Luther Park Community
Embracing the aging experience with Christian compassion.

Trinity Center
At Luther Park
www.lutherparkcommunity.org

APPLICATION FOR ADMISSION

The information contained in this application will be held in strict confidence. This application does not constitute any guarantee of admission. However, upon admission, the application becomes a part of the Admission Agreement. Please complete the application in its entirety including the financial statement on the following pages. Information should be only for the person being admitted.

APPLICANT:

❑ Mr. ❑ Mrs. ❑ Miss _____

Applicant

_____
Current Address | Phone with area code/Cell Number

_____
City | State | Zip Code | County

_____
Date of Birth | Birth Place/State | Age

MARITAL STATUS (Check One) ❑ Single ❑ Married ❑ Widowed ❑ Divorced

_____
Social Security Number | Medicare Number | Medicaid Number

_____
List Co-Insurances | Name, Address, City, State Zip Code | Policy Number (s)

CHURCH:

_____
Name of Church | Name of Pastor

_____
Address | *City, State* | *Zip Code* | *Phone with area code*

HAVE YOU OR YOUR SPOUSE EVER SERVED IN THE ARMED SERVICES? You: ❑ Yes ❑ No
Spouse: ❑ Yes ❑ No

HOW DID YOU HEAR ABOUT US? ❑ Friend ❑ Internet ❑ Phone Book ❑ Advertisement

❑Other_____

PHYSICIANS:

_____
Name | Street Address/PO Box | City, State Zip | Phone with area code

_____
Name | Street Address/PO Box | City, State Zip | Phone with area code

DENTIST:

_____
Name | Street Address/PO Box | City, State Zip | Phone with area code

PHARMACY:

_____
Name | Street Address/PO Box | City, State Zip | Phone with area code

HOSPITAL:

Name | Street Address/PO Box | City, State Zip | Phone with area code

RESIDENT IS BEING ADMITTED FROM: _____

RESIDENT WAS REFERRD BY: _____

DESCRIBE PATIENT ILLNESS: _____

PREVIOUS STAY IN NURSING HOME: _____ Skilled Care _____ Intermediate Care
Date Date

DOES APPLICANT HAVE THE FOLLOWING? ***IF MARKED "YES", PLEASE PROVIDE COPIES OF THE DOCUMENTS***.

DOCUMENT	**Yes**	**No**	**Name of POA's, Conservator, Guardian**
Living Will			
***Physician statement enacting POA's**			
General Power of Attorney			
Healthcare Power of Attorney			
Financial Power of Attorney			
Conservator			
Guardian			
Pre-paid Burial			

FUNERAL HOME PREFERENCE

Name | Street Address/PO Box | City, State Zip | Phone with area code

IN CASE OF AN EMERGENCY, PLEASE NOTIFY THE FOLLOWING (*PLEASE LIST IN ORDER OF PREFERENCE*):

Name, Mailing Address, PO BOX City, State, Zip	Relationship	Phone numbers with Area Code Work, Home, Cell

PERSON RESPONSIBLE FOR ACCOUNT (*PLEASE PROVIDE DOCUMENTATION OF FINANCIAL P.O.A.*)

Name, Mailing Address, PO BOX City, State, Zip	Relationship	Phone numbers with Area Code Work, Home, Cell

FINANCIAL STATEMENT *(FOR APPLICANT ONLY)*

MONTHLY INCOME:

1. Social Security	$ _____
2. Pension	$ _____
3. Interest and Dividends	$ _____
4. Other Income (Describe)	$ _____
_____	$ _____
_____	$ _____
MONTHLY TOTAL (Add lines 1 through 4:)	$ _____

ASSETS AND LIABILITIES:

A. Assets owned jointly and separately by the admitting applicant and other person(s) which are available to the applicant only:

1. Real Estate	$ _____
2. All other assets (i.e., stocks, bonds, mutual funds, savings accounts, Certificate of Deposits, etc.)	$ _____
3. Less: Off-Setting Liabilities (If not already included above.)	$ _____
Net Assets owned which are available to the applicant only.	$ _____

B. Other assets in which the admitting applicant has an interest (Describe property and interest held):

_____

_____

C. Nursing Home Insurance (*for the admitting applicant only*)

_____
Name of Insurance Company

_____
Street Address/Box Number, City State Zip Code Phone with area code

_____
Policy Number (s)

$ _____ PER DAY FOR _____ YEARS

I certify that the information I have provided in the foregoing application is true and correct and that I am signing as the responsible party. I have either been authorized to provide the information contained in this application or am acting as the applicant's guardian and/or conservator. I understand that Trinity Center at Luther Park Community is relying on the accuracy of the information provided in this application in order to make a decision on admission. I understand and agree that any misrepresentation of any information provided in this application is grounds for rejection of this application. I further understand and agree that if any misrepresentation of any information provided in this application is discovered after admission, and admission would not have been granted if the correct information had been provided, or if it is discovered after admission that assets have been transferred which materially alter the applicant's personal net worth, Trinity Center at Luther Park Community reserves the right to pursue any legal, equitable, or other remedies it may have against the applicant and/or responsible party signing the application below on behalf of the applicant.

I further understand that Trinity Center at Luther Park Community is committed to promoting good health and safety among its residents and, therefore, **SMOKING BY RESIDENTS IS PROHIBITED ON FACILITY PROPERTY.**

By: _____
SIGNATURE OF APPLICANT AND/OR RESPONSIBLE PARTY

Date: _____