



Stone Gardens

An Assisted Living Residence

27090 Cedar Road
 Beachwood, Ohio 44122
 Phone: (216) 292-0070
 Fax: (216) 292-0033

Date Issued _____ 20____
 Date Received _____ 20____

APPLICATION FOR ADMISSION

The undersigned hereby applies for admission as a resident to Stone Gardens and agrees, if admitted, to comply with all current and future policies and procedures of Stone Gardens.

Apt. Type: 2 Bedroom 1 Bedroom Deluxe 1 Bedroom Studio

NOTE: A non-refundable \$50 application fee must accompany this application. Fee enclosed? Referred by _____

PERSONAL INFORMATION

Applicant's Name		Current Resident of <input type="checkbox"/> The R.H. Myers Apartments <input type="checkbox"/> Menorah Park	
Address		City, State	Zip
Telephone Number	Date of Birth	Age	Education
Present Housing (apartment, private home, condo, etc.)	Place of Birth	My Last Occupation Was:	
I have lived in the United States since:	I have lived in Cleveland since:	Religion	Synagogue/Religious Affiliation

MARITAL STATUS Applying as couple Yes No

I am: Single Married Widowed Divorced Separated Date of Separation, Divorce or Spouse's Death _____

Spouse's Name		Current Resident of <input type="checkbox"/> The R.H. Myers Apartments <input type="checkbox"/> Menorah Park	
Spouse's Address		City, State	Zip
Spouse's Telephone Number	Date of Birth	Age	Education
Spouse's Present Housing (apartment, private home, condo, etc.)	Place of Birth	Spouse's Employment:	
Spouse has lived in the United States since:	Spouse has lived in Cleveland since:	Religion	Synagogue/Religious Affiliation

INSURANCE INFORMATION The following information is very important and must be thorough and accurate.

Social Security Number		Medicare Number	Medicaid Number
Medicare Hospital Insurance (Plan A) <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare Hospital Insurance (Plan B) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Blue Cross Contract Number	Group Number	Service	
Address of Plan	City, State	Zip	
Other Hospitalization Plan	Group Number	Service	
Address of Plan	City, State	Zip	

SPOUSE INSURANCE INFORMATION The following information is very important and must be thorough and accurate.

Social Security Number		Medicare Number	Medicaid Number
Medicare Hospital Insurance (Plan A) <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare Hospital Insurance (Plan B) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Blue Cross Contract Number	Group Number	Service	
Address of Plan	City, State	Zip	
Other Hospitalization Plan	Group Number	Service	
Address of Plan	City, State	Zip	

FINANCIAL INFORMATION

(Must be completed in its entirety. Use a separate sheet if more space is needed to answer any question)

MONTHLY INCOME

Social Security per month		SSI per month	Veterans Benefits per month	Veterans Admin. Claim Number
Pension Income	Pension Name	Pension Claim Number	Pension Address	
Income from Savings	Bank	Account Number	Bank Address	
Income from Savings	Bank	Account Number	Bank Address	
Other Income	Source	Account Number	Address	
Other Income	Source	Account Number	Address	

REAL PROPERTY

Location and Description	Yearly Income	Value	Mortgage
Location and Description	Yearly Income	Value	Mortgage
If no property owned presently, give location and description of last property owned	Year Sold	Sale Price	Mortgage Paid

PERSONAL PROPERTY AND FINANCIAL ASSETS

Cash on Hand	Government Bonds	Other Securities		
Notes or Mortgages	Held By	Address		
Bank Account Type	Balance	Bank	City	Account Number
Bank Account Type	Balance	Bank	City	Account Number
Bank Account Type	Balance	Bank	City	Account Number
Certificates of Deposit	Balance	Bank	City	Account Number
Individual Retirement Accounts	Balance	Bank	City	Account Number

Other property or Assets (specify type, value and location)

LIFE INSURANCE

Insurance Company or Lodge	Type	Beneficiary	Surrender Value	Face Amount	Premiums Paid By	Loans on Policy
Insurance Company or Lodge	Type	Beneficiary	Surrender Value	Face Amount	Premiums Paid By	Loans on Policy

GIFTS AND TRANSFERS

I have made the following gifts or transfers of real or personal property within 36 months prior to making this application. (Include all gifts to family members).

TRUSTS

I have established the following trusts within the last five years.

In order to process this application, you must provide a copy of each of the following that applies:

- | | |
|---|--|
| <input type="checkbox"/> Social Security Card | <input type="checkbox"/> Private Insurance Card |
| <input type="checkbox"/> Medicare Card | <input type="checkbox"/> AARP and Other Association Cards |
| <input type="checkbox"/> Medicaid Card | <input type="checkbox"/> Pre-need Burial Contracts |
| <input type="checkbox"/> Power of Attorney | <input type="checkbox"/> Living Will |
| <input type="checkbox"/> Guardianship | <input type="checkbox"/> Durable Power of Attorney for Health Care |

POWER OF ATTORNEY/GUARDIAN AND FAMILY INFORMATION

The following are the names, ages, residences and occupations of my guardian, the holder of my power of attorney and all of my children. If no children, list interested relatives and friends.

1. Guardian/Power of Attorney (circle one)		Age	Relationship	Spouse's Name	
Address (Include City, State and Zip)			Home Phone	Work Phone	Spouse's Work Phone
Occupation and Employer			Spouse's Occupation and Employer		
2. Name		Age	Relationship	Spouse's Name	
Address (Include City, State and Zip)			Home Phone	Work Phone	Spouse's Work Phone
Occupation and Employer			Spouse's Occupation and Employer		
3. Name		Age	Relationship	Spouse's Name	
Address (Include City, State and Zip)			Home Phone	Work Phone	Spouse's Work Phone
Occupation and Employer			Spouse's Occupation and Employer		
4. Name		Age	Relationship	Spouse's Name	
Address (Include City, State and Zip)			Home Phone	Work Phone	Spouse's Work Phone
Occupation and Employer			Spouse's Occupation and Employer		
5. Name		Age	Relationship	Spouse's Name	
Address (Include City, State and Zip)			Home Phone	Work Phone	Spouse's Work Phone
Occupation and Employer			Spouse's Occupation and Employer		

BURIAL PREPARATIONS

Stone Gardens Assisted Living does not assume responsibility for burial.
Next of kin are exoected to make all arrangements and assume all expenses.

Reserved Plot? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what cemetery
Monument	Other Information
Pre-paid Funeral Arrangements? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of undertaker
Special Instructions	

Certification

I represent that each and every statement above set forth, including any accompanying tax returns, is true and that I have not withheld any information requested herein, and also represent that I have not transferred any property in trust for myself, nor given away any property other than stated in "gifts and transfers" and that I have read this application or had it read to me and that it has been fully explained to me.

Signature of Applicant

Witness

If Applicant's Signature is by Mark, Second Witness

Responsible Parties

Responsible parties including: All children, spouse, and other relatives, guardian or interested parties are to sign below: Each of the undersigned, being either husband or wife, child, or other relatives or interested friends of the above named applicant, does hereby request his or her admission to Stone Gardens Assisted Living. The undersigned also represent that the information set forth in this application is true to the best of his or her knowledge and that the applicant has not transferred any property to any of the undersigned within the past three years, except as set forth below:
List exceptions

Signatures

Person who assisted applicant in completing this application: _____

NOTE: A non-refundable \$50 application fee must accompany this application.	Fee enclosed? <input type="checkbox"/>	Referred by

For office use only:
Above application and all necessary signatures are complete and application is approved for further processing.
Date _____ Social Worker _____ Fee _____