



- Independent Living
- Assisted Living – Camden
- Assisted Living-Ionic
- Health Care

Name	Date of Birth	SSN
Applicant _____	_____	____-____-____
Address _____		
Telephone: _____	Cell _____	
Religion _____	Marital Status _____	

Who holds Power of Attorney (POA) for you?

Name: _____ Telephone No.: _____

Address: _____

Telephone No.: _____

Attorney's Name: _____ Telephone No.: _____

Address _____

Do you have a will?

Location of will: _____

Do you have prepaid funeral arrangements?

If yes, Funeral Home Name: (Please provide a copy of contract)

_____ Telephone No. _____

Cemetery _____

MASONIC ELIGIBILITY

Name of Master Mason or O.E.S. member through whom you are eligible:

_____ (first) (middle) (last)

Your relationship to him/her: _____

Date of Birth _____ Date of Death _____
(If applicable)

Masonic Lodge: _____ # _____

If out of state please indicate where: _____
(city) (state)

O.E.S. Chapter: _____

May we contact your Lodge/Chapter in the event of your admission, hospitalization or in the event of your death? (Please Circle) YES OR NO

CONTACT LISTING

Please list your living children, blood relatives and friends in the order they are to be contacted in case of any emergencies:

1. (Mr., Mrs., Ms.) _____
(first) (middle) (last)

Address _____

Telephone: _____ Cell: _____

E-Mail Address: _____ Relationship: _____

2. (Mr., Mrs., Ms.) _____
(first) (middle) (last)

Address _____

Telephone: _____ Cell: _____

E-Mail Address: _____ Relationship: _____

3. (Mr., Mrs., Ms.) _____
(first) (middle) (last)

Address _____

Telephone: _____ Cell _____

E-Mail Address: _____ Relationship: _____

Primary Care Physician _____

Telephone No. _____ Fax: _____

MEDICAL INSURANCE

(Please provide copies of front and back of all insurance cards)

<u>Type of Insurance</u>	<u>Account Numbers</u>
Medicare	_____
Supplemental	_____
Prescription	_____
Dental/Vision	_____
Other	_____
Premiums	\$ _____

Long Term Care Insurance: Yes No

If yes,

Term of policy in years _____

Daily benefit – Skilled Nursing _____

Daily benefit – Assisted Living _____

Premiums \$ _____

All applicants for admission must complete the financial application. All financial information provided will remain confidential. It is our policy to admit residents without regard to race, color, national origin, age, ancestry, sex, religious creed, handicap or disability. This is a tobacco-free community.

Monthly Income – Please indicate your monthly income available to pay for your living expenses.

Applicant

Social Security per month _____

Pension per month* _____

Annuity per month _____

Other (Describe) _____

Total Monthly Income _____

*Survivor Benefits _____%

Assets – Please list all assets that are available to pay for your living expenses.

Are assets jointly owned with someone else? Yes No

If yes, who is the joint owner? _____ Relationship _____

Checking Balance _____

Savings Balance _____

Investments _____

Investments _____

Assets held in Trust _____

Certificates of Deposit _____

Real Estate _____

Cash Value of
Life Insurance Policy _____

Other (Describe) _____

Other (Describe) _____

Total Assets _____

During the past five years, have you transferred assets greater than \$5,000 in total to others without receiving fair market value in return? Yes No

If yes, what was the approximate value of property transferred and the approximate date of transfer?

Date of Transfer _____ Value of Assets Transferred _____

Do you own assets that are not listed in the asset section of this application? Yes No

If yes, what are they and why are they not listed above?

Outstanding Debt

Mortgage _____

Reverse Mortgage _____

Home Equity Loan _____

Credit Cards _____

Automobile Loan _____

Other (Describe) _____

Other (Describe) _____

Total Outstanding Debt _____

Veteran Status:

A Veteran? Yes No

A Spouse of a Veteran? Yes No

A Widow/widower of a Veteran? Yes No

Do you have special housing needs that require reasonable accommodations? If yes, please describe _____

A \$300.00 (non-refundable) processing fee is due with the submission of this application.

An additional (refundable) \$1,000.00 reservation fee is due at the time of room or apartment selection or to secure placement on the waiting list.

Submit a copy of your Power of Attorney (POA), Living Will, Advance Directives, DNR (Do Not Resuscitate), Funeral and Cemetery Documents and copies of your health insurance cards with this application.

Applicant(s) hereby authorize the Maryland Masonic Homes to perform whatever credit investigations it deems necessary and authorize insurance companies, bank agencies, and past creditors to release personal financial information to the Maryland Masonic Homes.

I hereby certify that the above questions and my answers thereto have been read and explained to me; and I further certify that my answers as given above are true and correct in every particular. Any fees I submit with this application are from my own funds and are not encumbered in any fashion.

The information provided is being used as a determinant for admissions eligibility. I attest that the information provided is complete and correct to the best of my knowledge.

Print Name Applicant

Date

Signature of Applicant