LUTHERAN CARE CENTER AT CONCORD VILLAGE
Admissions Department
965 Dutchess Turnpike – Poughkeepsie – NY 12603
Phone (845) 486-9494 x234 - 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 Carlisha Derello, Admissions Coordinator, in the Admissions Department at 845-486-9494, ext 234 (office), 845-416-1914 (mobile), or by email at cderello@tlcn.org. Admission documents can be faxed to 845-486-9498. Once again, thank you for your interest in Lutheran Care Center.

Sincerely,

Erica Rosa-Geliga
Director of Admissions
(845) 486-9494 x215 (office)
(845) 554-6411 (mobile)
egeliga@tlcn.org

Notes: (This section is for internal use only)
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ADMISSION APPLICATION

LUTHERAN CARE CENTER AT CONCORD VILLAGE
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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:*___________________________

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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: ____