

**Kitty Rhoades Memorial Memory Care Center**

1446 North 4<sup>th</sup> Street  
New Richmond, WI 54017  
Phone: (715) 246 8300  
Fax: (715) 246-8331



**Admission Application**

Application Date: \_\_\_\_\_

**Personal Information:**

Name of Resident \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

County of Legal Residence \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_ If deceased, Date of Death \_\_\_\_\_

Present Housing ☐ Alone ☐ With Spouse ☐ Assisted Living ☐ Other \_\_\_\_\_

Name/Location of Present Housing \_\_\_\_\_

Applicant's Former Occupation \_\_\_\_\_ Religion/Church \_\_\_\_\_

**Contact Information:**

Desired Date of Admission \_\_\_\_\_

Contact Person \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Power of Attorney or Guardian and Family Information:**

List below the applicant's Power(s) of Attorney or Guardian(s) and the names of children. If there are no children, interested relatives and/or friends may be listed. Additional names may be provided on a separate sheet of paper.

☐ Power of Attorney or ☐ Guardian For ☐ Healthcare ☐ Finance

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

☐ Power of Attorney or ☐ Guardian For ☐ Healthcare ☐ Finance

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Other Children/Family or Friends Listed in Order of Priority:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Add any additional names and contact information on the back of last page.

**Assets:**

Does Resident own his/her own home: Yes \_\_\_\_ No \_\_\_\_ Does Resident own other property: Yes \_\_\_\_  
No \_\_\_\_

If yes, explain \_\_\_\_\_

Residents Monthly Income: Social Security \$ \_\_\_\_\_ Pension \$ \_\_\_\_\_ Other Income  
\$ \_\_\_\_\_

Checking Account: Yes \_\_\_\_ No \_\_\_\_ \$ \_\_\_\_\_ Date \_\_\_\_\_ Bank \_\_\_\_\_

Savings Account: Yes \_\_\_\_ No \_\_\_\_ \$ \_\_\_\_\_ Date \_\_\_\_\_ Bank \_\_\_\_\_

Money Markets: Yes \_\_\_\_ No \_\_\_\_ \$ \_\_\_\_\_ Date \_\_\_\_\_ Bank \_\_\_\_\_

Certificate of Deposits: Yes \_\_\_\_ No \_\_\_\_ \$ \_\_\_\_\_ Date \_\_\_\_\_ Bank \_\_\_\_\_

Other: Please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Monthly Income:

Resident

Spouse

Total Monthly Pension(s)	\$ _____	\$ _____
Monthly Social Security	\$ _____	\$ _____
Monthly Interest Income	\$ _____	\$ _____
Monthly Dividend Income	\$ _____	\$ _____
Monthly Investment Property Income	\$ _____	\$ _____
Veteran's Benefits	\$ _____	\$ _____
(List Others) _____	\$ _____	\$ _____

Total Amount of All Monthly Incomes: \$ \_\_\_\_\_ \$ \_\_\_\_\_

**Liabilities:**

List of Substantial Gifts/Donations over \$3000 Given Annually \$ \_\_\_\_\_

\_\_\_\_\_

List Debt on Purchases over \$3000 Annually \$ \_\_\_\_\_

\_\_\_\_\_

List ongoing Monthly Payments and Amounts for each: \$ \_\_\_\_\_

\_\_\_\_\_

In the last five years, has the resident divested of any money? Yes \_\_\_\_\_ No \_\_\_\_\_

Divestment is giving away one's resources, such as income, non-exempt assets and property for less than fair market value in order to enroll in Medicaid for Elderly, Blind or Disabled (EBD). Divestment is also an action taken to avoid receiving income or assets that one is entitled to receive. For example, waiving pension income or disclaiming an inheritance. Visit the Wisconsin Department of Health Services website for more information (<https://www.dhs.wisconsin.gov>)

If yes to who and how much \$ \_\_\_\_\_ To \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Insurance:**

Medicare # \_\_\_\_\_ Part A \_\_\_\_\_ Part B \_\_\_\_\_ Effective Date \_\_\_\_\_  
(Please turn in copy of card to Business Office)

Medicaid # \_\_\_\_\_  
(Please turn in copy of card to Business Office)

Medicare Advantage Plan: Yes \_\_\_\_\_ No \_\_\_\_\_ Medicare Supplement: Yes \_\_\_\_\_ No \_\_\_\_\_

Health Insurance: Yes \_\_\_\_\_ No \_\_\_\_\_

Other: Explain \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Phone# \_\_\_\_\_  
(Insurance Verification Form to be completed by Business Office)  
(Please turn in copy of card to Business Office)

Medicare and insurance information must accompany the applicant at the time of admission.  
Photocopies will be made of the cards and a photo ID.

**Life Insurance Policies:**

Name of Insurance Co \_\_\_\_\_ Policy # \_\_\_\_\_ Cash Value \_\_\_\_\_

Name of Insurance Co \_\_\_\_\_ Policy # \_\_\_\_\_ Cash Value \_\_\_\_\_

Social Security Number \_\_\_\_\_

If applicant has Long Term Care Insurance, list name of the insurance  
provider \_\_\_\_\_ Policy/ Group Numbers \_\_\_\_\_

If applicant has prescription drug insurance, list name of the insurance  
provider \_\_\_\_\_ Policy/ Group Numbers \_\_\_\_\_

**Medical Provider Information:**

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

Eye Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

**Special Arrangements:**

Kitty Rhoades Memorial Memory Care Center, nor St Croix County assumes responsibility for burial in the event of the applicant's death. Next of kin or legally responsible person are expected to make all arrangements and assume all expenses.

Name of Funeral Home \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

**Consents:**

Kitty Rhoades Memorial Memory Care Center personnel conduct pre-admission evaluations, whenever possible, at the residence or facility where the applicant is staying to ensure the appropriate placement of the applicant. The pre-admission evaluation includes a personal interview with the resident, when possible, or their legal representative and the viewing of the applicant's medical record at the healthcare facility in which they may be staying. If the applicant is residing at home at the time of the application, the applicant consents to disclosure of medical records from various clinics and/or hospitals. The competent applicant or their designated healthcare power of attorney or guardian must provide consent for this to occur. This consent will remain in force until the applicant is admitted to Kitty Rhoades Memorial Memory Care Center or this application is withdrawn by contacting the Kitty Rhoades Memorial Memory Care Center Admissions Coordinator.

I hereby consent to a pre-admission evaluation which may include viewing the healthcare record of the facility in which the applicant is currently staying.

\_\_\_\_\_  
Signature of Applicant or Designated Representative\*

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Relationship

\* Resident's Representative understands and agrees that by signing this Agreement he/she is signing in both a representative and individual capacity.