Simpson Memorial Home, Inc.

West Liberty and Wilton, Iowa

SELECT FACILITY APPLICATION IS FOR:

West Liberty Campus:
____ Simpson Memorial Home
____ Heath Manor
____ West Liberty Assisted Living
____ Simpson Village Townhouses

Wilton Campus:
____ Wilton Retirement Community
____ Leland R. Smith Assisted Living

RESIDENT / TENANT APPLICATION

Resident Name _____ Phone Number _____

Home Address _____
Street City State Zip Code

Current Location (if not at home address) _____

****

Name of Inquirer _____ Relationship _____

Address _____ Phone Number _____
Street City State Zip Code

****

Anticipated Admission Date _____

Contact/Emergency Person _____ Relationship _____

Address _____ Phone Number _____
Street City State Zip Code

****

Financially Responsible Party/P.O.A. _____ Relationship _____

Address _____ Phone Number _____
Street City State Zip Code

Durable Medical Power of Attorney _____ Relationship _____

Address _____ Phone Number _____
Street City State Zip Code

OTHER CONTACT PERSONS:

Name _____ Relationship _____

Address _____ Phone Number _____
Street City State Zip Code

Name _____ Relationship _____

Address _____ Phone Number _____
Street City State Zip Code

INSURANCE INFORMATION:

Applicant's Date of Birth _____ Social Security Number _____

Medicare Number _____ Part A (Hospital)? Yes/No Part B (Doctor)? Yes/No Both?

Medical Insurance Company _____ Number _____

Long Term Care Insurance Company _____ Number _____

Additional Insurance Coverage _____ Number _____

Is the applicant a veteran? Yes/No Is the applicant a surviving spouse of a veteran? Yes/No

Veteran's Name/Branch of Service _____ Veteran's Dates of Service _____

REFERENCES / BACKGROUND:

Church Membership _____ Phone Number _____

Name of Pastor _____

Physician _____ Phone Number _____

Address _____
Street *City* *State* *Zip Code*

Dentist _____ Phone Number _____

Address _____
Street *City* *State* *Zip Code*

Podiatrist _____ Phone Number _____

Address _____
Street *City* *State* *Zip Code*

Pharmacist _____ Phone Number _____

Address _____
Street *City* *State* *Zip Code*

Mortician _____ Phone Number _____

Address _____
Street *City* *State* *Zip Code*

Hospital Choice _____ Phone Number _____

Address _____
Street *City* *State* *Zip Code*

Previous Occupation _____

Hobbies or Clubs _____

Marital Status (circle one) Married - Single - Divorced - Surviving Spouse

MEDICAL INFORMATION:

Current and Past Diagnoses _____

_____

Physical Limitations _____

_____

Condition of Sight _____ Hearing _____

Allergies _____

CHECK ALL THAT APPLY TO DESCRIBE CURRENT PHYSICAL STATUS

☐ Mentally Alert	☐ Walks with assistance	☐ Forgetful
☐ Ambulatory	☐ Confused	☐ Special Diet
☐ Continent	☐ Feeds Self	☐ Incontinent
☐ Requires Help with Feeding	☐ Bed-Ridden	☐ Chair-Ridden

CONFIDENTIAL FINANCIAL DATA:

ASSETS		MONTHLY INCOME	
Savings / Checking	$_____	Social Security	$_____
Investments	_____	Pension / Retirement	_____
Real Estate Value	_____	Rental Income	_____
Other Assets	_____	Investment Income	_____
	_____	Other Income	_____
TOTAL ASSETS	**$**_____	**TOTAL INCOME**	**$**_____

Will you be applying for Title XIX assistance? Yes/No If so, when?_____
(Assets must be $2000 or less before application is made to Muscatine DHS)

I DECLARE THAT THE ABOVE STATEMENTS are true and accurate to the best of my knowledge. In witness whereof, I have hereunto set my hand to this application this _____ day of _____, _____.

_____
Applicant / Responsible Party