The Nottingham

Confidential Data Application

Personal Information

Applicant's Name (First, Middle, Last)		
Present Address Street		
City	**State**	**Zip**
Home Phone Number	**Mobile Phone Number**	
Social Security Number	**Date of Birth** (month, date, year)	
Email Address		
Marital Status (check one) ☐ Single ☐ Married ☐ Widowed ☐ Divorced		
Name of Spouse (even if deceased)		
Spouse's Social Security Number	**Spouse's Date of Birth** (month, date, year)	

Health Insurance Coverage (Please provides copies of any marked Yes)

	APPLICANT	SPOUSE
MEDICARE Part A (check one)	☐ Yes ☐ No	☐ Yes ☐ No
MEDICARE Part B (check one)	☐ Yes ☐ No	☐ Yes ☐ No
MEDICARE Number(s)	#	#
	APPLICANT	**SPOUSE**
Secondary Insurance (check one)	☐ Yes ☐ No	☐ Yes ☐ No
Secondary Insurance Carrier Address Street		
City	**State**	**Zip**
Group Plan Number(s)	#	#

Emergency Contact Information

Emergency Contact #1:

Name (First, Last)	Relationship	
Address Street		
City	**State**	**Zip**
Home Phone Number	**Work Phone Number**	
Mobile Phone Number	**Email Address**	

Emergency Contact #2:

Name (First, Last)	Relationship	
Address Street		
City	**State**	**Zip**
Home Phone Number	**Work Phone Number**	
Mobile Phone Number	**Email Address**	

Physicians

Primary Care Physician		**Phone Number**	
Address Street	**City**	**State**	**Zip**
Spouse's Primary Care Physician		**Phone Number**	
Address Street	**City**	**State**	**Zip**

Other Health/Mental Health Providers

Name/Care Specialty		**Phone Number**	
Address Street	**City**	**State**	**Zip**

Hospital Preference

Advanced Care Directives (Please provides copies of any marked Yes)

Health Care Proxy (check one)	☐ Yes	☐ No
Living Will (check one)	☐ Yes	☐ No
Non-hospital D.N.R. (check one)	☐ Yes	☐ No

Financial Disclosure Statement

(Must be completed by each individual; joint holdings must also be noted). Please attach copy of recent account statements.

Trust

Has the applicant and/or spouse created a Trust?	☐ Yes ☐ No
Is the trust Irrevocable or Revocable?	☐ Irrevocable ☐ Revocable
Date Established	Attorney's Name
Is the applicant and/or spouse currently working with an attorney?	☐ Yes ☐ No
If yes, Attorney Name	Attorney Phone Number

Sources of Current Monthly Income

	APPLICANT	SPOUSE
Social Security	$	$
Veterans Pension	$	$
Other Pension	$	$
Dividends	$	$
Interest	$	$
IRA/TDA/TSA	$	$
Trust	$	$
Other Income (list sources)	$	$
TOTAL MONTHLY INCOME	$	$

Sources of Cash Assets

	APPLICANT	SPOUSE
Savings	$	$
Checking	$	$
CDs	$ /Maturity Date	$ /Maturity Date
Stocks and Bonds	$	$
IRA/Annuities	$	$
Irrevocable Trust	$	$
Revocable Trust	$	$
Life Insurance	$ /Cash Value	$ /Cash Value
TOTAL CASH ASSETS	$	$

Transfer of Assets Within the Last Five Years:

Asset Transferred	$ Amount or Value	Date of Transfer	Receiver Name
	$		
	$		
	$		
	$		
	$		

Long Term Care Insurance

	APPLICANT	SPOUSE
Company Name		
Daily Benefit	$	$
Maximum Benefit	$	$
Services Covered		

Real Estate

Property Address	Value $
Property Address	Value $

Rental Property

☐ Yes ☐ No	Rental Address	Monthly Rental Income $

Debts and Obligations (Please list all debts and obligations)

Debt/Obligation	$
Debt/Obligation	$
Debt/Obligation	$

Legal Information

Person Responsible for Finances (Who writes the checks)

Name (First, Last)	Relationship	
Address Street		
City	**State**	**Zip**
Home Phone Number	**Work Phone Number**	
Mobile Phone Number	**Email Address**	

Power of Attorney (Must provide copy)

Name (First, Last)	Relationship	
Address Street		
City	**State**	**Zip**
Home Phone Number	**Work Phone Number**	
Mobile Phone Number	**Email Address**	

PLEASE NOTE: Both Federal and State laws impose severe penalties for obtaining Medicaid fraudulently. Therefore, you must provide an accurate and complete financial disclosure statement, which is required to verify the nature and use of your assets. This complete section of The Nottigham Residency Application and Financial Disclosure Statement may be used in the future, if necessary, to substantiate your request and application for Medicaid.

Please be advised that Federal Law prohibits the transfer of most assets for 60 months (5 years) prior to applying for Medicaid.

Burial Instructions (Optional)

The Nottingham Deposit and Apartment Rental

1. A nonrefundable administrative processing fee of $ $3,900 is required at the time of application.

2. Upon application approval and acceptance of apartment offered, the following will become payable and due. (All rates will reflect current market rate.)

   The first month's rent in the amount of $ _____ will be payable prior to move in.

3. Based on the financial information provided in this application, the applicant is:

   ☐ Approved / not approved for admission to The Nottingham's Enhanced Assisted Living Residence

   ☐ Approved / not approved for admission to The Nottingham's Residential Health Care Facility

I hereby declare that all statements made herein are true to the best of my knowledge.
I authorize you to verify financial information through credit checks and inquiry to financial institutions.

Applicant's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

The Nottingham
Executive Director's Signature: _____ Date: _____

An approved application does not guarantee residency.