

CONFIDENTIAL FINANCIAL INFORMATION

Date: _____

In addition to the information provided in the Application for Residency, the following financial and personal information is provided for consideration by Oak Hammock at the University of Florida.

Applicant Information	Co-Applicant Information
Name:	Name:
SSN:	SSN:
Date of Birth:	Date of Birth:
Gender:	Gender:
Type of Residence/Club Home:	

FINANCIAL INFORMATION

Please use Black Ink Pen to fill out.

<u>Assets:</u>	<u>Applicant</u>	<u>Co-Applicant</u>	<u>Joint</u>	<u>Total</u>
Cash	\$ _____	\$ _____	\$ _____	\$ _____
Accounts:				
Checking	_____	_____	_____	_____
Savings	_____	_____	_____	_____
Money Market	_____	_____	_____	_____
Investments:				
Certificates of Deposits	_____	_____	_____	_____
Bonds	_____	_____	_____	_____
Stocks	_____	_____	_____	_____
Mutual Funds	_____	_____	_____	_____
IRA	_____	_____	_____	_____
Other	_____	_____	_____	_____
Real Estate:				
Market Value of Residence	_____	_____	_____	_____
Other Real Estate	_____	_____	_____	_____
Misc.:				
Life Insurance	_____	_____	_____	_____
Cash Value of Life Insurance	_____	_____	_____	_____
Other (Describe)	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
TOTAL ASSETS:	\$ _____	\$ _____	\$ _____	\$ _____

Please check which plan you are interested in.

Standard Plan ____ 50% Refund Plan ____ 95% Refund Plan ____

<u>Liabilities:</u>	<u>Applicant</u>	<u>Co-Applicant</u>	<u>Joint</u>
Notes	\$ _____	\$ _____	\$ _____
Mortgages	_____	_____	_____
Other (Describe)	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
TOTAL LIABILITIES:	_____	_____	_____
<u>Monthly Income:</u>			
Social Security	_____	_____	_____
Pensions & Retirement	_____	_____	_____
Survivor Income Percentage	_____	_____	_____
Annuities	_____	_____	_____
Survivor Income Percentage	_____	_____	_____
Trust Income	_____	_____	_____
Survivor Income Percentage	_____	_____	_____
Investments & Savings	_____	_____	_____
Estimated Survivor Income	_____	_____	_____
Current Employment	_____	_____	_____
Other (Describe)	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
TOTAL MONTHLY INCOME:			
\$ _____			

MONTHLY EXPENSES AFTER OCCUPANCY

Monthly Expenses:	Applicant	Co-Applicant	Joint	Total
Health Insurance and/or Medicare Supplement Insurance	\$ _____	\$ _____	\$ _____	\$ _____
Prescription(s)	_____	_____	_____	_____
Long Term Care Insurance Premium	_____	_____	_____	_____
<input type="checkbox"/> Monthly <input type="checkbox"/> Annual				
Do you plan to keep your Long Term Care Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please answer the following)				
Benefit Period	_____	_____	_____	_____
Elimination Period	_____	_____	_____	_____
Assisted Living Daily Benefit	_____	_____	_____	_____
Inflation Adjustment Rider	_____	_____	_____	_____
Skilled Nursing Daily Benefit	_____	_____	_____	_____
Premium Inflation Rider	_____	_____	_____	_____
Total of Medical Expenditures	\$ _____	\$ _____	\$ _____	\$ _____
Groceries	_____	_____	_____	_____
Travel (tickets....etc)	_____	_____	_____	_____
Clothes	_____	_____	_____	_____
Entertainment (movies, dinning out...)	_____	_____	_____	_____
Charitable Contribution / Gifts..	_____	_____	_____	_____
Auto (Insurance, gas, maintenance)	_____	_____	_____	_____
Additional Expenses (hobbies,..etc)	_____	_____	_____	_____
Total of all Monthly Expenses	\$ _____	\$ _____	\$ _____	\$ _____

I/we hereby certify that the above is a correct and full disclosure of my/our financial information as of this date. **Both Signatures Required if Applicable.**

First Applicant Signature: _____ Date: _____

Second Applicant Signature: _____ Date: _____