



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