# Application for Admission

**Updated 10-20-15**

## Care-Age of Brookfield

1755 N. Barker Rd Brookfield, WI 53045
Ph: 262-821-3939 Fx: 262-821-3944 Email: admit@care-age.com

**To be considered for admission to Care-Age of Brookfield, a fully completed Application must be submitted.**

Applicant Name_____ Age_____ ☐ Male ☐ Female

Home Address_____

_____Home Phone_____

Home Address is: ☐ House/Condo ☐ Independent Apartment ☐ Assisted Living ☐ Nursing Home ☐ Other

Applicant lives with: ☐ Alone ☐ Spouse ☐ Adult Child ☐ Sibling ☐ Significant Other ☐ Other_____

Date of Birth_____ Social Security #_____

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Never Married

Applicant is currently at (example: Home, Elmbrook Hospital, etc):_____

Has the Applicant had a previous stay in a Rehab Facility or Nursing Home? ☐ No ☐ Yes, where/when_____

_____

### Requested Length of Stay at Care-Age:

☐ **Short-Term / Temporary Stay:** ☐ 1 – 30 Days ☐ 31 – 60 Days ☐ 61 – 100 Days

☐ **Long-Term / Permanent Residence**

Type of Room Desired: ☐ Semi-Private ☐ Private ☐ Private Suite ☐ No Preference

Main Contact Person_____Phone_____

Health Care Power of Attorney Agent_____Phone_____

Durable Financial Power of Attorney Agent_____Phone_____

Legal Guardian of Person / of Estate_____Phone_____

# INSURANCE

**Medicare:**

Applicant has ☐ Traditional Medicare #_____

OR

☐ Medicare Advantage / Replacement #_____

List Company Name, i.e. AARP, United HealthCare, Humana, Anthem Blue Cross, etc… and Claims Address & Phone Number:

_____

_____

**Medicaid:** Does the Applicant have Medicaid Title 19? ☐ No ☐ Yes, Medicaid #_____

If Yes, please check Type of Medicaid T19: ☐ Regular

OR

☐ Family Care (Care WI, Community Care, etc…)

Does Applicant have **Long-Term Care Insurance**? ☐ No ☐ Yes, Name of Company:_____

_____

**List Company Name, Policy / ID #, Claims Address, Phone Number:**

☐ Secondary / Supplemental Plan:_____

_____

☐ Primary Commercial / Employer Plan (full-time employment):_____

_____

☐ Prescription Drug Plan:_____

_____

☐ Other Plan:_____

# Financial Application

**Updated 07/01/2020**

## Care-Age of Brookfield

1755 N. Barker Rd Brookfield, WI 53045 Ph: 262-821-3939 Fx: 262-821-1749 Email: sjacobs@care-age.com

**To be considered for long term to Care-Age of Brookfield, a fully completed Application must be submitted.**

Applicant Name_____ Date of Birth_____

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Never Married

Main Contact Person_____ Phone_____

Financial Information

| SOURCES OF INCOME | AMOUNT | HOW OFTEN RECEIVED? |
|---|---|---|
| 1. | $ | ☐ WEEKLY ☐ MONTHLY ☐ QUARTERLY ☐ ANNUALLY |
| 2. | $ | ☐ WEEKLY ☐ MONTHLY ☐ QUARTERLY ☐ ANNUALLY |
| 3. | $ | ☐ WEEKLY ☐ MONTHLY ☐ QUARTERLY ☐ ANNUALLY |

### Assets

| | Current Value/ amount | Applicant owns | Marital property | Asset Name/location |
|---|---|---|---|---|
| **Checking account:** | $ | % | Y/N | |
| **Savings account:** | $ | % | Y/N | |
| **Stocks:** | $ | % | Y/N | |
| **Bonds/Annuities/Etc.** | $ | % | Y/N | |
| **CDs:** | $ | % | Y/N | |
| **Additional Assets:** | $ | % | Y/N | |
| **Home:** | $ | % | Y/N | |
| **Any liens or mortgages?** | Y/N | | | |
| **Any real estate sold or transferred in last 5 years?** | Y/N | | | |

Expenses

| Whom is payment made? | AMOUNT | HOW OFTEN Paid? |
|---|---|---|
| 1. | $ | ☐ WEEKLY ☐ MONTHLY ☐ QUARTERLY ☐ ANNUALLY |
| 2. | $ | ☐ WEEKLY ☐ MONTHLY ☐ QUARTERLY ☐ ANNUALLY |
| 3. | $ | ☐ WEEKLY ☐ MONTHLY ☐ QUARTERLY ☐ ANNUALLY |

Applicant acknowledges that this Application was filled out in Good Faith and the information provided in this Application is current and accurate to the best of his/her knowledge. Applicant understands that providing false or misleading information to Care-Age of Brookfield can be considered fraud and may disqualify Applicant from being admitted to Care-Age. If Applicant chooses to apply for government benefits, i.e. Medicaid Title 19, to help cover the cost of healthcare, Applicant understands that providing false or misleading information to the government is considered fraud and can disqualify Applicant from obtaining benefits. If Applicant or Spouse chooses to do the following with their Assets within 5 years prior to applying for Medicaid Title 19, the government may issue a Penalty Period. During a Penalty Period, an Applicant will not receive Medicaid Title 19 benefits to pay for their healthcare or Care-Age bills. If an Applicant's Care-Age bill is not paid, Applicant may be issued a Discharge Notice: *Sell Assets for less than Fair Market Value; Gift Assets; Transfer Assets out of name; Divest Assets; Put Assets in a Trust or Protect Assets.*

Applicant Signature_____ Date_____

Representative Signature_____ Date_____

Specify Relationship / Authority (i.e. Son, Durable Power of Attorney)_____