



PRE-APPLICATION VIABILITY REVIEW

Patients Name: _____

What state is the Patient seeking benefits in? _____

Current resident? _____

Your Name: _____

Relationship to Patient: _____

Power of Attorney? _____

Patient DOB: _____

Marital Status: _____

Veteran? _____

Is the Patient currently in a Nursing Home or a similar facility? _____

If so, what is the name of this facility and care level? _____

What is the Patient's approximate total monthly income? _____

What is the Patient's approximate total assets, not including their home and primary vehicle? _____

This form is extremely important. Your accuracy and completeness in responding will help us best provide the proper direction to help you meet your concerns. All information provided on this form is considered personal and confidential and will not be shared without your permission.