



RE: _____
(Applicants Name)

Completion of this form does not guarantee custodial placement, all requirements must be met including Residency.

Please attach copies of 12 months of bank statements and recent investment statements to support the information provided below. We also ask for a current real estate tax bill or mortgage statement and a copy of last year’s income tax return if applicable.

Financial Statement		
Regular Monthly Income	Applicant	Spouse
Social Security	\$	\$
Pension	\$	\$
Dividends:	\$	\$
Interest	\$	\$
Mortgage/Rental Income	\$	\$
IRA Income	\$	\$
Trust Income	\$	\$
Other (Identify source)	\$	\$

Assets	
*Cash – Savings: Bank:	Balance \$
Checking: Bank:	Balance \$
CD's: \$	Money Market: \$
Stocks: \$	Bonds: \$
IRA's: \$	Annuities: \$
Home/Condo: \$	Trust Fund: \$
Life Ins: \$	Other: \$

Liabilities / Expenses			
Primary Residence:	\$	Second Residence:	\$
Auto 1:	\$	Auto 2:	\$
Loan Guarantees	\$		\$
Other Monthly Liabilities			
Gas \$	Electric \$	Phone \$	Cable \$
Water \$	Sewer \$	Disposal \$	Other \$

Please tell us about the applicant.

Activities of Daily Living					
In order for our staff to assess the applicant to establish a plan of care, the following information is required. <u>Please place a check mark next to all assistance that the applicant requires.</u>					
Dressing:	Bathing:	Eating:	Standing:	Walking:	Use Walker:
Wheelchair:	Transferring to Chair/Wheelchair:	Bed:	Uses Motorized W/C*:		
*Please note that DPCC retains the right to evaluate a resident’s ability with an electric mobility device prior to the use of one in this facility. DPCC will provide a manual wheelchair when appropriate.					
Is the applicant able to manage their own finances?					
Please list other activities with which the applicant requires assistance:					

Please indicate YES or NO for the following:			
Sociable:	Forgetful:	Mentally Alert:	Verbally aggressive:
Timid:	Confused:	Grouchy:	Physically aggressive:
Independent:	Suspicious:	Anxious:	Strikes out:
Withdrawn:	Cries easily:	Wanders off:	Prefers being alone:
Prefers groups:	Depressed:	Chronic complainer:	

Affidavit of Applicant

I, the undersigned, hereby certify that the answers to the foregoing questions are true, correct and complete, and that I have not knowingly or intentionally withheld any facts or circumstances, which would, if disclosed, unfavorably affect my application for admission.

I hereby authorize a full investigation of any statements contained in this application by DPCC. I understand that misrepresentation or omission of facts or information requested will be considered sufficient cause for denial of my application for residency at DPCC.

Signed: _____ Date: _____
Applicant

Signed: _____ Date: _____
Representative

DPCC Rep.: _____ Date: _____

If the applicant is currently a Post-Acute Rehab patient, please indicate if there have been any changes in the applicant's Advance Directives or Insurance coverage since admission.

Advance Directives Changes (Provide copies of all documentation)

Living Will Power of Attorney for Health Care Power of Attorney for Property
 Court Appointed Guardian Surrogate Decision Maker

Health Insurance Information Changes (Provide copies of all cards)

Medicare Number: _____ Part A: _____ Part B: _____
 Medicaid Information: Has Medicaid been applied for? _____ Date: _____
 Recipient Number: _____ Case or Pending Case Number: _____
 Insurance: _____ Primary or Secondary?
 1. Insurance Name: _____ Policy No.: _____

You will be contacted by a DPCC Financial Coordinator to discuss assets and pay source as a part of our application process.

If you have any questions, please contact the Admissions Department at: 630/784-4315. You may fax a copy of this affidavit to: 630/784-4319.

DuPage Care Center
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 Wheaton, IL 60187