



Saint Elizabeth Community
Where RI seniors come first

Contact Information of Relative or Responsible Party

Name _____ Phone # (H) _____ (W) _____

Address _____ City/Town _____

State _____ Zip _____ Relationship _____

E Mail Address _____

Financial Power of Attorney (please include a copy of the POA)

Name _____ Phone _____

Relationship _____

Healthcare Power of Attorney (please include a copy of the POA)

Name _____ Phone _____

Relationship _____

Physician

Primary Care Physician _____ Phone _____

Address _____

Financial / Billing Information

Health Insurance (please provide copies of all cards)

Social Security	# _____	
Federal Medicare	# _____	Medicare Part B Yes No
State Medicaid	# _____	
Other (name)	_____	# _____



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Part I

By definition, a patient in Rhode Island is considered private paying until their individual assets are spent down to the RI Medicaid Eligibility Limit of \$4000.00. Anyone who has less than \$4000.00, upon application, would be eligible to apply for RI Medicaid Assistance through the RI Department of Human Services, prior to admission. In order for our home to project the Private Pay and Medicaid Census, we request your assistance in completing the following questions.

Based on the above criteria, the applicant would be: (Please circle one)

Private Pay or Medicaid Eligible

A. If paying privately, the applicant estimates that they would remain private paying for how many months _____

B. If there is a need for Medicaid Long Term Care Assistance, the applicant has:

Applied with a decision of eligibility _____

Applied with decision pending _____

Not begun application yet _____

A need to obtain further information regarding the Medicaid application _____

Part II

A. The applicant has Long Term Care Insurance Yes No

B. If yes, with whom is the applicant insured? _____

Name of Insurance Company

C. If yes, please summarize the applicant's coverage by the Long Term Care Insurance Policy: (Please indicate the payment amount and length of duration of coverage)

D. Burial Plan Yes No

E. Funeral Home _____

Address, Phone _____



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Current Monthly Income

	Amount
Social Security	_____
Pension	_____
Stocks and Bonds	_____
Investment Income	_____
VA Benefits	_____
Other	_____

Capital Assets (including holdings jointly held)

(Please provide current account statements or a certified letter from a bank official for all financial assets)

	Amount
Checking Account	_____
Savings Account	_____
Real Estate (owned and mortgaged)	_____
Life Insurance (list value)	_____
Other	_____

I fully understand that this is just an application for the waiting list. I also understand that medical information will be required prior to placement.

Applicant/Responsible Name (please print) _____

Signature of Applicant/Responsible Party _____

Date _____