



**St. Paul's**  
**Senior Homes & Services**  
*A Full Service Retirement Community*

**John A McColl Family Health Center**  
 Skilled Nursing  
 235 Nutmeg Street  
 San Diego, CA 92103  
 Ph: (619) 239-8687 Fax: (619) 239-1201  
 Lic. # 080000181

**APPLICATION FOR RESIDENCY**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

PRESENT ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

MARITAL STATUS:  Married  Widowed  Divorced  Single

SOCIAL SECURITY NUMBER \_\_\_\_\_ MEDICARE NUMBER \_\_\_\_\_

OTHER INSURANCE \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_

PLACE OF BIRTH \_\_\_\_\_ CITIZENSHIP \_\_\_\_\_

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

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

PREVIOUS OCCUPATION \_\_\_\_\_

RELIGIOUS DENOMINATION \_\_\_\_\_  Active  Inactive

PLACE OF WORSHIP OR MINISTER'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

NAME OF FACILITY ADMITTED FROM \_\_\_\_\_

DATE OF ADMISSION \_\_\_\_\_

**REQUEST ADMISSION BY THE FOLLOWING DATE** \_\_\_\_\_

PRIVATE PAY ACCOMMODATIONS:  Private  Double room  Triple room

**NAME(S) AND COMPLETE ADDRESS OF ATTENDING PHYSICIAN**

PHYSICIAN \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

ALTERNATE PHYSICIAN

PHYSICIAN \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

DENTIST \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

PHARMACY \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**HOW DID YOU FIRST LEARN OF THE JOHN A. McCOLL FAMILY HEALTH CENTER?**

Newspaper or other Advertisement (Please specify name): \_\_\_\_\_

Yellow Pages

Church Church Name: \_\_\_\_\_

Church Address: \_\_\_\_\_

Ministers Name: \_\_\_\_\_

Open House (Date): \_\_\_\_\_

Physician (Name): \_\_\_\_\_

Current Resident: \_\_\_\_\_

Family Member (Relationship and name): \_\_\_\_\_

Friend (Name): \_\_\_\_\_

Other (Please explain): \_\_\_\_\_

## LEGAL/RESPONSIBLE (GUARANTOR) PERSON

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
CITY/ST \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

## PERSON(S) TO NOTIFY IN CASE OF EMERGENCY

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
CITY/ST \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
CITY/ST \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

## BILLING DATA

Please check the following services desired. A charge will be added to your monthly bill. Laundry and incontinence fees are not optional.

	<u>Yes</u>	<u>No</u>
Wheelchair rental	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric chair rental	<input type="checkbox"/>	<input type="checkbox"/>
Television rental	<input type="checkbox"/>	<input type="checkbox"/>
Trust account	<input type="checkbox"/>	<input type="checkbox"/>
Beauty Shop	<input type="checkbox"/>	<input type="checkbox"/>
Billed to you directly	<input type="checkbox"/>	<input type="checkbox"/>

There is a minimum two week charge for equipment rentals.

BILL TO:

NAME \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

## INTERMENT PLANS

MORTUARY NAME \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

## LEGAL DOCUMENTATION

The following documents are recommended to be on file for all residents of the Health Center. Please review and provide the following:

1. Durable Power of Attorney for Health Care  YES  NO
2. Conservator Information  YES  NO

If yes:

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE (\_\_\_\_\_) \_\_\_\_\_

3. Directive to Physician  YES  NO
4. Power of Attorney (fiduciary)  YES  NO
5. Living Will  YES  NO

Please return this form along with the Financial Disclosure Form and other requested documents to:

### **John A. McColl Family Health Center**

Admissions Department  
235 Nutmeg Street  
San Diego, CA 92103





# Financial Disclosure to St. Paul's Senior Homes & Services



St. Paul's Senior Homes & Services (St. Paul's) respects the privacy of every applicant and does not desire to intrude into any applicant's personal financial circumstances other than to have assurance that the necessary amounts needed to provide for the applicant's extended lodging, food, health care and personal needs are available to the potential resident.

The applicant and/or responsible party understands that St. Paul's will rely on the financial information regarding the applicant's assets, liabilities, income and expenses in making its determination as to whether the applicant will be admitted to St. Paul's facilities and that St. Paul's would not admit the resident to the facilities but for the accuracy and truthfulness of such information. The applicant and/or responsible party understands that the resident may be discharged by St. Paul's if it discovers that any such information has been misrepresented or omitted by the resident/responsible party, regardless of whether such misrepresentation or omission could have been discovered earlier by St. Paul's.

## Financial Statement

Applicant's Full Name \_\_\_\_\_ Social Security # \_\_\_\_\_

### Income & Expenses:

#### Monthly Income -

Social security	\$ _____
Pensions	\$ _____
Annuities (____ (X) lifetime or ____ years ending _____)	\$ _____
Interest income	\$ _____
Dividends	\$ _____
Rental income	\$ _____
Other income (_____)	\$ _____
(_____)	\$ _____

#### Monthly Expenses -

Health insurance	\$ _____
Other household & personal expenses	\$ _____

### Assets -

Bank - checking	\$ _____
savings/CDs	\$ _____
Broker - money market funds	\$ _____
fixed income securities (bonds, preferred stocks)	\$ _____
equities (stocks)	\$ _____
Real estate - residence (net of any outstanding loans)	\$ _____
other (vacation home/rentals) (net)	\$ _____
Other assets - (_____)	\$ _____

**I DECLARE UNDER PENALTY OF PERJURY** that the foregoing financial information is a **true statement** of facts known by me, and that it is submitted as part of an application for residency at St. Paul's facilities. I also declare that all of the above assets are **available to the Applicant to provide for the future needs of the Applicant**, and that **none of the assets will be transferred to another individual or individuals to avoid liability** for those needs.

\_\_\_\_\_  
Date                      Applicant for Residency                      or                      Date                      Financially Responsible Party