SOLHEIM
SENIOR COMMUNITY
2236 Merton Avenue, Los Angeles, CA 90041-1915
Phone: (323) 257-7518, Fax: (323) 255-3544 DHS #970000049/ DHS# 191802082
www.SolheimSenior.org

APPLICATION FOR ADMISSION TO SKILLED NURSING

Name _____ Nickname _____ Phone_____

Address _____

Birthdate _____ Birthplace _____

Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single ☐

Education: _____ Occupation(s) _____

Religion/Church_____ _____
denomination)

Address: _____
city state zip

Emergency Contact #1 _____ _____
Relationship

Address: _____
city state zip

phone / e-mail _____
home work mobile email

Emergency Contact #2 _____ _____
Relationship

Address: _____
city state zip

phone / e-mail _____
home work mobile email

Send Solheim bills to _____

_____
Please provide phone and address if not already listed

Financial Alternate _____

_____
Please provide phone and address if not already listed

Other family and friends of personal importance:

Name	Relationship	City/State	Zip Code
Name	Relationship	City/State	Zip Code

Physician _____ _____
phone (including area code)

Address: _____
city state zip

Alternate Physician _____ _____
phone (including area code)

Address: _____
city state zip

Dentist _____ _____
phone (including area code)

Address: _____
city state zip

Preferred Hospital _____ **Phone:** _____

Preferred Pharmacy _____ **Phone:** _____

List major illnesses, hospitalizations and surgeries, including approximate dates: _____

_____

_____

Allergies (medications / foods) _____

_____

Attorney _____ _____
phone (including area code)

Address: _____
city state zip

Mortuary _____ _____
phone (including area code)

Address: _____
city state zip

Do you have an advance healthcare directive such as a Durable Power of Attorney for Healthcare or a Living Will, POLST or CMA? ☐ Yes ☐ No If yes, please provide a copy for your Solheim file.

Medicare #: _____ Social Security #: _____

Do you belong to an HMO organization, like Kaiser, Cigna or Secure Horizons? ☐ Yes ☐ No

If yes, what is its name? _____

If yes, is your Medicare signed over to the above organization? ☐ Yes ☐ No
If your Medicare has been signed over, will your health plan pay for care at Medicare-approved but non-contracted skilled nursing facility like Solheim? ☐ Yes ☐ No If no, and if you consider this an unacceptable risk, you will want to investigate skilled nursing facilities which are contracted by your health plan.

Other health insurance (supplemental or secondary to Medicare): _____

Prior to admission, we will need to make copies of both sides of the following cards:
☐ Social Security ☐ Medicare ☐ Medi-Cal (if applicable) ☐ Other health insurance

CONFIDENTIAL FINANCIAL INFORMATION

ESTATE PRESERVATION

At Solheim, we recognize that the true purpose of your financial estate is to provide for your care and support during your retirement years. Part of the decision regarding your eligibility for residency is based upon the financial condition you present in this application. Any divestiture of the assets listed on the following pages that limits your ability to pay for your current or future care may jeopardize your continued residency.

STATEMENT of ASSETS* and INCOME, for _____
Name

**For each listed asset and monthly income, please provide a copy of the latest account and income statement.

ASSETS	Current Value	Include Income Produced by Assets	
		Monthly Income [x12=]	Annual Income
**Checking Account			
**Savings Account			
**Other Cash (explain)			
**Receivables/Notes			
**Certificates of Deposit			
**Mutual Funds			
**Stocks/Bonds			
**Real Estate–Residence			
**Real Estate–Rental			
**Cash Value of Life Insurance			
**Other Assets (explain)			
**Other Assets (explain)			
TOTAL ASSETS*			
OTHER INCOME			
**Social Security	SSN:		
**Pension			
**Annuities/Retirement/Gift Income (explain)			
**Other Income, including long term care insurance (explain)			
	TOTAL INCOME		

* If assets are shared with any other person, indicate that person, their relationship to you, and <u>your share</u> of the assets. _____

Debts

Description of Debt	Principal Balance
Total Debts	

Expenses

Description of Expenses	Monthly Amount
Expenses for Real Estate not being sold	
Healthcare Costs (Premiums, Co-Pays, Medications, Insurance, etc.)	
Taxes and Assessments	
Travel, Entertainment, Enrichment	
Significant Gifts (Personal & Charitable)	
Personal Living Expenses	
Other (explain)	
Total Monthly Expenses	

Real Estate

Address of Property	Plan to Sell?	Mortgage Balance	Current Value
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Financial Relationships

Do you have commitments for the full or partial support of another person(s)? ☐ Yes ☐ No

If "yes," please explain: _____

_____

If your financial resources are marginal to meet Solheim's residency criteria, is there another person who would guarantee payment for your care and services should you be unable to do so? ☐ Yes ☐ No

If "yes," whom? _____

I understand that approval of this application to Solheim Senior Community is contingent upon the above listed assets remaining in my name and being used for my benefit. I hereby give my consent for authorized representatives of Solheim Senior Community to verify the above information submitted on my behalf by myself, my family, my physician or other sources. I also agree to provide a written accounting of any real estate sold within one year of my moving to Solheim. If move-in does not take place within three months of signing this application, I understand Solheim will require updated financial information.

Applicant's Name (printed)	Signature	Date
Responsible Party's Name (printed)	Signature	Date

office use only

Application approved by	Executive Director	Date
and	Officer, Board of Directors	Date
Physician's Report approved by	Director of Skilled Nursing	Date