Community Name: _____

Financial Support Application

INSTRUCTIONS

Trinity Health Senior Communities (hereinafter "**Ministry**") is committed to providing financial support in its facility to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, other third-party coverage or otherwise unable to pay, for medically necessary care or housing needs based on their individual financial situation.

The information requested in this application is required to determine whether you are appropriate for Ministry's financial support.

Please answer each question truthfully and completely. Incomplete or inaccurate answers to questions may result in a denial of the application, and untruthful answers will result in a denial of the application.

The application process cannot proceed until this application form (along with all supporting documentation) has been completed, signed, and returned to Ministry.

The completed application should be forwarded to:

Trinity Health Senior Communities
Attn: _____
_____
_____

The information provided will be reviewed by Ministry and is subject to independent verification by third parties. Ministry will take reasonable steps to ensure the confidentiality of the information provided, however, we cannot guarantee that the information will be kept confidential.

Ministry does not discriminate on the basis of race, color, age, military status, religion, sex, handicap, familial status, or national origin or sexual orientation.

IDENTIFICATION OF APPLICANT

Name _____

Date of Birth _____

Address _____

Phone Home: _____ Cell: _____ Work: _____

Social Security No. _____

Drivers License No. _____

IDENTIFICATION OF PERSON COMPLETING THE APPLICATION

Name _____

Address _____

Phone Home: _____ Cell: _____ Work: _____

Email Address _____

HEALTH INSURANCE

Medicare # _____ ☐ Not applicable

Medicaid # _____ ☐ Not applicable

Veterans Admin. # _____ ☐ Not applicable

Private Insurance Name _____ ☐ Not applicable
Policy # _____

Private Insurance Name _____ ☐ Not applicable
Policy # _____

Have you ever applied for Medicaid before? Yes_____ No_____

If yes, when? _____ What State? _____ What county? _____

HOUSEHOLD INCOME SOURCES

For each income source below, indicate the monthly amount, to whom and where the payments are currently being sent. If any of the following are being directly deposited, then indicate the name of the financial institution, the account number, and in whose name the account is listed. You should indicate all income sources for both you and your spouse.

1. **Social Security** $_____ ☐ Not applicable

Checks currently sent to:

_____
Name

_____
Address

Direct deposit to:

_____
Financial institution

_____
Account number

_____
Names on account

2. **Veterans' Benefits** $_____☐ Not applicable

Checks currently sent to:

_____
Name

_____
Address

Direct deposit to:

_____
Financial institution

_____
Account number

_____
Names on account

3. **Pension and/or Annuities** $_____☐ Not applicable

Checks currently sent to:

_____
Name

_____
Address

Direct deposit to:

_____
Financial institution

_____
Account number

_____
Names on account

4. **Dividends & Interest** $_____☐ Not applicable

Checks currently sent to:

_____
Name

_____

Address

Direct deposit to:

_____
Financial institution

_____
Account number

_____
Names on account

5. **Rental Property** $_____ ☐ Not applicable

Checks currently sent to:

_____
Name

_____
Address

Direct deposit to:

_____
Financial institution

_____
Account number

_____
Names on account

6. **Litigation**

Do you (or your spouse) have any pending legal actions from which you may receive money?

Yes _____ No _____

If yes, please explain: _____
_____
_____
_____

7. **Other Income**

Please identify any income that you (or your spouse) are currently receiving (or that you expect to receive in the future) that you have not otherwise disclosed in this application:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

LIABILITIES

1. **Spousal Support**

   Are you currently required to pay alimony or spousal support? Yes _____ No _____

   If yes, please identify the amount: $_____ per _____

2. **Child Support**

   Are you currently required to pay child support? Yes _____ No _____

   If yes, please identify the amount: $_____ per _____

3. **Student Loans**

   Do you have any outstanding federally-funded student loans? Yes _____ No _____

   If yes, are you current in all of your payments on the student loans? Yes _____ No _____

   If yes, please identify the amount: $_____ per _____

4. **Spousal Agreement**

   Have you entered into a pre- or post-nuptial agreement? Yes _____ No _____

   If yes, please explain: _____
   _____

5. **Taxes**

   Do you currently owe any taxes that you have not yet paid? Yes _____ No _____

   If yes, please identify the amount: of tax owed $_____ and the circumstances:
   _____

6. **Other Liabilities**

   Please identify any liabilities that you currently owe (or that you expect to owe in the future) that you have not otherwise disclosed in this application. Keep in mind that you will be required to pay these liabilities in full prior to receiving financial assistance.

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

ASSETS

	Name of Institution	Account #	Value/Amount	Names on Acct in addition to Resident	Held in trust?	
Saving					Yes	No
Saving					Yes	No
Checking					Yes	No
Checking					Yes	No
Certificate					Yes	No
Certificate					Yes	No
Certificate					Yes	No
Stock					Yes	No
Stock					Yes	No
Stock					Yes	No
Stock					Yes	No
Bond					Yes	No
Bond					Yes	No
Bond					Yes	No
Mutual Fund					Yes	No
Mutual Fund					Yes	No
Mutual Fund					Yes	No
Life Insurance					Yes	No
Life Insurance					Yes	No
Real Estate					Yes	No
Real Estate					Yes	No
Other:					Yes	No
					Yes	No
					Yes	No
					Yes	No
					Yes	No
					Yes	No
					Yes	No
					Yes	No
					Yes	No

ASSET TRANSFERS & TRUSTS

1. Have you (or your spouse) transferred any assets (i.e., gifts, real estate, bank accounts, money, cars, houses, , bonds, stocks, etc.) to anyone in the last five (5) years?

   Yes _____ No _____

   If yes, then please provide the following the name of the person to whom you (or your spouse) made the transfer, what was transferred, the amount/value of what was transferred, and when the transfer was made:

Name	Asset Transferred	Amount/Value	Date of Transfer

Please attach additional pages, if necessary.

2. Have you (or your spouse) created any trusts in the last five (5) years?

   Yes _____ No _____

   If yes, then please provide the following the name of the trustee, the type of trust, the amount/value of the trust, and the date the trust was created:

Trustee	Type of Trust	Amount/Value	Date of Creation

Please attach additional pages, if necessary.

AUTHORIZATION TO ACCESS FINANCIAL INFORMATION

Name

Address

Social Security Number

To Whom It May Concern:

I hereby authorize Ministry, its trustees, officers, directors, shareholders, members, agents, employees, servants, representatives, instructors, partners, affiliates, attorneys, subsidiaries, predecessors, successors and assigns (collectively the "**Organization**") to have access to my financial records and credit reports, and to consult with any person or entity, including, without limitation, my banks and personal bankers, brokerage firms and brokers, financial institutions, accountants, attorneys, trustees, creditors, health care institutions, government agencies, or other entities or persons that may have information concerning my qualifications for admission to Ministry's nursing facility (collectively "**Persons**"). I authorize the Organization to obtain information related to my income, assets, trusts, real and personal property holdings, life insurance, annuities, debts, obligations, guaranties, and any other encumbrances. I further authorize and request all Persons possibly having information relevant to my application to supply such information to the Organization.

I further authorize and consent to the release by the Organization to Persons of any information and/or documents the Organization may have concerning my application, as long as such release of information is made in good faith.

I hereby release the Organization and any Persons from any and all liability arising out of the release of information, including otherwise privileged or confidential information, concerning my income, assets, trusts, real and personal property holdings, life insurance, annuities, debts, obligations, guaranties, and any other encumbrances.

Photocopies of this release will be as binding as the original.

Signature	*Signature*
Print Name	*Print Name*
Date	*Date*

CERTIFICATION & SUBMISSION OF APPLICATION

The undersigned person(s) grant Ministry, its employees and representatives permission and authority to consult with any health care institutions, government agencies, financial institutions, or other entities or persons that may have information concerning the information provided in this admission application and to cooperate with Ministry in providing any additional follow-up information, and completing any additional documentation, as requested. The undersigned person(s) further authorize and request all persons and entities possibly having information relevant to the material in this application to supply such information to Ministry. The undersigned person(s) agree to timely complete any additional documentation required by Ministry or any third party to effectuate the access to this information.

The undersigned person(s) extend immunity to and hereby release Ministry and any persons or entities from any and all liability arising out of the release of information, including otherwise privileged or confidential information.

Photocopies of this release will be as binding as the original.

The undersigned person(s) warrant that they can legally give the consent and authorizations made above.

THE UNDERSIGNED PERSON(S) REPRESENT(S) THAT THE INFORMATION CONTAINED ON THIS APPLICATION FORM AND ANY ATTACHED DOCUMENTS ARE TRUE TO THE BEST OF HIS/HER/THEIR KNOWLEDGE AND BELIEF. THE UNDERSIGNED PERSON(S) UNDERSTAND THAT TRINITY SENIOR LIVING COMMUNITIES WILL RELY UPON SUCH INFORMATION, AND AGREE THAT ANY MISREPRESENTATION OR MATERIAL OMISSION MADE BY THE UNDERSIGNED PERSON(S) IN CONNECTION WITH THIS APPLICATION MAY RESULT IN THE DENIAL OF THE APPLICATION, THE FUTURE DISCHARGE OF THE RESIDENT, RECOUPMENT OF FINANCIAL ASSISTANCE RECEIVED BY THE APPLICANT, AND/OR POSSIBLE LEGAL ACTION AGAINST THE UNDERSIGNED PERSON(S). THE UNDERSIGNED PERSON(S) UNDERSTAND THAT RECEIPT OF FINANCIAL ASSISTANCE IS NOT GUARANTEED AND THAT TRINITY SENIOR LIVING COMMUNITIES MAY DENY OR REVOKE SUCH ASSISTANCE TO ANY INDIVIDUAL, FOR ANY REASON, AT ITS SOLE DISCRETION.

_____ _____

Applicant Signature Date

_____ _____

Representative Signature Date