

APPLICATION FOR SHORT TERM REHAB ADMISSION

MR#: _____
RM#: _____
Date: _____

Name: _____ Last First Initial

Address: _____ City, State, Zip: _____

Phone #: _____ Email: _____

SS#: _____ County of Residence: _____ FY||]cb.SSSSSSSSSSSSSSSSSSS

Date of Birth: _____ Age: _____ Sex: A M W D Marital Status: S M W D

Medicare :# _____ Medicaid #: _____

Medicare Supplement Provider _____

Policy #: _____ Group #: _____

Medicare Replacement Policy Provider _____

Policy #: _____ Group #: _____

Other Insurance Plans (i.e. Long Term Care/Medicare D) _____

Primary Physician: _____ Staff Physician Assigned: _____

Please attach/bring copies of insurance cards to application to ensure accurate billing

HOSPITALIZATIONS

Have you been hospitalized and/or in a skilled nursing facility in the last 12 months? Yes No

If yes, please complete the following information:

Acute Hospital: _____ Admit Date: _____ Discharge Date: _____

Skilled Nursing Facility: _____ Admit Date: _____ Discharge Date: _____

Resident is now at: _____ Admit Date: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Business/Cell Phone: _____

Email: _____

Name: _____ Relationship: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Business/Cell Phone: _____

Name: _____ Relationship: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Business/Cell Phone: _____

CONFIDENTIAL FINANCIAL STATEMENT

MONTHLY INCOME

Social Security \$ _____ Pension \$ _____
Investment Income \$ _____ Other* \$ _____

*Please describe other income _____

ASSETS

Checking Accounts \$ _____ Savings Accounts (CD's \$ _____
Money Market)
Investments (Stocks, Bonds, Mutual Funds, Annuities, IRA's) \$ _____ Real Estate \$ _____

Do you own your home? Yes No
If yes, is it in your name? Yes No

Do you currently have a mortgage, home equity loan, reverse mortgage, line of credit or lien on your home?
Yes, amount owed: _____ No

Do you have any other significant liabilities such as outstanding credit balances, medical bills?
Yes, amount owed: _____ No

Have you given away or sold any assets/resources within the last three (5) years (i.e. cash, real estate, cars)?
Yes, type of asset/resource: _____ No

Have you set up or funded a trust in the last five (5) years?
Yes, type of trust: _____ No

Do you have a Healthcare Power of Attorney? Yes No Name: _____

Do you have a Financial Power of Attorney? Yes No Name: _____

Do you have a court-appointed legal guardian? Yes No Name: _____

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 is relying on the above information and that providing false information may result in the termination of any agreement to provide care.

Signature (Resident or Authorized Representative) Date