St. Camillus
San Camillo
10101 West Wisconsin Avenue
Wauwatosa, WI 53226
(414) 259-6310

DATE: _____

St. Camillus campus application, please circle area you are applying for:

San Camillo Retirement Community Assisted Living at St. Camillus Memory Care

Skilled Nursing Home Care Hospice St. Camillus at Home

Unit Preference: _____

Name: _____

Home Address: _____
Street City State Zip

Home Phone: _____ Marital Status: _____ Email: _____

Gender: _____ Age: _____ Birthdate: _____

Social Security No.: _____ Medicare No.: _____

Title XIX No.: _____ Long Term Care Insurance: _____

Health Insurance: _____ No.: _____ Group #: _____

Medicare Part D P.D.P.: _____ #: _____

U.S. Citizen: ❑ Yes ❑ No

Veteran: ❑ Yes ❑ No Dates of Service: _____ Branch of Service: _____

Lifetime Occupation: _____

Company retired from: _____ When: _____

***Please supply copies of Medicare and other insurance cards.**

Primary Care Physician: _____
Name Phone

Address: _____

Dentist: _____
Name Phone

Address: _____

***UPON ADMISSION PLEASE PROVIDE THE FACILITY WITH COPIES OF THESE DOCUMENTS:**

Does the applicant have Advanced Directives? ❑ Yes ❑ No POA HC Activated? ❑ Yes ❑ No

Does the applicant have a Do Not Resuscitate Order? ❑ Yes ❑ No POA Finances? ❑ Yes ❑ No

Does the applicant have a Living Will? ❑ Yes ❑ No

ST. CAMILLUS IS A SMOKE-FREE CAMPUS.

List in order of preference persons to be notified in a medical emergency or change of condition. Also, please indicate type of **Legal Authority** such as Power of Attorney for Finances, Power of Attorney for Health Care or Guardianship.

1) _____ _____
Name Relationship Type of Legal Authority

Address Home Phone Work Phone

City / State / Zip Cell Phone Email

2) _____ _____
Name Relationship Type of Legal Authority

Address Home Phone Work Phone

City / State / Zip Cell Phone Email

3) _____ _____
Name Relationship Type of Legal Authority

Address Home Phone Work Phone

City / State / Zip Cell Phone Email

Please send all facility bills to: _____
Name

_____
Address City State Zip

Religion / Affiliation

Religion: _____ Church Name: _____

Funeral Home

Name: _____ Address: _____

City, State, Zip: _____ Phone: _____

Burial Trust ❑ Yes ❑ No Burial Plot ❑ Yes ❑ No

ST. CAMILLUS HEALTH CENTER, HOME CARE, AND HOSPICE APPLICANTS ONLY.

Hospital Preference (Required): _____

Hospitalization

Have you been hospitalized in the last 12 months? ❑ Yes ❑ No
If yes, please complete the following information:

Acute Hospital: _____ Admit Date: _____ Discharge Date: _____

Skilled Nursing Facility: _____ Admit Date: _____ Discharge Date: _____

Resident is now at: _____ Admit Date: _____

Plans to discharge within 3 months: ❑ Yes ❑ No ❑ Uncertain

I give my permission, and release St. Camillus from liability, that this information has been kept in resident/client file, is considered confidential, and available to appropriate staff, all medical care providers, Fire Department and/or Paramedics in the event of an emergency.

Resident / Client Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

ALL APPLICANTS MUST COMPLETE THIS ENTIRE PAGE.

CONFIDENTIAL FINANCIAL STATEMENT OF:

Name(s): _____ Date: _____

***If applicant is married, spouse's assets must also be included.**

ACCOUNT: (Banks, Savings and Loans, Credit Unions, IRA's, Certificates of Deposit, Etc.)

Name of Institution	Amount	For each, indicate: Self, Joint*, Other

INVESTMENTS: (Stocks, Bonds, Mutual Funds, Annuities, Etc.)

Description	Number of Shares	Market Value	Assets Liquid?	For each, indicate: Ownership Self, Joint, Other
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	

If you own property, fill in this section. If you rent, mark with"N/A".

Description / Location	Market Value	Balance Due	Mortgage Holder	For each, indicate: Ownership Self, Joint, Other
Primary Residence:				
Other:				

RESOURCE-INCOME TRANSFER:

Sold any assets for less than fair market value: ❑ Yes ❑ No

Traded assets or income: ❑ Yes ❑ No

Transferred or gave away any assets: ❑ Yes ❑ No

TRUST FUNDS:

Are any of your assets held in revocable or irrevocable trust? ❑ Yes ❑ No

Are you the beneficiary of the Principle of the trust? ❑ Yes ❑ No

If so, please list estimated value: _____

Are you the beneficiary of the income of the trust? ❑ Yes ❑ No

If so, please list monthly value: _____

ALL APPLICANTS MUST COMPLETE THIS ENTIRE PAGE.

LIFE INSURANCE:

Company / Policy Number	Cash Surrender Value	Face Value (Death Benefit)	Beneficiary

LOANS: (Banks, Consumer, Life Insurance, Credit Cards, Etc.)

Lender	Account Number	Amount

ANY OTHER LOANS OR LIENS ON ASSETS: (Describe and List)

Has there been any sale of house or property gifts of money, or transfer of assets in the last 5 years? If any, please explain:

MONTHLY INCOME:

	Social Security Income
Applicant	
Spouse	

Pension: _____

Other: _____

_____

Investments, Interest, Dividends, Rents Etc.: _____

_____

MONTHLY EXPENSES:

Medical: _____

Other: _____

Financial Conditions Acceptable: Internal Use Only

Yes _____ No _____

By: _____

Title: _____

Date: _____

Signature terms:

Each undersigned represents and warrants that the information provided is true and correct. St. Camillus is authorized to make all inquiries deemed necessary to verify the accuracy of the statement herein and to determine individual or joint financial position. Each undersigned is aware that additional information may be needed before application is considered complete.

Resident / Client Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____