State: _____ Zip: _____

E-mail: _____ I would like to opt-out of receiving e-mails

Date of Birth: _____ Age: _____ Sex: Male Female I am a Veteran: Yes No

Date of Birth: _____ Age: _____ Sex: Male Female I am a Veteran: Yes No

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.

Physician Contact

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: _____

I would like to opt-out of receiving e-mails

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

I would like to opt-out of receiving e-mails

Family Contacts

Information is the same as above

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? Yes 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. All funds are available for services provided by the Three Pillars continuum and will not be divested or transferred in a method that will prematurely entitle the applicant(s) to financial assistance.

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? _____

