



**TWINING VILLAGE**  
A DIAKON LUTHERAN SENIOR LIVING COMMUNITY

280 Middle Holland Road  
Holland, PA 18966  
Phone: 215.322.6100  
Fax: 215.396.7231  
TTY/TDD: 1.800.654.5984  
(Pa. Relay Service)

**APPLICATION FOR ADMISSION TO AGENCY HOMES**  
*Senior Living Services*



*\*Please attach a copy of the front and back of your medical insurance cards and return to Twining Village with a \$150 per-person application-processing fee.*

**Senior Living Accommodations**

Lifecare       Lease

One-bedroom A  
 One-bedroom B

One-bedroom Standard  
 One-bedroom Deluxe

Large Standard  
 Two-bedroom

**Personal Care**

Studio       One-bedroom

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 \_\_\_\_\_

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 \_\_\_\_\_

# 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.

## 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 Twining Village 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.

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Applicant's Signature

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Power-of-Attorney  
Nearest Relative

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Office use only

Date application was received \_\_\_\_\_

Application received by \_\_\_\_\_

(Staff Person)