



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:** _____

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.

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 ☐ Withdrawn ☐ Wanders ☐ Combative

Mental Status: ☐ Alert ☐ Forgetful ☐ Understands ☐ Oriented ☐ Disoriented



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)
