



## APPLICATION FOR ADMISSION

Please complete all items.

### PERSONAL HISTORY

NAME: \_\_\_\_\_ HEBREW NAME: \_\_\_\_\_  
LAST FIRST MIDDLE/MAIDEN

CURRENT ADDRESS: \_\_\_\_\_

CITY STATE ZIP CODE PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_ AGE: \_\_\_\_\_

MARITAL STATUS  MARRIED  SINGLE  DIVORCED  WIDOWED

U.S. CITIZEN?  YES  NO PLACE OF BIRTH \_\_\_\_\_  
 BY BIRTH  BY NATURALIZATION

FORMER OCCUPATION: \_\_\_\_\_

IF MARRIED, SPOUSE'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

CURRENT LIVING ARRANGEMENT:  ALONE  WITH RELATIVES RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

OWN HOUSE  CONDO  NURSING HOME: \_\_\_\_\_

RENT  ASSISTED LIVING FACILITY: \_\_\_\_\_

YEARS OF RESIDENCE IN ANY OF THE FOLLOWING COUNTIES:

\_\_\_\_\_ PINELLAS \_\_\_\_\_ HILLSBOROUGH \_\_\_\_\_ SARASOTA \_\_\_\_\_ MANATEE \_\_\_\_\_ PASCO \_\_\_\_\_ POLK

\_\_\_\_\_ OTHER FLORIDA AREAS (SPECIFY): \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

FATHER'S HEBREW NAME \_\_\_\_\_

MOTHER'S HEBREW NAME \_\_\_\_\_

FATHER'S PLACE OF BIRTH \_\_\_\_\_

MOTHER'S PLACE OF BIRTH \_\_\_\_\_

RELIGIOUS PREFERENCE: \_\_\_\_\_ NAME OF SYNAGOGUE: \_\_\_\_\_

CITY: \_\_\_\_\_ RABBI: \_\_\_\_\_ PHONE #: \_\_\_\_\_

DO YOU OBSERVE KOSHER DIETARY LAWS:  YES  NO  AT HOME ONLY

## FAMILY

### PLEASE LIST FAMILY MEMBERS:

1. NAME: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ PHONE (HOME): \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
OCCUPATION & EMPLOYER: \_\_\_\_\_ PHONE (work): \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_  
EMAIL: \_\_\_\_\_  CHECK HERE TO OPT OUT OF EMAIL CORRESPONDENCE  
RELATIONSHIP: \_\_\_\_\_ SPOUSE'S PHONE \_\_\_\_\_  WORK  CELL  
 CONTACT FOR HEALTH CARE MATTERS  CONTACT FOR FINANCIAL MATTERS  
 HEALTHCARE SURROGATE  POWER OF ATTORNEY  
 OTHER \_\_\_\_\_
2. NAME: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ PHONE (HOME): \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
OCCUPATION & EMPLOYER: \_\_\_\_\_ PHONE (work): \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_  
EMAIL: \_\_\_\_\_  CHECK HERE TO OPT OUT OF EMAIL CORRESPONDENCE  
RELATIONSHIP: \_\_\_\_\_ SPOUSE'S PHONE \_\_\_\_\_  WORK  CELL  
 CONTACT FOR HEALTH CARE MATTERS  CONTACT FOR FINANCIAL MATTERS  
 HEALTHCARE SURROGATE  POWER OF ATTORNEY  
 OTHER \_\_\_\_\_
3. NAME: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ PHONE (HOME): \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
OCCUPATION & EMPLOYER: \_\_\_\_\_ PHONE (work): \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_  
EMAIL: \_\_\_\_\_  CHECK HERE TO OPT OUT OF EMAIL CORRESPONDENCE  
RELATIONSHIP: \_\_\_\_\_ SPOUSE'S PHONE \_\_\_\_\_  WORK  CELL  
 CONTACT FOR HEALTH CARE MATTERS  CONTACT FOR FINANCIAL MATTERS  
 HEALTHCARE SURROGATE  POWER OF ATTORNEY  
 OTHER \_\_\_\_\_

PLEASE SUBMIT COPIES OF POWER OF ATTORNEY AND/OR HEALTH CARE SURROGATE PAPERS.

## CONFIDENTIAL FINANCIAL REPORT

MEDICARE NUMBER: \_\_\_\_\_ MEDICAID NUMBER: \_\_\_\_\_

SUPPLEMENTAL HEALTH INS. COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POLICY #: \_\_\_\_\_

LIFE INSURANCE: COMPANY \_\_\_\_\_ POLICY #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ AMOUNT: \_\_\_\_\_ BENEFICIARY: \_\_\_\_\_

PREPLANNED FUNERAL?  YES  NO FUNERAL HOME \_\_\_\_\_ PHONE #: \_\_\_\_\_

IF YOU HAVE NOT MADE FUNERAL ARRANGEMENTS, PLEASE INDICATE WHICH FUNERAL HOME YOU WOULD WANT US TO CONTACT SHOULD THE NEED ARISE. NAME \_\_\_\_\_ PHONE #: \_\_\_\_\_

RESERVED PLOT?  YES  NO NAME OF CEMETERY? \_\_\_\_\_ PHONE #: \_\_\_\_\_

### REGULAR MONTHLY INCOME

	Applicant	Spouse
Social Security	\$ _____	\$ _____
Pension	\$ _____	\$ _____
Dividends	\$ _____	\$ _____
Interest	\$ _____	\$ _____
Property Income	\$ _____	\$ _____
IRA Income	\$ _____	\$ _____
Trust Income	\$ _____	\$ _____
Other Income	\$ _____	\$ _____
Total	\$ _____	\$ _____

Total Regular Monthly Income \$ \_\_\_\_\_

### ASSETS

Cash (Savings & Checking)	\$ _____	\$ _____
CDs, Money Markets, etc.	\$ _____	\$ _____
Stocks & Bonds	\$ _____	\$ _____
IRAs / Annuities	\$ _____	\$ _____
House or Condo	\$ _____	\$ _____
Other Real Estate	\$ _____	\$ _____
Trust Fund	\$ _____	\$ _____
Life Insurance	\$ _____	\$ _____
Other Asset(s)	\$ _____	\$ _____
Total	\$ _____	\$ _____

Total Capital Asset \$ \_\_\_\_\_

IF RESOURCES HAVE BEEN TRANSFERRED WITHIN 5 YEARS PRIOR TO THIS APPLICATION, ATTACH A SEPARATE PAGE WITH THE PARTICULARS. ALL APPLICANTS MUST SUBMIT MOST RECENT TAX RETURN.

# HEALTH INFORMATION

CURRENT PRIMARY CARE PHYSICIAN (NAME): \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PSYCHIATRIST/PSYCHOLOGIST: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

REASON FOR APPLYING TO MENORAH MANOR: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I HEREBY VOLUNTARILY MAKE APPLICATION FOR RESIDENCY AT MENORAH MANOR. I AND MY IMMEDIATE FAMILY WHO HAVE SIGNED BELOW, AFFIRM THAT ALL INFORMATION PROVIDED IS FACTUAL TO THE BEST OF OUR KNOWLEDGE AND AGREE TO ABIDE BY THE RULES AND REGULATIONS OF MENORAH MANOR.

DATE: \_\_\_\_\_

APPLICANT'S SIGNATURE: \_\_\_\_\_

SIGNATURES OF IMMEDIATE FAMILY AND/OR HEALTH  
CARE SURROGATE OR POWER OF ATTORNEY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





MENORAH MANOR  
RELEASE/REQUEST OF INFORMATION FORM

Resident name: \_\_\_\_\_ Social Security # \_\_\_\_\_

I, \_\_\_\_\_, hereby give permission to Menorah Manor to obtain/release any medical, psychiatric and/or financial information needed for any of the following:

- Evaluation of application for admission
- Evaluation for continued care
- Correspondence with insurance company/managed care, Medicare or Medicaid
- For Medicaid applicants and beneficiaries - permission to have access to financial information from resident's bank

A copy of this release shall serve the same as the original.

\_\_\_\_\_  
Resident or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Resident

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Fax: 727 345-3957  
Email: [admissions@menorahmanor.org](mailto:admissions@menorahmanor.org)