Parker
we make aging part of life ®

FINANCIAL STATEMENT

Applicant Name:_____ Date of Birth:_____

Applicant Address:_____ Phone Number:_____

Application Completed By:_____ Relationship:_____

Address of Person Completing Application:_____

Phone # of Person Completing Application:_____ Date of Application:_____

GENERAL INFORMATION

Please provide information about the applicant

Applicant's Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

If married, where does the spouse currently live? _____

Have you applied for Medicaid? ☐ Yes ☐ No If yes, date of application: ___/____/____

County: _____ Medicaid Number: _____

How soon do you anticipate needing skilled nursing?

☐ ASAP ☐ Within 30 Days ☐ Within 90 Days ☐ Within 6 Months

Will someone else be paying for your care? ☐ Yes ☐ No

If yes, who/relationship? _____/_____

Please note, if a guarantor is involved, a signed Guarantor Agreement is required prior to admission.

MONTHLY INCOME

Source of Income	Description/Notes	Amount	Owned By
Social Security:		$	☐Applicant ☐Spouse ☐Joint
Pension:	Source(s):	$	☐Applicant ☐Spouse ☐Joint
Insurance or Annuities:	Source(s):	$	☐Applicant ☐Spouse ☐Joint
Interest or Dividends:	Source(s):	$	☐Applicant ☐Spouse ☐Joint
Rental Income:		$	☐Applicant ☐Spouse ☐Joint
Mortgage Income:		$	☐Applicant ☐Spouse ☐Joint
Other Income:		$	☐Applicant ☐Spouse ☐Joint
TOTAL MONTHLY INCOME:		$	☐Applicant ☐Spouse ☐Joint

ASSETS			
Assets	Description/Bank/ Financial Institution	Amount	Owned By
Home: (Market value less unpaid mortgages)		$	☐Applicant ☐Spouse ☐Joint
Other Real Estate:		$	☐Applicant ☐Spouse ☐Joint
Savings & Money Market Accounts:		$	☐Applicant ☐Spouse ☐Joint
Checking:		$	☐Applicant ☐Spouse ☐Joint
Certificates of Deposit		$	☐Applicant ☐Spouse ☐Joint
Stocks and Bonds:		$	☐Applicant ☐Spouse ☐Joint
Trust Fund:		$	☐Applicant ☐Spouse ☐Joint
Other Assets:		$	☐Applicant ☐Spouse ☐Joint
TOTAL ASSETS:		$	☐Applicant ☐Spouse ☐Joint

APPLICANT'S HEALTH INSURANCE AND MONTHLY MEDICAL EXPENSES	
Health Plans (Select all that apply)	Premium
☐ Medicare Part A Date eligible: ____/____/_____	$
☐ Medicare Part B Date eligible: ____/____/_____	$
☐ Medicare Part C Date eligible: ____/____/_____	$
☐ Medicare Part D Date eligible: ____/____/_____	$
☐ Medicaid Date eligible: ____/____/_____ County: _____	$
☐ NJ FamilyCare Health Plan ☐ Aetna Better Health of New Jersey ☐ Amerigroup New Jersey, Inc. ☐ Horizon NJ Health ☐ United Healthcare Community Plan ☐ WellCare Health Plans of New Jersey	
☐ LTC Insurance Company: _____ Premium: _____ Summary of Benefit: _____	
☐ Other out-of-pocket medical expenses: Type: _____ Monthly Amount: _____	

I UNDERSTAND THAT AN UPDATE TO THIS INFORMATION WILL BE REQUIRED PRIOR TO AND/OR UPON ADMISSION AND EACH YEAR, ALONG WITH SUPPORTING DOCUMENTS. I/WE HEREBY DECLARE THAT ALL STATEMENTS MADE HEREIN ARE TRUE AND COMPLETE ACCORDING TO MY/OUR BEST KNOWLEDGE AND BELIEF AND THAT THE ASSETS LISTED ARE IN FACT AVAILABLE TO THE RESIDENT TO PAY FOR THE RESIDENT'S CARE. I/WE UNDERSTAND THAT ANY MISREPRESENTATION OR FALSIFICATION OF THIS INFORMATION MAY RESULT IN BEING REMOVED FROM THE REGISTRY AND/OR DISCHARGE FROM PARKER SERVICES.

Signature of Applicant Date	Signature of Person Completing Application Date
Signature of Parker Representative Date	CFO Initials Date
Title	

Once this Financial Statement is completed and submitted, you will be placed on the Active List in order of your initial Registry date. Prior to admission, additional information will be requested depending on your financial situation, possibly including the following items to support this Financial Statement:

- Financial Records - Statements for savings, checking, investment, retirement, and trust accounts
- Proof of age, residency, and marital status
- Social Security, Medicare, health insurance, and LTC insurance cards
- LTC insurance policy
- Medicaid application and eligibility information
- Powers of Attorney and/or guardianship/conservatorship