RIVERGARDEN SENIOR SERVICES | Hebrew Home Wolfson Health & Aging Center

11401 Old St. Augustine Road • Jacksonville, Florida 32258 • Phone: 904-260-1818 • Fax: 904-260-9733 • www.RiverGarden.org

Dear Applicant:

As part of your application, we are requesting the information on the attached Applicant Financial Resources Questionnaire. This information will be held in strict confidence.

The purpose of the questionnaire is to allow the Home the opportunity to verify your ability to meet the ongoing financial obligations incurred during your stay at River Garden. In the event you do not have sufficient resources to meet your ongoing financial obligations in the Home, the information provided on this questionnaire will assist us in financial counseling.

When you have completed the questionnaire, please insert it in the enclosed envelope and attach it to your application.

Sincerely,

Mauri Mizrahi
Executive Director / Chief Executive Officer

MM/ss

FINANCIAL RESOURCES QUESTIONNAIRE

Applicant's Name _____ **Soc. Sec. #** _____
(Please Print)

(This information will be treated in the strictest of confidence)

1. If you and/or your spouse own, or are buying, any real estate – including homestead or life estate, give the following information:

OWNER(S) NAME	USE	MARKET VALUE

2. Is there a mortgage or lien on any of the above property? YES ☐ NO ☐
   If yes, please give:
   a. Name/Address of Lien Holder _____
   _____
   b. Balance owed $_____ Date of Lien _____

3. Is property owned with another or in trust? YES ☐ NO ☐
   If yes, give name(s): _____

4. Are you free to sell your interest in the property? YES ☐ NO ☐
   If no, please explain: _____
   _____

5. Do you or your spouse own a cemetery lot, plot, vault, crypt, or mausoleum? YES ☐ NO ☐
   a. Owner _____
   b. Item _____
   c. Location (address, city, state) _____
   d. Current value _____

6. Do you own a prepaid funeral? YES ☐ NO ☐
   If yes, with what company? _____

7. Do you and/or your spouse own a motor vehicle(s)? YES ☐ NO ☐

8. Give the following information on property or valuables you and/or your spouse own:

ITEM	AMOUNT/VALUE	OWNER	
		YOU	YOUR SPOUSE
		(Check one or both)	
Cash on Hand			
Checking Account			
Savings Account			
Money Market			
U.S. Savings Bonds			
Stocks, Bonds, Certificates of Deposit			
Safe Deposit Box			
Trusts			
Personal funds at facility			
Mobile Home			
Other (Specify)			

9. List all financial liabilities (current and long-term):

CREDITOR	ADDRESS	BALANCE	MONTHLY	PAYOFF

10. List all life insurance policies on your life, owned by you or your spouse.

OWNER	COMPANY	POLICY NO. / TYPE	FACE VALUE	INSURED	BENEFICIARY	ANY LOANS ON POLICY? (Yes) (No)

11. List all health or medical insurance coverage available to you or your spouse.
(Please provide photocopies of cards.)

INSURED	COMPANY	POLICY NUMBER/TYPE	OTHERS COVERED

12. Does the applicant currently have Florida Medicaid coverage? Yes ☐ No ☐
If yes, please list Medicaid Number:_____
If no, will the applicant or someone on his/her behalf be applying for Medicaid benefits within the next twelve months? Yes ☐ No ☐ Not Sure ☐

13. Do you or your spouse receive income from work performed? Yes ☐ No ☐

	YOU	SPOUSE
Type of Work		
Weekly Wages		
Employer's Name, Address & Telephone Number		

14. Do you or your spouse receive income from self-employment? Yes ☐ No ☐
If yes, give:

	YOU	SPOUSE
Type of Business		
Last Year's Gross Income		
This Year's Expected Gross		
Next Year's Expected New or Loss		

UNEARNED INCOME

15. a)

	YOU		SPOUSE		WHEN	ORGANIZATION
	Yes	No	Yes	No		
Been in military service?						
Worked for a railroad?						
Worked for any federal, state, county or city government?						
Worked for an employer with a pension plan?						
Filed for public assistance?						

b)

TYPE	YOU		SPOUSE		AMOUNT OF APPLICANT'S BENEFIT	I.D.
	Yes	No	Yes	No		
Social Security						
Black Lung Benefits						
Railroad Retirement						
Federal Civil Service						
Supplemental Security Income (SSI) (Gold Check)						
Unemployment Compensation						
Worker's Compensation						
Private Pension						
Insurance Annuity or Proceeds						
Cash Support or Expense Paid By Another						
Rents, Dividends, Interest, Royalties						
Veteran's Administration Pension or Compensation						
Assistance From Another Agency						
State or Local Government Agency						
Children's Income						
OTHER (Specify)						

Are any of the checks sent to address(es) other than the applicant's primary address?
Yes ☐ No ☐

TRANSFER OF ASSETS

16. Have you or your spouse sold any property, or given as a gift, any cash or property to any person within the last five (5) years?
Yes ☐ No ☐
If yes, please describe _____

_____

_____

17. Person to be billed _____
Address _____

_____

Home Phone _____ Work Phone _____

How do you plan to finance your stay at River Garden?

- Your own resources? _____
- Help from family? _____
- Medicaid? _____

18. I understand that prior to long-term care admission to River Garden I must remit a deposit in the amount of 30 days resident responsibility. This will either be refunded if admission is not approved or applied to the first month's bill.

Date _____

Applicant's Name *(Printed)* _____

Applicant's Signature _____

Signature of Person Assisting Applicant _____

When you have completed the questionnaire, please insert it in the envelope provided, attach it to your admission application, and return it to the Admission's Office.