

Resident Information

Memory Care Application Date

Name: _____

Current Address: _____

City, State, Zip: _____

Social Security Number _____ Age: _____ Birthdate: _____

Sex: M F Marital Status: Single Married Widowed Divorced

Why are you currently seeking placement? _____

POA for Health Activated: Yes No

Name: _____ Relationship _____

Address _____

City, State, Zip: _____

Telephone: Home _____ Work _____ Cell _____

Email: Home _____ Work _____

POA for Finance / Guarantor

Name: _____ Relationship _____

Address _____

City, State, Zip: _____

Telephone: Home _____ Work _____ Cell _____

Email: Home _____ Work _____

Primary Physician

Name: _____

Telephone: Office _____ Fax No: _____

Address _____

City, State, Zip: _____

Other Physicians

DENTIST _____ Phone # _____

EYE DOCTOR _____ Phone # _____

PODIATRIST _____ Phone # _____

PSYCHIATRIST _____ Phone # _____

OTHER SPECIALISTS _____ Phone # _____

Current Diagnosis: _____

Have you been hospitalized in the last 12 months? **YES** **NO**

HOSPITAL PREFERENCE _____

FUNERAL HOME PREFERENCE _____

RELIGIOUS PREFERENCE/CHURCH _____

EMERGENCY CONTACTS

Please list all applicable phone numbers, i.e. home, work, cell etc., and email addresses if we may contact you by email

Emergency Contact #2: _____ Relationship _____

Address _____

City, State, Zip: _____

Telephone: Home _____ Work _____ Cell _____

Email: Home _____ Work _____

Emergency Contact #3: _____ Relationship _____

Address _____

City, State, Zip: _____

Telephone: Home _____ Work _____ Cell _____

Email: Home _____ Work _____

INSURANCE INFORMATION

Medicare Number _____

MEDICARE: YES NO **MEDICARE B:** YES NO

SUPPLEMENTAL COVERAGE: YES NO **If yes, indicate carrier**

Insurance Carrier _____

Policy # _____

ADDITIONAL INSURANCE PLANS

(i.e. Long-Term Care; Dental)

Company Name: _____

Policy #: _____

Company Name: _____

Policy #: _____

CONFIDENTIAL

FINANCIAL INFORMATION FOR APPLICANT:

Do you rent _____ Own your home _____ Approximate Value \$ _____

FIXED MONTHLY INCOME:

Social Security \$ _____

Private Pensions \$ _____

Annuities or Trust Funds \$ _____

TOTAL \$ _____

MONTHLY INCOME FROM OTHER SOURCES:

Interest and CD Earnings \$ _____

Dividend from Stocks, Bonds
Securities and Other Sources \$ _____

TOTAL \$ _____

ASSETS:

Cash (savings, CD's
& checking) \$ _____

Stocks, Bonds &
Mutual Funds \$ _____

Other \$ _____

Real Estate/Property
(other than home) \$ _____

Totals \$ _____

LIABILITIES:

Mortgages \$ _____

Personal
Loans \$ _____

Other
Obligations \$ _____

\$ _____

By signing this form, I represent and warrant that the above information is true and correct and accurately reflects the funds that are available to provide for my care. I understand that Lutheran Home Health Care Services is relying on the above information and that providing false information may result in the termination of any agreement to provide care.

Signature of Authorized Representative

Date