2236 Merton Avenue, Los Angeles, CA 90041-1915
Phone: (323) 257-7518, Fax: (323) 255-3544 RCFE License # 191802082
www.SolheimSenior.org

APPLICATION FOR RCFE RESIDENCY

Name ____________________ Nickname ______________ Phone____________

Address ____

Birthdate ____________________ Birthplace ______________________________

Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single ☐

Do you live alone? ☐ Yes ☐ No If not, with whom do you live? ____________________

In what way(s) do they assist you? ____

Previous occupation(s) ____

Spouse's previous occupation ____

Education High School ☐ Some College ☐ BA/BS ☐ Masters ☐ PhD ☐

Interests, hobbies, travels (past & present) ________________________________

____

____

Hobbies or activities of particular DIS-interest ____________________________

____

____

List family and friends of personal importance:

____

Name Relationship City/State Zip Code

____

Name Relationship City/State Zip Code

____

Name Relationship City/State Zip Code

____

Name Relationship City/State Zip Code

List spouses, children or siblings who have died:

Name	Relationship	Year of Passing
Name	Relationship	Year of Passing
Name	Relationship	Year of Passing
Name	Relationship	Year of Passing
Name	Relationship	Year of Passing

Food likes, dislikes, habits: ____________________

____

Evening / Sleeping Habits ____________________

Allergies (meds / food) ____________________

How is your overall health at present? ☐ Good ☐ Fair ☐ Poor

How is your hearing? ☐ Good ☐ Fair ☐ Poor How is your vision? ☐ Good ☐ Fair ☐ Poor

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

In what city does your doctor practice? ____________________

List major illnesses, hospitalizations and surgeries, including approximate dates.

____

____

____

____

Comments (attach separate page if necessary)

____

____

____

Physician ______________________________ ______________________
phone (including area code)

Address: ____
city state zip

Alternate Physician ______________________________ ______________________
phone (including area code)

Address: ____
city state zip

Preferred Hospital ______________________ **Preferred Pharmacy** ______________________

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

Emergency Contact #3 ______________________________ ______________________
Relationship

Address: ____
city state zip

phone / e-mail ____
home work mobile email

Emergency Contact #4 ______________________________ ______________________
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

Attorney ______________________________ ______________________
phone (including area code)

Address: ____
city state zip

Dentist ______________________________ ______________________
phone (including area code)

Address: ____
city state zip

Mortuary ______________________________ ______________________
phone (including area code)

Address: ____
city state zip

Religion ______________________________ ______________________
denomination)

Address: ____
city state zip

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

Do you have a will? ☐ Yes ☐ No If yes, who holds it? ______________________

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

Will you bring a car? ☐ Yes ☐ No If yes, what is the license number? ______________________

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.

CONFIDENTIAL FINANCIAL INFORMATION

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 your share 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.

Enclosed is $500 in payment of the **non-refundable** application fee (Initials: ___________)
(The $500 fee is not applicable for admission to skilled nursing).

______________________ ______________________ ______________________
Applicant's Name (printed) Signature Date

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

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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