Menorah MANOR

APPLICATION FOR ADMISSION

Please complete all items.

PERSONAL HISTORY

NAME: _____ HEBREW NAME: _____
LAST FIRST MIDDLE/MAIDEN

CURRENT ADDRESS: _____

_____ PHONE: _____
CITY STATE ZIP CODE

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____ AGE: _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

U.S. CITIZEN? ☐ YES ☐ NO PLACE OF BIRTH _____

☐ BY BIRTH ☐ BY NATURALIZATION

FORMER OCCUPATION: _____

IF MARRIED, SPOUSE'S NAME: _____ PHONE: _____

CURRENT LIVING ARRANGEMENT: ☐ ALONE ☐ WITH RELATIVES RELATIONSHIP: _____

NAME: _____ ADDRESS: _____ PHONE: _____

☐ OWN HOUSE ☐ CONDO ☐ NURSING HOME: _____

☐ RENT ☐ ASSISTED LIVING FACILITY: _____

YEARS OF RESIDENCE IN ANY OF THE FOLLOWING COUNTIES:

_____ PINELLAS _____ HILLSBOROUGH _____ SARASOTA _____ MANATEE _____ PASCO _____ POLK

_____ OTHER FLORIDA AREAS (SPECIFY): _____

FATHER'S NAME _____ MOTHER'S NAME _____

FATHER'S HEBREW NAME _____ MOTHER'S HEBREW NAME _____

FATHER'S PLACE OF BIRTH _____ MOTHER'S PLACE OF BIRTH _____

RELIGIOUS PREFERENCE: _____ NAME OF SYNAGOGUE: _____

CITY: _____ RABBI: _____ PHONE #: _____

DO YOU OBSERVE KOSHER DIETARY LAWS: ☐ YES ☐ NO ☐ AT HOME ONLY

FAMILY

PLEASE LIST FAMILY MEMBERS:

1. NAME: _____ SPOUSE'S NAME: _____

ADDRESS: _____ PHONE (HOME): _____

CITY: _____ STATE: _____ ZIP: _____

OCCUPATION & EMPLOYER: _____ PHONE (work): _____

CELL PHONE: _____ FAX: _____

EMAIL: _____ ☐ CHECK HERE TO OPT OUT OF EMAIL CORRESPONDENCE

RELATIONSHIP: _____ SPOUSE'S PHONE _____ ☐ WORK ☐ CELL

☐ CONTACT FOR HEALTH CARE MATTERS ☐ CONTACT FOR FINANCIAL MATTERS

☐ HEALTHCARE SURROGATE ☐ POWER OF ATTORNEY

☐ OTHER _____

2. NAME: _____ SPOUSE'S NAME: _____

ADDRESS: _____ PHONE (HOME): _____

CITY: _____ STATE: _____ ZIP: _____

OCCUPATION & EMPLOYER: _____ PHONE (work): _____

CELL PHONE: _____ FAX: _____

EMAIL: _____ ☐ CHECK HERE TO OPT OUT OF EMAIL CORRESPONDENCE

RELATIONSHIP: _____ SPOUSE'S PHONE _____ ☐ WORK ☐ CELL

☐ CONTACT FOR HEALTH CARE MATTERS ☐ CONTACT FOR FINANCIAL MATTERS

☐ HEALTHCARE SURROGATE ☐ POWER OF ATTORNEY

☐ OTHER _____

3. NAME: _____ SPOUSE'S NAME: _____

ADDRESS: _____ PHONE (HOME): _____

CITY: _____ STATE: _____ ZIP: _____

OCCUPATION & EMPLOYER: _____ PHONE (work): _____

CELL PHONE: _____ FAX: _____

EMAIL: _____ ☐ CHECK HERE TO OPT OUT OF EMAIL CORRESPONDENCE

RELATIONSHIP: _____ SPOUSE'S PHONE _____ ☐ WORK ☐ CELL

☐ CONTACT FOR HEALTH CARE MATTERS ☐ CONTACT FOR FINANCIAL MATTERS

☐ HEALTHCARE SURROGATE ☐ POWER OF ATTORNEY

☐ OTHER _____

PLEASE SUBMIT COPIES OF POWER OF ATTORNEY AND/OR HEALTH CARE SURROGATE PAPERS.

CONFIDENTIAL FINANCIAL REPORT

MEDICARE NUMBER: _____ MEDICAID NUMBER: _____

SUPPLEMENTAL HEALTH INS. COMPANY: _____

ADDRESS: _____ POLICY #: _____

LIFE INSURANCE: COMPANY _____ POLICY #: _____

ADDRESS: _____ AMOUNT: _____ BENEFICIARY: _____

PREPLANNED FUNERAL? ☐ YES ☐ NO FUNERAL HOME _____ PHONE #: _____

IF YOU HAVE NOT MADE FUNERAL ARRANGEMENTS, PLEASE INDICATE WHICH FUNERAL HOME YOU WOULD WANT US TO CONTACT SHOULD THE NEED ARISE. NAME _____ PHONE #: _____

RESERVED PLOT? ☐ YES ☐ NO NAME OF CEMETERY? _____ PHONE #: _____

REGULAR MONTHLY INCOME

	Applicant	Spouse
Social Security	$ _____	$ _____
Pension	$ _____	$ _____
Dividends	$ _____	$ _____
Interest	$ _____	$ _____
Property Income	$ _____	$ _____
IRA Income	$ _____	$ _____
Trust Income	$ _____	$ _____
Other Income	$ _____	$ _____
Total	$ _____	$ _____

Total Regular Monthly Income $ _____

ASSETS

Cash (Savings & Checking)	$ _____	$ _____
CDs, Money Markets, etc.	$ _____	$ _____
Stocks & Bonds	$ _____	$ _____
IRAs / Annuities	$ _____	$ _____
House or Condo	$ _____	$ _____
Other Real Estate	$ _____	$ _____
Trust Fund	$ _____	$ _____
Life Insurance	$ _____	$ _____
Other Asset(s)	$ _____	$ _____
Total	$ _____	$ _____

Total Capital Asset $ _____

IF RESOURCES HAVE BEEN TRANSFERRED WITHIN 5 YEARS PRIOR TO THIS APPLICATION, ATTACH A SEPARATE PAGE WITH THE PARTICULARS. ALL APPLICANTS MUST SUBMIT MOST RECENT TAX RETURN.

HEALTH INFORMATION

CURRENT PRIMARY CARE PHYSICIAN (NAME): _____

PHONE: _____ FAX: _____

ADDRESS: _____

PSYCHIATRIST/PSYCHOLOGIST: _____

PHONE: _____ FAX: _____

ADDRESS: _____

REASON FOR APPLYING TO MENORAH MANOR: _____

_____

_____

_____

I HEREBY VOLUNTARILY MAKE APPLICATION FOR RESIDENCY AT MENORAH MANOR. I AND MY IMMEDIATE FAMILY WHO HAVE SIGNED BELOW, AFFIRM THAT ALL INFORMATION PROVIDED IS FACTUAL TO THE BEST OF OUR KNOWLEDGE AND AGREE TO ABIDE BY THE RULES AND REGULATIONS OF MENORAH MANOR.

DATE: _____

APPLICANT'S SIGNATURE: _____

SIGNATURES OF IMMEDIATE FAMILY AND/OR HEALTH CARE SURROGATE OR POWER OF ATTORNEY:

_____

_____

_____

_____

Menorah
MANOR

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MANOR

MENORAH MANOR
RELEASE/REQUEST OF INFORMATION FORM

Resident name: _____ Social Security #_____

I, _____, hereby give permission to Menorah Manor to obtain/release any medical, psychiatric and/or financial information needed for any of the following:

- Evaluation of application for admission
- Evaluation for continued care
- Correspondence with insurance company/managed care, Medicare or Medicaid
- For Medicaid applicants and beneficiaries - permission to have access to financial information from resident's bank

A copy of this release shall serve the same as the original.

_____ _____
Resident or Responsible Party Date

_____
Relationship to Resident

_____ _____
Witness Date

Fax: 727 345-3957
Email:admissions@menorahmanor.org