Liabilities and Debts:

Mortgages Amount Owed:$_____

Credit Card Debt Owed:$_____

Loans Owed:$_____

Other debts owed:$_____

Total Amount of Debt:$_____

Net Worth:

Total Assets:$_____

Total Debts:$_____

Total Net Worth (subtract total debt amount from total Asset amount):$_____

If funds other than those of the potential resident's will be used to pay for the cost of the stay and care, please indicate the name(s) of the person(s) who will be financially responsible (guarantor(s). While a guarantor is not required for move-in, Villa Raffaella does require that a source of payment be identified to pay for the resident's stay and care.

Guarantor/ Relationship Address Telephone Number

_____

_____

I hereby warrant and represent that the information provided is accurate and complete. I understand that Villa Raffaella will rely upon the accuracy and completeness of the above financial information in making a move-in decision. I also understand that if any of the information is not accurate or not complete, Villa Raffaella will have detrimentally relied upon the financial information and will suffer financial loss and Harm. The assets listed are in fact available to the Applicant to pay for the Applicant's care.

_____ _____

Resident's or Responsible Party Signature Date

_____ _____

Guarantor's Signature **Date**

Villa Raffaella

A senior Assisted Living Community operated by the Hospitaler Sisters of Mercy

917 S. Main Street, Pleasantville, New Jersey 08232

Phone: 609-645-9300 Fax: 609-645-9600 Visit us at www.VillaRaffaella.com

Villa Raffaella Assisted Living

917 S. Main St. Pleasantville NJ 08233

APPLICATION FOR RESIDENCY

Thank you for considering Villa Raffaella Assisted Living. To apply for residency, please complete the following questionnaire, sign and return it to our Administrator. Please be sure to answer all questions. All information will be held in confidence. All 4 pages must be completed.

Date: _____

Perspective Resident Information

Last Name:_____ First_____ Middle_____

Current Address:_____

Home Tel. #:_____ Mobile Tel. #_____

Email:_____ Social Security Number:_____

Age:_____ Date Of Birth:_____ Sex:_____ Male ____ Female

Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced _____ Separated

Anticipated date applicant would like to move in? _____/_____/_____

Information of Applicant's Responsible Party/ Next of Kin

Name: Last_____ First:_____ M.I.:_____

Current Address:_____

Home Tel. #:_____ Mobile Tel. #_____

Work Tel. #:_____Email:_____

Relationship:_____

Does Applicant Have a POA? ___ Yes ___ No Does Applicant have a Legal Guardian?___ Yes ___ No

(If Yes to either POA or Guardian please attach a copy of the documentation)

Medical Insurance Information

Medicare ____ Yes ___ No If Yes ID #_____

Medicare Part A ___Yes ___ No Part B ___ Yes ___ No Is Medicare the Primary Insurance? Yes/ No

NJ Medicaid: ___ Yes ___ No If Yes ID#_____

Secondary Insurance: Name:_____

Subscriber ID #_____ Group # _____

Other Medical Insurance: Name:_____

Subscriber ID #_____ Group # _____

Prescription Insurance: Name:_____

Subscriber ID #_____ Group # _____

Any Long Term Care Insurance that covers Assisted Living or Supportive Services? ___ Yes ___ No

If yes, Company Name:_____

Policy #_____ Amount paid for Services: $_____

(Please attach copies of all Medical Insurance ID Cards)

Applicant's Personal Care Needs

Please list all Medical Diagnosis and health concerns:_____

_____

Please use an "X" to describe the applicant's need for assistance in the following areas:

Task	None	Some	Complete
Eating			
Bathing			
Toileting			
Dressing			
Walking			
Housekeeping			
Laundry			
Shopping			
Finances			
Transportation			
Medications			

What other assistance does the applicant require?_____

What special equipment or devices does the applicant require?_____

Primary Language:_____ Secondary Language:_____

Does applicant have memory impairment? ___ Yes ___ No

Does applicant have behavioral challenges, wandering or combative behavior? If Yes please explain:_____

Does applicant have a history of Drug addiction or Alcoholism? ___ Yes ___ No If Yes, please explain:_____

Please list all current medications:_____

_____

Does the applicant require a special diet?_____

Primary Care Physician Name:_____

Address:_____

Telephone:_____

Referral Information:

Were you referred to Villa Raffaella Assisted Living by a Friend? ____Yes ___ No Perhaps a Professional in the area? ____ Yes ___ No If yes, please provide their Name, Address and Telephone number so we may thank them._____

Please note for the Comfort and Safety of Our Residents

Villa Raffaella and its Grounds are *SMOKE FREE*

FINANCIAL INFORMATION FOR PROSPECTIVE RESIDENT

Total Monthly income:

Social Security:$_____

Pensions:$_____

Interest/ dividend Income:$_____

VA benefits:$_____

SSI Benefits $_____

Other Income:$_____

Total Monthly Income:$ _____

Assets

Real Estate Holdings Value:$_____

Checking Accounts Value:$_____

Savings Accounts Value:$_____

Cert. of Deposits Value:$_____

Stocks/Bonds Value : $_____

Trusts Value:$_____

Other Value:$_____

Total Value of Assets:$_____