HIAWATHA CARE CENTER

405 N 15TH AVENUE
HIAWATHA, IOWA 52233
Phone (319)378-8583 Fax (319)378-8598
EMAIL: hccinfo@hiawathacarecenter.com

Skilled Nursing Facility
APPLICATION FOR RESIDENCY

Application Date: _____ SSN _____

Applicant Name: _____

Financial POA:	**Durable POA:**
Name_____	Name:_____
Address_____	Address _____
Phone (H)_____	Phone (H)_____
(W)_____	(W)_____
(C) _____	(C)_____
Relationship_____	Relationship _____

CONFIDENTIAL FINANCIAL INFORMATION (required only if Long Term Possibility)

Assets		Monthly Income	
Checking account balance	$_____	Social security	$_____
Savings accounts	$_____	Pension/Retirement	$_____
Investments/CD's	$ _____	Rental income	$_____
Stocks/bonds	$_____	Investment income	$_____
Real estate	$_____	Other	$_____
Other	$_____		
Total Assets	$_____	Total monthly income	$_____

I declare that the above statements are true and accurate to the best of my knowledge.

_____
Applicant/Responsible party

_____
Date

Code Status	
DNR	Full Code