# Healthcare or Personal Care Center Application

Please specify the level of care for which you are applying: ☐ Health Care ☐ Memory Care (Telford only) ☐ Personal Care

Please specify which Community you are interested in:

☐ Lutheran Community at Telford ☐ The Community at Rockhill ☐ Open to both or either

Last Name: First Name:

Middle Name: Social Security Number:

Prefers to be called: Primary Language Spoken:

Date of Birth: Age: Place of Birth:

Street Address:

City: State: Zip Code:

Home Phone Number: Mobile Phone Number:

Email Address:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

U.S. Citizen: ☐ Yes ☐ No Veteran: ☐ Yes ☐ No

Are you licensed to drive? Would you bring a car?

***Spouse***

Last Name: First Name:

Middle Name: Social Security Number:

Prefers to be called: Primary Language Spoken:

Date of Birth: Age: Place of Birth:

**Admitted From**

Facility/Home/Other:

Phone Number: Dates of Stay:

Primary Physician Name: Phone Number:

Address:

| **Health Insurance Information** | **Applicant** | **Spouse** |
|---|---|---|
| **Medicare Beneficiary ID Number** | | |
| **Medicaid Access Number** | | |
| **Supplemental Insurance** | | |
| Policy Number | | |
| **Insurance (Other than Medicare)** | | |
| Policy Number | | |
| **Medicare Plan D** | | |
| Company | | |
| Policy Number | | |
| **Long-Term Policy Company** | | |
| Policy Number | | |
| Benefit Amount | | |
| Benefit Period (number of years or lifetime) | | |

| **Financial Information** | **Applicant** | **Spouse** |
|---|---|---|
| Social Security (per month) | | |
| Pension (per month) | | |
| Annuity (per month) | | |
| Trust Income (per month) | | |
| Rental (per month) | | |
| Dividends (per month) | | |
| Other Income (per month) Please describe: | | |

| **Assets (must include spouse assets if applicable)** | | **Joint** | **Applicant** | **Spouse** |
|---|---|---|---|---|
| **Checking Account Bank:** | | $ | $ | $ |
| **Savings Account Bank:** | | $ | $ | $ |
| **Certificates of Deposit** | | | | |
| Bank: | Matured Value: | $ | $ | $ |
| Bank: | Matured Value: | $ | $ | $ |
| **IRA** | | | | |
| **Stocks & Bonds:** | | | | |
| Description: | Current Value: | $ | $ | $ |
| Description: | Current Value: | $ | $ | $ |
| Description: | Current Value: | $ | $ | $ |

| **Real Estate (type & location)** | Current Value: | $ | $ | $ |
|---|---|---|---|---|

Do you intend to liquidate this resource and make the funds available to pay for the cost of your health care facility expenses? ☐ Yes ☐ No (please explain below)

| **Life Insurance Policies** | **Applicant** | **Spouse** |
|---|---|---|
| **Company** | **$** | **$** |
| **Policy** | **$** | **$** |
| **Face Value** | **$** | **$** |
| **Cash Value** | **$** | **$** |

| **Debts/Monthly Expenses** | **Joint** | **Applicant** | **Spouse** |
|---|---|---|---|
| **Mortgage** | **$** | **$** | **$** |
| **Line(s) of credit** | **$** | **$** | **$** |
| **Credit Card(s)** | **$** | **$** | **$** |
| **Health Insurance** | **$** | **$** | **$** |
| **Long Term Care Insurance** | **$** | **$** | **$** |
| **Prescriptions** | **$** | **$** | **$** |
| **Other** | **$** | **$** | **$** |

**Funeral/Burial Arrangements**

Have funeral burial arrangements been made? ☐ Yes ☐ No Date Established:

If yes, are arrangements paid in full and irrevocable? ☐ Yes ☐ No

Funeral Home: Value of Account:

Within the past 5 years have you (or your spouse) closed, given away, sold or transferred any assets such as: home, land, personal property, life insurance policies, annuities, bank accounts, certificates of deposit, stocks, IRA, bonds, trust funds or right to income? (This includes assets jointly held with another person that are no longer in your name). ☐ Yes ☐ No

If yes, please explain circumstances:

Have you (or your spouse) established a trust or added any money to a trust within the past 5 years? ☐ Yes ☐ No

If yes, please explain circumstances:

**Contact Information – Please list in priority order**

Name #1:

Address:

City: State: Zip:

Home Phone: Work Phone:

Mobile Phone: Email Address:

Power of Attorney Type: ☐ Health Care (please attach) ☐ Financial (please attach) ☐ Neither

Name #2:

Address:

City: State: Zip:

Home Phone: Work Phone:

Mobile Phone: Email Address:

Power of Attorney Type: ☐ Health Care (please attach) ☐ Financial (please attach) ☐ Neither

**Complete if different from above.**

**Durable Power of Attorney – Finances (please attach)**

Name: Relationship:

Address:

City: State: Zip:

Home Phone: Work Phone:

Mobile Phone: Email Address:

**Durable Power of Attorney – Medical (please attach)**

Name: Relationship:

Address:

City: State: Zip:

Home Phone: Work Phone:

Mobile Phone: Email Address:

Do you have a living will or advanced directive? ☐ Yes ☐ Not presently *(If yes, please attach.)*

Once an applicant has been accepted as a resident of a Grace Inspired Living Community will not terminate the residential status for financial reasons. However, a Grace Inspired Living Community expects, and the applicant understands, that all financial information provided is accurate and current. Any change or transfer to another person or entity of the applicant's assets or any change by the applicant in the value of his or her assets made without the knowledge and consent of a Grace Inspired Living Community will be considered as a change of status and a basis for reevaluation of applicant's (or resident's) status and right to be or remain a resident.

I, _____, submit the attached information for admission to a Grace Inspired Living Community, and so declare and affirm that the facts contained therein are true and correct to the best of my information, knowledge, and belief. Further, I do hereby declare that I have read, and understand the admission and application policies governing residence in a Grace Inspired Living Community and agree to accept and be governed by them and any amendments thereto, without reservation.

Upon notice of acceptance and at or before entrance in a Grace Inspired Living Community, I will comply with the financial requirements of the plan of admission for which I have been approved and will be admitted and will complete any and all other forms or documents that may be required.

Signature: _____ ☐ Applicant ☐ POA ☐ Other

Date: _____

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*Internal Use Only*

Level of Care at time of application: _____

Date application received by Grace Inspired Living Community: _____

Reviewed by: _____

Decision/Determination: _____