APPLICATION FOR RESIDENCY
Kearny County Hospital
d/b/a High Plains Retirement Village (HPRV)
500 Thorpe Street
Lakin, KS 67860

If admitted, this Application for Residency will become a part of the "Resident Agreement." All information will be held in confidence. To avoid delay on admission determination, please answer all questions.

1. Name of Applicant: ____
   (Last) (First) (Middle) (Maiden Name)

2. Address: ____
   (Street)

   ____ County:______________
   (City) (State) (Zip)

3. Home Phone: ( )____________ Work Phone: ( )____________ Cell Phone: ( )____________

4. Social Security #: _____________ Medicare #: __________________ Veteran #: ________________

5. Date of Birth: __________________ Place of Birth: ______________________________________

6. Race (Circle One): White Black Hispanic American Indian Asian Other (describe):_________

7. Martial Status (Circle One): Single Married Widowed Divorced

8. Name of Spouse: ______________________ Date & Place of Marriage: ________________________

9. Date of Death of Spouse (if widowed):_________________________

10. Last regular occupation of Applicant:___________________________ Year Retired:_________

11. Last regular occupation of Spouse: _____________________________ Year Retired:_________

12. Type of Accommodation Desired (Circle One): Long Term Care Assisted Living

STAFF USE ONLY
Date of Application: ______________

13. Number of Children:_______ List living children below:

(Name) (Complete Address with Zip Code) (Telephone No.)

Work:________________
Home:________________
Cell:________________
E-Mail:________________

Work:________________
Home:________________
Cell:________________
E-Mail:________________

Work:________________
Home:________________
Cell:________________
E-Mail:________________

Work:________________
Home:________________
Cell:________________
E-Mail:________________

Work:________________
Home:________________
Cell:________________
E-Mail:________________

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14. Who is to be notified in case of emergency?

(Name) (Complete Address with Zip Code) (Telephone No.)

Work:________________
Home:________________
Cell:________________
E-Mail:________________

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15. Where have you lived in the past (five) years?____

16. Were you ever in another nursing home? ___ Yes ___No

If yes, please give name and address and state reason for leaving:
____

____

17. Hospital Preference: ____

18. Physician: ____
(Name) (Address with zip) (Phone)

I authorize Dr. _________________ to be the physician in charge of treatment. In an emergency or if the attending physician is not available to provide the services as required by Federal or State guidelines, I authorize the designated doctor on call to assume responsibility for my medical care.

19. Dentist: ____
(Name) (Address with zip) (Phone)

20. Optometrist: ____
(Name) (Address with zip) (Phone)

21. Pharmacy Services: Medications will be procured from a local pharmacy. This facility will not be responsible for any errors that might be made by a pharmacy outside the facility in filling resident's prescriptions. The facility retains the right to obtain emergency medications, as ordered by the attending physician.

Pharmacy: ____
(Name) (Address with zip) (Phone)

22. Release of Information: I do ___do not ___ authorize facility's release of information to public, radio, television, or other news agencies by the facility for reason of admission, discharge, or public relations.

23. Photographs:
I do ___do not ___ agree to allow the facility to take a photograph of me for the purpose of identification.
I do ___ do not ___ give the facility my consent to display photographs of me participating in facility activities in public displays within the facility or in news releases or other information publications provided by this facility.

24. Resident's mail is to be delivered as follows:

____ All to the Resident.

____ Personal mail to the resident with all business mail forwarded to:

____
(Name) (Address with zip) (Relationship)

____ I agree to allow a representative of the facility to open and read my mail, if my condition warrants, through my oral consent.

25. Resident's Personal Funds (Trust Account):
The facility recommends that the resident keep only a minimum of cash on their person. Provisions are made for handling personal funds in the business office and they are readily available to the resident or responsible person as needed. Business hours are Monday through Friday 8:00 AM to 4:00 PM. Upon request of the resident or responsible party, resident funds may be deposited and withdrawn as desired from a resident trust account during stated hours. The resident or responsible party shall receive a quarterly accounting of all financial transactions in the resident trust account. A monthly accounting may be provided upon request.

I do ___ do not ___ authorize the facility to open and maintain a trust account on my behalf during my stay at this facility.

I do ___ do not ___ authorize the facility to pay out of my trust account, on my behalf, my expenses with the facility and the expenditures listed below:
____

26. I have the following sources of income and/or assets:

SOCIAL SECURITY (YOU)		
Amount Per Month: $	Where Deposited:	Account No.:
SOCIAL SECURITY (SPOUSE)		
Amount Per Month: $	Where Deposited:	Account No.:
SUPPLEMENTAL SOCIAL SECURITY INCOME (YOU)		
Amount Per Month: $	Where Deposited:	Account No.:

SUPPLEMENTAL SOCIAL SECURITY INCOME (SPOUSE)		
Amount Per Month: $	Where Deposited:	Account No.:
PENSION (YOU)		
Amount Per Month: $	Where Deposited:	Account No.:
PENSION (SPOUSE)		
Amount Per Month: $	Where Deposited:	Account No.:
VETERAN BENEFITS OR PENSION (YOU)		
Amount Per Month: $	Where Deposited:	Account No.:
VETERAN BENEFITS OR PENSION (SPOUSE)		
Amount Per Month: $	Where Deposited:	Account No.:
OTHER RETIREMENT INCOME (COMBINED)		
Amount Per Month: $	Where Deposited:	Account No.:
INCOME FROM CONTRACTS FOR DEED (COMBINED)		
Amount Per Month: $	Where Deposited:	Account No.:
INCOME FROM RENTERS (COMBINED)		
Amount Per Month: $	Where Deposited:	Account No.:
Address of Rental Property(ies):		
SAVINGS ACCOUNT (COMBINED)		
Current Account Balance: $	Where Deposited:	Account No.:
CHECKING ACCOUNT (COMBINED)		
Current Account Balance: $	Where Deposited:	Account No.:
INSURANCE BENEFITS/PAYMENTS (COMBINED)		
Amount Per Month: $	Where Deposited:	Account No.:
Description:	Insurer:	Policy No.:
INVESTMENTS, STOCKS, BONDS, ANNUITIES (COMBINED)		
Amount Per Month: $	Where Deposited:	Account No.:
Description:	Company Name:	Method of Holding:

REAL ESTATE (SELF)		
Address:		
Any liens, options, or other documents recorded on property to potentially transfer title:		
Approximate Value:	Outstanding Balance of any Mortgages:	Year originally obtained:
WORKERS' COMPENSATION (YOU)		
Amount Per Month: $	Where Deposited:	Account No.:
CERTIFICATE OF DEPOSIT (COMBINED)		
Amount of CD: $	Where Held:	Maturity Date:
SAVINGS BONDS (COMBINED)		
Amount of Bond: $	Where Held:	Maturity Date:
VEHICLE (COMBINED)		
Make:	Model:	Year:
Approximate Value:	Value of all outstanding loans:	Year originally obtained:

27. Are any of your assets located in any trusts? YES ______ NO ______

28. For how long do you estimate your personal resources will be sufficient to provide for your care while a resident at the facility? _____ Years

29. Have you and/or your spouse given any gifts valued in excess of $1,000 within the last 3 years?
Yes ____ No ____. If yes, fill in below:

____

(Name) (Address with zip) (Relationship)

____

(Date of Gift) (Amount of Gift) (Purpose of Gift)

30. Do you have any of the following: Power of Attorney, Guardian, or Other Legal Appointee.
Yes ____ No ____. If yes, circle one of the above and fill in below:

____

(Name) (Address with zip) (Phone)

31. Have you made a will? ___ Yes ___ No

32. To whom do you wish the bill to be sent? Name ____

Address ____City__________State________Zip______

Telephone: Work ( ) _____________ Home ( ) _____________ Cell ( )_____________

33. Have you been convicted of a Felony? Yes ___ No ___ Are you a Sex Offender? Yes ___ No ___

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ACKNOWLEDGEMENT

By signing this acknowledgement, I represent, warrant, and certify that I have answered all questions and disclosed all assets in a complete, thorough, and honest manner. I understand that misrepresentations, omissions, or deceptive completion of this document or submission of any false information or lack of disclosure may result in the denial of the Application for Residency, termination of the Admission Agreement, and may result in the discharge of Resident from the Facility at the Resident and/or Responsible Party's expense.

APPLICANT

____
[Name]

RESPONSIBLE PARTY

____
[Name]
Legal representative/representative individual

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It is the policy of the facility to consider applications for admission provide service to admitted persons without regard to any protected class in compliance with 45 CFR Parts 80, 84 and 91 respectively.