

Application for Admission



715 Falconer Street • Jamestown, NY 14701

(716) 665-4905

www.lutheran-jamestown.org

Director of Admissions: Cindy Steele RN

(716) 665-8139 or Fax: (716) 665-8152

Date: ___/___/___

1. **Applicant's Name:** _____ Home Phone #: (____) ____-_____

2. **Home Address:** _____
Street City State Zip Code

Cell Phone #: (____) ____-_____ E-mail: _____

3. **Present location of applicant** (other than his/her home address): _____

Since when: ___/___/___ For what reason: _____

4. **Date of Birth:** ___/___/___ Age: _____ Sex: M F Birthplace: _____

American Citizen? Yes No If foreign born, date of naturalization: _____

5. **Former Occupation:** _____

6. **Church:** _____

7. **Highest level of education completed:** _____

8. **Social Security Number:** _____-_____-_____

9. **U.S. Veteran?** Yes No Branch: _____ Was spouse a veteran? Yes No

10. **Name of Parents** (even if deceased) Father: _____

Mother's First and Maiden Name: _____

11. **Applicant's primary physician:** _____ Phone #: (____) ____-_____

12. **Marital status:** Married Single Divorced Widowed Separated

Name of Spouse (even if deceased): _____

Date of Spouse's Birth: ___/___/___ Date of Marriage: ___/___/___

Life well lived. Every day.



13. Persons to be notified in case of an emergency:

#1 Name: Relationship Home Phone #: Cell Phone #: Home Address: Street City State Zip Code Place of Business: Business Phone #: E-mail Address:

#2 Name: Relationship Home Phone #: Cell Phone #: Home Address: Street City State Zip Code Place of Business: Business Phone #: E-mail Address:

#3 Name: Relationship Home Phone #: Cell Phone #: Home Address: Street City State Zip Code Place of Business: Business Phone #: E-mail Address:

14. Advanced Directives -- Does applicant have any of the following?

Do Not Resuscitate Order? Yes No Living Will? Yes No Health Proxy? Yes No

Health Care Proxy Agent's Name:

15. Burial Preference (whether arrangements have or have not been made):

Funeral Home: Place of Burial:

16. Resident Representative (manages the affairs and finances for applicant):

Lutheran requests that to the greatest extent possible, the individual named as the Resident Representative for the applicant be an existing Power of Attorney for the applicant or be named a Power of Attorney by the applicant as soon as possible to ensure continuity of payment of all expenses incurred from the applicant's income and resources.

Who is the Resident Representative?

Name: Relationship Home Phone #: Cell Phone #: Home Address: Street City State Zip Code Place of Business: Business Phone #: E-mail Address: Power of Attorney? Yes No Guardian? Yes No (If yes, please provide a copy)

Other Contacts:

Name: Relationship Home Address: Street City State Zip Code

17. Insurances:

Medicare #: _____ Effective Date: ___/___/___

Other Insurances:

_____ ID#: _____ Effective Date: ___/___/___

_____ ID#: _____ Effective Date: ___/___/___

_____ ID#: _____ Effective Date: ___/___/___

Pharmacy Plan: _____ ID#: _____ Effective Date: ___/___/___

Long-Term Insurance: _____ ID#: _____

Medicaid #: _____ County: _____

Approximately how long has the applicant had Medicaid coverage? _____

18. Resources:

A. <u>Monthly Income:</u>	<u>Applicant:</u>	<u>Spouse:</u>
Salary:	\$ _____	\$ _____
Social Security:	\$ _____	\$ _____
SSI:	\$ _____	\$ _____
Retirement Pension(s):	\$ _____	\$ _____
Veteran(s) Pension:	\$ _____	\$ _____
Other Income:	\$ _____	\$ _____

B. Real Estate: Yes No

1. If yes, location: _____ Value: \$ _____

Owned by: Applicant only

Applicant and other individuals name(s): _____

Life Estate only: Yes No

If yes, who gets the property when you pass? _____

2. If yes, location: _____ Value: \$ _____

Owned by: Applicant only

Applicant and other individuals name(s): _____

Life Estate only: Yes No If yes, who gets the property when you pass? _____

C. Life Insurance: Yes No

If yes, Face Value: \$ _____ Cash Value: \$ _____

If yes, Insurance Company: _____ Policy Number: _____

Name(s) of Beneficiaries: _____



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D. Prepaid Funeral Fund: Yes No

If yes, Value: \$ _____ Location: _____

E. Checking Account(s): Yes No

If yes, Value: \$ _____ Location: _____

Individual Account(s): Yes No

If yes, names of other individual(s) on account: _____

F. Savings Account(s): Yes No

If yes, Value: \$ _____ Location: _____

Individual Account(s): Yes No

If yes, names of other individual(s) on account: _____

G. Certificate(s) of Deposit: Yes No

If yes, Value: \$ _____ Location: _____

Individual Account(s): Yes No

If yes, names of other individual(s) on account: _____

H. Stocks/Annuities: Yes No

If yes, Value: \$ _____ Location: _____

Individual Account(s): Yes No

If yes, names of other individual(s) on account: _____

I. Retirement Account(s): Yes No

If yes, Value: \$ _____ Location: _____

Individual Account(s): Yes No

If yes, names of other individual(s) on account: _____

J. Other Investments: Yes No

If yes, Value: \$ _____ Location: _____

Individual Account(s): Yes No

If yes, names of other individual(s) on account: _____

K. Funds in Trust: Yes No

If yes, Value: \$ _____ Location of Trust: _____

Name of Trustee: _____ Trustee's Phone Number: (____) ____-_____

19. Liabilities

- A. Home Mortgage Yes No (If yes, amount owed): \$ _____
- B. Loans Yes No (If yes, amount owed): \$ _____
- C. Home Mortgage Yes No (If yes, amount owed): \$ _____
- D. Home Mortgage Yes No (If yes, amount owed): \$ _____

20. Transfers:

- A. Has applicant/financial representative transferred assets or property in the past 60 months to anyone? Yes No
 (If yes, value): \$ _____ Date of Transfer: ____/____/____
 Describe asset or property transferred: _____
 Who was the property transferred to? _____
- B. Has applicant given gifts of money in the last 60 months? Yes No
 (If yes, value): \$ _____ Date of Gift: ____/____/____
 To whom was/were the gift(s) given? _____
- C. Has applicant signed any Promissory Note(s)? Yes No
 (If yes, value): \$ _____ Date of Issue: ____/____/____
 To whom did the applicant loan money? _____

21. Legal Counsel:

Are you currently working with an attorney or other firm? Yes No
 (If yes, provide name of attorney or firm): _____
 (If yes, please state what services you are utilizing. Estate Planning Medicaid Planning

COPIES OF THE FOLLOWING MUST BE ATTACHED

Social Security Card Insurance Card Medicare Card Medicare Part D
 Health Care Proxy Living Will Power of Attorney Epic Card

Upon satisfactory review of the application, Lutheran will consider the Applicant for admission. The Applicant and the Designated Representative certify that they have provided the information contained in this application and represent that it is factually true, accurate and complete. Upon satisfactory review of the application by Lutheran, the Applicant will be considered for admission. Upon acceptance of the Applicant, the Applicant and Designated Representative further agree to sign the Lutheran Agreement for Admission prior to or on the day of.

Applicant's Signature

_____/_____/_____
Date

Designated Representative's Signature

_____/_____/_____
Date

