THE LUTHERAN HOME FOR THE AGED ASSOCIATION-EAST

Application for Admission

(Confidential)

This application is for: (check all that apply)

☐ Nursing Facility ☐ Medicare (Skilled) Service ☐ Veteran Status (☐ spouse)
☐ Assisted Living ☐ Home Health Care
☐ Town Homes ☐ Respite
☐ Special Care Unit (Alzheimer's)

This request for information DOES NOT constitute an admission agreement. Information submitted herein will be reviewed by the Home to determine if further admittance procedures are advisable. No obligation is placed on the Home or the party submitting the information by completion and acceptance of this form. However, if admission is deemed advisable, the information submitted on this form, including your financial information, will become permanent to admittance and will become a part of any Residency Agreement entered into. False or misleading statements may nullify any and all future Agreements.

PLEASE READ CAREFULLY. PLEASE PRINT PLAINLY...

Last Name			First Name	Middle Name
Address			City, State, Zip.	Telephone
Social Security Number	Date of Birth	Sex	Marital Status (circle one): Married Single Divorced Widow(er)	
Ethnic Origin			Religious Denomination	Home Congregation
Medicare Number ***please provide a copy of the card.**			**Medicaid Number** ***please provide a copy of the card.**	
Medicare D Number ***please provide a copy of the card.**			**Other Insurance's:** Nursing Home Insurance's: (need numbers) ***please provide a copy of the card.**	

▶ Primary emergency Contacts (list in order of preference):

Name	Address: City, State, Zip.	Telephone Number	Relationship
		E-mail:	
Name	Address: City, State, Zip.	Telephone Number	Relationship
		E-mail	

▶ Health Care Power of Attorney (POA): (*Please check:* ☐ Yes ☐ No ***Please provide a copy if you check yes)***

Name	Address: City, State, Zip.	Telephone Number	Relationship
		E-mail	
Name	Address: City, State, Zip.	Telephone Number	Relationship
		E-mail	

▶ Living Will: (*Please check:* ☐ Yes ☐ No ***Please provide a copy if you check yes)***

▶ Financial Power of Attorney (POA): (*Please check:* ☐ Yes ☐ No ***Please provide a copy if you check yes)***

Name	Address: City, State, Zip.	Telephone Number Relationship	
		E-mail	
Name	Address: City, State, Zip.	Telephone Number Relationship	
		E-mail	

References (Apartment/Town Home Applications Only):

Name	Address: City, State, Zip.	Telephone Number	Relationship
		E-mail	
Name	Address: City, State, Zip.	Telephone Number	Relationship
		E-mail	

Financial Resources

As a facility participating in the Medicare and Medicaid Programs, it is essential that we receive an accurate and complete statement of applicant's financial status. Please note if these are solely or jointly owned.

Monthly Income Resources	Assets
Retirement/Pension $	Checking $
Social Security $	Saving/Money Market $
Other Income $	Investments $
	Property $
	Mortgage Amount $
	Other Liabilities $

Cost For Care

Do you have Long term Care Insurance? (Yes / No)

Applicant (Yes / No)

Co-applicant (Yes / No)

If YES, how much will the policy cover?

1) The applicant(s) agrees that The Lutheran Home for the Aged Association-East, or its authorized representative, is granted permission to verify any and all information submitted with this application including financial information. The Association will keep such inquires and verifications confidential.

2) It is the policy of The Lutheran Home for the Aged Association-East that all available services are provided without regard to sex, race, color, ancestry, national origin, religious creed, handicap or disability.

The applicant(s) states that all of the information submitted on this application is true and correct to the best of his/her knowledge and belief and that said information will be used by the Association in determining suitability for acceptance of the Applicant(s) into the facility.

Signed_____ Date_____

(If signed by other than the Applicant(s) please print name, address and legal authority below)

Name _____

Street Address _____City, State, Zip_____

Legal Authority _____

(Conservator, Guardian, Power of Attorney, etc.)

FOR OFFICE USE ONLY

Date Received:_____

Received By:_____

Title:_____

Admission Date:_____

Contact made:
Name:_____
Date:_____
Response:_____
_____

Contact made:
Name:_____
Date:_____
Response:_____
_____

Contact made:
Name:_____
Date:_____
Response:_____
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Contact made:
Name:_____
Date:_____
Response:_____
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