Jewish Home Assisted Living

KAPLEN FAMILY SENIOR RESIDENCE

An Elegant Community

Date:_____

1. GENERAL INFORMATION

A. Applicant

Applicant's Name _____ Age _____

Birth Date _____ Birth Place _____

Social Security No. _____

Medicare No. _____ PAA Drug Card No_____.

Medicare Part D No. _____

Home Address _____

City _____ County _____ State _____ Zip Code _____

Applicant is now at ❑ Home ❑ Hospital ❑ Nursing Home ❑ Other (Specify) _____

Please identify location: Name _____

Address _____

Telephone No. _____

How Long? _____ Own or Rent? _____

Live alone or with others—
Please specify name, age and relationship to Applicant:_____

_____

Primary Language ❑ English ❑ Other (please specify) _____

Is Applicant a U.S. Citizen? ❑ Yes ❑ No If no, explain citizenship status, give date of entry into the U.S.:

_____

Marital Status_____Spouse's Name _____

Is he or she living? ❑ Yes ❑ No If no, date of death:_____

Did you or your spouse serve in the Armed Forces? ❑ Yes ❑ No If yes, please provide:

Branch of Service _____ Dates of Service _____

Religion _____Place of Worship _____

Clergy_____Telephone No. _____

What type of suite are you applying for *(see enclosed fee schedule)*? ❑ Studio ❑ 1 BR ❑ 2 BR ❑ Memory Unit Studio

Do you plan to share this living unit? ❑ Yes ❑ No If yes, with whom?_____

_____

Copies of the following documents must be supplied, if applicable, in order to process this application:

- Applicant's Birth Certificate or Naturalization or Legal Alien Card
- Social Security Card and Award letter Computer Printout
- Medicare Card
- Medicaid Card and Medicaid approval letter

Does the Applicant have a Living Will/Advance Directive or a Medical Power of Attorney? ❑ Yes ❑ No

Does this include a DNR? ❑ Yes ❑ No

If yes, attach copies and

Name of the Medical Power of Attorney _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. Home _____ Business _____

Does the Applicant have a Financial Power of Attorney? ❑ Yes ❑ No

If yes, attach copies and

Name of the Financial Power of Attorney _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. Home _____ Business _____

Note: This person must sign Admission Agreement and complete Addendum thereto.

Does the Applicant have a Legal Guardian? ❑ Yes ❑ No

If yes, please attach copies of Guardianship Papers and

Name of Legal Guardian _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. Home _____ Business _____

Please identify a family member, guardian, responsible person and/or designated community agency to be notified in case of illness, incident or other emergency:

1. Name _____ Relationship to Applicant _____

   Address _____

   City _____ State _____ Zip Code _____

   Telephone No. Home _____ Business _____

2. Name _____ Relationship to Applicant _____

   Address _____

   City _____ State _____ Zip Code _____

   Telephone No. Home _____ Business _____

3. Name _____ Relationship to Applicant _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. Home _____ Business _____

Does the Applicant have children? ❑ Yes ❑ No

If yes, please provide:

1. Name _____ Relationship to Applicant _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. Home _____ Business _____

2. Name _____ Relationship to Applicant _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. Home _____ Business _____

3. Name _____ Relationship to Applicant _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. Home _____ Business _____

4. Name _____ Relationship to Applicant _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. Home _____ Business _____

Attach additional sheets of paper listing the above information for any additional children of the applicant.

Funeral/Burial Arrangements

Name of Funeral Home _____ Telephone No. _____

Name of Undertaker _____

Address _____

Name of Cemetery _____ Telephone No. _____

Address _____

Please attach a copy of any burial contracts or plots.

B. Financial Sponsor/Representative *(Party responsible for making payment)*

Name _____ Relationship to Applicant _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. Home _____ Business _____

Facsimile No. Home _____ Business _____

Will Sponsor/Representative use Applicant's assets as described in Section III to pay for Applicant's care?

❑ Yes ❑ No

If yes, attach copies of any Power(s) of Attorney.

If no, identify what will be the assets or monies used, to pay for Applicant's care? _____

_____

Does Applicant intend to bring a car? ❑ Yes ❑ No

If Yes, describe (year/make/model) _____

II. APPLICANT'S MEDICAL INFORMATION

A. Applicant's Medical History

Current problem/diagnosis _____

How long has this problem existed? _____

Other medical problems _____

Applicant's last hospitalization _____

For what? _____ How long? _____

Has the Applicant ever been hospitalized for a psychiatric diagnosis? ❑ Yes ❑ No

For what? _____ How long? _____

Has the Applicant ever been in a nursing home or assisted living? ❑ Yes ❑ No

If yes, where? _____ How long? _____

Why did the applicant leave the nursing home? _____

_____

Any problems there? _____

_____

_____

Does the Applicant have a personal physician? ❑ Yes ❑ No If yes, please identify:

Physician's name _____ Telephone No. _____

Address _____

Alternative Physician's name _____ Telephone No. _____

Address _____

Does the Applicant have a personal dentist? _____

If yes, please identify:

Dentist's name _____ Telephone No. _____

Address _____

Is the Applicant presently under the care of a psychiatrist? ❑ Yes ❑ No If yes, please identify:

Psychiatrist's name _____ Telephone No. _____

Address _____

Does Applicant intend to bring a pet? ❑ Yes ❑ No Describe _____

Does Applicant smoke? ❑ Yes ❑ No ***NOTE: This is a non-smoking facility**

B. Applicant's Care Needs

Grooms self: ❑ Yes ❑ No Bathes self: ❑ Yes ❑ No Dresses self: ❑ Yes ❑ No Feeds self: ❑ Yes ❑ No

Physical mobility: ❑ Walks unassisted ❑ Needs assistance ❑ Uses cane
❑ Uses walker ❑ Uses wheelchair ❑ Propels own wheelchair
❑ Bed bound

Is the Applicant continent? ❑ Yes ❑ No ❑ Bladder ❑ Bowel ❑ Both

Does the Applicant need assistance with toileting? ❑ Yes ❑ No

Does the Applicant wear glasses? ❑ Yes ❑ No

Date of last eye exam_____

Does the Applicant need catheter? ❑ Yes ❑ No Oxygen? ❑ Yes ❑ No Feeding Tube? ❑ Yes ❑ No

Receiving wound care? ❑ Yes ❑ No

Does the Applicant have any physical deformities that require special care and attention? ❑ Yes ❑ No

If yes, please describe _____

_____

C. Applicant's Mental Status

Is the Applicant alert? ❑ Yes ❑ No Confused? ❑ Yes ❑ No

Is the Applicant depressed or withdrawn? ❑ Yes ❑ No

Does the Applicant wander? ❑ Yes ❑ No

Does the Applicant have outbursts of temper? ❑ Yes ❑ No

Does the Applicant have episodes of crying, screaming or yelling? ❑ Yes ❑ No

Does the Applicant generally get along well with others? ❑ Yes ❑ No

Does the Applicant enjoy conversation? ❑ Yes ❑ No

Does the Applicant enjoy activities? ❑ Yes ❑ No

Please describe the activities that Applicant enjoys _____

_____

State any other significant event or occurrence about the Applicant's mental condition
(or anything else the Facility should know about the applicant's mental condition):_____

_____

_____

_____

All applications for those individuals currently hospitalized or living in another facility must include a preliminary transfer sheet including recent medical consultations.

III. APPLICANT'S FINANCIAL INFORMATION

A. Current Income/Benefits

PLEASE FURNISH COPY OF MOST CURRENT TAX RETURN.

	Monthly	Annually	Name of Recipient or Potential Recipient and from what Company/Source Name, Address and Phone No.
Social Security	$	$	
Pension Government Private	 $ $	 $ $	
Annuity(ies)	$	$	
Interest	$	$	
Reparations	$	$	
Veterans Benefits	$	$	
Railroad Retirement	$	$	
Sup. Security Income (SSI)	$	$	
Fed. Civil Service Annuity	$	$	
Unemployment Compensation (UIB)	$	$	
Workers' Compensation	$	$	
Sick or Disability Payments	$	$	
Strike Benefits	$	$	
Military Allotments	$	$	
Payment from Boarders	$	$	
Public Assistance	$	$	
Black Lung Benefits	$	$	
Dividends, Royalties, etc.	$	$	
Estates/Trusts	$	$	
Rents	$	$	
Other Income (i.e. cash support such as child/alimony, inheritance, gifts, winnings, wages, benefits, etc.)	$	$	
Total Income	$	$	

B. Assets

PLEASE ATTACH COPY(IES) OF MOST RECENT ACCOUNT STATEMENTS FOR ITEMS BELOW IN ORDER FOR THIS APPLICATION TO BE PROCESSED.

	Name of Bank/Institution/Person, Address & Phone Number & Account or Certificate Number(s) & Ownership (i.e., Joint, Self, etc.)	Total Value (As of Date of Application)
Cash, both on hand and monies held for Applicant by third party(ies)		$
Checking Account(s)		$
Savings Account(s)/Savings & Loan (including Certificates of Deposit, Money Market, Funds, Savings Certificates, Christmas, Vacations or other Club Savings Accounts, etc.)		$ $ $ $ $
U.S. Savings Bonds or other Stocks and Bonds or other Securities		$ $ $
Trust Funds		$
IRA, Keogh or other similar tax deferred income		$ $ $
Notes or other contracts of value		$
Tangible Personal Property including such things as art, antiques, etc.—identify items, value and location		$
Credit Union Membership		$
Mutual Funds		$ $ $
Vehicles		$
Other		$ $
Total:		$

Broker/Agent's Name _____

Address _____ Telephone No. _____

Does the Applicant have any pending claims such as lawsuits, divorce settlements, inheritance, accident claims, sale of property, other claims or does anyone owe Applicant money? ❑ Yes ❑ No

If yes, provide details _____

_____

_____

Attorney's Name _____ Telephone No. _____

Real Estate

1. I own the following real estate situated in the town/city of _____

   County of _____ State of _____

   Description (i.e., residential home, land, etc.) _____

   _____

   Estimate Market Value $_____

   The property is owned by: _____

2. I own the following real estate situated in the town/city of _____

   County of _____ State of _____

   Description (i.e., residential home, land, etc.) _____

   _____

   Estimate Market Value $_____

   The property is owned by: _____

The following mortgages are on the property listed above as #1 and/or #2:

1. Bank _____

   Address _____

   Mortgage _____

   Amount _____

2. Bank _____

   Address _____

   Mortgage _____

   Amount _____

Please attach copies of deeds for the above property in order for this application to be processed.

C. Insurance

1. Life Insurance

Insurance Company Name _____

Policy No._____

Face Value_____ Cash Value _____

Name of Policy Holder _____

Name of Insured_____

Named Beneficiary(ies) and relationship to the Insured _____

_____

Contingent Beneficiary(ies) and relationship to the Insured _____

_____

Please attach copies of any policies in order for this application to be processed.

Applicant named as Beneficiary on other's insurance policy? _____

If yes, name and relationship to Applicant _____

2. Long Term Care Insurance

Insurance Company Name _____

Policy No._____

Name of Insured_____

Please attach copies of any policies in order for this application to be processed.

3. Medical Insurance

a. Insurance Company Name and Address _____

_____

Name of person carrying coverage for Applicant _____

Type of coverage (ex: Part A, Part B, Part D, Catastrophic, etc.) _____

Policy/Certificate Number _____

b. Insurance Company Name and Address _____

_____

Name of person carrying coverage for Applicant _____

Type of coverage (ex: Part A, Part B, Part D, Catastrophic, etc.) _____

Policy/Certificate Number _____

Copy of last bill(s) must be attached with application.

C. Liabilities as of Date of Application

	Description	Amount	Payable to What Bank, Person, etc.
Notes		$	
Loans		$	
Mortgages		$	
Unpaid Bills		$	
Other		$	
Total Liabilities		$	

IV. PAYMENT INFORMATION

Will the Applicant pay for stay with his/her own funds? ❑ Yes ❑ No

Has the Applicant applied for Medicaid or Public Assistance? ❑ Yes ❑ No

If yes, provide Medicaid No. _____

If Applicant has received one, provide a copy of the Medicaid Approval Letter. ❑ Yes ❑ No

Date of Application to Medicaid _____

Caseworker's name _____

Where _____ Telephone No. _____

Has the Applicant received required medical approval from Medicaid? ❑ Yes ❑ No

If yes, PAS # _____

Has the Applicant been denied for medicaid or Public Assistance? ❑ Yes ❑ No

If yes, attach copy of denial letter.

V. MISCELLANEOUS INFORMATION

Is the Applicant aware of this application and agreeable to placement? ❑ Yes ❑ No

Can s(he) be contacted regarding status of application? ❑ Yes ❑ No

Please check appropriate box:

❑ I am ready for immediate placement when a bed becomes available.

❑ I am not ready for immediate placement when a bed becomes available.

CERTIFICATION

I understand no application is considered for admission until all requested information is furnished. I agree, if admitted, to abide by the rules, regulations and policies of the Jewish Home Assisted Living Kaplen Family Senior Residence.

I represent that to the best of my knowledge the above statements and information are true and correct.

Witness

Signature of Applicant

Print Name

Date

Witness

Signature of Representative

Print Name

Date

Jewish Home Assisted Living
KAPLEN FAMILY SENIOR RESIDENCE
An Elegant Community

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