ADMISSION APPLICATION

LUTHERAN CARE CENTER AT CONCORD VILLAGE
965 Dutchess Turnpike – Poughkeepsie – NY 12603
Phone (845) 486-9494 - Fax (845) 486-9498

It is our policy to prohibit discrimination on the basis of race, creed, color, national origin, handicap, blindness, sex, age, source of payment, marital status, sexual preference, sponsorship or any other legally protected status in the admission, retention and care of residents.

Applicant's Name: _____ ***SS#:*** _____

Address: _____ ***Phone:*** _____

Last Tax Paying Address:_____

Age: _____ ***Gender:*** __***Male*** __***Female*** ***Birth Date:*** _____ ***Birth Place:*** _____
US Citizen: __ ***yes*** __ ***no*** ***Veteran:*** __ ***yes*** __ ***no***

Current Marital Status: __ ***Married*** __ ***Single*** __ ***Widowed*** __ ***Divorced*** __ ***Separated***
__ ***Companion/Partner***

Is Spouse living? __ ***no*** __ ***yes*** __ ***not applicable*** ***If yes, name:*** _____
Address: _____
_____

If the applicant has been a resident of another skilled nursing facility, provide name and dates:
_____
_____

RELATIVE/SIGNIFICANT OTHERS TO BE CONTACTED – SPECIFY IN ORDER OF RESPONSIBILITY:

1. ***Name:*** _____ ***Relationship:*** _____

Address: _____

Home Telephone: _____ ***Cell Phone:*** _____
Email Address:_____

Does this person have: Power of Attorney? __ ***yes*** __ ***no HCP?*** __ ***yes*** __ ***no***

2. ***Name:*** _____ ***Relationship:*** _____

Address: _____

Home Telephone: _____ ***Cell Phone:*** _____
Email Address:_____
Does this person have: Power of Attorney? __ ***yes*** __ ***no HCP?*** __ ***yes*** __ ***no***

CURRENT MEDICAL INSURANCE INFORMATION:

Medicare *__ yes __ no*
Policy # _____Effective Date: Part A _____ Part B _____

Managed Medicare *__ yes __ no*
Name of Carrier _____Policy # _____ Effective Date _____
If the applicant has managed Medicare, please indicate the following:
Contact Phone Number: _____

Supplemental to above *(for example, BC/BS, AARP, etc.) __ yes __ no*
Name of Carrier:_____ Policy # _____
Does this supplement provide coverage for skilled nursing care? __ yes __ no
Details:_____

Insurance Other than above*: __ yes __ no*
Name of Carrier:_____ Policy #_____
Contact Phone Number: _____
Prescription Drug Coverage: __ yes __ no
Name of Carrier:_____ Policy # _____

Medicaid: *__ yes __ no __pending (date submitted _____)*
If yes: Number: _____ County: _____
Name of Medicaid Worker: _____ Phone: _____

Long Term Care Insurance *__ yes __ no*
Name of Carrier:_____ Policy # _____
Details of Coverage: _____

FINANCIAL DISCLOSURE

Monthly Income	*Applicant*	*Spouse*	*Where Sent or Deposited?*
Social Security	*$_____*	*$_____*	*_____*
Pension	*$_____*	*$_____*	*_____*
Dividends/Interest	*$_____*	*$_____*	*_____*
Annuities	*$_____*	*$_____*	*_____*

Other Income $_____ $_____ _____
Checking Account Name & Address of Bank: _____
Account # _____ Name(s) on Account _____
Balance: $_____ On Date: _____
Comments if needed:
_____
_____
_____

Savings Accounts, Certificates of Deposit, Money Market Funds, Stocks:

1. Name & Address of Bank _____
Account #: _____
Name(s) on Account: _____
Balance: $ _____ On Date: _____

2. Name & Address of Bank _____
Account #: _____
Name(s) on Account: _____
Balance: $ _____ On Date: _____

3. Annuity /401K/IRA _____
Account #: _____
Name(s) on Account: _____
Balance: $ _____ On Date: _____

Trusts: __ yes __ no If yes, type: _____
Please provide any other financial asset information that is not noted above:
_____
Life Insurance: Company: _____Policy #: _____Beneficiary: _____
Does Applicant own their home? __ no __ yes (Value $_____)
Name(s) on Deed: _____
Does Applicant own other real estate or property? __ no __ yes
Description: _____ (Value $_____)
Name(s) on Deed: _____
HAS THERE BEEN ANY TRANSFER OF ASSETS (FUNDS, PROPERTY OR REAL ESTATE) WITHIN THE PAST 60 MONTHS? __ yes __ no
If yes, amount and explanation:
_____
Applicant's Attorney Name: _____ Phone: _____
If funeral arrangements have been made, please provide the name, address, and phone number of funeral home:
_____

Please provide copies of the Power of Attorney, Guardianship, Trust, recent bank statements, Social Security card, Medicare card, Medicaid card, other insurance cards, Long Term Care Insurance Policy, and prescription drug card. All copies must be submitted in paper.

MEDICAL DATA
Primary Care Physician: _____ Phone #: _____ Fax #: _____
Current Diagnosis:_____ Past Medical History:_____
_____

NURSING NEEDS
Amount of assistance needed for ambulation: □ Independent □ Assist of 1 □ Assist of 2
Assistive Device: □ Cane □ Walker □ Wheelchair □ None ***Continence***: □ Continent □Incontinent
Behaviors: □ Cooperative □ Wanders □ Combative
Mental Status: □ Alert □ Forgetful □ Understands □ Oriented □ Disoriented

I certify that the information provided is true and accurate.

X _____

Signature of ( ) Applicant ( ) Responsible Person Date_____
Print Name: _____

LUTHERAN CARE CENTER AT CONCORD VILLAGE
Admissions Department
965 Dutchess Turnpike – Poughkeepsie – NY 12603
Phone (845) 486-9494 - Fax (845) 486-9498

Date: _____

Applicant Name:_____

Thank you for your interest in Lutheran Care Center, a 160 bed skilled nursing facility owned and operated by The Lutheran Care Network, a non-sectarian, non-profit organization dedicated to serving the needs of the community.

In order to be considered for admission, it is necessary to complete the enclosed Lutheran Care Center application and return it to us. In addition, a PRI (Patient Review Instrument) and screen must be completed by a qualified nurse and forwarded to us. Also, all copies of financial records must be received. These records include bank statements, pension and social security amounts, investments, assets, etc. We need these documents to determine if application for Medicaid is necessary.

After receipt of documents, we will review the information and determine if the applicant is appropriate for the services we provide.

It is also mandatory that we receive your insurance cards so that we may verify coverage and make copies for our records.

For further information, or to make arrangements for a personal tour of the facility, please contact the Admissions Department at 845-486-9494, ext 234. Admission documents can be faxed to 845-486-9498. Once again, thank you for your interest in Lutheran Care Center.

Sincerely,

Stephanie DiStabile
Director of Admissions
845-554-6411

Notes: (This section is for internal use only)

_____
_____
_____
_____
_____
_____