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(Pa. Relay Service)

APPLICATION FOR ADMISSION TO AGENCY HOMES

Retirement & Health Care Services



Continuing Care Retirement Community

Personal Care

The information asked for on this form is needed to evaluate the applicant's request for admission. All information will be considered by the Admissions Committee and will be held in strict confidence. The acceptance of this form does not bind either party to admission. **Failure to complete the application in its entirety could result in denial of consideration for admission.** If you are making the application on behalf of another person, please answer each question with regard to the applicant.

Date _____

1. Name _____ Sex _____
Last First Middle

Address _____
Street Town State Zip

Age _____ Social Security No. _____ Telephone _____

Date of Birth _____ Place of Birth _____
Town County State

Present Marital Status: Single _____ Married _____ Widowed _____ Divorced _____
Date Date Date

2. Name of Husband or Wife _____ Place of Birth _____

3. List below, beginning with Power of Attorney/Guardian and other nearest relatives/contact persons. (Please attach copy of Power of Attorney/Guardianship)

Name & Relationship	Address	Telephone - Home No.	Telephone - Work No.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Living Will/Advanced Directive Yes _____ No _____ (please attach copy)

5. Have applications been made to other facilities? _____ Date & Name _____

6. What kind of care is needed? Personal Care _____ Independent Living _____

7. Pastor's Name _____ Church Name _____ Home Phone No. _____

Church Address _____ Church Phone No. _____

8. Personal Physician's Name _____ Address _____ Phone No. _____

9. What medical conditions require admission to be requested? _____

Current medications: _____

10. Recent Hospitalizations/Nursing Home Admissions (List dates and reasons for treatment)

11. Who will be responsible for providing transportation for various doctor appointments and other personal needs?

12. Financial Status: (Specify all income and assets involving the applicant) *(Attach verification of assets)*

Regular Monthly Income Amounts:	Amount	Address where received	
Social Security	\$ _____	_____	
Veteran's Pension	\$ _____	_____	
Railroad Retirement	\$ _____	_____	
Other Retirement Annuity	\$ _____	_____	
Other Pension	\$ _____	_____	
Rental Income	\$ _____	_____	
Other	\$ _____	_____	

Cash Assets/Investments:

Type	Amount	Bank	Owners
Checking Account(s)	\$ _____	_____	_____
	\$ _____	_____	_____
Savings Account(s)	\$ _____	_____	_____
	\$ _____	_____	_____

Stocks/Bonds Name (Company)	Current Value	Owners
_____	_____	_____
_____	_____	_____
_____	_____	_____

Certificate of Deposit Date Due	Amount	Owners
_____	_____	_____
_____	_____	_____
_____	_____	_____

Real Estate: Type: (Residential, Rental, etc.)	Estimated Value	Owners
_____	_____	_____
_____	_____	_____

Life Insurances: Company Name	Face Value	Cash Value	Owners
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name of ambulance _____ Hospital Preference _____

Funeral Director of Choice _____

Prepaid Burial Reserve

Financial Institution Where Held _____

Dollar Amount Reserved _____

Is This Agreement Irrevocable? Yes _____ No _____

Is any income paid to another person for the applicant? (i.e. Representative Payee)

Yes _____ No _____ Name: _____

Have there been any assets transferred to another person in the past three years?

Yes _____ No _____ If yes, specify amount _____
and to whom: _____

13. Insurance Information - Specify which types of insurance are currently held: (*Attach copies of medical cards*)

Medicare? Yes _____ No _____ Medicare # _____

Hospitalization? (Part A) Yes _____ No _____ Medical (Part B) Yes _____ No _____

Blue Cross? Yes _____ No _____ Contract # _____ Group # _____ Plan # _____

Blue Shield? Yes _____ No _____ Contract # _____ Group # _____ Plan # _____

Other Health and/or Co-insurance coverage? Yes _____ No _____

Name of Company _____

Long Term Care Insurance? Yes _____ No _____ (*please attach copy*)

Name of Company _____

Medical Assistance? Yes _____ No _____

Medical Assistance # _____ County _____ Expiration Date _____

14. Is there any special date by which admission is needed? _____

For what period of time is care requested? _____

15. Who has completed this application? _____ Applicant

_____ Other (Please give name and relationship)

Applicant referred by _____

COMMENTS:

ADMISSION POLICY

This facility is a non-profit retirement community for the aging, managed by Diakon Lutheran Social Ministries.

Mission Statement

In response to God's love in Jesus Christ, Diakon Lutheran Social Ministries will demonstrate God's command to love the neighbor through acts of service.

Our Philosophy of Care

We believe that older persons desire to live in their home communities as long as this is practicable. Our service program to the aging is designed to help maintain older persons in their own homes, but when this is no longer possible or desirable, we then consider the use of our facility to respond to the needs of the aging. We are interested in the whole person, in providing the highest quality of resident care in the nursing facility, and in responding to the individual needs of the resident.

Who Is Eligible?

Men and women who are 55 years of age or over at the time the application is filed. In cases of special need, admission may be made at a lower age.

Application Review Process:

Upon receipt of this application, the application will be reviewed by the Admissions Committee to determine appropriateness of need. If an appropriate vacancy occurs you will be contacted. Factors that may include, but are not limited to determining service are urgency of need, health, present living arrangements, family ability to care, adaptability to group living. A facility representative is available to serve applicants during the interim.

Policy Statement of Non-Discrimination in Admission and Services

It is the policy of Diakon Lutheran Social Ministries to operate each of its facilities and programs, and provide services without regard to race, religion, color, national origin, ancestry, age, sex, handicap, or disability.

No person shall be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination in the provision of any care or service because of race, religion, color, national origin, ancestry, age, sex, handicap, or disability. There shall be no segregation of facilities or services in the provision of service for reasons or race, religion, color, national origin, ancestry, age, sex, handicap or disability (except that required for related care).

This non-discrimination policy applies to applicants, patients, clients, physicians, service personnel, and other independent contractors.

Persons and organizations having occasion to refer individuals for admission or service, or to recommend any facility, program or service of Diakon Lutheran Social Ministries, are advised to do so without regard to the individual's race, religion, color, national origin, ancestry, age, sex, handicap, or disability.

I certify that I have read the admission policy of Cumberland Crossings or have had it explained to me, and apply for admission with the understanding that these conditions will apply as a resident in the village.

Applicant's Signature

Power-of-Attorney
Nearest Relative

Office use only

Date application was received _____

Application received by _____

(Staff Person)