For Office Use:
Rm#__________
Admit#__________
Dr.__________
Assisted Living____
Al Memory______

6701 Jersey Ridge Road, Davenport, IA 52807
PHONE (563) 324-1621 FAX (563)324-1723

ASSISTED LIVING APPLICATION FOR ADMISSION

NAME____PHONE______________
ADDRESS____
CITY/STATE______________________________________ZIP CODE__________
DATE OF BIRTH____________________
MARITAL STATUS: MARRIED SINGLE (-Never married) DIVORCED WIDOWED
FUNERALHOME____
ADDRESS____PHONE_____________
HOSPICE (IF APPLICABLE) __________________________PHONE_____________
PHYSICIAN FOLLOWING AT KAHL HOME__________________PHONE_____________
OTHER PHYSICIANS(SPECIALISTS):_____________________________________

INSURANCE INFORMATION

SOCIAL SECURITY NO.____________________ MEDICARE NO.____________________
SUPPLEMENTAL INSURANCE______________________ POLICY NO.________________
MANAGED MEDICARE PLOICY NAME___________________POLICY NO:______________
MEDICAID NO._________________________VETERANS NO.____________________
Long Term Care Insurance (if Applicable) POLICY NO.___________________________

Copies of Medicare, Medicaid and insurance cards must be attached (front and back) to this application.

RESPONSIBLE PARTY FOR BILLING

NAME____PHONE______________
ADDRESS____
CITY/STATE______________________________________ZIP CODE__________

POA FINANCIAL:
NAME______________________________PHONE___________________________
ADDRESS____

POA HEALTH:
NAME______________________________PHONE___________________________
ADDRESS____

GUARDIAN:
NAME______________________________PHONE___________________________
ADDRESS____

KAHL HOME ASSISTED LIVING APPLICATION

EMERGENCY CONTACTS

1) NAME____PHONE______________
   ADDRESS____CELL PHONE__________
   CITY/STATE____ZIP CODE____________
   RELATIONSHIP____E-MAIL______________

2) NAME____PHONE______________
   ADDRESS____CELL PHONE__________
   CITY/STATE____ZIP CODE____________
   RELATIONSHIP____E-MAIL______________

FINANCIAL RESOURCES-REQUIRED FOR ASSISTED LIVING APPLICATION

AS A FACILITY PARTICIPATING IN THE MEDICARE AND MEDICAID PROGRAMS, IT IS ESSENTIAL THAT WE RECEIVE AN ACCURATE AND COMPLETE STATEMENT OF THE APPLICANT'S FINANCIAL STATUS. PLEASE NOTE IF THESE ARE SOLEY OR JOINTLY OWNED.

INCOME RESOURCES (MONTHLY)

RETIREMENT$ ______________________________ PENSION $__________________

SOCIAL SECURITY $________________________

RENTAL $ _________________________________ FARM $____________________

OTHER $ ______________________________

LIFE INSURANCE $________________________

ASSETS

CHECKING $____

SAVINGS $____

MONEY MARKET$____

MONEY MARKET____

INVESTMENTS____

INVESTMENTS____

401k /401A/401C____

PROPERTY____

MORTGAGE__________________________REVERSE MORTGAGE_________________

FUNERAL PRE-PAID _____YES ____NO

Please note any changes in asset ownership or allocation in the last 5 years____

KAHL HOME ASSISTED LIVING APPLICATION

Disclosure: Management requires the following information for the protection and well being of all residents and staff of the Community.

Have you, your spouse or any occupant listed in this Application ever been charged, detained, or arrested for a sex crime that was resolved by conviction, probation, deferred adjudication, court ordered community supervision or pre-trial division?
____Yes ____NO

Have you, your spouse or any occupant listed in this Application ever been charged, detained, or arrested for a felony crime that was resolved by conviction, probation, deferred adjudication, court-ordered community service, or pre-trial division?
____Yes ____No

Management may conduct criminal background and sex offender checks on Applicants. By signing this Application, Tenant acknowledges that such checks may be made and that information contained therein may be a basis for denial of occupancy at this time. Tenant hereby authorizes and consents to Management conducting such investigation and obtaining such information.

It is the policy of the Kahl Home that all available services are provided without regard to sex, race, color, ancestry, national origin, religious creed, handicap or disability.

In order for Kahl Home to protect both the organization and its tenants/residents, we need sound financial planning. It is necessary for us to know about the resources of future tenants/residents. This information will be kept in the strictest confidence.

The information provided is complete, correct and accurate to the best of my knowledge for application to Kahl Home Assisted Living.

APPLICANT/APPLICANT LEGAL REPRESENTATIVE SIGNATURE
____DATE__________