Lutheran SeniorLife
St. John Community

Application for Admission

St. John Community
Marketing/Admission Department
P.O. Box 928
500 Wittenberg Way
Mars, PA 16046

724-625-1571
Fax: 724-625-4809

www.lutheranseniorlife.org

Facility of Choice:

- ☐ The Residence at St John Apt.
- ☐ Overbrook Pointe Apartments
- ☐ St. John Specialty Care Center
- ☐ Edgewood Grove Personal Care
- ☐ RoseCrest Assisted Living-Memory Sup.

St John Community

Application Packet Instructions

Please answer all questions on the application.

Note: If a couple are applying for admission, separate applications are required; however, one financial application may be submitted unless the finances are kept separately.

Please check off the required information provided with the application:

____ Proof of assets: Submit recent account statements for:
- Saving & CD's
- Stocks
- IRA's
- Trust information may be requested if applicable

____ Real Estate listing if applicable

____ Long Term Care Insurance Summary page of policy

____ Power of Attorney: HealthCare & Advanced Directive

____ Power of Attorney: Financial

____ Healthcare insurance cards photo identification:
- Medicare card
- Other Health insurance cards (front and back)
- Prescription Drug Plan card or PACE (front and back)

____ Photo Identification

____ Application must be signed by the applicant, or applicant's representative which may the Power of Attorney or the legal guardian

____ Personal Care/Assisted Living & Independent Living, please submit application fees as outlined on the following page.

For questions, please contact the Marketing Department at 724-625-1571

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Demographics

Name of Applicant: _____
Last First Middle

Permanent Address: _____
Street/Box # Apt. County

_____ Home #: _____
City State Zip Cell #: _____

E-mail: _____

Current Location (if different from above):

Own Home☐ Family Home☐ Personal Care ☐ Nursing Facility ☐ Other _____

Facility Name: _____
(if applicable)

Address: _____
Street/Box # Apt. County

_____ Home #: _____
City State Zip Cell#: _____

Date of Birth: _____ Social Security #: _____

Medicare #: _____

Primary Insurance _____

Policy #: _____ Group #: _____

Secondary Insurance _____

Policy #: _____ Group #: _____

Other Insurance: _____

Prescription Drug Plan: _____
Name Policy #

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Ambulance Membership? No ☐ Yes ☐ Name_____

Are you eligible for VA benefits? No ☐ Yes ☐

If the applicant is a veteran or the widow of a veteran, please call the Veterans Administration Office to inquire about possible eligibility for benefits. The toll-free number is 1-800-362-8262.

Race:		Marital Status:	
☐	White, Not of Hispanic Origin	☐	Married
☐	Black, Not of Hispanic Origin	☐	Widowed
☐	Hispanic	☐	Divorced
☐	American Indian/Alaskan Native	☐	Separated
☐	Asian/Pacific Islander	☐	Never Married

Name of Spouse: _____ If deceased, date: _____

Religious Affiliation: _____

Background Check

A background check is required for each individual entering St. John Community.

Your signature below authorizes a background check to be completed.

I hereby authorize the release of the requested information.

_____ _____

Signature Date

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Person holding **Durable Power of Attorney – <u>Healthcare/Medical</u>** ☐ N/A

_____
Name Relationship

_____
Address City State Zip code

_____ _____ _____
Home Phone Work Phone Cell Phone

E-mail: _____

It is strongly recommended that each resident appoint a Durable Power of Attorney and designate your wishes through a Living Will prior to admission.

Person holding **Durable Power of Attorney - <u>Financial</u>** ☐ N/A

_____
Name Relationship

_____
Address City State Zip code

_____ _____ _____
Home Phone Work Phone Cell Phone

E-mail: _____

Resident Representative: _____
Name Relationship
(Person who resident designates to receive billing statements or handles resident's funds for facility payment)

_____
Address City State Zip code

_____ _____ _____
Home Phone Work Phone Cell Phone

E-mail: _____

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Emergency Contacts:

Note: The facility will contact one person in an emergency. In turn, that person is responsible for contacting alternate contacts. Please submit additional contacts on a separate sheet of paper.

Contact #1:

_____
Name Relationship

_____
Address City State Zip code

_____ _____ _____
Home Phone Work Phone Cell Phone

E-mail: _____

Spouse: _____Phone: _____

Contact #2:

_____
Name Relationship

_____
Address City State Zip code

_____ _____ _____
Home Phone Work Phone Cell Phone

E-mail: _____

Spouse: _____Phone: _____

Primary
Care Physician: _____ Phone: _____

Hospital of Choice: _____

Funeral Home: _____ Phone: _____

Funeral Home Address: _____

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Financial Application

Date: _____

Last Name	First Name	Middle Initial

Street Address

City	State	Zip code

STATEMENT: Each resident who is admitted must give evidence of his/her ability to pay. Each resident must represent and warrant that no action has been, or will be taken to dispose of, or transfer any assets for less than fair market value, or take any other action, or inaction, which would disqualify the resident for governmental or third party assistance programs.

Please do not leave any blank spaces. Write a zero or 'N/A' where appropriate. Thank you.

Long-Term Care Policy: (name) _____

Benefit period (years): _____
Personal Care daily benefit: $_____
Nursing daily benefit: $_____

Life Insurance Policy (Applicant #1)

Name of Beneficiary: _____ Value: _____

Life Insurance Policy (Applicant #2)

Name of Beneficiary: _____ Value: _____

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APPLICANT #1:

I. **INCOME**: (Please declare all monthly income.)

Applicant #1	
SOURCE	AMOUNT PER MONTH
Social Security	$
Pension	$
Rental/Mortgage Income	$
Other Income (Rentals, trusts, etc…)	$
TOTAL	$

Explain any change in the event of either spouse's death:

_____

II. **ASSETS:** Please declare all assets. (Assets refer to anything that is not monthly income.)
Attach a copy of statements for the most recent month with the applicant's name shown.

Applicant #1			
TYPE	VALUE	Dividends/ Interest	% APR
Primary Residence (If on the market- please list anticipated net profit)	$		
Savings/ CDs	$		
Annuity	$		
Stocks, Bonds, IRAs	$		
Other (Please list)	$		
TOTAL	$		

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APPLICANT #2:

☐ N/A- there is only 1 applicant

I. **INCOME**: (Please declare all monthly income.)

Applicant # 2	
SOURCE	AMOUNT PER MONTH
Social Security	$
Pension	$
Rental/Mortgage Income	$
Other Income (Rentals, trusts, etc…)	$
TOTAL	$

II. **ASSETS:** Please declare all assets. (Assets refer to anything that is not monthly income.)
Attach a copy of statements for the most recent month with the applicant's name shown.

Applicant #2			
TYPE	VALUE	Dividends/ Interest	% APR
Primary Residence (If on the market- please list anticipated net profit)	$		
Savings/ CDs	$		
Annuity	$		
Stocks, Bonds, IRAs	$		
Other (Please list)	$		
TOTAL	$		

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III. **LIABILITIES:** (Please declare all liabilities that would infringe upon your ability to pay for your care at this facility.)

TYPE	AMOUNT
Mortgage, Insurance, Taxes	$
Personal Debts	$
Monthly Health Insurance Premium/ Long-Term Care Policy	$
Monthly Medication Expense	$
TOTAL	$

Have you set up an Irrevocable Trust? No ☐ Yes ☐ Date:_____

Have you transferred any real or personal property in the past five years? No ☐ Yes ☐
If YES, all dates and property values must be listed:

_____

Have you made any gifts of money or securities in the past five years? No ☐ Yes ☐
If YES, all dates and values of gifts must be listed:

_____

I hereby attest that the information stated herein is true and correct. I hereby agree that prior to my move to the facility and each year thereafter, I will submit an updated financial application.

Resident Representative **Applicant #1 /Date**

Resident Representative **Applicant #2 /Date**

DISCRIMINATION IS AGAINST THE LAW

Lutheran SeniorLife does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (including pregnancy, sexual orientation, gender identity, and sex characteristics), age, or disability.

Lutheran SeniorLife:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact: **Corporate Compliance Office**

If you believe that Lutheran SeniorLife has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Corporate Compliance Officer
Lutheran SeniorLife
191 Scharberry Lane
Mars, PA 16046
724-742-2295 (phone)
724-772-2960 (fax)

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the **Corporate Compliance Officer** is available to help you.

You can also file a civil rights complaint with the U. S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaints Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, S W
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-368-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

English: **ATTENTION**: If you do not speak or understand English, language assistance services, free of charge, are available to you. Call (724) 742-2295 (TTY Relay Services 711)

Español: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-724-742-2295 (TTY: 711). (Spanish)

Italiano: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-724-742-2295 (TTY: 711). (Italian)

Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-724-742-2295 (TTY: 711). (German)

le français: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-724-742-2295 (TTY: 711). (French)

Pennsilfaanisch Deitsch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-724-742-2295 (TTY: 711). (Pennsylvania Dutch)

汉语/漢語: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-724-742-2295 (TTY: 711).(Chinese)

Ру́сский язы́к: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-724-742-2295 (TTY: 711). (Russian)

język polskih: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-724-742-2295 (TTY: 711). (Polish)

한국어/조선말: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-724-742-2295 (TTY: 711)번으로 전화해 주십시오. (Korean)

tiếng Việt: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-724-742-2295 (TTY: 711). (Vietnamese)

العَرَبِيَّة (724) 742-2295 (TTY 711) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم رقم (Arabic)

Ελληνικά: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-724-742-2295 (TTY: 711). (Greek)

українська мова: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-724-742-2295 (TTY: 711). (Ukrainian)

Nederlands: AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-724-742-2295 (TTY: 711). (Dutch)

हिन्दी: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (724) 742-2295 (TTY 711) पर कॉल करें। (Hindi)