



**MARQUARDT MEMORIAL MANOR**

1020 Hill Street • Watertown, WI 53098-3099  
 Telephone: 920-261-0400; Fax: 920-261-4840

**For Office Use Only**

Date Admitted	Rm# Bed#	Admitted From	File No.
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**ADMISSION APPLICATION**

NAME: LAST	FIRST	MIDDLE	MAIDEN	BIRTHDATE	AGE	SEX	MARITAL STATUS (S M W D)	RACE
NAME PREFERS TO BE CALLED	USUAL RESIDENCE	STREET	CITY	COUNTY	STATE	ZIP	HOME PHONE	
BIRTH PLACE	CITY	COUNTY	STATE	NAME OF SPOUSE	CAUSE OF DEATH	DATE OF DEATH	DATE OF MARRIAGE	PLACE OF MARRIAGE
FORMER OCCUPATION	EDUCATION		MILITARY SERVICE – WAR OR DATES					
ATTENDING PHYSICIAN	ADDRESS	PHONE	SPECIALIST INVOLVED	ADDRESS	PHONE			
DENTIST PREFERENCE	PHONE	PODIATRIST PREFERENCE	PHONE	OPTOMETRIST PREFERENCE	PHONE			
FUNERAL HOME PREFERENCE	PHONE	RELIGION	CHURCH / SYNAGOGUE	ADDRESS	CLERGY	PHONE		
MANAGER OF ACCOUNT	RELATIONSHIP	ADDRESS	PHONE	LEGAL GUARDIAN	Advance Directives <input type="checkbox"/> POA –HC <input type="checkbox"/> Living Will <input type="checkbox"/> DPOA <input type="checkbox"/> Other			
SOCIAL SECURITY #	MEDICARE #	MEDICAID # / FAMILY CARE			VA #			
MEDICARE SUPPLEMENTAL INSURANCE COMPANY NAME	SUBSCRIBER #	POLICY #	MEDICARE PART D (PRESCRIPTION DRUG COVERAGE) COMPANY NAME	SUBSCRIBER #	POLICY #			
MEDICARE PART C (MEDICARE ADVANTAGE) COMPANY NAME	SUBSCRIBER #	POLICY #	LONG-TERM CARE INSURANCE / OTHER INSURANCE COMPANY NAME	SUBSCRIBER #	POLICY #			

HAVE YOU SOLD OR GIVEN AWAY PROPERTY, LAND, STOCKS, BONDS, CASH, ETC. WITHIN THE LAST 60 MONTHS?  Yes  No  
 IF SO, DESCRIBE AND INCLUDE DATES (Any divestment made within the last 60 months may disqualify the applicant from Medicaid Eligibility.)

HAVE YOU EVER BEEN A RESIDENT AT ANOTHER NURSING HOME?  Yes  No If so, where and indicate admission & discharge dates.

I request MMM to furnish personal laundry.  Yes  No If NO, person laundry will be done by: Hearing Aid?  Yes  No Where purchased or currently serviced:

I have my own wheelchair.  I request to rent a wheelchair from MMM.

**MAIL**  
 Cards and letters to be sent to: Business Mail to be sent to:

Signature: \_\_\_\_\_

**EXHIBIT A**

**CONFIDENTIAL FINANCIAL STATEMENT**

For purposes of applying for admission to Marquardt Memorial Manor, Inc. ("Facility"), I am providing the following complete and accurate description of my financial condition. I understand that I am required to provide Facility with updates of my financial condition as it changes by submitting this form or any other form(s) provided to me by Facility with updated, accurate, and complete information.

**BACKGROUND.**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_ If married, name of spouse: \_\_\_\_\_

**INCOME.** Please identify your monthly income. If you are married, please include the income of your spouse. If you receive a type of income that is not listed, please use the "other" category to identify this income. Unless expressly noted, you represent that all income is available to pay for your care and/or services. All boxes should be completed. If a source of income is not applicable, mark "N/A" in the box. Please use additional pages as necessary.

Monthly Income	Applicant (per month)	Spouse (per month)
Social Security	\$	\$
Veterans Benefits	\$	\$
SSI (Supplemental Security Income)	\$	\$
Alimony	\$	\$
Unemployment Compensation	\$	\$
Pension	\$	\$
Retirement Plans	\$	\$
Disability Plans	\$	\$
Income from Stocks and Bonds	\$	\$
Rental Income Paid to You	\$	\$
Annuities	\$	\$
Trust Fund	\$	\$
Interest Income from Savings	\$	\$
Other: Description _____	\$	\$

Total Monthly Income	\$	\$

**ASSETS.** Please list your current assets. If an asset is owned by a trust, indicate the name and type of trust. If an asset is jointly owned, identify the other owners and your percentage of ownership. Unless expressly noted, you represent that the listed assets are available to pay for your care and/or services. All boxes should be completed. If an asset type is not applicable, mark "N/A" in the box. Please use additional pages as necessary.

Assets	Mark If Applicable	Who owns (applicant, spouse, jointly, trust). If joint, identify co-owner. If trust, identify name of trust.	Amount
Checking Account/Name of Bank _____ Interest Bearing Yes/No Account # _____			\$
Savings Account/Name of Bank _____ Account # _____			\$
Cash on Hand			\$
Stocks: Description _____ _____			\$
Bonds: Description _____ _____			\$
Certificates of Deposit			\$
Money Owed to You			\$
Real Estate Owned: Description _____ _____			\$
Land Contract			\$
Farm Equipment			\$
Livestock			\$
Vehicles			\$
Other: Description _____ _____			\$

**TRANSFER OF ASSETS.** Please identify any assets or other financial resources worth over \$5,000 that you have given away or sold for less than fair market value within the last year five years. Please use additional pages as necessary.

Description of What Was Sold or Given Away: \_\_\_\_\_  
 By Whom: \_\_\_\_\_  
 To Whom: \_\_\_\_\_  
 Date of Gift or Sale: \_\_\_\_\_  
 Total Market Value: \_\_\_\_\_  
 Amount Received: \_\_\_\_\_

**LIABILITIES.** Indicate any significant liabilities that you owe. All boxes should be completed. If a liability is not applicable, mark "N/A" in the box. If a liability type is not listed, please use the "other" category to identify those liabilities. Please use additional pages as necessary.

Liabilities	Mark If Applicable	Amount
Credit Cards		\$
Taxes		\$
Medical Bills		\$
Loans: Description: _____ _____		\$
Health Insurance Costs		\$
Other: Description: _____ _____		\$

**POWER OF ATTORNEY FOR FINANCES.**

Do you have a Power of Attorney for Finances? Yes \_\_\_ No \_\_\_. If yes, please provide name of agent: \_\_\_\_\_

**MEDICARE.**

Are you enrolled in Medicare Part A? Yes \_\_\_ No \_\_\_. If you are not eligible, do you have an equivalent insurance policy? Yes \_\_\_ No \_\_\_.

Do you have a supplemental Medicare policy ("Medigap")? Yes \_\_\_ No \_\_\_.

**LONG-TERM CARE INSURANCE.**

Do you have long-term care insurance? Yes \_\_\_ No \_\_\_. If yes, provide name of insurance company: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

**LIFE INSURANCE.**

Do you have life insurance? Yes \_\_\_ No \_\_\_. If yes, provide the following:

Cash Value: \_\_\_\_\_

Face Value: \_\_\_\_\_

Company Name: \_\_\_\_\_

Date Issued: \_\_\_\_\_

**ACKNOWLEDGEMENT.**

By signing this form, I represent and warrant that the above information is true and correct and accurately reflects my financial condition and the resources that are available to pay for my care and/or services. I agree to provide Facility with updates regarding changes in my financial condition. I understand that Facility will be relying on the information provided herein and may terminate any and all agreements with me if I provide false or misleading information or fail to provide Facility notice of changes in my financial condition. I further give Facility permission to verify the information provided herein. I also understand that I may be required to provide supporting documentation regarding the financial data I have provided and provide updated financial information and agree to do so upon request. I believe I have adequate resources to meet my financial responsibilities, including those that will attach if I am accepted into Facility.

\_\_\_\_\_  
Signature of Prospective Resident

\_\_\_\_\_  
Date

If prospective resident is unable to sign, complete the following:

Name of Personal Representative: \_\_\_\_\_

Authority to Act: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date

**FOR FACILITY USE ONLY:**

Received on \_\_\_\_\_

by \_\_\_\_\_.