

Date application was received _____ Application received by _____
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APPLICATION FOR ADMISSION TO NURSING FACILITY

1 Longsdorf Way, Carlisle, PA 17013
Phone: (717) 245-9941 Fax: (717) 240-6017
www.diakon.org/cumberlandcrossings

The information asked for on this form is needed to evaluate the prospective resident's request for admission. All information provided will be held in strict confidence. Submission of this form does not bind either party to admission. **Failure to complete the application in its entirety may result in denial of consideration for admission.** If you are completing this application on behalf of another person, please answer each question with regard to the prospective resident.

PERSONAL BACKGROUND

Name _____ Gender: M F
Last First Middle

Address _____
Street City State Zip Code

Age _____ Social Security No. _____ Telephone _____

Date of Birth _____ Place of Birth _____
City County State

Present Marital Status: Single ____ Married ____ Widowed ____ Divorced ____ Separated ____

Name of Spouse _____ Place of Spouse's Birth _____

Father's Name _____ Mother's Maiden Name _____

Present Living Status: Lives alone ____ Lives with spouse ____
 Lives with member of family or friends ____ If so, who _____
 Lives in a nursing facility ____ Name of nursing facility _____
 Other living arrangements (please explain) _____

Wishes admission now: Yes No Wishes admission _____
Date

List legal representatives of prospective resident (i.e. agent under a Power of Attorney, court-appointed guardian) and other relatives/contact persons. *(Please attach copy of legal documents)*

Name & Relationship	Address	Telephone-Home	Telephone-Work
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pastor's Name _____ Church Name _____
Church Address _____

MEDICAL INFORMATION

Living Will/Advance Directive: Yes No (*Please attach copy*)

What medical conditions have led to application for nursing care?

Current medications:

Recent hospitalizations/other facility admissions (List dates and reasons for treatment within last five (5) years):

Personal Physician's Name: _____ Phone No. _____

Physician's Address: _____

Other physicians (e.g. cardiologist, neurologist, podiatrist, etc.): _____

FINANCIAL INFORMATION

Please specify all of prospective resident's income and assets (*You will be requested to provide documentation.*)

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

Cash Assets/Investments:	Amount	Bank	Owners
Checking Account(s)	\$ _____	_____	_____
	\$ _____	_____	_____
U.S. Saving Bond(s)	\$ _____	_____	_____
	\$ _____	_____	_____
Savings Account(s)	\$ _____	_____	_____
	\$ _____	_____	_____
Mutual Fund(s)	\$ _____	_____	_____
	\$ _____	_____	_____

Certificate(s) of Deposit

Due Date	Amount	Owners
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

Stocks/Bonds

Name (Company)	Current Value	Owners
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

Real Estate

Type (residential, rental, etc.)	Estimated Value	Owners
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

Life Insurance(s)

Company Name	Face Value	Cash Value	Owners
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Miscellaneous Income

Is any of prospective resident's income paid to another person? (i.e. representative payee)

Yes No Name: _____

Have any of prospective resident's assets been transferred to another person in the past three years?

Yes No If yes, specify amount _____ To whom? _____

Does prospective resident have any outstanding debt (e.g. credit cards, mortgage, etc.)?

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

INSURANCE INFORMATION

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

Medicare: Yes No Medicare Number _____

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 _____

Consistent with the reimbursement regulations of the Commonwealth of Pennsylvania, residents who are or who become beneficiaries of Medical Assistance will be accommodated in semi-private rooms.

OTHER INFORMATION

For what period of time is care requested? _____

Name of ambulance _____ Hospital preference _____

Funeral Home of Choice _____

Prepaid Burial Reserve: Yes No

Financial Institution Where Held _____

Dollar Amount Reserved _____ Is this agreement irrevocable? Yes No

What is/was your occupation? _____

Name of last employer _____

Are you a veteran? Yes No

Diakon’s Mission: 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.

Values: Respect, Stewardship, Service, Quality

Diakon’s Non-Discrimination Policy: Diakon Lutheran Social Ministries and its facilities and programs do not discriminate in admissions, the provision of services, or referrals of clients on the basis of race, color, religious creed, disability, marital status, ancestry, national origin, sexual orientation, age or sex.

All information has been provided to the best of my knowledge. I understand that any misrepresentation or willful omission of information on this application will disqualify the prospective resident from admission and may be cause for discharge if discovered after resident’s admission.

Prospective Resident’s Signature

Date

Person completing form if other than applicant:

Name (*please print*)

Relationship

Signature

Address

Phone