SEM HAVEN
Health & Residential Care Center

Residency Application For:
Assisted Living ____
Assisted Living Memory Care ____
Nursing Health Care Center ____
Nursing Memory Care ____

Date: _____

Applicant Name:		
Address		
City/State/Zip		
Phone	E-mail	
SS#	Religion: (optional)	
Birthplace	DOB: / /	US Citizen: Yes No
Marital Status: S M W D	Gender: M F	Military

INSURANCE INFORMATION: ***Please attach a copy of your photo ID & all insurance cards.**

Medicare Part A Number:	
Secondary or Gap Insurance :	
Policy Number:	Group Number:
Managed Medicare Insurance:	
Policy Number:	Group Number:
Other Insurance:	
Policy Number:	Group Number
Medicaid Number:	
Medicaid Managed Care:	
Policy Number:	Group Number

RESPONSIBLE PARTY#1

Name	
Address	
City/State/Zip	
Phone	Cell Phone
Other Phone	Email
Relationship to resident	
Circle if applicable: POA DPOA	

RESPONSIBLE PARTY#2

Name	
Address	
City/State/Zip	
Phone	Cell Phone
Other Phone	Email
Relationship to resident	
Circle if applicable: POA DPOA	

POWER OF ATTORNEY

Name	
Address	
City/State/Zip	
Phone	Cell Phone
Other Phone	Email
Relationship to resident	

BILLING INFORMATION Please note who should receive your billing statements:

- ☐ Self
- ☐ Responsible Party/POA – Specify name _____
- ☐ Other – Provide name & address:

_____
_____
_____

FINANCIAL INFORMATION – If married, list only applicant's financial information.

Monthly Income

Social Security (Monthly check/deposit amount)	$_____
Pension & Retirement	$_____
Interest/Dividends	$_____
Other Income (please list source)	$_____
_____	$_____
Total Monthly Income	$_____

Monthly Expenses

Health Insurance	$_____
Medical Expenses not covered	$_____
by insurance (medications, etc.)	$_____
Other _____	$_____
Other _____	$_____
Other _____	$_____
Total Monthly Expenses	$_____

Assets

Total value of Real Estate	(as of_____)	$_____
Savings Accounts/CD's	(as of_____)	$_____
Checking Accounts	(as of_____)	$_____
Stocks & Bonds	(as of_____)	$_____
Other Investments	(as of_____)	$_____
Life Insurance cash value	(as of_____)	$_____
Other_____	(as of_____)	$_____
Other_____	(as of_____)	$_____
Other_____	(as of_____)	$_____
Total Assets		$_____

Long Term Care Insurance

Per day rate_____ for number of _____ months or years

Are any of your assets held in a trust? Yes No

If so, what type? _____

Liabilities

Mortgages	$_____
Installment Loans	$_____
Credit Card Balances	$_____
Other Obligations	$_____

Do you have funeral expenses prepaid? Yes No

Funeral Home (Name, address & phone)_____

_____

How soon do you wish to make SEM Haven your home?_____

How did you hear about SEM Haven?

Please note that additional information may be requested at a later date.
I hereby declare that all statements made herein are true to the best of my knowledge.

Applicant Signature Date

Person completing application & relation to applicant Date

Address & telephone number of person completing application:

***<u>Please attach:</u>**

- **a copy of the photo ID & all insurance cards.**
- **If COVID vaccinated, please attach a copy of the vaccine card.**

Current Primary Care Physician:

Name: _____

Address:_____

_____

Phone: _____