Hubbard Hill
Retirement Community

Apt. #____________, Date keys given (rent begins): ______________

APPLICATION FOR RESIDENCY

Name: Ms / Mrs. / Mr. ____ Phone: ______________________

Address: ____

Date of Birth: _____________________ Age: _________ County of Residence: ________________________

Name of Spouse: ________________________________ if deceased, when? __________________________

Anniversary Date: _________________________________

U.S. Citizen? Yes____ No____ Served military duty? Yes____ No____ What branch? _________________

Social Security #_________-_______-_________ **Medicare #**_________-_______-_________

Primary Language: ___________________________ Secondary Language: __________________________

Supplemental Insurance Company(s) ____

I.D. #__________________ Acct. #__________________ Code: ______________________________

Long Term Care Insurance Company s) ____

I.D. #_________________ Acct. #__________________ Code: ______________________________

LIST OF CONTACTS

Name: ____ Relationship: ____________________________

Address:

____

Phone #________________________ Cell #________________________ Work #________________________

Email Address: ____

Name: ____ Relationship: ____________________________

Address:

____

Phone #________________________ Cell #________________________ Work #________________________

Email Address: ____

Name: ____ Relationship: ____________________________

Address:

____

Phone #________________________ Cell #________________________ Work #________________________

Email Address: ____

Name: ____ Relationship: ____________________________

Address:
____

Phone #_______________________ Cell #_______________________ Work #_______________________

Email Address: ____

Whom do you wish notified in the event of emergency?

Name: ____ Relationship: ____________________________

Address:
____

Phone #_______________________ Cell #_______________________ Work #_______________________

MEDICAL HISTORY

1. Do you have any chronic illnesses? Yes No (circle one)
2. Have you had any serious illness in the past 5 years? Yes No (circle one)
   If yes, please list:
   ____
   ____
   ____
   ____
3. List the current medications you are taking:
   ____
   ____
   ____
   ____
4. Do you use tobacco, alcohol, or narcotics in any form? Yes No (circle one)
5. Do you see your physician regularly? Yes No (circle one)

   When was your last visit? ____

Your Physician: Name____________________________________ Phone #_____________________

Address: ____

Your Dentist: Name______________________________________ Phone#______________________

Address: ____

Your Pharmacy: Name___________________________________ Phone #______________________

Address: ____

Hospital Preference: ____

Funeral Home preference:

Name____ Phone #_____________________

Address: ____

SOCIAL SERVICE INFORMATION

1. What are your current living arrangements? ____
2. How long can these arrangements continue? ____
3. What are your reasons for desiring to live at Hubbard Hill?
   ____
4. With what other facilities do you have application for admission?
   ____
5. Your profession or occupation?
   ____

   Year of Retirement__________________
6. Have you been a resident in any other facility? Yes No (circle one)

   If yes, give name:
   ____
7. Church membership or affiliation: ____

   Clergyman: ____ Phone: _____________________

   Hobbies, interests, or talents: ____

   ____

   Clubs, memberships or civic organizations you are involved in: _______________________________

   ____

NECESSARY FINANCIAL INFORMATION

Will the resident be paying for the services provided out of own funds? Yes____ No____

If the resident is paying out of own funds, the resident must qualify financially. It is important, in the interest of prospective residents, as well as the facility, to determine in advance whether or not an applicant is able to pay the cost of residency at Hubbard Hill. The following information is needed for such an evaluation. If you should desire not to disclose your financial status, a statement from your banker, financial planner, or trust officer assuring the facility that you will have adequate resources to meet your monthly obligations, will be accepted.

1. Approximate monthly income is: ____

2. Cash Assets:

Bank: ___________________________________ Location: _____________________________________

Checking Account #: _______________________ Savings Account #____________________________

Balance in Account: _______________________ Balance in Account: ___________________________

Certificates of Deposit? Yes______ No______

If yes, identify the bank or institution where held and amount:

____
(Institution) (Amount)

____
(Institution) (Amount)

____
(Institution) (Amount)

Safe Deposit Box? Yes______ No______

If yes, indicate location. Bank Name: ____

Real Estate Assets: Do you own your home? Yes______ No______

Approximate value: $______________________ Mortgage balance: $______________________
Is it your intention to use proceeds from that sale of your home to pay for your living expenses at Hubbard Hill? Yes_____ No_____

Do you own any other property? Yes______ No______

Do you own any Life Estates? Yes______ No______

If yes, where is the property located? ____

Do you have any "rental" income? Yes______ No______

How much per month? $________________________ per year $______________________________

3. Life insurance Cash Value:

   Do you have life insurance policies with cash value? Yes______ No______

   The approximate amount of cash value? ____

   Annuities: $____

   Company Name: ____

   Agents Name: _____________________________________ Agents telephone #____________________

   Is there a Burial Trust Fund? Yes______ No _______

   If yes, where? ____

4. Securities:

Do you have stocks and/or bonds? Yes______ No ______

Approximate value of all securities: $ ___________________________

Agent handling securities: Name: ____

Address: ____

Telephone Number: ____

5. Other Income:

Social Security Check: $________________________ Disability Check: $_________________________

Pension: $____________________ From: ________________ Other: $___________________________

Annuity: $____________________ From: ________________

Identify who receives each monthly check: ____

7. The Hubbard Hill monthly statement should be mailed to:

Name: ____

Address: ____

Phone # ________________________________ Relationship: _________________________________

AUTHORIZATION AND CONSENT FOR APPLICATION

Everything stated in this application is true and correct. I understand that Hubbard Hill Estates, Inc. will check my bank references and credit history and I authorize this. I also understand Hubbard Hill Estates, Inc., considers this application as a continuing statement of financial condition and I agree to notify the facility in writing of any substantial change in financial condition. All of this information will be kept strictly confidential by the facility. I agree that a photocopy shall have the full force and effect as the original of this application.

Signature of Resident: ____ Date: ______________________

Sponsor/Responsible Party: ____ Date: ________________

I heard about Hubbard Hill from: ____

NONDISCRIMINATION POLICY

As a recipient of Federal financial assistance, Hubbard Hill does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Hubbard Hill directly or through a contractor or any other entity with which Hubbard Hill arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Provider Name: Hubbard Hill Estates, Inc.

Contact Person/Patrick Pingel

Telephone number: 574-295-6260

Thank You for choosing

28070 C.R. 24 West, Elkhart, IN 46517-9717
Phone: 574.295.6260 Toll Free: 866-295-6260 Fax: 574.295.5852
e-mail:info@hubbardhill.org www.hubbardhill.org Find us on Facebook!