



# MERCY CENTER NURSING UNIT / PERSONAL CARE UNIT, INC.

Box 370, Lake Street, Dallas, PA 18612

(570) 675-2131 Fax: (570) 674-0521

Include Copies Of Living Will  
Power of Attorney  
Insurance & SS Cards

## Resident Information

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
(last) (first) (middle initial)

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Phone \_\_\_\_\_

Home address \_\_\_\_\_ County \_\_\_\_\_ Physician \_\_\_\_\_

US Citizen yes no Veteran yes no Spouse of Veteran who served during war yes no

Please provide copies of the following if applicable:

Applicant has: Power of Attorney yes no Durable Power of Attorney for Health Care yes no Living Will yes no Legal Guardian yes no

Funeral Home \_\_\_\_\_  
(Name) (Address) (Phone)

## Responsible Person Information

Primary Contact \_\_\_\_\_ Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Relationship \_\_\_\_\_ Address \_\_\_\_\_

Secondary Contact \_\_\_\_\_ Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Relationship \_\_\_\_\_ Address \_\_\_\_\_

## Insurance Information (Please provide copies of social security card and all other insurance cards.)

Medicare # \_\_\_\_\_ Part A yes no Part B yes no Long Term Care Insurance yes no

Medicare Supplement Insurance Co. \_\_\_\_\_ ID # \_\_\_\_\_

Do you have Medicaid (Medical Assistance) Coverage? yes no Access # \_\_\_\_\_

Prescription Coverage (company name) \_\_\_\_\_ ID# \_\_\_\_\_

HMO / Managed Care Insurance \_\_\_\_\_ ID# \_\_\_\_\_

## List all Hospitalizations and Skilled Nursing Home Stays in the last 60 (sixty) days

Hospital \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

Skilled Nursing Home \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

Past/Present Psychiatric Treatment (if so please list when, where, & diagnosis) \_\_\_\_\_

## List Monthly Income Amounts

Social Security \$ \_\_\_\_\_ SSI \$ \_\_\_\_\_ Pension \$ \_\_\_\_\_ Dividends \$ \_\_\_\_\_ Black Lung \$ \_\_\_\_\_ VA Benefits \$ \_\_\_\_\_ Annuity \$ \_\_\_\_\_

## List all Assets and Approximate Value

	<u>Name of Institution</u>	<u>Approximate Value</u>
Checking accounts	_____	\$ _____
Savings accounts	_____	\$ _____
Other bank accounts	_____	\$ _____
Certificates of deposit	_____	\$ _____
Stocks / Bonds	_____	\$ _____
Mutual funds	_____	\$ _____
Other investments	_____	\$ _____
	<u>Name on Deed</u>	<u>Approximate Value</u>
Residential property	_____	\$ _____
Other property / land / assets	_____	\$ _____
	_____	\$ _____

## HAVE ANY ASSETS BEEN GIFTED OR TRANSFERRED TO ANOTHER PERSON WITHIN THE LAST (5) FIVE YEARS? yes no (If "yes" please fill in the information below)

	<u>Date of gifting / transfer</u>	<u>To whom</u>	<u>Amount gifted / transferred</u>
1.	_____	_____	\$ _____
2.	_____	_____	\$ _____
3.	_____	_____	\$ _____
4.	_____	_____	\$ _____

I do swear to and confirm all information present on the application is factual and current to the best of my knowledge. I further attest that I have not transferred/gifted any assets to another person within the last (5) five years or have disclosed in writing assets transferred/gifted. I understand that a facility may check my bank references and credit history and I authorize this. All of this information will be kept strictly confidential by the facility.

Signature of Applicant / Responsible Party \_\_\_\_\_

Date \_\_\_\_\_